Medicare Payment Advisory Commission

425 I Street, NW · Suite 701
Washington, DC 20001
202-220-3700 · www.medpac.gov

Michael E. Chernew, Ph.D., Chair
Amol Navathe, M.D., Vice Chair
James E. Mathews, Ph.D., Executive Director

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Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

RE: File code CMS-1785-P

Dear Ms. Brooks-LaSure:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's) proposed rule entitled "Medicare Program; Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Rural Emergency Hospital and Physician-Owned Hospital Requirements; and Provider and Supplier Disclosure of Ownership," *Federal Register* 88, no. 83, pp. 26658–27309 (May 1, 2023). We appreciate CMS's ongoing efforts to administer and improve Medicare's payment systems for hospitals, particularly given the many competing demands on the agency's staff.

In this letter, we comment on CMS's:

- request for information on future hospital safety-net policies;
- proposal to add a health equity adjustment bonus to the hospital value-based purchasing program;
- description of recent case law on geographic reclassifications and estimated implications for wage index values and capital disproportionate share hospital (DSH) payments; and
- proposal to continue special uncompensated care payments to Puerto Rico.

<u>Request for information on future hospital safety-net policies</u>

CMS has requested comments on several aspects of payments to hospitals that serve as a safety net for low-income patients. CMS referenced MedPAC's past work on Medicare safety-net

payments and asked for comments on how to define safety-net hospitals, how to determine safety-net payments, and some specific questions on how to construct MedPAC's recommended Medicare Safety-Net Index (MSNI). A fundamental question asked by CMS is: "How helpful is it to have multiple types or definitions of safety-net hospitals that may be used for different purposes or to help address specific challenges?"

Comment

The Commission holds that different payers may choose different metrics to distribute safety-net payments because payers are responsible for different populations and those populations may have distinct clinical and socioeconomic circumstances. In our June 2022 and March 2023 reports to the Congress, we outlined a Medicare-centric approach to supporting Medicare safety-net providers, and recommended redistributing and augmenting Medicare's current safety-net payments to hospitals consistent with this approach.[1,2] This approach was premised on a determination that current Medicare safety-net payments to hospitals (DSH and uncompensated care payments) are not properly targeted to hospitals that serve large shares of low-income *Medicare* patients. Given the financial pressures facing the Medicare program, we concluded that a Medicare-centric approach to supporting safety-net hospitals was appropriate for the Medicare program.

The Commission recommended an MSNI that could be used to determine the magnitude of each hospital's Medicare safety-net payments. We computed this index based on the share of a hospital's patients that have Medicare, the share of those Medicare patients that are low income, and the share of a hospital's total revenue that is spent on uncompensated care. We highlighted how low-income Medicare patients can create more financial challenges than higher income Medicare patients and how Medicare should provide additional support to hospitals with high shares of low-income Medicare patients.

Principles guiding Medicare safety-net payments

As CMS contemplates a new safety-net adjuster for Medicare inpatient hospital payments, we recommend that CMS construct an MSNI based on five foundational principles:

Medicare safety-net payments should be used to support Medicare patients

Medicare's current safety-net payments are insufficiently focused on the needs of Medicare patients. For example, Medicare's current DSH payment policy includes Medicaid days as a factor in the DSH formula. In essence, the larger a hospital's Medicaid share, the larger the Medicare DSH add-on payment it will receive. Tying Medicare payments to Medicaid shares is not consistent with the Commission's goal of directing Medicare safety-net payments to support

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[1] Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

[2] Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

hospitals that care for large shares of Medicare patients. Therefore, the Commission's MSNI does not include Medicaid patient share as a factor. Instead, the MSNI is primarily made up of a hospital's Medicare share and the share of its Medicare patients that receive the Part D low-income subsidy (LIS), which we use as a proxy to identify beneficiaries with low incomes. The emphasis on Medicare patients reflects the Medicare program's responsibility to pay the efficient cost of caring for Medicare patients, including those at hospitals that treat a high share of low-income Medicare beneficiaries. The Commission's MSNI also includes a hospital's uncompensated care costs, which would allow the Medicare program to continue to indirectly support uncompensated care, but Medicare safety-net payments would be paid as an add-on to Medicare payment rates, with the largest add-ons for hospitals with the highest shares of low-income Medicare patients.[3]

To be clear, we are not opining on whether hospitals with high Medicaid patient shares and uncompensated care burdens should receive more or less funding from Medicaid and local governments. However, just as Medicaid DSH payments are focused on hospitals with high uninsured and Medicaid shares, Medicare safety-net payments should be focused on hospitals that provide care to larger shares of low-income Medicare patients rather than the uninsured or Medicaid patients.

Medicare's safety-net metric should primarily be based on patient characteristics, with geographic factors, such as the Area Deprivation Index, included only if they are empirically justified

CMS asked for comments on an alternative to using an MSNI that would be based on characteristics of patients living in certain geographic areas—for example, the Area Deprivation Index (ADI). The ADI is a geographically based measure of social risk that is a composite of 17 variables, including an area's poverty rate, unemployment rate, income level, educational attainment, median home value, housing units without complete plumbing, vehicle access, telephone access, and share of single-parent households. The hypothesis is that a geography-based index such as the ADI could potentially better target payments to address both the social determinants of health and the lack of community resources that may increase risk of poor health outcomes and risk of disease in the resident population.

While the Commission's analyses have found that a hospital's average ADI (as measured by its patients' zip codes) is correlated with greater risk of closure and lower all-payer margins, our empirical work suggests that patient characteristics (e.g., Medicare patients' dual eligibility or LIS status) are a better predictors of hospitals' risk of closure and financial condition. Adding the ADI to our multivariate models that already included patient characteristics did not improve the ability of our models to predict hospital profitability or closure. In other words, given data on Medicare patients' characteristics (such as Medicaid or LIS status), adding information on the

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[3] We include uncompensated care costs as a factor in the MSNI because they are partially generated by Medicare patients (unreimbursed Medicare bad debts) and because adding uncompensated care costs to our models that analyzed hospital financial margins and closures improved the predictive power of those models (Medicare Payment Advisory Commission 2022).

patients' neighborhood characteristics (i.e., the ADI of the zip code where the patient resides) did not improve our MSNI's ability to predict hospitals' financial condition.[4]

One reason the ADI does not appear to be as predictive as patient-level information is that individuals with different incomes can live in close proximity, and neighbors may choose to go to different hospitals. For example, some research has shown that patients who are dually eligible for Medicare and Medicaid are less likely to bypass their local hospital for a different hospital.[5] This correlation between patient dual-eligibility status and bypass rates makes the ADI a problematic indicator. In addition, the ADI uses resident income and home values without any adjustment for the cost of living, which is also problematic.[6] Therefore, the safety-net index should depend on patient characteristics (e.g., LIS status) if those characteristics are more predictive of hospitals' financial condition than the ADI or other geographic data that is based on where the hospital's patients live.

In addition, CMS should periodically consider whether the addition of new patient-level data would increase the performance of its safety-net index. For example, future codes indicating if patients are experiencing homelessness could be empirically evaluated for inclusion.

Medicare safety-net payments should reflect where low-income Medicare patients go for care

The safety-net funds should follow Medicare patients. This means that Medicare safety-net payments should be distributed as percentage add-ons to Medicare payment rates and should apply to services provided under both the inpatient prospective payment system (IPPS) and the outpatient prospective payment system (OPPS). One reason to distribute safety-net payments as an add-on to Medicare payments is that the add-on increases hospitals' marginal incentives to serve low-income Medicare beneficiaries. The add-on itself is an incentive to serve Medicare beneficiaries, but hospitals also can increase the magnitude of their add-on percentage by serving a larger share of low-income Medicare patients.

Medicare's safety-net payment adjustments should avoid cliffs

Medicare's current DSH policy includes a minimum percentage threshold in order for hospitals to qualify to receive DSH payments. This creates a "cliff," whereby hospitals just over the threshold qualify for DSH payments, while hospitals just under the threshold (despite caring for some low-income patients) do not. Experience with cut-off points for hospitals to qualify for special payments suggests that it is difficult to empirically justify a cut-off point and to maintain

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[4] Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.
[5] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2020. *Understanding rural hospital bypass among Medicare fee-for-service (FFS) beneficiaries in 2018*. Data highlight, no. 19. Baltimore, MD: CMS
[6] Azar, K. M. J., M. Alexander, K. Smits, et al. 2023. ACO benchmarks based on area deprivation index mask inequities. *Health Affairs* (February 17)

that cut-off point over time. For example, the Medicare DSH program's requirements have changed over time as providers below the threshold ask to be included in the DSH program. As a result of changes to DSH criteria and Medicaid expansion, the share of urban hospitals qualifying for the DSH adjustment increased from 35 percent in 1988 to 42 percent in 1991, to 52 percent in 1997, and to 82 percent in 2020. The Commission's MSNI would avoid this problem by recognizing that caring for *any* low-income Medicare patient could require additional resources. Therefore, the MSNI would create a continuous adjustment to payments that would increase as low-income Medicare beneficiaries represent a larger and larger share of a hospital's patient population.

Beneficiaries should not be liable for higher cost sharing due to safety-net add-on payments

The Commission asserts that beneficiary coinsurance under both the IPPS and the OPPS should continue to be based on payment amounts prior to safety-net add-ons. This approach would ensure that beneficiaries using hospitals with higher shares of low-income Medicare patients do not pay more than beneficiaries using hospitals with lower shares.

CMS should directly pay providers safety-net payments for Medicare Advantage (MA) patients and exclude such payments when calculating MA benchmarks

CMS should calculate MSNI add-on payments for services provided to MA enrollees by applying the add-on percentage to each hospital's encounter records for MA beneficiaries and paying the resulting amount directly to hospitals. However, MSNI payments for fee-for-service (FFS) beneficiaries should be excluded from MA benchmarks. This approach would be similar to the way indirect medical education payments are currently made to hospitals for their FFS and MA patients but are excluded from MA benchmarks. Making MSNI payments for MA enrollees directly to hospitals would reduce incentives for MA plans to steer patients away from hospitals with high MSNI add-on payments.

Computation of the hospital Medicare Safety-Net Index

CMS also asks for comments on how to compute a hospital MSNI and outlines one approach using most of the principles discussed above in our March 2023 report. The computations of the LIS share, the Medicare share, and the uncompensated care share outlined by CMS are all reasonable. In addition, the option of using several years of data to smooth changes over time is appropriate. The one material difference between CMS's method and the Commission's method is that CMS focuses on FFS and MA inpatient claims only. As noted above, the Commission recommended that a MSNI should be computed using both inpatient and outpatient data for FFS and MA patients. As the provision of hospital care continues to shift toward outpatient settings, inpatient care will become a smaller share of care in some markets. Therefore, the computation of the safety-net index should be based on all Medicare hospital encounters (inpatient and outpatient, FFS and MA).

Adding a health equity adjustment bonus to the hospital value-based purchasing program

Under the hospital value-based purchasing (VBP) program, CMS makes incentive payments to hospitals that meet performance standards on a set of quality measures covering four domains (i.e., clinical, cost and efficiency, safety, and person and community engagement). CMS is proposing to add Health Equity Adjustment (HEA) bonus points to the VBP scoring methodology beginning in fiscal year (FY) 2026. The HEA would be calculated using a hospital's performance in each of the four measure domains and its proportion of patients who are dually eligible for Medicare and Medicaid. First, a hospital would receive 4, 2, or 0 points for being in the top third, middle third, or bottom third of performance, respectively, on each of the four domains. The sum of the points earned for each domain would be the "performance scaler" for the hospital. Next, an "underserved multiplier" would be calculated for a hospital as the proportion of inpatient stays for dually eligible patients during a defined time period divided by the hospital's total number of inpatient Medicare stays, translated using a logistic exchange function. HEA bonus points would then be calculated as the product of the performance scaler and the underserved multiplier, with the result added to the total domain scores.

CMS also requests feedback on an alternative approach to calculating the performance scaler. In this alterative scoring methodology, hospitals in the top third of performance for a domain would receive 4 points, and all other hospitals would receive 0 points for the domain.

Comment

The Commission supports CMS's efforts to account for differences in the social risk of providers' patient populations in the VBP scoring. In our March 2019 report to the Congress, the Commission recommended that the Congress replace Medicare's current hospital quality programs, including the hospital VBP, with a new hospital value incentive program (HVIP).[7] A key component of the HVIP is that it would account for differences in patients' social risk factors by distributing payment adjustments through peer grouping. In our peer grouping approach, a hospital would earn points based on its performance relative to national performance scales, but how those points would be converted to incentive payments would vary by peer group, with larger multipliers (i.e., the payment adjustment per point) for peer groups with higher shares of beneficiaries at high social risk. Adjusting Medicare's quality payments based on a provider's performance compared with its peers is preferred over adjusting performance measures for patient's social risk factors because the latter can mask disparities in performance across providers.

Both CMS's proposed HEA and MedPAC's HVIP would allow hospitals the opportunity to receive higher payments if they have higher shares of low-income patients. CMS's proposed approach would accomplish this goal through the underserved multiplier, whereby among hospitals with equal performance, those with higher shares of dually eligible patients would receive a higher HEA (and thus higher payments) relative to those with lower shares of dually

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[7] Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC

eligible patients. In the Commission's approach, hospitals' performance points would be converted to incentive payments, with larger multipliers (i.e., the payment adjustment per point) for hospital peer groups with higher shares of low-income beneficiaries. Our approach also would establish separate pools of dollars for each peer group to be distributed among its members. By establishing separate funding pools and calculating the payment adjustment by peer group, hospitals within each group compete to earn payment adjustments on a more level playing field.

While we support CMS's efforts to account for differences in the social risk of provider populations in the VBP scoring, the Commission urges CMS to consider further how a peer grouping approach with the features we modeled in our March 2019 report would compare to the proposed HEA, particularly with respect to impacts on payments for providers with different shares of dually eligible patients. In addition, while we understand that CMS uses dual-eligibility status in other hospital quality programs, we urge CMS to continue to explore alternative proxies for beneficiary social risk, such as the share of patients who receive Part D's low-income subsidy.

We do not support CMS's proposed alternative scoring methodology in which hospitals must be in the top third of all performers nationally in a measure domain to receive bonus points for that measure. Such an approach would effectively create performance cliffs. As we noted in our March 2019 report, we sought to avoid establishing a minimum performance standard for earning performance points in our HVIP. Applying a minimum threshold would undercut the purpose of a health equity adjustment that is designed to counter the disadvantages these providers face in achieving good performance. Preventing the lowest-performing providers from earning any points would create even larger disparities between the lowest-performing and other providers. The disparity would result from the dollars withheld from the lowest-performing providers being redistributed to the other providers, raising these other providers' incentive payments (or reducing their penalties).

Including health equity measures can help providers prioritize areas for particular focus; specific measures targeting equity within existing quality reporting programs can motivate a focus on reducing disparities and signal that health equity is an important component of delivery system transformation. The HEA that CMS proposes is a mechanism to account for differences in the social risk of hospital patient populations, but it would not reward hospitals for improving health equity. We encourage CMS to develop and add health equity measures to hospital quality payment programs. For example, as the Commission discussed in November 2022, CMS could develop and incorporate a measure of improving within-hospital disparities into a hospital quality payment program. If a hospital reduces differences in readmission rates across race/ethnicity groups over time, it could receive bonus points in the scoring of a quality payment program. There are several methodological issues that would need to be considered in the design and testing of health equity measures, such as the minimum sample sizes needed for reliable comparisons across patient populations. The minimum would exclude providers that do not treat a sufficient number of patients with social risk factors.

Recent case law on geographic reclassifications and estimated implications

For FY 2024 and subsequent years, CMS proposes to change how the agency treats hospitals that reclassified to a rural area via a certain pathway (§412.103), both in the calculation of IPPS wage index values and for capital DSH payments. (The §412.103 rural reclassification pathway implements the Social Security Act §1886(d)(8)(E), which allows urban hospitals to reclassify to a rural area if any of several criteria are met, including if the hospital would otherwise be eligible to be designated as a sole community hospital or rural referral center. Because one eligibility pathway for a rural referral center designation is that the facility be located in a rural area and have at least 275 beds, any urban IPPS hospital with at least 275 beds can reclassify via §412.103 to a rural area (and become a rural referral center).)

Regarding IPPS wage index values, CMS revisited recent case law (including Citrus HMA vs. Becerra), prior comments, and relevant statutory language and now agrees with the rationale in recent court decisions that wage index statute (1886(d)(8)(E)) instructs CMS to treat hospitals that reclassified to a rural area via §412.103 the same as *geographically rural* hospitals—even if these hospitals have a second reclassification back to an urban area. The beginning of 1886(d)(8)(E) reads " (i) For purposes of this subsection, not later than 60 days after the receipt of an application (in a form and manner determined by the Secretary) from a subsection (d) hospital described in clause (ii), the Secretary shall *treat the hospital as being located in the rural area* (as defined in paragraph (2)(D)) of the State in which the hospital is located" (emphasis added). The proposed rule states, "while CMS has previously treated section §1886(d)(8)(E) reclassifications as one among many reclassifications provided for under section §1886(d) and so limited its scope in several ways, we now read it to provide that a §412.103 reclassification functions the same as if the reclassifying hospital had physically relocated into a geographically rural area." This change in interpretation would affect both the calculation of rural areas' wage index values and the calculation of rural floors that establish minimum values for urban areas in each state. While these wage index changes would be budget neutral in aggregate, CMS notes that the change in its treatment of §412.103 hospitals would have significant effects on wage index values and associated financial consequences for individual hospitals. For example, the change would result in the rural floor for hospitals located in California to increase from 1.25 in 2023 to 1.5 in 2024. To offset the increases in many states' rural floors, CMS projects that the rural floor budget-neutrality factor would need to increase from 0.9 percent in 2023 to 1.9 percent in 2024. In other words, all IPPS hospitals' geographic-adjusted payments would be reduced by 1.9 percent in order to offset increased payments to the subset of hospitals receiving the rural floor.

Regarding IPPS capital DSH payments, CMS notes how a court case (Toledo Hospital vs. Becerra) requires CMS to treat hospitals that reclassified to a rural area via §412.103 the same as *geographically urban* hospitals. In response, starting in FY 2024, CMS proposes to treat §412.103 hospitals as eligible for capital DSH payments (which are limited to urban hospitals with more than 100 beds). CMS estimates this change in eligibility would increase IPPS capital payments by $170 million in 2024.

In addition, CMS proposes to continue its low wage index hospital policy through at least 2024 as it only has one year of wage data to evaluate the policy (which began in 2020). (CMS notes that this policy is also the subject of pending litigation.)

Comment

While we are not positioned to weigh in on the specific case law CMS discusses in this rule, the Commission has long been concerned with flaws in the wage index system that Medicare uses to adjust hospital payments to reflect geographic differences in labor costs.[8] The number of wage index exceptions and their effects has continued to grow over time, resulting in greater inaccuracies and inequities. In 2022, about two-thirds of hospitals have had their wage index values affected by exceptions.

According to CMS's interpretation of recent case law, urban hospitals that reclassify to rural via §412.103 are (1) treated as rural for the purposes of the calculation of the wage index value of the rural area to which it reclassified and of that state's rural floor—even when the hospitals have a subsequent reclassification to a different area—which generally increases those wage index values; and (2) simultaneously treated as urban for the purpose of determining capital DSH payment eligibility. At the same time, based on prior case law, these urban hospitals that reclassify to rural via §412.103 are treated as rural—even when the hospitals have a subsequent reclassification to a different area—for the purpose of determining eligibility for certain additional payments limited to "rural" hospitals. In other words, hospitals that have reclassified have sued—and courts have agreed—to be treated in a way that maximizes their payments under each different payment policy, including maintaining simultaneous rural and urban statuses. And because the effects of reclassifications on the IPPS wage index are required to be budget neutral, any increases to reclassified hospitals' wage index values inevitably decrease the payments Medicare makes to other hospitals. CMS's proposed changes to the IPPS wage index and capital DSH eligibility for FY 2024 in response to the cited court cases illustrate the complexity, inconsistency, and even irrationality of the current system, and highlight the need to reform Medicare's wage index systems consistent with the Commission's recent recommendation.[9]

To improve the accuracy and equity of Medicare's wage index systems for IPPS hospitals and other providers (such as, but not limited to, skilled nursing facilities), Medicare needs wage indexes that are less manipulable, more accurately and precisely reflect geographic differences in market-wide labor costs, and limit how much wage index values can differ among providers that are competing for the same pool of labor. In the Commission's forthcoming June 2023 report to the Congress, we recommend that the Congress repeal the existing Medicare wage index statutes, including current exceptions, and require the Secretary to phase in new wage index systems for hospitals and other types of providers that:

- use all-employer, occupation-level wage data with different occupation weights for the wage index of each provider type;

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[8] MedPAC 2007.
[9] Medicare Payment Advisory Commission. 2023. April public meeting.

- reflect local area level differences in wages between and within metropolitan statistical areas and statewide rural areas; and
- smooth wage index differences across adjacent local areas.

Supplemental uncompensated care payments to Puerto Rico

For FY 2023, CMS is using its exceptions authority to provide about $80 million of supplemental payments to Puerto Rico hospitals. The goal was to limit the decline in uncompensated care payments to Puerto Rico hospitals that began when CMS started to use cost report data to estimate those hospitals' uncompensated care costs. The supplemental payments are distributed via a a new per discharge add-on to inpatient payment rates, designed to preserve the magnitude of Puerto Rico hospitals' FFS uncompensated care payments relative to the size of the uncompensated care pool. To compute the new add-on payment, CMS starts with historic hospital-specific uncompensated care payments from 2022, makes small adjustments, and then divides that hospital's aggregate uncompensated care payment by the estimated number of FFS discharges for the current year. That creates the interim add-on payment for each FFS discharge. As FFS discharges decline, the add-on per discharge increases. For FY 2024, CMS projects add-on payments for Puerto Rico hospitals ranging from approximately $2,000 per discharge at the hospital with the smallest per discharge add-on to $104,000 at the hospital with the largest per discharge add-on. The average base payment amount per discharge in Puerto Rico was slightly under $7,000 in 2021. Therefore, the proposed add-on payments would range from approximately 30 percent to 1,500 percent of base payment amounts.

Comment

The primary problem is not that Puerto Rico hospitals will receive an additional $80 million in supplemental payments. As we noted in our comments on last year's proposed rule, the primary problem with the method CMS uses to distribute uncompensated care payments in Puerto Rico is that it dramatically distorts FFS payment rates and thus distorts MA benchmarks. We previously estimated that the $80 million in supplemental payments to Puerto Rico hospitals in 2023 would inappropriately boost payments to MA plans operating in the commonwealth by almost $1 billion per year.[10] In last year's comment letter, we also warned that these additional payments to MA plans would grow far in excess of $1 billion as MA penetration increases and the number of FFS discharges shrinks. The data in CMS's 2024 proposed rule file shows that the number of FFS discharges from Puerto Rico hospitals continues to fall, dropping 26 percent over the past three years.[11] Because of the method CMS uses to make supplemental payments to Puerto Rico hospitals, fewer FFS discharges will result in higher add-on payments per discharge. Higher add-

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[10] Medicare Payment Advisory Commission. 2022. MedPAC comment on CMS's proposed rule on the hospital inpatient prospective payment system and the long-term care hospital prospective payment system for FY 2023. June 16. https://www.medpac.gov/wp-content/uploads/2022/06/06162022_FY2023_IPPS_LTCH_MedPAC_COMMENT_v2_SEC.pdf

[11] Centers for Medicare & Medicaid, FY 2024 IPPS Proposed Rule DSH Supplemental Data File.

on payments mean greater distortion of FFS rates and create large distortions in MA benchmarks.

We continue to urge CMS to alter its method of making supplemental payments to Puerto Rico hospitals to avoid distorting FFS rates and MA benchmarks. Waiting to address the problem will make it more difficult to correct due to MA plans becoming accustomed to higher and higher benchmarks.

Conclusion

MedPAC appreciates your consideration of these issues. The Commission values the ongoing collaboration between CMS and MedPAC staff on Medicare policy, and we look forward to continuing this relationship. If you have any questions regarding our comments, please contact James E. Mathews, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

Michael E. Chernew, Ph.D.
Chair