April 4, 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 April 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;

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 APRIL MEETING AGENDA ITEMS: MedPAC’s April agenda includes a number of more general Medicare policy issues, primarily because the Commission had already voted on specific payment recommendations at the January meeting. Those recommendations were included in its March Annual Report to Congress. However, IHA does offer the following comments specific to a couple of items on its April agenda:

• Expanding the Use of Value-Based Payment in Medicare: At its April meeting, the Commission will discuss how a stronger incentives to control costs could be implemented within the existing fee-for-service programs. The current value-based purchasing program includes as one of its scoring domains, a “Medicare Spending per Beneficiary” (MSPB) domain—the equivalent of a cost-driven scoring measure. IHA has been monitoring its
members’ scoring results within that domain, and have been concerned that:

- The current weighting of the MSPB domain factor is 25% of the total VBP composite score. This is the one domain in which hospitals are unable to file or report improved operational efficiencies because an individual hospital’s scoring is based upon its submitted Medicare claims.
- As is the case with the other VBP domain measures (Safety of Care, Person and Community Engagement and Clinical Outcomes), an individual hospital’s performance and scoring is based upon a two or three year period prior to the payment year. This approach dilutes the effect of recent operational improvements made by our members, as these improvements will not impact the hospital’s scores until at least two years in the future.

IHA supports any improvements to the current fee-for-service quality-based payment systems (assuming that they have been vetted by industry stakeholders), but recommends that MedPAC proceed carefully with any incentives it considers to amend the cost domain. Our members have told us that under the current scoring methodology, achieving the maximum (or near the maximum) of 10 points is very difficult. If it is the Commission’s objective to examine the incentives to reduce costs within the current VBP program, it should also examine ways to better reward those facilities that achieve cost reduction, but are not rewarded sufficiently under the current program.

II. IHA’S OPPOSITION TO HOSPITAL PAYMENT REDUCTIONS FOR ADMINISTRATION OF 340B PROGRAM DRUGS: In its calendar year (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 6% to the average sales price minus 22.5%, effectively reducing payments to 340B Program eligible hospitals by almost 30%. 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 2017/2018 was \textit{minus 15.4\%}.

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, \textit{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.}

\section*{III. \textbf{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 CYs 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 2019, Medicare payments to Illinois hospitals and rehabilitation facilities would be reduced by approximately $96.1 million. Over a 10-year period, the reduction compounds to over $1.2 billion. Additionally, we have estimated that the nine-year impact (2010 – 2018) of Medicare reductions already implemented on Illinois hospitals and health systems, including the Affordable Care Act and sequestration, is approximately $6.5 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

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