January 17, 2019

Francis J. Crosson, M.D., Chair
Medicare Payment Advisory Commission
425 Eye Street, N.W.
Washington, D.C. 20001

Dear Dr. Crosson:

On behalf of our 200 member hospitals and 50 health systems, the Illinois Health and Hospital Association (IHA) supports the Commission’s dedication to improve Medicare payment policies. As stated in our previous MedPAC letters, IHA hopes that you will look to us as a vital resource while Medicare payment deliberations continue. This letter contains four sections:

I. IHA comments on specific January meeting agenda items;

II. IHA’s continued opposition to payment reductions to hospitals providing drugs to patients under the 340B program;

III. Availability of emergency services in rural communities; and

IV. A summary of IHA’s continued opposition to the Commission’s site-neutral policy, including updated financial impact estimates.

I. IHA COMMENTS ON SPECIFIC JANUARY MEETING AGENDA ITEMS:

IHA understands that during this meeting, the MedPAC Commissioners will vote on various recommendations for Medicare payment updates for 2020. If approved, those recommendations will be included in MedPAC’s Annual Report to Congress. As the Commission begins its deliberations of Medicare payment adequacy and recommended payment updates for federal fiscal year (FFY) 2020, IHA offers the following relating comments:

- **Recommendation concerning sequestration:** During previous meetings, MedPAC has discussed the effects of the two percent sequestration payment reduction adjustment and made its payment update recommendations independent of the impact of that adjustment. However, the Commission has gone on record as saying that the sequester produces rates that are inadequate for hospitals.
IHA supports MedPAC’s conclusion that the sequester results in inadequate rates for providers. However, because the Commission bases its payment policy recommendations on what it believes to be adequate payments in order for providers to efficiently provide services to Medicare patients, until (or if) the sequester is repealed, IHA strongly recommends that MedPAC increase its final recommended percentage changes by two percent.

- **Assessing payment adequacy and updating payments: Hospital inpatient and outpatient services and Redesigning Medicare’s hospital quality incentive programs.** During discussions regarding payment adequacy at its December meeting, MedPAC recommended that Medicare payment updates for hospital inpatient and outpatient services be made according to current law; an estimate of the market basket increases according to current law for both inpatient and outpatient services is 2.8 percent. **IHA does support the Commission’s recommendation to set payments for those services, in accordance with the current law in 2020, with the caveat that the two percent reduction for sequestration would be added back to those recommended amounts.**

- **Assessing payment adequacy and updating payments: Physician and other health professional services and Medicare payment policies for advanced practice registered nurses and physician assistants.** During discussions regarding payment adequacy at its December meeting, MedPAC recommended that Medicare payment updates for physician and other health professional services be based on current law. The current law governing payments for these services in 2020—the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)—mandates a 0 percent update; any changes in payment will be based on clinicians’ 2017 performance as reported under either the Merit-Based Incentive Payment Program (MIPS) or the Advanced Alternative Payment Models (AAPMs).

The Commission has discussed its concerns with MIPS and intends to present a policy option. Since the MACRA’s passage, IHA has devoted significant staff resources and time expanding its visibility and policy work with our members’ medical staff administration. This increased effort includes the development of MACRA Quality Payment Program (QPP) workbook “tool” for member hospitals and their medical staffs to help prepare them for the effect of the legislation on Medicare payments beginning in 2019. **We stress that any future financial improvements to the current Medicare Physician Fee Schedule (PFS) payment system must not be financed through the reduction of Medicare payments made to hospitals or to other post-acute service providers.** Our Illinois providers simply cannot endure further payment reductions in a system that has already seen significant legislative and regulatory changes primarily from the enactment of the Affordable Care Act (ACA). We encourage the Commission to continue to review and discuss reforms to the current Medicare physician fee schedule payment system, but in doing so, hold other Medicare providers harmless
from further cutbacks. Consequently, we are very interested in MedPAC’s discussions in this area and are happy to offer our assistance and share our work in this area up to this time.

- **Assessing payment adequacy and updating payments: MedPAC’s recommendation that no payment increase be made for certain services.** During discussions regarding payment adequacy at its December meeting, MedPAC recommended that a zero percent payment update be applied in 2019 for the following services:
  - Ambulatory surgery services (ASC), and
  - Skilled nursing services.
During those December discussions, the Commission concluded that no increase is justified because those services have historically experienced high Medicare profit margins. **IHA has always maintained that development of Medicare payment policy should not be influenced by financial margins, positive or negative, but should be dictated by sound patient care needs and protocols that recognize the important role of those providers in reducing readmissions and improving health outcomes.**

The arguments put forth by the Commissioners are grounded primarily in dollars and statistics and do not represent good public health policy. Determining a rate of increase based solely on previous profit margins and volume shifts ignores the fact that a higher payment rate of increase would ensure that these providers can continue to provide the types of services that Medicare beneficiaries need and have come to expect. For skilled nursing services, in particular, our latest data indicates that IHA’s hospital-based skilled nursing facilities have experienced significant negative margins serving Medicare patients. **At a minimum, therefore, IHA recommends that the Commission apply the Medicare payment principles as stipulated in current law for skilled nursing and ambulatory surgery services for which it has recommended a zero percent update in 2020.**

- **Assessing payment adequacy and updating payments: MedPAC’s Deferral of Recommending a Payment Adjustment for Long-Term Care Services:** Historically, the Commission has recommended a zero percent increase for long-term care payment rates, applying the same logic as that presented in the above discussion. However, at its December meeting, the Commissioners did acknowledge that the financial conditions of long-term care facilities, in particular, have worsened over the last couple of years, due primarily to the implementation of CMS’ site-neutral policy, which reduces Medicare payments for certain long-term care patients to the payment level of the inpatient acute MS-DRG amount; therefore, MedPAC deferred recommending a payment update for these services. **In light of this, and because the site-neutral policy could result in a reduction of long-term care services for Medicare beneficiaries in the future, IHA recommends that the Commission recommend a full market basket increase in FFY 2020 if it continues this discussion**
at its January meeting.

- **MedPAC’s recommendation that payment decrease be made for certain services.**

  At its December meeting, the Commission concluded that a payment decrease is justified for the following services because those services have historically experienced high Medicare profit margins:

  o **Inpatient Rehabilitation:** The Commission justifies its five percent reduction for hospital-based rehabilitation facilities by stating that those facilities are able to cover their direct costs. Our most recent estimates of the Medicare margins for our members that provide rehabilitation services is 0.02 percent, before the application of the sequestration reduction, which reduces payments even further by two percent. This almost negligible modest profit margin is not sufficient to cover inflationary increases in direct costs, much less the total costs, of the facility. A payment update of minus five percent, coupled with the two percent sequestration adjustment, would place significant financial stress on our members.

  As hospital-based rehabilitation units continue to serve Medicare patients needing highly specialized care, IHA strongly recommends that the Commission support a positive update, as would be provided in current law. Simply covering direct costs is not a valid reason for limiting payment increases. Hospital-based programs, in particular, incur greater overhead costs than their free-standing counterparts, including costs of technology, 24-hour access and services, patient billing, and building and equipment expenses and depreciation.

  o **Hospice:** At its December meeting, MedPAC recommended a payment update for Medicare hospice services of minus two percent. Although the Commission rationalizes that hospice facilities can withstand a payment reduction due to their strong financial performances in the past, its recommendation is still puzzling. In studies conducted over the past several years, Medicare beneficiaries have indicated a strong preference for hospice as a more acceptable choice for end-of-life treatment. Hospice care is significantly less expensive than inpatient hospitalization or traditional home health care. **Consequently, IHA recommends that MedPAC change its recommendation to one that would allow a full market basket increase in 2020.**

  o **Home Health:** In its December meeting, MedPAC again concluded that Medicare payments for home health services were more than adequate due to comparatively low capital needs and consistent double-digit profit margins. Consequently, the Commission recommended a five percent decrease for home health services. Our experience in Illinois, however, does not support MedPAC’s conclusions regarding home health agency profitability. Our most recent
estimates of the Medicare margins for our members that provide home health services is **minus 16.3** percent, *before the application of the sequestration reduction, which reduces payments even further by two percent*. Our projections for CY 2019 for Illinois home health agencies conclude that in the aggregate, our member hospital-based, home health agencies are estimated to experience a 3.4 percent increase in Medicare payments under current law. That increase does not approach eliminating the current negative financial picture, nor does it take into account the additional two percent sequestration reduction.

**IHA respectfully disagrees with the Commission’s recommendation to decrease Medicare home health payments and continues to recommend a minimum increase of the full market basket for 2020.** Our reasons are twofold: First, home health agencies have already faced payment reductions legislated through the ACA or enacted as CMS regulatory reductions (i.e., the documentation and coding reduction). Second, more importantly, Congress should act to encourage the growth of home health services, as these are cost-effective alternatives to inpatient care. Limiting the amount of Medicare payment increases for these services discourages that potential for growth.

II. **IHA’S OPPOSITION TO HOSPITAL PAYMENT REDUCTIONS FOR ADMINISTRATION OF 340B PROGRAM DRUGS:** In its CY 2018 Medicare OPPS final rule, CMS implemented a significant reduction in payments to hospitals that participate in the Health Resources and Service Administration’s (HRSA’s) 340B Drug Pricing Program. The policy revises the payment methodology from payments based on the average sales price (ASP) of the drug plus an inflation factor of six percent to the average sales price minus 22.5 percent, effectively reducing payments to 340B Program eligible hospitals by almost 30 percent. CMS cites previous work performed in this area by MedPAC as one of its supporting arguments for the change.

The 340B program allows covered entities, including eligible hospitals, to stretch scarce resources while continuing to provide access to care. This policy does great harm to our member hospitals that serve our most vulnerable citizens, effectively undermining the purpose of the 340B program established by Congress. It not only diminishes the 340B program’s value as a tool for lowering drug prices, but also disrupts access to care for those in greatest need, including low-income Medicare beneficiaries. Many 340B hospitals are a vital access point for healthcare services in their communities, and the discounts they receive through the 340B program play an important role in allowing these organizations to care for patients. However, these facilities are financially vulnerable. According to the latest estimates available for Illinois hospitals, the average Medicare margin for outpatient services in 2016/2017 was **minus 16.3** percent.
In conclusion, IHA believes that any reductions in Medicare Part B payments for 340B drugs will put significant financial pressure on our hospitals, negatively impacting their ability to provide access to high-quality care to their Medicare beneficiaries and their communities at large. Therefore, IHA urges MedPAC to request that CMS reverse its CY 2018 OPPS final rule policy and instead, offer recommendations to strengthen the 340B program, including ensuring that providers (including hospitals) are fairly reimbursed for the cost of drugs administered through the program.

III. AVAILABILITY OF EMERGENCY SERVICES IN RURAL COMMUNITIES:

In previous meetings the Commission indicated it recognized that inpatient services at many small, rural hospitals have declined significantly, resulting in financial strains for those hospitals. IHA agrees with MedPAC that these changes necessitate updated payment policy options and other changes to help stabilize access to care in vulnerable communities. IHA would also like to point out that some CMS rules and requirements have contributed to physicians referring patients away from rural and critical access hospitals. This could be partially resolved by eliminating unnecessary “Direct Physician Supervision” of therapeutic services (such as chemotherapy) that have been provided safely in rural hospitals. In addition, the 96-hour attestation requirement strongly encourages individual physicians to refer patients away or not accept patients who may require a length of stay that could exceed 96 hours.

Recent CMS regulations have lessened the burden of both the direct supervision and 96-hour rule; the moratorium on the enforcement of the direct supervision requirements on critical access and small rural hospitals was reinstated for calendar years 2018 and 2019, and the agency has directed its Medicare contractors to assign low priority to claim reviews involving the 96-hour rule. Assisting our rural hospital members in their transformation of the delivery of healthcare services in their communities, and throughout the state, is a high priority of our association. IHA is pleased that the Commission has discussed the needs of rural hospitals in today’s changing environment of healthcare delivery and hopes that it will continue to do so; however, we continue to recommend that both of the previously mentioned regulatory constraints on rural hospitals that have been temporarily removed be permanently repealed.

IHA appreciates that in its June 2018 report to Congress, the Commission recommended the establishment of a rural alternative payment model to allow certain struggling rural hospitals to continue to provide emergency and outpatient services and receive the combination of a fixed facility fee plus the standard prospective rate for services. This recommendation is similar to bipartisan, IHA-supported legislation, the Rural Emergency Medical Center Act of 2018 (H.R. 5678), which would establish a rural emergency medical center (REMC) designation under the Medicare Program, and payment of a fixed facility and the outpatient rate for services. Coupled with transfer
agreements with acute care hospitals, H.R. 5678 would enable qualifying hospitals to stabilize access to essential health services in their communities and maintain financial viability. IHA suggests that MedPAC, as part of its focus on the availability of emergency services in rural areas, consider performing a financial analysis looking at the financial and demographic impacts of this legislation and again recommends Congress take action to pass legislation in this area.

IV. IHA’S CONTINUED OPPOSITION TO SITE-NEUTRAL POLICIES:
Addressing MedPAC’s previous recommendations on CMS’ Hospital Outpatient Department (HOPD) site-neutral policies, IHA reiterates its objection to the Commission’s four principal areas of service:

- Medicare payment for outpatient evaluation and management office visits provided in hospital outpatient departments be reduced to the level of payment made for those same visits to a private physician’s office;
- Medicare payment for 66 specified ambulatory payment classifications (APCs) be made based on the Medicare Physician Fee Schedule (PFS) amount;
- Medicare payment for 12 Ambulatory Surgery APCs be made at the Medicare rate currently paid to free-standing ASCs; and
- Medicare payment for certain inpatient rehabilitation services be made at the rate currently paid to skilled nursing facilities for those same services.

Based on our most recent impact estimates of all of the site-neutral payment adjustments in 2018, Medicare payments to Illinois hospitals and rehabilitation facilities would be reduced by approximately $223.4 million. Over a 10-year period, the reduction compounds to over $2.4 billion. Additionally, we have estimated that the eight-year (2010 – 2017) impact of Medicare reductions already implemented on Illinois hospitals and health systems, including the Affordable Care Act and sequestration, is approximately $5.3 billion. Our member hospitals simply cannot withstand further reductions.

Dr. Crosson, we hope that as MedPAC continues to discuss policy improvements to transform the Medicare payment system through incentives for clinical integration strategies and quality care across the continuum of services, we can continue our dialogue with you.

Sincerely,

A.J. Wilhelmi
President & CEO
Illinois Health and Hospital Association