December 6, 2018

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. We recognize that the importance of the Commission’s work on Medicare payment policies is heightened as the delivery and payment of healthcare services continues to undergo significant transformation.

In Illinois, we are working with our member hospitals and health systems to help them transform their individual healthcare delivery systems to better meet the needs of their communities. For example, we are currently working with various healthcare stakeholders to improve the quality of care and availability of behavioral health services. We are also working with our member hospitals to better match the specific needs of their communities with the services they provide. As stated in our previous MedPAC letters, IHA hopes that you will look to us as a vital resource for information from our member hospitals while Medicare payment deliberations continue. This letter contains four sections:

I. IHA comments on specific December 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 DECEMBER MEETING AGENDA ITEMS:

As the Commission begins its deliberations of Medicare payment adequacy and recommended payment updates for 2020, IHA offers the following relating comments:

- **Assessing payment adequacy and updating payments: physician and other health professional services.** In 2015, the Medicare and
CHIP Reauthorization Act of 2015 (MACRA) legislated a 0 percent increase in calendar year (CY) 2020; the previously-legislated increases would be replaced by payment adjustments based on physicians’ performance on various quality of care measures. IHA supports the continued emphasis of Medicare payment methodologies based on the quality of care provided to Medicare beneficiaries, including Medicare physician payment methodologies, as well as the roll-out of payment reforms legislated by MACRA.

The Commission has discussed its concerns with the Merit-Based Incentive Payment System (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.

The Commission indicates that it will include a discussion of Medicare’s payment policies for advanced practice registered nurses and physician assistants at this meeting. This year, IHA established a MACRA-QPP member subcommittee, comprised of a cross-section of our members’ clinical and other administrative staffs, including representatives for advanced practice nurses and behavioral health services. The subcommittee’s discussions will contribute to IHA’s efforts to work with CMS to improve the QPP policies. Thus far, we have held two group meetings and the feedback we have received has been most informative and helpful, with any recommendations for improvement communicated directly to CMS.

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: ambulatory surgical**
centers (ASCs). A hospital outpatient site neutral payment policy was implemented in CY 2017 and was also applied to off-campus, hospital-acquired ambulatory surgical centers, resulting in reduced Medicare payments to those facilities. IHA strongly recommends that any ASC payment recommendations put forth by the Commission take the negative impact of this policy into consideration.

- **Assessing payment adequacy and updating payments: Hospital inpatient and outpatient services.** In the past, the Commission has reviewed the current Medicare payment methodology for both hospital inpatient acute and hospital outpatient payments. It has often recommended annual increases lower than the market basket rate of inflation, irrespective of the two percent reduction applied to Medicare payments as a result of the sequestration legislation included in the Budget Control Act of 2011. One justification that the Commission has used for its recommendation is its conclusion that hospitals still experience 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 approaches.

Based on our most recent projections, Illinois hospitals, in aggregate, will experience a 2.4 percent increase in their Medicare hospital inpatient payments, but only a 0.25 percent increase in their Medicare hospital outpatient payments. Furthermore, a significant number of Illinois hospitals that are eligible to participate in the 340B Drug Program will continue to experience decreases in their Medicare outpatient payments in 2019, resulting from CMS’ promulgation of a near 30 percent reduction in Medicare payments for separately billable drugs in the CY 2018 Outpatient Prospective Payment System (OPPS) final rule.

The estimated outpatient payment increase does not include the Medicare hospital outpatient department site-neutral payment reductions (as legislated by the Bipartisan Budget Act of 2015), that were implemented in January 2017. For those services, that payment equals 40 percent of the corresponding Ambulatory Payment Classification (APC) rate. And those estimates do not include the additional two percent sequestration reductions, applied to all Medicare service levels. **However, those reductions do include the impact of CMS’ two-year payment transition (beginning in 2019) for Evaluation & Management (E & M) visits from payment under the OPPS to payment under the PFS.** For Illinois hospitals, we estimate the aggregate reduction in Medicare E & M outpatient payments to be $11.7 million in 2019. In order to ensure continued access to these outpatient services for
Medicare beneficiaries, we urge the Commission to rethink its position on hospital-acquired, off-campus physician practices. We ask that the Commission recommend to Congress that the Centers for Medicare & Medicaid Services’ (CMS’) current policies implementing the legislation must continue to be improved. Some provisions of the current rule (most notably, the application of the policy to facilities that have relocated) should be repealed.

- **Assessing payment adequacy and updating payments: Skilled Nursing Facility (SNF) Services.** The Commission has indicated that it welcomes recommendations on how the Medicare payment system for skilled nursing facility services can be improved. Consequently, IHA reiterates its support of a previous Commission’s recommendation that an outlier policy for those services be implemented in 2019. Also, in 2019, CMS will implement a Value-Based Purchasing (VBP) program for SNFs for the first time. We have estimated the impact on Medicare payments in 2019 (inclusive of the VBP program) to be an increase of only 2.1 percent; consequently, we recommend to the Commission that it advise an increase in Medicare skilled nursing payments based on the full market basket increase in 2020.

- **Assessing payment adequacy and updating payments: Inpatient Rehabilitation Services.** The Commission’s supporting information indicates that margins for hospital-based rehabilitation units have been steadily declining on an annual basis. However, the Commission justified its recommendation for a five percent decrease for hospital-based facilities in 2019 by stating that those facilities are able to cover their direct costs. For 2019, we estimate a 1.6 percent profit margin for our members that provide rehabilitation services, before the application of the sequestration reduction. This is hardly adequate to cover inflationary increases in direct costs, much less the total costs of the facility.

As hospital-based rehabilitation units continue to serve Medicare patients needing highly specialized care, IHA strongly recommends that the Commission support a positive update. 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, building and equipment expenses and depreciation.

- **Assessing payment adequacy and updating payments: Long-term care hospital services.** Last year, the Commission had recommended a 0 percent update for inpatient long-term care facilities last year, based on profit margin
data. Our experience in Illinois, however, does not support MedPAC’s conclusions regarding long-term care hospital profitability. Our FFY 2019 projections for Illinois long-term care facilities illustrate that in the aggregate, our member hospital-based, long-term care hospitals are estimated to experience a 0.6 percent increase in Medicare payments under current law. A primary reason for this comparatively small increase is the site-neutral payment policy that was implemented beginning in 2016. But this increase does not include the additional two percent sequestration reductions. Therefore, IHA believes that the Commission should recommend a full market basket update, as these facilities continue to treat Medicare patients with highly specialized and critical needs, and our Illinois LTCHs are not seeing the proliferation of profits that MedPAC believes exist.

• **Assessing payment adequacy and updating payments: Hospice Services.**
  IHA is pleased to see that the Commission is examining the adequacy of Medicare payments for hospice services. Hospice services are much less costly alternatives to inpatient hospitalization, and have proven to be a preferred setting of treatment by patients and their families. At the same time, reimbursement must be equitable, and IHA believes that a full market basket percentage in Medicare payments is appropriate.

• **Assessing payment adequacy and updating payments: Home Health Services.** In previous meetings, MedPAC has concluded that Medicare payments for home health services were more than adequate due to comparatively low capital needs and double-digit profit margins in previous years. Consequently, the Commission recommended a 5 percent decrease for home health services last year. Our experience in Illinois, however, does not support MedPAC’s conclusions regarding home health agency profitability. 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, but that increase does not include the additional two percent sequestration reduction. So, at best, our home health providers would receive an approximate 1.4 percent increase, before the reduction as recommended by MedPAC.

IHA respectfully disagreed with the Commission’s previous recommendations for home health payment increases 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). 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 PAYMENT REDUCTIONS TO HOSPITALS PROVIDING DRUGS TO PATIENTS UNDER THE 340B DRUG PROGRAM: In its CY 2018 Medicare OPPS final rule, CMS implemented significant reductions 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, and we must continue to express our strong objections to the implementation of this policy. Furthermore, in its final CY 2019 Medicare OPPS rule, CMS is expanding the 340B payment reductions to non-excepted, off-campus hospital outpatient facilities.

The 340B Drug 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 and undermines 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 the economic engines of their community, 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 16.4 percent.

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 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 and CY 2019 final rule policies 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. During its October 2015 meeting discussions, the Commission indicated it recognized that inpatient services at many small, rural hospitals have declined significantly, resulting in financial
strains for those hospitals. IHA would 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 therapy services (such as chemotherapy and blood transfusions) that have been provided safely in rural hospitals. 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. 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.

In addition, the Rural Emergency Medical Center Act of 2018 would create a new hospital designation under the Medicare program which would allow those rural hospitals struggling to maintain financial viability and which meet certain criteria to transition to an emergency medical center with higher Medicare reimbursement. Coupled with transfer agreements with other acute care hospitals, this law would enable qualifying hospitals to continue to provide much-needed emergency services in their communities. 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.

IV. IHA’S CONTINUED OPPOSITION TO SITE-NEUTRAL POLICIES. Addressing MedPAC’s past recommendations on CMS’ Hospital Outpatient Department (HOPD) site-neutral policies, IHA reiterates its objection to the Commission’s previous site-neutral payment policies. Based on our most recent impact estimates of all of the site-neutral payment adjustments, in the first year alone, Medicare payments to Illinois hospitals and rehabilitation facilities would be reduced by approximately $219.2 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.

It is important to point out that hospitals are economic engines for their local communities, serving as catalysts for job growth and community vibrancy. The potential impact of the loss of healthcare services and jobs, not only in those hospitals, but also in the communities in which they serve, will result in a diminishing availability of much-needed healthcare services for Illinois’ most vulnerable citizens, requiring the elderly and the handicapped to unnecessarily travel further for their care and services.
Dr. Crosson, thank you again for the opportunity to comment. If you or your staff has any questions on the comments, they should be addressed to Thomas Jendro, senior director of finance, at 630-276-5516 or tjendro@team-iha.org.

Sincerely,

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