MEDPAC | Medicare Payment Advisory Commission

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Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Attention: CMS-1808-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 and Medicaid Programs and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes," *Federal Register* 89, no. 86, pp. 35934–36649 (May 2, 2024). 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 proposals to:

- increase the inpatient prospective payment systems (IPPS) operating payment rate by 2.6 percent and the IPPS capital base rate by 2.5 percent;
- create the Transforming Episode Accountability Model (TEAM);
- add a new payment to small, independent hospitals for maintaining a buffer stock of essential medicines;
- update wage index values and policies; and
- update outlier reconciliation thresholds.

Proposed fiscal year (FY) 2025 update to the Medicare payment rate for general acute care hospitals (ACHs)

CMS proposes a 2.6 percent increase to the IPPS operating payment rate and 2.5 percent increase to the IPPS capital base rate, reflecting the applicable market basket increase and statutory adjustments.

Comment

We understand that the Secretary does not have the authority to deviate from statutorily mandated updates and that, therefore, CMS is required to implement this statutory update. However, we appreciate that CMS cited our March 2024 recommendation to increase the IPPS payment rate by an additional 1.5 percent over the statutory update and transition to using the Medicare Safety-Net Index (MSNI) to distribute the disproportionate share hospital (DSH) and uncompensated care payments and adding $4 billion to the MSNI pool.[1] We made this recommendation after reviewing many indicators of payment adequacy, including beneficiary access to hospital services, the supply of hospitals, quality of care, access to capital, and fee-for-service (FFS) Medicare payments and costs overall and for a subset of hospitals identified as relatively efficient (relatively lower costs and higher quality of care). These hospital payment adequacy indicators were mixed and suggested that FFS Medicare payments to general ACHs were below costs for most hospitals; we projected that this disparity will persist under current law updates. Given hospitals' worsened financial circumstances in 2022 and the approximately $3 billion decline in existing Medicare DSH and uncompensated care payments from 2019 to 2024, the Commission contends that all hospitals—and in particular those serving large shares of low-income Medicare patients—warrant greater support. In addition, our recommendation would better target limited Medicare resources toward those hospitals that are key sources of care for low-income Medicare beneficiaries and are facing particularly significant financial challenges

Proposed creation of the Transforming Episode Accountability Model

CMS proposes a new mandatory episode-based payment model for FFS Medicare beneficiaries that would be tested by CMS's Innovation Center for five years (from 2026 to 2030). TEAM draws on lessons from two other episode-based payment initiatives the Innovation Center has been testing, the Comprehensive Care for Joint Replacement model and the Bundled Payment for Care Improvement Advanced model. According to CMS, those models have shown promise in terms of reducing episode payments and maintaining quality of care, but certain design features (e.g., length of episodes, methods for calculating episode prices, and provider participation requirements) have meant that they did not reach their full potential. TEAM is intended to address many of these issues.

TEAM would hold acute care hospitals in 200 core-based statistical areas accountable for spending on five types of surgical procedures plus all related care in the 30 days post-discharge. (The five procedures are coronary artery bypass graft, lower extremity joint replacement, major bowel procedure, surgical hip/femur fracture treatment excluding lower extremity joint replacement, and spinal fusion.) When actual episode spending for a beneficiary is below an episode's target price, the hospital would receive a bonus; when actual spending is above the target, the hospital would receive a penalty.

Generally speaking, episode target prices would reflect expected spending during a given type of episode in a given region, minus a 3 percent discount, and would be risk-adjusted

[1] Medicare Payment Advisory Commission. 2024. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

based on beneficiary characteristics. The size of the bonus or penalty would be influenced by participating providers' performance on three outcome measures: hospital-wide all-cause readmissions, a composite measure that captures rates of various patient safety and adverse events, and a patient-reported measure of clinical benefit gained following a hip or knee replacement episode. The size of the bonus would also be influenced by the track that a hospital participates in: (1) a track for safety-net hospitals, rural hospitals, and certain other types of hospitals would cap bonuses and penalties at 10 percent of the episode target price; (2) a track for all other hospitals would have a 20 percent cap. Hospitals would be permitted to share bonuses and penalties with other providers that care for a TEAM hospital's beneficiaries and with organizations that help hospitals participate in TEAM (e.g., by providing data analysis or by helping a hospital stay in compliance with the model's requirements).

In contrast to CMS's current practice of prohibiting beneficiaries in certain advanced alternative payment models (A–APMs) from being attributed to providers in episode-based payment models, Medicare beneficiaries attributed to health care providers in TEAM could be concurrently attributed to most other A–APMs, including accountable care organization (ACO) models.[2] Performance-based payments made to providers in TEAM would not be included when tallying up actual spending for providers in an ACO or other A–APM, and vice versa.

Comment

The Commission supports this new model, which is directionally consistent with our June 2022 report encouraging CMS to implement a new mandatory episode-based payment model.[3] Mandatory A–APMs are more likely to generate net savings for Medicare than voluntary A–APMs because mandatory models do not experience the selection problems that have undermined voluntary models: Providers in a mandatory model who expect to owe penalties cannot avoid paying them by exiting the model.[4] Indeed, as we noted in our June 2021 chapter on A–APMs, hospitals that were initially mandated to participate in the Comprehensive Care for Joint Replacement model generated net savings for Medicare during their first three years in this model—yielding more promising results than have been achieved in CMS's voluntary episode-based payment models.[5]

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[2] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2024. TEAM Model frequently asked questions. April 10. https://www.cms.gov/team-model-frequently-asked-questions.
[3] Medicare Payment Advisory Commission. 2022. "An approach to streamline and harmonize Medicare's portfolio of alternative payment models," in *Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC, June. https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch1_MedPAC_Report_to_Congress_SEC.pdf.
[4] Medicare Payment Advisory Commission. 2021. "Streamlining CMS's portfolio of alternative payment models," in *Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: June. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/default-document-library/jun21_ch2_medpac_report_to_congress_sec.pdf.
[5] Medicare Payment Advisory Commission. 2021. "Streamlining CMS's portfolio of alternative payment models," in *Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC, June. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/default-document-library/jun21_ch2_medpac_report_to_congress_sec.pdf.

Rural hospitals in TEAM

After the first year of the model, TEAM hospitals would be required to assume financial risk, but eligible hospitals could select a track with lower risk (plus or minus 10 percent instead of 20 percent). Under CMS's proposal, eligible hospitals for the lower risk track would be safety-net hospitals, rural hospitals, Medicare dependent hospitals (MDHs), sole community hospitals (SCHs), and essential access community hospitals. Rural hospitals would include both geographically rural hospitals, reclassified rural hospitals, and rural referral centers (RRCs).

We support CMS's proposal to allow hospitals that face more financial pressure to participate in a lower risk track. However, we note that CMS's proposed criteria for eligibility is likely to encompass a large share of hospitals. To better target the lower risk track, rural hospitals should be defined as those located in geographically rural areas and not those that have been reclassified as rural or RRCs. The Commission has previously reported on the growth in rural reclassifications, now composing nearly a third of hospitals.[6] In addition, we note that since 2018, hospitals can maintain a "dual reclassification" status, in which they first reclassify as rural through one pathway and then reclassify to a different area (potentially their original geographic area) through a different pathway, allowing urban IPPS hospitals to reclassify as rural to gain benefits without decreasing their wage index. In 2022, over 450 hospitals maintained dual reclassifications, and over a quarter of these hospitals reclassified back to their original geographic area.[7] Of these, over 350 were urban hospitals that dually reclassified and became RRCs, which are subject to lower eligibility thresholds for the 340B drug savings programs.[8] To avoid further fueling such reclassifications, CMS should restrict the definition of rural participants to hospitals that are geographically located in rural areas.

Setting target prices

CMS proposes a reasonable method of calculating episode target prices in order to provide meaningful incentives for participants to deliver care efficiently and make improvements in care delivery, but there are issues that should be addressed and monitored over time. Specifically, target prices under TEAM would be set at a regional level (rather than basing them on spending at the hospital level) and be rebased each year to reflect multi-year changes in episode spending at the regional level. This approach raises several concerns.

First, upon launch of the model, hospitals with historical spending patterns less than regional benchmarks could initially receive large positive reconciliation payments, while hospitals with spending patterns above their regional benchmarks could face significant repayment requirements. While negative and positive payments would be capped, repayments could cause meaningful hardship among high-cost providers and induce them to avoid high-cost patients. The extent of this concern depends on the magnitude of

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[6] Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.
[7] Medicare Payment Advisory Commission. 2023, o*p cit.*
[8] Medicare Payment Advisory Commission. 2023, o*p cit.*

spending variation within each region and the effectiveness of risk adjustment (about which we have some concerns, as discussed below). One way to address these concerns would be to initially base benchmarks on a blend of hospital-specific and regional spending and each year increase the share of the blend based on regional spending. This approach would reduce the likelihood that large positive or negative payments would result from pre-existing hospital level spending, while allowing benchmarks to converge to a regional basis over time.

Second, the Commission has previously expressed concerns about using realized spending to rebase spending targets because doing so makes it increasingly difficult for participants to keep actual spending below the targets, which can theoretically result in providers seeking to exit a model or reduce the number of beneficiaries they treat.[9] For voluntary ACO models, such as the Medicare Shared Savings Program, the Commission has supported CMS increasing spending targets by an administratively determined growth rate that is decoupled from changes in participants' actual spending.[10] However, given the fact that changes in spending for episodes can fluctuate more than population-based spending in ACOs (and secular changes in episode spending mean an administratively determined growth rate may be less appropriate), and the fact that TEAM is a mandatory rather than voluntary model, CMS's proposed method for updating TEAM's target prices is reasonable. That said, we urge the agency to carefully monitor target prices to ensure that participants are adequately compensated. Specifically, if inefficiency is removed from episode spending, the 3 percent discount may be harder to reach with additional efficiency gains and, if risk adjustment is imperfect, organizations could be further subject to payment increases or decreases unrelated to their performance.

The TEAM hierarchical condition category (HCC) count for risk adjustment

To risk adjust episode target prices, CMS proposes to calculate a "TEAM HCC count" based on diagnoses from Medicare FFS claims that occurred during the 90 days prior to the start of the episode. Using the period immediately preceding the hospitalization instead of full-year HCC scores reduces incentives to increase coding intensity. Nevertheless, the Commission is concerned about coding, and therefore we encourage CMS to use only FFS claims for hospital inpatient stays, hospital outpatient visits, and visits with a clinician in the TEAM HCC count (as in the Medicare Advantage (MA) HCC model). In addition, we urge CMS to remove codes generated from health risk assessments (including annual wellness visits) from the TEAM HCC count to ensure that diagnosis codes contribute to the risk score only if they are related to actual health care services received. That said, it is important to note that in this model, unlike in MA, coding creep relative to an external population would

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[9] Medicare Payment Advisory Commission. 2022. "An approach to streamline and harmonize Medicare's portfolio of alternative payment models," in *Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC, June. https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch1_MedPAC_Report_to_Congress_SEC.pdf.

[10]Medicare Payment Advisory Commission. 2022. Comment letter on CMS's proposed rule on CY 2023 revisions to the payment policies under the physician fee schedule and other changes to Part B payment policies. September 2. https://www.medpac.gov/wp-content/uploads/2022/09/09022022_Part_B_2023_CMS1770P_MedPAC_COMMENT_v2_SEC.pdf

not be a concern. Coding creep relative to baseline might be of concern but could be dealt with by capping annual growth in risk scores.

We caution CMS that social risk adjustment may not be sufficient to capture variation in factors that are difficult to measure or not in available data (e.g., cognitive status, obesity, and caregiver support). Adding a hospital-specific historic spending component to target prices, as discussed above, could mitigate some of this concern. CMS may also consider a longer lookback period than 90 days (such as 180 days or a year). Even with these approaches, it will be important to monitor changes in utilization and access to care.

Model overlap policy

The Commission supports testing CMS's proposed model overlap policy, which is consistent with our June 2022 report's suggestion that CMS allow beneficiaries to be concurrently attributed to providers in an episode-based payment model and providers in an ACO model.[11] That said, it will be important for CMS to monitor the effects of this model overlap policy, since it would result in two different A–APMs (TEAM plus some other A–APM, such as an ACO model) holding two sets of providers accountable for spending generated by a single beneficiary during a single, shared period of time (i.e., a 30-day episode in TEAM, which could also end up being included in the 12-month performance period of another A–APM). The Commission has said that concurrent attribution should (1) ensure that providers in an episode-based payment model have an incentive to furnish an efficient mix of services to FFS Medicare beneficiaries under their care; and (2) ensure that providers in an ACO model always have an incentive to refer their attributed beneficiaries to efficient episode-based providers. Further, when combined, these incentives should not be so large that they increase total Medicare spending. Since the model overlap policy proposed for TEAM would essentially result in double-paying of full-sized performance bonuses, it will be interesting to see if net savings to Medicare can be generated; if the policy results in net losses, we suggest that CMS reassess the model overlap policy.

Proposed separate payment for establishing and maintaining access to essential medicines

Effective for cost reporting periods beginning in FY 2025, CMS proposes a new, non–budget-neutral IPPS payment to small, independent hospitals that establish and maintain a 6-month buffer stock of any of the 86 essential medicines prioritized in the Advanced Regenerative Manufacturing Institute's report entitled *Essential Medicines Supply Chain and Manufacturing Resilience Assessment*.[12] The IPPS payment would be based on each hospital's IPPS share of its additional reasonable costs for maintaining this buffer stock, as

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[11] Medicare Payment Advisory Commission. 2022. "An approach to streamline and harmonize Medicare's portfolio of alternative payment models," in *Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch1_MedPAC_Report_to_Congress_SEC.pdf.
[12] Advanced Regenerative Manufacturing Institute. 2022. Essential medicines supply chain and manufacturing resilience assessment. Manchester, NH: ARMI. https://www.armiusa.org/wp-content/uploads/2022/07/ARMI_Essential-Medicines_Supply-Chain-Report_508.pdf.

recorded on a new cost report form. These costs would not include the costs of the essential medicines themselves; rather, payments for drugs would remain as they are now.

In last year's outpatient prospective payment system (OPPS) rulemaking, CMS proposed a similar policy—a non–budget-neutral IPPS payment to all hospitals that establish and maintain a 3-month buffer stock of the 86 essential medicines.[13] However, the agency did not finalize the policy due to stakeholder concerns. Specifically, CMS stated that stakeholders raised concerns about the potential for the policy to induce hoarding behaviors, cause demand-driven shocks to the pharmaceutical supply chain, and exacerbate pharmaceutical access issues for hospitals—particularly smaller hospitals, due to their smaller purchasing power. To address these concerns, CMS's current proposal would narrow the policy to include only small hospitals that are not part of chains (an estimated 493 hospitals nationwide) and to provide payments only for maintaining a 6-month buffer stock of drug products that were established before a shortage occurred (not for buffer stocks established during a shortage). Per CMS's estimate, the proposal would increase IPPS spending in FY 2025 by $0.3 million, with the average IPPS payment per eligible hospital totaling approximately $620.

Comment

Ensuring a sufficient inventory of essential medicines is vitally important for the nation's public health and security. However, CMS's proposed policy is unlikely to be an effective approach to ensuring access to essential medicines for all patients because drug supply chain issues are driven by factors beyond Medicare.[14,15,16]

As the Commission stated in its comment letter on CMS's CY 2024 OPPS proposed rule, ensuring that hospitals have a sufficient inventory of essential medicines for all their patients likely involves solutions beyond the Medicare program (e.g., direct purchases and stockpiling of essential medicines by the federal government or other broader federal efforts to support the essential drug supply).[17] Further, CMS's proposal to pay hospitals' reasonable costs for maintaining a buffer stock is a departure from Medicare's prospective, bundled approach to inpatient hospital payments. As we noted in our comment letter on CMS's FY 2023 IPPS proposal for a new payment for the purchase of domestically produced N-95 masks, adding new Medicare hospital payments for specific

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[13] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2023. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Payment for Intensive Outpatient Services in Hospital Outpatient Departments, Community Mental Health Centers, Rural Health Clinics, Federally Qualified Health Centers, and Opioid Treatment Programs; Hospital Price Transparency; Changes to Community Mental Health Centers Conditions of Participation, Changes to the Inpatient Prospective Payment System Medicare Code Editor; Rural Emergency Hospital Conditions of Participation Technical Correction. Final rule. *Federal Register* 88, no. 224 (November 2023): 81540–82103.

[14] Government Accountability Office. 2014. *Drug shortages: Public health threat continues, despite efforts to help ensure product availability*. GAO–14–194. https://www.gao.gov/products/gao-14-194.

[15] Food & Drug Administration. 2022. *Report to Congress: Drug shortages CY 2022*. White Oak, MD: FDA. https://www.fda.gov/media/169302/download?attachment=.

[16] Medicare Payment Advisory Commission. 2024. Generic drug pricing under Part D. https://www.medpac.gov/wp-content/uploads/2023/10/Generic-prices-Part-D-April-2024-SEC.pdf.

[17] Medicare Payment Advisory Commission. 2023. Comment letter on the hospital outpatient and ambulatory surgical center payment systems. https://www.medpac.gov/wp-content/uploads/2023/09/09112023_CY2024_OPPS_MedPAC_comment_v2_SEC.pdf.

national public health goals would create a precedent that could open opportunities to establish separate cost-based payments for other supplies and other providers.[18] Indeed, this current proposal would be one such expansion.

Medicare payment policy is neither a sufficient, nor the best suited, mechanism to support adequate supplies of essential medicines for all patients (whether or not they are covered by Medicare). However, if CMS determines that this proposal could be helpful in the short run for certain small providers, the agency should ensure that (1) the integrity of Medicare's prospective payment systems is maintained; (2) administrative burden is minimized; and (3) opportunity for manipulation is limited. In addition, it will be important for CMS to carefully monitor and evaluate its impact on the payments, identify any lessons learned, and report the agency's findings to the public in a timely fashion.

Proposed update to wage index values and policies

For FY 2025, CMS proposes to continue existing IPPS wage index policies, including:

- using the post-reclassification, post-floor wage index;
- updating the wage index with newer wage data and Office of Management and Budget (OMB) labor market area delineations;
- capping the wage index decrease a provider can experience in a given year at 5 percent; and
- extending the low-wage index policy through at least FY 2027.

Comment

The Commission supports CMS's annual process to update the IPPS wage index with newer wage data and OMB delineations. The Commission also supports having a policy to cap the wage index decreases that a provider can experience in a given year. We continue to urge CMS to apply a cap to the wage index increases that a provider can experience in a given year as well.

However, the Commission has long been concerned with flaws in the wage index system that Medicare uses to adjust IPPS payments to reflect geographic differences in labor costs.[19] These concerns have continued to grow along with the rise in the number of

[18] Medicare Payment Advisory Commission. 2022. Comment letter on hospital inpatient prospective payment systems for acute care hospitals and the long-term care hospital prospective payment system. June 16. https://www.medpac.gov/wp-content/uploads/2022/06/06162022_FY2023_IPPS_LTCH_MedPAC_COMMENT_v2_SEC.pdf
[19] Medicare Payment Advisory Commission. 2007. *Report to the Congress: Promoting greater efficiency in Medicare.* Washington, DC: MedPAC.

reclassifications. In 2025, 610 IPPS hospitals have new Medicare Geographic Classification Review Board reclassifications, up from 466 in 2024.[20]

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 June 2023 report to the Congress, we recommended 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;
- 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.

Proposed update to the outlier reconciliation threshold

Current CMS regulations state that IPPS and long-term care hospital outlier reconciliation at cost report settlement will be based on cost-to-charge ratios (CCRs) calculated from the final cost report compared to the CCR available at the time of billing.[21] To allow Medicare Administrative Contractors (MACs) to focus their limited resources on only those hospitals that appear to have been disproportionately affected by the time lag between the CCR used to calculate outlier payments at the time of billing and the final CCR, CMS has instructed MACs to reconcile outlier payments at cost report settlement for hospitals if:

(1) the actual CCR is found to be plus or minus *10 percentage points* from the CCR used to calculate outlier payments; and

(2) outlier payments exceeded $500,000 for that cost reporting period.[22]

In 2019, the Department of Health and Human Services' Office of Inspector General (OIG) found that hospitals received millions in excessive outlier payments because of these

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[20] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2023. Medicare program: 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; and Medicare disproportionate share hospital (DSH) payments: counting certain days associated with Section 1115 demonstrations in the Medicaid fraction. Final rule. *Federal Register* 88, no. 165 (August 2023): 58640–59438.
[21] 42 CFR 412.84(i)(4) https://www.ecfr.gov/current/title-42/part-412/section-412.84#p-412.84(i)(4) and 42 CFR §412.525(a)(4)(D) https://www.ecfr.gov/current/title-42/part-412/subpart-O#p-412.525(a)(4)(i)
[22] Sections 20.1.2.5 and 150.26 of Chapter 3 of the *Claims Processing Manual*. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c03.pdf .

limits on the reconciliation process. OIG recommended that CMS require reconciliation of all hospital cost reports with outlier payments.[23]

In March 2024, CMS modified the outlier reconciliation instructions, effective for cost reports beginning in FY 2025.[24] Specifically, the first criterion was expanded to reconcile outlier payments if:

(1) a hospital's actual CCR is found to be plus or minus *20 percent or more* from the CCR used during that time period to make outlier payments.

In addition, all new hospitals will be referred for outlier reconciliation in their first cost reporting period.

Consistent with the expanded criterion for identifying hospitals subject to outlier reconciliation payments, CMS is proposing changes to its methodology to incorporate outlier reconciliation payments into its calculation of the fixed loss threshold.

CMS believes the new criteria balance current administrative feasibility with the goal of expanding the scope of cost reports identified for outlier reconciliation approval to increase the accuracy of outlier payments.

Comment

The Commission supports this change and agrees with CMS that the expanded criteria for identifying hospitals subject to outlier reconciliation payments would increase the accuracy of outlier payments while maintaining relatively low administrative burden. We also encourage CMS to continue to monitor outlier payments and administrative burden, to inform if additional changes to eligibility criteria are warranted in future years.

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 MedPAC's Executive Director, Paul Masi, at 202-220-3700.

Sincerely,

Michael E. Chernew, Ph.D.
Chair

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[23] Office of Inspector General, Department of Health and Human Services. *Hospitals received millions in excessive outlier payments because CMS limits the reconciliation process.* A-05-16-00060. Washington, DC: OIG. https://oig.hhs.gov/oas/reports/region5/51600060.pdf .

[24] Change Request (CR) 13566, which is available at https://www.cms.gov/medicare/regulations-guidance/transmittals/2024-transmittals/r12558cp.