November 1, 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 November 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 NOVEMBER MEETING AGENDA ITEMS:
IHA offers the following comments specific to its November agenda:

• **Mandated Report: Long-Term Care Hospitals:** At its November meeting, MedPAC will discuss its analyses of post-acute care usage, including Long-Term Care Hospital (LTCH) usage, spending and quality.
In accordance with the Bipartisan Budget Act of 2013, beginning in 2016, Medicare has reimbursed LTCHs under two methodologies: the standard payment rate for those cases that meet its criteria for long-term care coverage and a site-neutral, acute care MS-DRG payment rate for those cases not meeting the criteria. In 2019, we estimate that Medicare payments to the seven Illinois hospital-based LTCHs will be reduced by more than $15 million, due to the application of the site-neutral policy. IHA has consistently expressed concern over this dual payment structure, fearing that the site-neutral policy could result in a reduction of certain services or possibly the closure of those providers. As the Commission analyzes its data on LTCH usage and costs, IHA offers its assistance. We are particularly interested in any data that measures the impact of the Medicare site-neutral payment policy on service reductions or closures of LTCHs across the country. We also recommend that if MedPAC suggests Medicare payment reforms in this area, those recommendations are vetted by other healthcare stakeholders.

• **Evaluating Patient Functional Assessment Data Used in Medicare Payment and Quality Measurement:** MedPAC has expressed its concern that because Medicare payments to Inpatient Rehabilitation Facilities (IRFs) are based on provider reported functional assessments of Medicare rehabilitation patients, the assessment data may not be accurate. There is an implication that IRFs will submit patient data that will result in the highest payment.

The Improving Post Acute Care Transformation (IMPACT) Act of 2014 includes provisions establishing criteria for standardized patient assessment data and payment for inpatient rehabilitation facilities. IRF clinicians have only begun reporting their patients’ functional status under the new assessment guidelines within the past year. Consequently, we believe that if reported data is inaccurate, it is because there has been insufficient guidance provided by CMS to ensure the accuracy of the data. **IHA supports MedPAC’s review of this data, especially in light of CMS’ intent to revise the Patient Assessment Instrument in FFY 2020 (as stated in its final FFY 2019 IRF-PPS payment rule).** We request that MedPAC recommend to Congress that it require CMS to provide more opportunities for education and outreach to IRF providers to ensure that the facilities are properly reporting their patients’ functional status.

• **Modernizing the Medicare-Dependent Hospital Program:** The Rural Medicare-Dependent Hospital (MDH) program provides vital funding for the 10 Illinois rural hospitals that qualify for the payment adjustment in FFY 2019. When legislation authorizing the program expired in past years, IHA strongly advocated for its extension; consequently, we are pleased that the Bipartisan Budget Act of 2018 extended the program through FFY 2022.
At its November meeting, MedPAC will review alternative criteria for redesigning the program, including the incorporation of outpatient data into the eligibility criteria. Our own work with our IHA rural hospital members helping them transform their healthcare delivery systems has shown a significant shift from inpatient to outpatient services, so we agree in principle with the Commission’s suggestion that outpatient services must be considered. However, we take exception to the concern that the MDH program may not appropriately target those hospitals with the greatest need; if funding for this program were to be significantly reduced, or if our current MDH-eligible hospitals were to lose eligibility altogether, the effects on services provided in their communities could be devastating. Consequently, we are very interested in the data MedPAC has developed and how it would be used to revise the MDH program, and would encourage the Commission to vet any conclusions and/or recommendations for this program with other healthcare industry stakeholders.

- **Examining the Medicare Advantage (MA) Quality Bonus Program:** MedPAC has indicated that it will review the criteria for establishing Star Ratings for Medicare Advantage plans at its November meeting; a plan’s Star Rating is a factor in determining payments the plan receives from CMS to administer its MA program. MedPAC indicates that it will also examine additional issues with the star rating system.

IHA continues to support transparency in the healthcare system, making more information available to help Medicare beneficiaries make choices about their healthcare; the Star Ratings system is intended to provide more of this information. However, since the Star Ratings system was developed, IHA believes that improvements in the Star Rating methodology could be made. Among our concerns are:

- The timing of the publication of the ratings reflects the most recent reported hospital performance period; however that performance period may exclude any recent operational improvements made by the hospital.
- There may be confusion over the definition of measures.
- The Star Ratings results must be consistent with other CMS public reporting data venues, such as the Value-Based Purchasing program.
- Combining inpatient and outpatient scores may skew the results.
- Re-weighting those domains for which there are no, or insufficient volumes of data may skew the results.
- Results for major teaching hospitals may be skewed because of the complexity of cases they treat.
IHA supports MedPAC as it examines the Star Ratings system, and is willing to offer its assistance in developing policies to revise the system.

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 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 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. 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 previous site-neutral payment policies which propose that:

- 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. For CY 2019, CMS proposes to extend 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,

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