American Hospital Association

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January 10, 2013

Glenn M. Hackbarth, J.D.
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Dear Mr. Hackbarth:

The Medicare Payment Advisory Commission (MedPAC or the Commission) will vote next week on payment recommendations for fiscal year (FY) 2015. On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, the American Hospital Association (AHA) asks that commissioners consider the following issues that will have a significant impact on hospitals, health systems, other providers and Medicare beneficiaries before making final recommendations. Specifically, we urge MedPAC to:

- Incorporate the negative impact of sequestration into formulating its update recommendations and margin projections for FY 2015;
- Increase its recommended update factor for inpatient and outpatient hospital payment rates to at least 5 percent in order to provide a net positive update that adequately considers the impact of current law and all standing MedPAC recommendations;
- Support a positive update recommendation for long-term care hospitals (LTCHs) and inpatient rehabilitation facilities (IRFs); and
- Look beyond the CARE Tool and B-Tool to other viable options that would achieve consistent measurement and reporting across post-acute settings.

IMPACT OF SEQUESTRATION

At its December meeting, the commissioners considered draft update recommendations that would either increase or maintain the Medicare payment rates for various health care services. These draft recommendations, however, do not take into account the negative impact of Congress' sequestration policies. Specifically, MedPAC indicated that it will not consider the impact of sequestration in its update process until next year, for its FY 2016 recommendations. **The AHA is extremely troubled by this framework, which represents an inaccurate and misleading picture of Medicare payments and provider margins.**

The sequestration policies, set forth in the *Budget Control Act of 2011* and later amended by the *American Taxpayer Relief Act of 2012*, originally decreased all Medicare payments by 2 percent from April 1, 2013 through March 31, 2022. Despite the fact that these policies are effective for almost a decade, commissioners did not consider the impact of sequestration in the draft update recommendations, stating that it is "temporary" or "short-term." Commissioners also stated their belief that Congress would repeal sequestration and instead implement a more targeted approach to control spending. However, last month, Congress not only retained the sequester, but also passed the *Bipartisan Budget Act of 2013*, which extended the sequester for an additional two years – through March 31, 2024. **MedPAC's position that sequestration is "temporary" is misguided – sequestration is current law and applies to Medicare payments for the next decade. The Commission's failure to include the sequestration payment cuts in formulating its update recommendations and margin projections for FY 2015 results in a misleading and inaccurate picture of hospitals' financial status. As such, the AHA urges MedPAC to incorporate the negative impact of sequestration into its update recommendations and margin projections for FY 2015.**

HOSPITAL INPATIENT AND OUTPATIENT UPDATE RECOMMENDATION

In December, the commissioners considered a package of three draft recommendations related to the hospital inpatient and outpatient prospective payment systems (PPSs). Specifically, the package included the following recommendations, each of which is addressed in detail below:

1. Reduce or eliminate differences in payment rates between outpatient departments and physician offices for selected ambulatory payment classifications (APCs).
2. Set LTCH payment rates for non-critically chronically ill (CCI) cases equal to acute-care hospital rates, and redistribute the savings to create additional inpatient outlier payments for CCI cases in inpatient PPS hospitals.
3. Increase payment rates for acute-care hospital inpatient and outpatient PPSs in 2015 by 3.2 percent concurrent with implementing the above changes to the acute-care hospital and LTCH payment systems.

Reduce or Eliminate Differences in Payment Rates Between Outpatient Departments and Physician Offices for Selected APCs. At the December meeting, Commissioners discussed a draft recommendation to reduce or eliminate differences in payment rates between hospital outpatient departments (HOPDs) and physician offices for selected APCs. This proposed "site-neutral" payment recommendation would reduce total payment for a set of 66 procedural APC services furnished in HOPDs based on the rate paid to physicians for providing the services in their private offices. MedPAC estimates that it would reduce payment for HOPD services by $1.1 billion per year.

In 2011, MedPAC adopted a site-neutral payment policy recommendation for 10 evaluation and management (E/M) clinic visit services, which it estimated would cut payments to HOPDs by $900 million per year. The Commission has also discussed applying a site-neutral payment policy to a set of 12 surgical service APCs, which would reduce HOPD payment to the level paid

in an ambulatory surgical center (ASC), resulting in HOPD payments cuts of $590 million per year.

The AHA opposes the draft recommendation presented by staff at the December meeting. As we have stated previously, we have a number of concerns with this recommendation:

- Hospitals already lose money treating Medicare patients in the HOPD (with negative 11.2 percent margins in 2012). We are concerned that further payment reductions would threaten access to critical hospital-based "safety net" services. HOPDs provide services that are not otherwise available in the community to vulnerable patient populations, such as care for low-income patients, for patients with multiple chronic conditions, the disabled and dual-eligible patients.
- Site-neutral payment reductions would endanger hospital's ability to continue to provide 24/7 access to emergency care and stand-by capacity for disaster response. Without adequate, explicit funding for these emergency standby services, the stand-by role is built into the cost structure of full-service hospitals and supported by revenue from direct patient care – a situation that does not exist for physician offices or any other type of provider.
- Payment to hospitals for outpatient care should reflect HOPD costs, not physician or ASC payments. HOPD payment rates are based on hospital cost report and claims data. In contrast, the physician fee schedule, in particular the practice expense component, which is relevant for the site-neutral payment methodology, is based on voluntary responses to physician survey data and has been held flat for years due to the cost of various physician payment "fixes." ASCs do not report their costs.
- The Medicare payment systems for physicians, ASCs and HOPDs are complex and fundamentally different, with many moving parts. Practically speaking, this makes the application of MedPAC's site-neutral policy unstable, with any number of small technical and methodological decisions changing the outcome significantly. Basing hospital payments on such a volatile methodology could have unintended consequences.

In addition, CMS made several sweeping changes in the calendar year 2014 outpatient PPS final rule that have a substantial impact on both MedPAC's already-approved and draft site-neutral recommendations. **The AHA urges the Commission to review these changes and the impact they have on hospital payment.**

In particular, the outpatient PPS final rule collapsed the 10 E/M codes for hospital outpatient clinic visits, and replaced them with one new code representing a single level of payment for all outpatient clinic visits. The previous clinic visit codes, including the distinctions between new and established patient visits, are no longer recognized in the outpatient PPS. The adoption of a single code for all hospital outpatient clinic visits means that there are no longer any E/M codes recognized in both the outpatient PPS and the physician fee schedule that can be used to calculate the reduced HOPD payment rate for clinic visits under MedPAC's site-neutral E/M payment policy. Given this change, the AHA is uncertain how the E/M policy, as recommended by MedPAC, could be enacted by Congress.

In addition, the outpatient PPS final rule identifies five new categories of items and services whose costs are now packaged into the payment for other services to which they are integral, ancillary or supportive. **This policy significantly increases the amount of packaging in all APCs and will likely affect the impact estimates of the 66 APC site-neutral payment recommendation. MedPAC should consider and discuss the implications of these changes before voting on its draft site-neutral recommendation.**

Set LTCH Payment Rates for Non-CCI Cases Equal to Acute-Care Hospital Rates, and Redistribute the Savings to Create Additional Inpatient Outlier Payments for CCI Cases in Inpatient PPS Hospitals. At the December meeting, Commissioners discussed a draft recommendation to reform the LTCH PPS by implementing site-neutral payment rates for certain cases. However, on December 26, President Obama signed into law the *Bipartisan Budget Act of 2013*, which, in addition to other provisions, broadly reformed the LTCH PPS by implementing site-neutral payment rates for certain cases beginning in FY 2016. Under this new system, Medicare will pay for LTCH services through either an LTCH PPS payment for cases that meet new statutory criteria, or a site-neutral payment with rates set at the lower inpatient PPS levels. To qualify for payment under the LTCH PPS, during an immediately prior stay in an inpatient PPS hospital, the LTCH case must have received three or more days of intensive care unit (ICU) or coronary care unit (CCU) services or been discharged with a Medicare-Severity diagnosis-related group (MS-DRG) related to 96+ hours of ventilator services. The lower inpatient PPS rate will apply to LTCH cases that do not meet these criteria and also to cases with a psychiatric or rehabilitation principal diagnosis. **Given these sweeping reforms enacted by the Congress, we urge MedPAC to withdraw its now unnecessary recommendation to reform the LTCH PPS. Instead, MedPAC should focus on supporting effective implementation of the new, reformed LTCH payment system.**

Increase Payment Rates for Acute-care Hospital Inpatient and Outpatient PPSs in 2015 by 3.2 Percent Concurrent with Implementing the Above Changes to the Acute-care Hospital and LTCH Payment Systems. The AHA appreciates MedPAC's recognition that Medicare payments will remain below the cost of providing care and that, in FY 2015, even relatively efficient providers will experience negative Medicare margins. **Therefore, AHA agrees with MedPAC that a substantial positive update for both hospital inpatient and outpatient payments is necessary in FY 2015. However, we are concerned that MedPAC's representation of the net payment update under its draft recommendations is misleading and does not provide for an adequate update to Medicare's inpatient and outpatient hospital payment rates.** Below is the table staff presented at the December meeting that depicts MedPAC's draft payment recommendation.

2015 Inpatient and Outpatient PPS Payment Changes Under Current Law and Under MedPAC's Draft Recommendations

	Current Law	Chairman's Draft Recommendation
Disproportionate Share Hospital Payment Changes	-2.0%	-2.0%
Other	-1.5%	-1.5%
Site Neutral Reform		-0.6%
LTCH Recommendation		1.2%
Update Factor	2.2%	3.2%
Net Update	**-1.3%**	**0.3%**
Prior Site Neutral Recommendation	-0.6%	

Source: MedPAC Presentation, December 2013 Public Meeting.

At the December meeting, MedPAC staff explained that the net update under the Chairman's draft recommendations is higher than under current law, and also provides for a net positive update of 0.3 percent, as opposed to the net negative update under current law. **Staff stated that "an update above current law is warranted." However, when fully considering all MedPAC's recommendations, it is actually recommending an update that is lower than current law.**

Specifically, MedPAC did not include in its net update calculation its active and standing recommendation to equalize payment rates for E/M services provided in HOPDs and physician offices; instead it included this "prior site neutral recommendation" as a note below the table. **It is inappropriate to exclude an active and standing recommendation from the net update calculation.** When taken into consideration, this recommendation decreases Medicare payments to hospitals by an additional 0.6 percent. When included in the net update calculation, this 0.6 percent cut lowers the net update under MedPAC's draft recommendations from an *increase* of 0.3 percent to a *decrease* of 0.3 percent.

Further, as discussed above, due to recently enacted Congressional LTCH PPS payment reforms, MedPAC's LTCH recommendation is unnecessary and should be withdrawn. The 1.2 percent of LTCH payments intended to be redistributed among PPS hospitals, that MedPAC includes in the table above, will not materialize. **When this 1.2 percent is taken out of consideration, it further lowers the net update under MedPAC's draft recommendations from a decrease of 0.3 percent to a decrease of 1.5 percent. Thus, when considering all its recommendations, the Commission is actually recommending a negative net update that is lower than the current law update, even at a time when relatively efficient providers will have negative margins. To provide the net positive update that MedPAC has stated is needed, the AHA urges the Commission to increase its recommended update factor to at least 5 percent.** The table below depicts AHA's recommended 2015 update framework, which includes adequate

consideration of the impact of current law and all standing MedPAC recommendations. As shown, an update factor of 5 percent is needed to provide the same very modest net positive update of 0.3 percent that the Commission discussed at the December meeting.

AHA's Recommended 2015 Update Framework

	MedPAC's Draft Recommendation Fully Considering Current Law and Standing Recommendations	AHA's Recommended Update Fully Considering Current Law and Standing Recommendations
Update Factor	3.2%	5.0%
Disproportionate Share Hospital Payment Changes	-2.0%	-2.0%
Other	-1.5%	-1.5%
Site Neutral Reform	-0.6%	-0.6%
Prior Site Neutral Recommendation	-0.6%	-0.6%
LTCH Recommendation	N/A	N/A
Net Update	**-1.5%**	**0.3%**

Source: AHA Adaption of MedPAC Presentation, December 2013 Public Meeting

LTCH UPDATE RECOMMENDATION

At the December meeting, MedPAC discussed a draft update recommendation of 0 percent for the LTCH PPS. However, as mentioned above, after the meeting at which this draft recommendation was discussed, the Congress enacted broad payment reform of the LTCH PPS. Given these major changes to the LTCH payment system, it is inappropriate to add further volatility to the mix by eliminating the market basket update. **Under the reformed system, AHA estimates that overall LTCH PPS payments will be cut by 19 percent (once the system is fully phased in). Therefore, any further LTCH cuts through elimination of the FY 2015 market basket would be excessive and unwarranted. As such, we ask the commissioners to support a positive market basket update for LTCHs.**

In addition to this update recommendation, as noted above, during the inpatient/outpatient PPS session, MedPAC put forth a draft recommendation to set LTCH payment rates for non-CCI cases equal to acute-care hospital rates. We were disappointed to see this concept presented as a formal draft recommendation in December, given that there was no accompanying impact data, and that one month earlier, it was characterized as "very much at a developmental stage." However, after the December meeting, Congress enacted the *Bipartisan Budget Act of 2013*, which broadly reformed the LTCH PPS by implementing site-neutral payment rates for certain cases beginning in FY 2016. **Therefore, MedPAC should withdraw its recommendation to reform the LTCH PPS because it is now unnecessary. Instead, we look forward to working**

with the Commission to monitor implementation of the new, reformed LTCH payment system.

We also note that the Commission's LTCH recommendation was not based on any impact analysis of its effect on beneficiaries and LTCHs, despite the fact that the recommendation would reduce Medicare payments to LTCHs by about $2 billion annually (on a base of only $5.4 billion annually) and for almost two-thirds of current LTCH discharges. **This lack of comprehensive analysis is extremely puzzling.** If the Commission chooses not to withdraw this recommendation as discussed above, we urge the conduct of a far more comprehensive analysis. This assessment should include the financial impact on both the inpatient PPS and the LTCH PPS as well as of the effect on access to care for patients needing the unique care LTCHs provide. **We urge the Commission not to make such a significant recommendation without fully considering all the consequences, unintended and otherwise, it would have on the LTCH field and the beneficiaries it serves.**

INPATIENT REHABILITATION FACILITY UPDATE

At the December meeting, MedPAC staff presented a draft recommendation to eliminate the market basket update to IRF payment rates for FY 2015. As we have stated previously, IRFs fulfill a unique clinical role – no other hospital or post-acute setting provides the same mix or intensity of hospital-level medical and therapy services. IRFs provide these services to a targeted group of patients, including those needing specialized care following brain injury, spinal cord injury, stroke, amputation or other acute medical events. The services provided by IRFs have become even more focused over the past decade as CMS has implemented significant policy changes to tighten IRF admission practices. Due to these policy changes, IRF volume has fallen by 24.4 percent since summer 2004 – from 355,030 discharges (for the 12-month period ending June 2004) to 268,357 discharges (for the 12-month period ending June 2012). **We urge MedPAC to acknowledge the substantial tightening of IRF admission practices and support a positive update in FY 2015, enabling IRFs to carry out their specialized role of treating beneficiaries recovering from acute medical events.**

COMMON ASSESSMENT INSTRUMENT FOR POST-ACUTE PATIENTS

During the December meeting, MedPAC staff presented a draft recommendation to develop a common patient assessment instrument for post-acute settings by 2016. The staff envisioned that such an instrument would be phased-in over time and would ultimately replace the currently used tools. The AHA has long supported this concept and the establishment of common metrics for collecting consistent data on the clinical status and health resources provided to patients in all post-acute settings – home health agencies (HHA), skilled-nursing facilities (SNFs), IRFs and LTCHs.

The establishment of such common metrics was the original purpose of CMS's CARE Tool. However, while the underlying concept for the CARE Tool is widely supported, the full version of the tool has been criticized for being too lengthy and time consuming and for failing to capture the clinical complexity and medical resources needed to treat sicker patients, especially LTCH patients. It appears CMS has scaled back its plans to use the CARE Tool across all

settings, and instead, is pursuing a far narrower goal of using *elements* of the CARE Tool to augment and improve consistency across the existing post-acute tools. AHA members participating in the current CMS bundling demonstration Models 2 and 3 report that CMS recognizes that the full CARE Tool is too burdensome and is unpopular with hospitals, and instead has directed the bundlers to use a streamlined version of the tool, called the B-Tool. Demonstration participants report more acceptance of the B-Tool, which began testing in October 2013.

While CMS has taken a step forward, we encourage MedPAC and other policymakers to look beyond the CARE Tool and B-Tool to other post-acute assessment instruments. We believe there are other viable options to achieve consistent measurement and reporting across settings. In November, the AHA convened a group of experts from hospitals and post-acute care providers to review and discuss five discharge support tools. These tools are used by hospitals and private payers to assess patient characteristics and post-acute needs following discharge from general acute-care hospitals. Each of these tools is quite different from the CARE Tool. Specifically, most have a more streamlined design than the CARE Tool and all focus on standardizing discharge processes for assessing whether post-acute services are needed (and if so, which type), improving transitions of care across settings, and reducing avoidable readmissions. MedPAC and CMS representatives participated in this discussion. We will share the forthcoming report from this meeting with MedPAC staff.

We appreciate your consideration of these concerns. Safeguarding adequate payment for hospital services will ensure Medicare beneficiaries continue to have access to high-quality, innovative and effective care in their communities. If you have any questions, please feel free to contact me or Priya Bathija, senior associate director of policy, at (202) 626-2678 or pbathija@aha.org.

Sincerely,

Linda E. Fishman
Senior Vice President, Public Policy Analysis and Development

Cc: Mark Miller, Ph.D.
MedPAC Commissioners