American Hospital Association™
Advancing Health in America

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January 5, 2024

Michael Chernew, Ph.D.
Chairman
Medicare Payment Advisory Commission
425 I Street, NW, Suite 701
Washington, D.C. 20001

Dear Dr. Chernew:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations; our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to share our comments and ask that commissioners consider the following issues before making their final payment update recommendations at the upcoming Medicare Payment Advisory Commission (MedPAC) meeting.

The decisions you reach on hospital payment updates will not only greatly affect America's hospitals and health systems, but also other providers and the patients and communities we serve. In response to discussions during the December 2023 meeting and the commission's draft recommendations, we:

- **Appreciate the draft recommendation to provide a current-law market basket update plus an additional 1.5% for the hospital inpatient and outpatient prospective payment systems (PPS). However, we urge the commission to recommend a higher update for hospitals in light of the sustained and substantial financial pressures and negative Medicare margins they face.**
- **Urge the commission to recommend current-law updates for inpatient rehabilitation facilities (IRFs), hospital-based skilled nursing facilities (SNFs), and home health (HH) agencies given the pivotal role they play in the entire health care continuum.**
- **Support the recommendation to increase physician reimbursement but encourage the commission to consider a higher update that will more fully account for the impact of inflation.**

Our detailed comments on these issues follow.

HOSPITAL UPDATE RECOMMENDATIONS

The AHA appreciates MedPAC's recognition of the dire financial challenges the hospital field is facing, and the commission's draft recommendation to increase hospital inpatient and outpatient PPS payments by the current-law market basket update plus an additional 1.5% for 2025. An update above-and-beyond current law is absolutely necessary; however, an additional 1.5% is still insufficient to account for the combination of providers' continued financial pressures and almost two decade of sustained-and-substantial negative margins that hospitals have experienced. Simply put, even after the recommended payment update, Medicare's payments to hospitals would remain significantly inadequate.

Therefore, we continue to urge MedPAC to recommend a one-time retrospective adjustment be added to the 2025 inpatient, outpatient and long-term care hospital (LTCH) PPS market basket updates to account for the difference between what hospitals should have received and what they did receive in FY 2022. Specifically, in FY 2022, CMS finalized a market basket increase of 2.7% when the actual market basket turned out to be 5.7%. This difference of 3.0 percentage points is significant. Moreover, given the market basket accruals annually, it has resulted in a continuous future underpayment for hospitals contributing to the very negative projected moving forward. Similarly, the LTCH market basket update in FY 2022 experienced a 2.9 percentage point difference between what was finalized in FY 2022 (2.6%) and the actual change in the market basket (5.5%).

As we detailed extensively in our November 2023 letter, health care providers continue to struggle with persistently high labor costs and additional downstream challenges because of the lasting and durable impacts of high inflation and the COVID-19 pandemic. **We urge MedPAC to consider such changing health care system dynamics, alongside the unlikelihood of these dynamics returning to normal trends and their net effects on hospitals. Specifically, we ask MedPAC to examine within this context the adequacy of the market basket and its labor inputs.** Appropriately accounting for recent and future trends in inflationary pressures and cost increases in the hospital payment updates is essential to ensuring that Medicare payments for hospital services more accurately reflect the cost of providing care.

Medicare payments have remained far below the cost of providing care for many years — a fact that the commission recognizes. Specifically, according to the MedPAC data book, the Medicare program has not fully covered the costs of serving Medicare patients *since 2002*. In fact, on average, Medicare only pays 84 cents for every dollar hospitals spend providing care to Medicare beneficiaries.[1] **According to MedPAC, Medicare margins hit a record low in 2022 at *negative* 12.7% when excluding COVID-19 pandemic relief funds and *negative* 11.6% when including COVID-19 pandemic relief funds.[2]** Furthermore, MedPAC projects 2024 Medicare margins to remain depressed at *negative* 13%.[3] Notably, MedPAC found that even for its group of relatively "efficient" hospitals, Medicare margins in 2022 were *negative*

[1] https://www.aha.org/fact-sheets/2020-01-07-fact-sheet-underpayment-medicare-and-medicaid
[2] https://www.medpac.gov/wp-content/uploads/2023/03/Hospital-Dec-2023-SEC.pdf
[3] MedPAC presentation in December 2023 meeting. -13% Medicare margins exclude one-time $9 billion 340B remedy payments to be paid out in 2024. MedPAC projects -8% Medicare margins when including the one-time $9 billion 340B remedy payments.

3%. **We continue to urge the commission to start to bring Medicare payments back to the level where they cover the cost of providing care to and ensure patients have adequate access to care.**

The commission also reaffirmed its support for its Medicare safety-net index (MSNI) proposal at the December 2023 meeting, which would redistribute disproportionate share hospital (DSH) and uncompensated care funds through the MSNI with an additional $4 billion to be added into the SNI pool. **The AHA thanks the commission for recognizing that more should be done to stabilize the financial health of safety-net hospitals and for including additional funds to help support these providers that care for patients in historically marginalized communities.** These hospitals serve as a key health care access point for low-income Medicare beneficiaries, including for behavioral health services and non-clinical services that affect patients' health, such as nutrition services, transportation and housing.

However, we urge the commission to consider further the implications of redistributing existing Medicare DSH and uncompensated care funds. The link between low payment rates and access to care is well documented.[4] Reducing payments to hospitals and health systems that treat a large number of patients who face economic hardship could shift funds away from patients and communities who need support the most. The commission should consider whether further fragmentation of federal funding for the safety net could have implications for all Medicare beneficiaries.

We also urge the commission to consider what effect capping MSNI payments would have on hospitals at or above the 95th percentile of the index. In the commission's simulation of the MSNI recommendation, the Commission included a maximum add-on, or cap, at the 95th percentile of the MSNI in order to, "…avoid extreme add-ons for outlier hospitals." We appreciate the complexity and thoughtfulness included in the design of the MSNI. However, many outlier hospitals are providing extraordinary levels of care for low-income Medicare beneficiaries and serve as the backbone of America's safety net in the communities which they serve. Capping the add-on could have significant implications for these patients, their communities, and for the hospitals that serve America's safety net. We are concerned that this design consideration, although not explicitly addressed in the recommendation, could be adopted without examining these implications. **The AHA urges MedPAC to examine what affect a cap on MSNI payments would have on hospitals who provide the most care to low-income Medicare beneficiaries, as reflected in MedPAC's index design.**

Finally, we urge the commission to consider whether this proposal would have implications for health equity. AHA has found that hospitals and health systems that that serve a disproportionate share of Medicare, Medicaid and uninsured patients are located in communities dealing with sustained hardships, whose patient populations have historically been marginalized.[5] This proposal seeks to redistribute funds such that the Medicare program would not subsidize low Medicaid payment rates. It is unclear what effect, if any, MedPAC's proposal would have to improve health equity.

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[4] https://www.macpac.gov/publication/report-to-the-congress-on-medicaid-and-chip-613/
[5] https://www.aha.org/system/files/media/file/2022/10/Exploring-Metropolitan-Anchor-Hospitals-and-the-Communities-They-Serve-202210.pdf

POST-ACUTE CARE UPDATE RECOMMENDATIONS

Inpatient Rehabilitation Facilities (IRF). During the December 2023 meeting, MedPAC commissioners discussed recommending a 5% reduction to fiscal year (FY) 2025 IRF PPS payments. **AHA disagrees with this draft recommendation, and instead urges MedPAC to support a current-law market-basket update for IRFs.**

In its discussion of inpatient and outpatient hospital services, MedPAC recognized the financial strain facing hospitals, noting a sharp rise in operating costs, as well as a notable decline in margins. As MedPAC is aware, these difficulties are driven by a workforce crisis and considerable increases in the costs of medical drugs and supplies.[6,7] These same challenges also impact IRFs. Indeed, 70% of all IRFs are units of short-term acute-care hospitals. As MedPAC noted in its presentation, the aggregate margin for IRF units is only 1%, and their access to capital is closely tied to their parent institutions. A 5% reduction in reimbursement would therefore be highly challenging for the vast majority of IRFs and their parent hospitals, potentially creating access problems for Medicare beneficiaries.

Hospital-based Skilled-nursing Facilities (SNF). Also during the December 2023 meeting, commissioners discussed a draft recommendation to lower SNF payments by 3% for FY 2025. AHA is concerned such a reduction would negatively impact both SNFs and upstream providers. More specifically, as AHA has noted, short-term acute-care hospitals are facing rising lengths of stay as they struggle to find appropriate post-acute discharge locations for patients, including at SNFs.[8] Further limiting SNFs resources could potentially exacerbate this problem and only add to the financial headwinds facing short-term acute-care hospitals.

When considering a potential reduction in reimbursement to SNFs, MedPAC should also be particularly mindful of hospital-based SNFs. Although making up a small percentage of all SNFs, they play an outsized role by focusing on treating medically complex patients, and nonetheless maintain higher quality indicators than freestanding SNFs. [9] In addition, as MedPAC has also noted, hospital-based SNFs have substantially negative Medicare margins, approaching -40% and -50% in recent years. A further reduction in reimbursement could jeopardize access to care for the medically complex patients who rely on hospital-based SNFs. **AHA therefore urges MedPAC to recommend a current law market-basket update for SNFs in FY 2025.**

Home Health (HH) Agencies. Finally, the commission also discussed a draft recommendation to lower HH payments by 7% for CY 2025. As is the case with the other post-acute sites of care, HH agencies play a crucial role in the continuum of care. Specifically, hospitals rely heavily on them as partners to care for patients as they continue their recovery. As mentioned previously, hospitals have faced increasing difficulty finding placement for patients, compounding financial strains on their operations. In particular, hospitals referring patients to HH agencies in CY 2023 faced a rejection rate of 76% due to

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[6] Syntellis and AHA, Hospital Vitals: Financial and Operational Trends at 2 (last visited May 8, 2023), https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2_Feb%202023.pdf
[7] American Hospital Association, Cost of Caring at 4 (Apr. 2023), https://www.aha.org/costsofcaring
[8] https://www.aha.org/issue-brief/2022-12-05-patients-and-providers-faced-increasing-delays-timely-discharges
[9] https://www.medpac.gov/wp-content/uploads/2021/10/mar21_medpac_report_ch7_sec.pdf

resource and staffing constrictions.[10] In addition, HH agencies, as MedPAC is aware, are dealing with the same workforce crisis and inflationary environment that other providers are, as well as continued budget neutrality reductions offsetting their annual pay increases from Medicare. Accordingly, a further reduction of the magnitude of 7% would be harmful not only to HH agencies, but also to short-term acute-care hospitals and Medicare beneficiaries. **AHA therefore urges MedPAC to recommend a current-law market-basket update for HH agencies in CY 2025.**

PHYSICIAN UPDATE RECOMMENDATIONS

The AHA appreciates the commission's presentation on the adequacy of payments for physician services. The impacts of inflation and rising input costs continue to outpace the reimbursement for services covered by the physician fee schedule (PFS). As such, the AHA directionally supports the draft recommendation to increase physician reimbursement outside the parameters of budget neutrality, and to make add-on payments for safety-net primary care and specialty care clinicians outside budget neutrality.

However, we urge MedPAC to recommend a higher update to physician reimbursement, one which more fully accounts for the impact of inflation and recent PFS cuts. Specifically, the commission's draft recommendation to increase PFS rates by current law plus 50% of the Medicare economic index will not fully offset the impact of rising input costs. **In fact, data from the Medicare Trustee's Report indicate that physician reimbursement has dropped over 20% over the last 20 years when accounting for inflation.[11]** We refer you to our January 2023 letter that details our concerns in greater detail on the PFS and add-on proposal.

We thank you for your consideration of our comments. Please contact me if you have questions or feel free to have a member of your team contact Shannon Wu, AHA's senior associate director of policy, at swu@aha.org or 202-626-2963.

Sincerely,

/s/

Ashley B. Thompson
Senior Vice President
Public Policy Analysis and Development

Cc: Paul Masi, M.P.P.
MedPAC Commissioners

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[10] https://www.aha.org/lettercomment/2023-08-28-aha-comment-letter-cms-home-health-prospective-payment-system-proposed-rule-cy-2024

[11] https://www.beckershospitalreview.com/hospital-physician-relationships/the-stark-reality-of-physician-reimbursement.html