American Hospital Association

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January 6, 2017

Francis J. Crosson, M.D.
Chairman
Medicare Payment Advisory Commission
425 I Street, N.W. Suite 701
Washington, DC 20001

Dear Dr. Crosson:

The Medicare Payment Advisory Commission (MedPAC, or the Commission) will vote next week on payment recommendations for fiscal year (FY) 2018. On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, the American Hospital Association (AHA) asks that commissioners consider the following issues that would have a significant impact on hospitals, health systems, other providers and Medicare beneficiaries before making final recommendations.

HOSPITAL INPATIENT AND OUTPATIENT UPDATE RECOMMENDATION

In December, the commissioners considered two draft recommendations related to the hospital inpatient and outpatient prospective payment systems (PPS). Specifically, these included the following recommendations for FY 2018, each of which is addressed in detail below:

- The Congress should update inpatient and outpatient payments by the amount specified in current law; and
- The Secretary of Health & Human Services should require hospitals to add a modifier on claims for all services provided at off-campus stand-alone emergency department facilities (OCEDs).

Hospital Payment Update Recommendation. **The AHA agrees with MedPAC that positive updates for both the hospital inpatient and outpatient PPS are necessary in FY 2018.** We appreciate the Commission's recognition that Medicare payments will remain below the cost of providing care – specifically, that, in FY 2017, the average hospital is projected to have an overall Medicare margin of *negative* 10.0 percent. Even when looking at MedPAC's analysis of "efficient" hospitals from the December meeting, overall Medicare margins were zero. AHA Annual Survey data illustrate the same trend – a staggering 63.9 percent, or 3,106 hospitals, were paid less than the cost of caring for Medicare patients in 2015. **Medicare payments are**

inadequate and a full market-basket increase for inpatient and outpatient hospital services is absolutely necessary.

Tracking OCEDs in Medicare Claims Data. At the December meeting, MedPAC discussed a recommendation that would require the Centers for Medicare & Medicaid Services (CMS) to use a separate modifier to identify claims or services provided in OCEDs. CMS does not currently identify claims or services provided in OCEDs, making it difficult to fully understand the type, scope and cost of services offered in this setting. **As such, we agree with MedPAC that it may be worthwhile for CMS to begin to track OCEDs in the Medicare claims data, provided the mechanism used to do so is not overly costly or burdensome for hospitals to implement.**

Site-neutral Discussion. While MedPAC did not make draft site-neutral recommendations at the December meeting, the commissioners did continue their discussion of potential site-neutral policies that could be considered for the future. The AHA has communicated our major concerns related to these site-neutral policies on numerous occasions, most recently in our Dec. 5, 2016 letter to the commissioners. **The AHA continues to oppose the Commission's previous site-neutral payment recommendations. We also believe that it would be premature and disruptive to providers, patients and communities to implement conflicting, potentially overlapping or entirely new site-neutral payment policies given CMS's current efforts to implement on Jan. 1, 2017 the site-neutral payment policies enacted by Congress in Section 603 of the Bipartisan Budget Act of 2015.**

INPATIENT REHABILITATION FACILITY UPDATE RECOMMENDATION

In its December meeting, MedPAC put forth a draft recommendation to, in FY 2018, reduce inpatient rehabilitation facility (IRF) PPS payments by 5.0 percent. Following multiple regulatory interventions, the IRF field has experienced significant change over the past 11 years, which has resulted in a major reduction in volume. Specifically, the number of cases treated annually by the field dropped by 23 percent, or 114,000 cases, from 2004 to 2015. In addition, since June 2016, IRFs have faced a new challenge – a narrower set of conditions that count toward the IRF 60% Rule presumptive compliance test due to oversights during the transition to ICD-10. Despite this regulatory upheaval, the field has steadily improved outcomes, as reported last month by MedPAC staff. For example, from 2011 to 2015 community discharge rates have increased to 76.0 percent and potentially avoidable rehospitalizations have continued to drop.

Additionally, the Commission discussed of the need to evaluate inter-rater reliability among IRFs completing patient assessments and claims. Such research may yield an opportunity for process improvements in the field, particularly given the complexity of these assessments. Specifically, the mandatory IRF patient assessment includes a complex review of 18 physical and cognitive elements using unique scales, and the medical records and claims that help assign patients to a payment category rely upon "etiologic diagnoses" solely used for IRFs. We believe any analyses should examine:

- the level of consistency among individuals completing the assessments;

- the influence of the tools being used to assess patients and assign to them to an IRF payment category; and
- the efficacy of training related to these important processes.

The AHA stresses the importance of transparency with the field on any inter-rater reliability research and findings, as they may provide our IRF members with important opportunities for learning and improvement.

LONG-TERM CARE HOSPITAL UPDATE RECOMMENDATION

Long-term care hospitals (LTCHs) treat high-acuity patients who need hospital care for extended periods of time. AHA claims analysis shows that 86 percent of LTCH patients have an extreme or major severity of illness (the two highest levels on the four-tiered scale from the APR-DRG classification system), which is a far greater than the proportions treated in general acute-care hospitals, their ICU units or other post-acute care settings.

In response to the staff slide presentation on LTCH payment adequacy, which states that "[r]esearch has shown that outcomes for the most medically complex beneficiaries who receive care in LTCHs are no better than those for similar patients treated in other setting," we highlight both prior MedPAC work and recent independent research that points to value of the LTCH setting for certain highly-acute patients and complex ventilator patients. Specifically, Lane Koenig, Ph.D., et al, in 2015 studied the five major diagnostic categories of patients commonly treated in LTCHs, excluding ventilator patients, to evaluate the effects of receiving care in an LTCH immediately following discharge from a short-term acute care hospital, as compared to receiving care in some other setting following discharge.[1] This work found that receiving care in an LTCH results in better outcomes for several condition categories, and recommended more research to better define the subsets of conditions for which LTCHs improve outcomes at the same or less cost. In addition, MedPAC's review of the literature on LTCH value found that LTCHs "may have value for very sick patients but not for those who are less severely ill."[2] We note that the new LTCH site-neutral payment system, discussed in greater detail below, aligns with this MedPAC view by paying materially less for LTCH patients with lower levels of medical acuity.

The statutorily mandated implementation of site-neutral payment for LTCHs, which, when fully implemented, affects one out of two LTCH cases with an average payment reduction of 54 percent, began in October 2015. Under this system, site-neutral cases will no longer be paid under the LTCH PPS, but will instead be paid inpatient PPS-level rates. During the December meeting, Commission staff acknowledged the magnitude of this change, and the resulting instability to the field. Given the challenge of modeling this complex and transformative change, Commission staff provided projected 2017 margin data for only non-site-neutral LTCH cases.

[1] Lane Koenig, Ph.D., et al; "The Role of Long-term Acute Care Hospitals in Treating the Critically Ill and Medically Complex; An Analysis of Nonventilator Patients;" *Medical Care*; July 2015.
[2] March 2013 MedPAC Report to Congress.

These data show a stark downward trajectory from a 7.5 percent margin in FY 2014 to a range of 3.2 to 5.8 percent projected for FY 2016.

The magnitude of the payment cut for site-neutral cases, together with the already decreasing margins for LTCH PPS cases, supports a current-law market-basket increase for LTCHs in FY 2018, rather than the draft recommendation that would eliminate the market basket. A current law update will help ensure that adequate resources are available for LTCH cases – the highest-acuity subset of Medicare beneficiaries – during this period of great regulatory instability.

PAYMENTS TO HOSPITAL-BASED SKILLED-NURSING FACILITIES

As noted by MedPAC, hospital-based skilled-nursing facilities (SNFs) have many attributes that policy makers are striving to make more prominent in the overall SNF field. Hospital-based SNFs are disproportionately represented among those SNFs with the highest shares of medically complex patients; had notably lower shares of intensive therapy days (59 percent) compared with freestanding facilities (82 percent) in 2014; had community discharge rates superior to those of their freestanding counterparts by 6.6 percentage points in 2013; and had lower readmission rates by 2.1 percentage points in 2014.

Given their alignment with the goals of policy makers, hospital-based SNFs warrant a current law market-basket update for FY 2018, rather than an elimination of their market basket, as would occur under the draft recommendation. We note that while the extremely negative Medicare margins of hospital-based SNFs (-70 percent in FY 2014) are partly due to their higher cost, they also are largely due to their high-acuity case mix. Further, MedPAC has found that routine costs in hospital-based SNFs were higher because they provide more staffing, higher skilled staffing, and shorter stays (over which to allocate costs). **A current law update in FY 2018 is needed for hospital-based SNFs to continue providing quality care to medically complex patients, in lieu of higher-margin, intensive therapy patients.**

We appreciate your consideration of these issues. If you have any questions, please feel free to contact me or have a member of your team contact Priya Bathija, senior associate director of policy, at (202) 626-2678 or pbathija@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development

Cc: Mark Miller, Ph.D.
MedPAC Commissioners