October 4, 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. 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 October meeting agenda items;

II. IHA’s 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 OCTOBER MEETING AGENDA ITEMS:

IHA offers the following comments specific to its October agenda:

• Opioids and Alternatives in Hospital Settings: Payments, Incentives and Medicare Data: At its October meeting, MedPAC will present a research paper discussing how the Medicare program pays for opioids
in the inpatient and other provider settings. Commission discussions will then focus on whether or not a separate Medicare opioid monitoring program should be introduced for both Medicare Parts A and B. Currently, data regarding the use and payment of opioid drugs among Medicare beneficiaries is very limited. IHA supports MedPAC’s interest in this area, offering its willingness to assist the Commission as it develops its work. We also recommend that if MedPAC suggests Medicare payment reforms in this area, those recommendations are vetted by other healthcare stakeholders in the field.

• **Medicare Payment Policies for Advanced Practice Registered Nurses (APRNs) and Physician Assistants (Pas):** As healthcare providers continue to transform its delivery systems to better provide patients with access and quality care, “non-physician practitioners,” including physician assistants and nurse practitioners, play an important role in this process. IHA and its Medical Executive Forum (a committee comprised of Chief Medical Officers of IHA member hospitals and systems) have discussed the importance and significance of these healthcare providers in today’s healthcare delivery system. Given the implementation of payment adjustment reforms legislated by the Medicare Access and CHIP Reauthorization Act (MACRA) Quality Payment Program (QPP) in January 2019, IHA agrees that the Commission should discuss options for Medicare payment reform for all non-physician practitioners (including nurse practitioners, psychologists and therapists). We are particularly interested in the development of appropriate performance measures for these groups as there is some concern that current measures for them are inadequate. IHA is willing to work with MedPAC as the Commission conducts its work in this area, consulting its Medical Executive Forum members in the process, as necessary.

• **Medicare’s Role in the Supply of Primary Care Physicians:** IHA is pleased to see that the Commission is examining the “supply and demand” situation surrounding primary care services. We are especially concerned about the impact that the lack of available primary care services will have on our rural communities. We have long supported Medicare’s add-on payment for physicians who practice in medically underserved areas, and recommend that MedPAC continue to support incentive payments for those primary care physicians who practice in these communities.

• **Assessing Medicare’s Payments for Services Provided in Inpatient Psychiatric Facilities:** IHA is pleased that the Commission will focus on Medicare payments for inpatient psychiatric services, as we have been working with state and federal agencies to improve access to those behavioral health services for patients that need them. Since its inception in 2005, the Medicare Inpatient Psychiatric Facility Prospective Payment System (IPF-PPS) has undergone very
few annual adjustments, with the exception of updates in the standardized per-diem rates. **IHA offers its assistance to the Commission as it takes on this undertaking.**

- **Episode-Based Payments and Outcome Measures Under a Unified Payment System for Post-Acute Care:**
  The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT) required that MedPAC develop a uniform prospective payment system for post-acute settings and present a report to Congress by June 30, 2017 on its recommendation and anticipated impacts. Currently, there are four individual post-acute payment systems in place: Inpatient Rehabilitation, Inpatient Skilled Nursing, Inpatient Long-Term Care, and Home Health. Several IHA hospital members operate post-acute services and are interested in any details regarding a consolidated payment system. At your meeting, more information regarding the payment methodology is scheduled to be presented, including an episode-based payment system and two performance-based measures—discharge to the community and potentially avoidable readmissions back to the acute care hospitals. **IHA is willing to support MedPAC in its work, but also points out that beginning in federal fiscal year (FFY) 2019, CMS will begin implementing a Medicare Value-Based Purchasing (VBP) program for skilled nursing services, which focuses on readmissions; this also merits MedPAC’s attention.**

II. **IHA’S OPPOSITION TO PAYMENT REDUCTIONS TO HOSPITALS PROVIDING DRUGS TO PATIENTS UNDER THE 340B 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.**

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 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 13.1 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 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:

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. 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. 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 four components of the Commission’s site-neutral payment policy which proposes that:

- Medicare payment for outpatient evaluation and management office visits provided in hospital outpatient departments is reduced to the level of payment made for those same visits to a private physician’s office. CMS in its proposed CY 2019 Medicare Outpatient Prospective Payment System (OPPS) rule, extends site-neutral payments to off-campus clinics, reducing payment from the OPPS payment system rates to the Physician Fee Schedule (PFS) rates, which would mean an approximate 60 percent payment reduction. **IHA strongly objected to this reduction in its comment letter to CMS.**
- Medicare payment for 66 specified ambulatory payment classifications (APCs) be made based on the Medicare PFS amount;
- Medicare payment for 12 Ambulatory Surgery APCs be made at the Medicare rate currently paid to free-standing Ambulatory Surgery Centers; 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 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 travel unnecessarily 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,
A.J. Wilhelmi
President & CEO

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