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Advancing Health in America

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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 this month on payment recommendations for 2021. On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, 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 patients before making final recommendations.

Regarding the discussions during the December meeting and the Commission's draft recommendations, we:

- **Support a recommendation to provide current law market-basket updates for the hospital inpatient and outpatient prospective payment systems (PPS), but urge the Commission to consider a higher update in light of the sustained and substantial negative Medicare margins hospitals face, even those deemed "efficient";**
- **Support the concept of appropriately linking quality performance to payment, but have significant concerns about the design of the Hospital Value Incentive Program (HVIP);**
- **Urge the Commission to recommend a full market-basket update for the long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs) and hospital-based skilled nursing facilities (SNFs).**

In addition, this letter discusses access challenges being faced by LTCH site-neutral patients and responds to the post-acute care (PAC) PPS Value Incentive Program agenda item discussed by the Commission in September 2019.

Our detailed comments on these issues follow.

HOSPITAL INPATIENT AND OUTPATIENT UPDATE RECOMMENDATION

The AHA agrees with MedPAC that current law updates for both the hospital inpatient and outpatient PPS are necessary in 2021. We appreciate the Commission's continued recognition that Medicare payments remain far below the cost of providing care. While the average hospital saw a very slight uptick in overall Medicare margin – from negative 9.9% in 2017 to negative 9.3% in 2018 – such a small improvement in a single year does not nullify, and indeed continues, the longstanding trend of substantially negative Medicare margins. Specifically, according to the 2010 MedPAC data book, Medicare has not fully covered the costs of caring for Medicare patients since 2002. **Moreover, for the third consecutive year, MedPAC found that overall Medicare margins are negative even for the small number of "efficient" hospitals, indicating that even those providers considered by MedPAC to be "efficient" cannot cover costs under Medicare. Payments that result in sustained negative margins for more than 15 years cannot be considered adequate, particularly in the face of the low-cost growth hospitals have kept to for nearly a decade.**

However, even these negative margins may obscure the breadth and depth of financial losses associated with Medicare payment for individual hospitals. For example, among nearly 5,200 hospitals surveyed by AHA, approximately two-thirds – more than 3,400 hospitals - lost money caring for Medicare patients in 2018. And according to the 2019 MedPAC data book, *a quarter of hospitals had Medicare margins of negative 21.3%* or lower in 2017. As some commissioners have noted, providers will do what they can to remain sustainable; however, such widespread low margins can make them hard-pressed to meet evolving patient needs, transform care delivery, or maintain access to care for Medicare patients and their communities.

The AHA continues to urge MedPAC to consider the fundamental role that the Medicare program plays in hospital sustainability as the commission makes its recommendation on hospital payment. While MedPAC maintains that hospitals still have a financial incentive to take additional Medicare patients despite negative margins, we believe this position overlooks Medicare's critical contributions to America's hospitals. Specifically, Medicare beneficiaries accounted for roughly 46% of hospital discharges in 2018 and are, thus, a dominant part of hospitals' missions of serving their communities. Even the most financially vulnerable hospital cannot and will not stop taking Medicare patients. **If a hospital is in dire financial straits, it does not stop taking Medicare patients – it closes.** Indeed, we continue to observe a concerning trend in closures in light of poor margins and financial hardship. As documented by the North Carolina Rural Health Research Program, 120 rural hospitals have closed since 2010, including 19 rural providers in 2019 alone, indicating a possible acceleration of this problem. Indeed, these closures reflect a troubling increase in closures across the country. According to MedPAC's own analysis, 47 hospitals closed this year, which is the highest number of closures in the past five years and more than the previous two years combined. This trend is expected to continue as a tipping point approaches in which private payers are

no longer willing to fund, and hospitals can no longer sustain operations on the cost-shift that such considerable Medicare underpayments necessitate. **We therefore continue to urge the Commission to acknowledge that Medicare payments are inadequate and that a higher-than-market-basket increase for inpatient and outpatient hospital services is absolutely necessary.**

Given the variation in provider characteristics and circumstances, we also continue to have concerns about utilizing average total all-payer margin for all U.S. hospitals – an aggregate average measure – as a sign of hospital profitability. Such averages can be misleading because they mask financial hardships of a substantial portion of hospitals: in 2018, more than one-fourth of hospitals had negative total margins, and nearly one-third had negative operating margins. Beyond this, individual hospital margins vary widely and are driven by a range of factors, including facility or system size and type; local payer mix; geographic location; patient demographics; clinical and non-medical services provided; and relationships and affiliations with other entities in the community. **In light of these factors, MedPAC should not draw conclusions on hospital financial conditions from total margin aggregate averages.**

HOSPITAL VALUE INCENTIVE PROGRAM

The AHA again urges the Commission to defer a final recommendation on the HVIP and use the time to delve more deeply into many critically important program design issues. The AHA appreciates MedPAC's interest in streamlining and focusing Medicare's hospital value programs. Indeed, we have long advocated for programs to use only "measures that matter" the most to improving outcomes. However, we remain concerned about the design of the HVIP program, and believe it could lead to unintended consequences that run counter to MedPAC's stated goals of driving even greater improvement in hospital performance. Our concerns about the design of the HVIP are outlined in greater detail in our January 2019 letter where we recommended that MedPAC:

- Ensure there is sufficient flexibility in measurement topics and measures to keep up with changes in care delivery and quality improvement priorities;
- Reconsider the appropriateness of all-condition mortality and readmission measures given the utility of condition specific measures;
- Carefully assess the risk adjustment models of the proposed HVIP measures – especially the mortality and Medicare spending per beneficiary (MSPB) measures – to ensure they adequately account for underlying differences in hospital patient populations, and have enough performance variation to rates to warrant their use; and
- Further assess whether prospective targets can be set equitably.

LONG-TERM CARE HOSPITALS

The AHA urges MedPAC to recommend a full market-basket update for LTCHs in FY 2021 based on the following considerations:

- LTCHs play a unique and valuable role by treating the highest-acuity, long-stay Medicare beneficiaries.
- The LTCH field has been in significant, sustained flux since 2015 when LTCH site-neutral policy was introduced. This has produced operational volatility, declining case volume and facility closures.
- As discussed below, site-neutral patients are experiencing access challenges caused by low site-neutral payment.
- During the December meeting, commissioners received a partial assessment of LTCH payment adequacy since the 2020 Medicare margin estimate was based on only a portion of the field. While staff reported that the estimate was based on 38% of LTCHs, AHA analysis indicates the possibility of only 18% of the field being included in this critical calculation, as discussed below. **To make a fully informed recommendation for LTCH payments for FY 2021, the commissioners need a 2020 margin estimate for *all* LTCHs.**
- The FY 2021recommendation to Congress also must account for the final phase-out of blended rates for site-neutral cases, which is occurring on a rolling basis in FY 2020. Under this change, AHA estimates that site-neutral cases will receive payment only covering up to 45% of the cost of care,[1] leaving the remaining costs unpaid.[2] In fact, despite their relatively high acuity and cost of care, AHA estimates that Medicare payment of LTCH site-neutral cases has declined by more than $1 billion from FYs 2016 through 2019.

The 2021 Recommendation Should Reflect the Payment Adequacy of All LTCHs

When considering the FY 2021 recommendation for LTCHs, it is inappropriate for MedPAC to consider margin data that exclude a majority of the field. Specifically, MedPAC reported in December that the 2020 margin estimate for LTCHs was based on 38% of LTCHs – those that meet its definition of "high-share LTCH," or those with at least 85% of cases paid a standard LTCH rate (rather than a site-neutral rate). Unfortunately, staff did not present a 2020 margin estimate for the entire LTCH field, which in FYs 2017 and 2018 were negative, -2.2% and -0.5%, respectively. Further, an AHA evaluation of the LTCH cost reports available for the 2020 LTCH margin estimate found that only 150 LTCHs had submitted data, with only 67 of those qualifying as high-

[1] AHA estimate for FY 2019 based on an analysis using FY 2017 MedPAR data, FY 2019 proposed rule payment information, and CMS provider specific file (April 2018 update).
[2] Underpayment of LTCH site-neutral cases is occurring for two reasons: 1) as MedPAC has pointed out, CMS is applying an unwarranted and duplicative budget-neutrality cut to all site-neutral cases; and 2) CMS continues to base site-neutral rates on the incorrect assumption that the acuity level and cost of care for LTCH site-neutral cases is the same as "comparable" inpatient PPS cases.

share LTCHs – 18% of the field.[3] **Hence, it appears that MedPAC has possibly excluded between 62% and 82% of providers from its 2020 LTCH margin estimate**. As such, prior to the final vote on the FY 2021 recommendation to Congress, we urge staff to share with the Commissioners and stakeholders 1) their 2020 estimate for ***all*** LTCHs; and 2) the exact number of facilities included in their various LTCH margin calculations. **If pending comprehensive margin data for 2020 show a negative or near-negative margin, it is clear a full market-basket update for LTCHs in FY 2021 should be considered.**

Site-Neutral Patients Facing Access Challenges

AHA members report a variety of access-to-care challenges for site-neutral patients seeking LTCH care, as outlined in the case examples and data below. As we have discussed in prior communications with MedPAC and CMS, and as validated below, the site-neutral patient population continues to be a high-acuity, long-stay group that benefits from the specialized care programs and clinical personnel in LTCHs. **As such, we urge MedPAC to analyze and report on access to care and clinical outcomes for these vulnerable LTCH patients.**

Table 1 lists a sample of conditions identified by AHA members for which patients are facing LTCH access challenges due to the inadequate site-neutral rate. Specifically, site-neutral patients with these conditions have an underpayment ranging from 42% to 73%, as estimated by AHA using the publicly available data noted in the chart. **For such patients to retain access to LTCH services, these substantial underpayments for site-neutral cases must be addressed.**

Osteomyelitis, Complications Associated with Diabetes, and other Wound-Related DRGs. Patients receiving specialized wound care in LTCHs are found in multiple MS-LTC-DRGs, including those in Table 1. (However, we note that some cases in this section of the table may not have received wound care.) This patient group generally has high medical complexity, long hospital stays, and requires specialized, costly care and equipment, such as care from wound, ostomy and continence nurses; specialty beds; wound vacuum-assisted closure devices; time-intensive wound dressing changes; antibiotics; and debridement. For wound patients who are able to access an LTCH, Table 1 shows high Medicare underpayment ranging from 42% to 73% – a great financial loss to the LTCH. For a portion of these patients, only having access to less-specialized care in settings other than LTCHs can result in greater debility, increased infection rates, failed wound healing/closure, inability to complete IV antibiotic courses of treatment and longer recovery.

[3] Using the June 2019 version of the Medicare cost report data contained in the Healthcare Cost Report Information System (HCRIS) as well as the FY 2020 LTCH PPS final rule impact file, the AHA found that only about 150 LTCH providers that were in the impact file filed a cost report in 2018, of which only 67 met the MedPAC definition of a high-share LTCH. Since the FY 2020 LTCH PPS impact file contains 384 providers, the sample size used was potentially only about 18%.

Table 1: Medicare Underpayment of Site-neutral LTCH Cases

LTCH Site-neutral Cases Select DRGs Rate of Underpayment by Medicare, 2018					
DRG	**DRG NAME**	**Average Length of Stay**	**Average Cost**	**Average Site-neutral Payment (No Blend)**	**Rate of Under-payment**
Osteomyelitis, Complications Associated with Diabetes, and Other Wound-related DRGs					
299	Peripheral vascular disorders w MCC	20.2	$29,810	$12,392	58%
500	Soft tissue procedures w MCC	35.1	$67,865	$39,096	42%
539	Osteomyelitis w MCC	31.5	$43,651	$20,994	52%
540	Osteomyelitis w CC	26.1	$36,160	$14,207	61%
541	Osteomyelitis w/o CC/MCC	19.3	$25,165	$9,562	62%
579	Other skin, subcut tiss & breast proc w MCC	34.3	$47,701	$25,870	46%
592	Skin ulcers w MCC	28.0	$35,128	$16,536	53%
622	Skin grafts & wound debrid for endoc, nutrit & metab dis w MCC	32.5	$53,157	$30,409	43%
637	Diabetes w MCC	25.8	$37,774	$16,113	57%
638	Diabetes w CC	21.1	$28,202	$9,038	68%
728	Inflammation of the male reproductive system w/o MCC	19.8	$24,047	$6,569	73%
919	Complications of treatment w MCC	32.4	$43,477	$20,666	52%
Respiratory Failure					
189	Pulmonary edema & respiratory failure	28.5	$32,785	$13,163	60%
Major GI Disorders					
371	Major gastrointestinal disorders & peritoneal infections w MCC	19.8	$27,005	$12,496	54%
Endocarditis					
288	Acute & subacute endocarditis w MCC	26.5	$41,906	$20,987	50%
289	Acute & subacute endocarditis w CC	23.4	$34,153	$14,730	57%
290	Acute & subacute endocarditis w/o CC/MCC	16.3	$17,729	$5,804	67%
Source: AHA analysis of FY 2018 LTCH proposed rule MedPAR data and CMS LTCH PPS FY 2020 proposed rule public use files.					

Pulmonary Edema & Respiratory Failure (MS-LTC-DRG 189). Patients with this complex condition tend to have multiple underlying co-morbidities, require high flow oxygen, frequent nebulizers, pulmonary consults, IV antibiotics, IV steroids, IV diuretics, and therapy needs. AHA members report that when these patients are treated in a non-

LTCH setting, some experience greater debility, longer recovery and costly readmissions.

Major Gastrointestinal Disorders & Peritoneal Infections w/MCC (MS-LTC-DRG 371). LTCH site-neutral patients in this DRG typically require care by specialized wound-care teams, including, but not limited to, the following services, which are atypical in less-intensive PAC settings. Our members also report those patients with a fistula are extremely difficult to discharge to a non-LTCH setting.

- Flushing of the peritoneal cavity;
- Bowel rest with total parenteral nutrition, which requires nasogastric tube feeding;
- Tube feeding of patients with a large wound, which is associated with a high risk of death due to tube migration;
- Electrolyte and hematology monitoring and fluid replacement for high-output fistulas from dehisced wounds, which is costly and requires extra time for certain required lab tests;
- Long term, high cost, multiple antibiotics including gram negative and fungal coverage;
- Ongoing management of blood pressure, pain management and blood glucose management (must use sliding scale insulin during this time); and
- Consult with certified wound care team & infectious disease physician.

Endocarditis (MS-LTC-DRG 288, 289, 290). Many patients with this condition have multiple co-morbidities, prolonged and costly IV antibiotics, IV diuretics, frequent labs and diagnostic testing, telemetry and oxygen (related to co-morbid conditions). Our members report that many are difficult to place in other PAC settings, but when they are, can be subject to readmissions, inability to complete antibiotic treatments and poor outcomes.

Select Ventilator Patients. Most ventilator cases in LTCHs automatically qualify for a standard payment, versus the far lower site-neutral payment. However, we note that while ventilator cases transferring from Veterans Administration or Department of Defense care to an LTCH are technically covered by Medicare, some Medicare Administrative Contractors (MACs) are neither approving this coverage nor processing payments. As a result, patients in these MAC jurisdictions are typically not able to utilize their coverage to access LTCH care. Thus far, efforts to achieve coverage for these beneficiaries have been unsuccessful. In addition, we note that ventilator patients transferring from a critical access hospital are limited to a site-neutral rate rather than a full LTCH PPS payment.

INPATIENT REHABILITATION FACILITIES

In December, the commissioners considered a draft recommendation to reduce fiscal year (FY) 2021 IRF PPS payments by 5%, relative to FY 2020 payments. However, the IRF field is currently transitioning to newly recalibrated and streamlined IRF PPS payment units known as case mix groups, which were implemented on Oct. 1, 2019. On that date, the field also began its transition from well-known patient assessment metrics for functional status, which are used to set IRF PPS payments, to different metrics that are still relatively new to the field. **In light of these multi-faceted and recent reforms, we ask MedPAC to support a current law update for IRFs in FY 2021.**

HOSPITAL-BASED SKILLED NURSING FACILITIES

As noted by MedPAC, hospital-based SNFs have many attributes that policymakers are striving to make more prominent in the overall SNF field. For example, they are disproportionately represented among those SNFs with the highest shares of medically complex patients; they had notably lower shares of intensive therapy days compared with freestanding facilities (65% vs 83% in 2016); and they had readmission rates in 2014 that were 2.1 percentage points lower than freestanding facilities. Further, these attributes have been recognized in the newly reformed SNF PPS, which shifts resources to medically complex patients, a change that aligns with the sicker patient-mix and service profile of hospital-based SNFs.

Given their alignment with policymaker goals and their historic underpayment, payments to hospital-based SNFs warrant a current law market-basket update for FY 2021, rather than an elimination of their market basket as was discussed at the December meeting. We note that while the extremely negative Medicare margins of hospital-based SNFs (*negative* 67% in FY 2016) are partly due to their higher costs, they also are the result of a higher-acuity patient mix. MedPAC has noted that this margin reflects "more staffing, higher skilled staffing, and shorter stays (over which to allocate cost)" – all of which makes sense in light of their sicker patient population. Unfortunately, the new SNF PPS model will address only a small portion of the negative margin they face.

PAC PPS VALUE INCENTIVE PROGRAM (VIP)

The AHA appreciates MedPAC's extensive PAC PPS policy work, including the development of a new payment model and related policies. With regard to the September 2019 meeting on policy considerations for a PAC PPS VIP, we comment below on several concerns raised by Commissioners, as well as other key themes from the robust discussion. **We ask MedPAC to proceed cautiously to ensure that each PAC PPS VIP concern raised in September is addressed before finalizing a formal proposal, and to take precautions to avoid an unintended reduction in access to care for higher-acuity PAC patients.**

VIP Design. MedPAC staff presented a preliminary approach for PAC PPS VIP design, including a call for a small set of claims-based outcomes and resource use measures, which would be uniform and risk-adjusted across the four PAC settings. Specifically, all-condition, in-stay hospitalizations (including observation stays); discharge to community; and MSPB (for Parts A and B for the stay and subsequent 30 days) were suggested as initial measures. To recognize patients' social risk factors, the VIP also would account for Medicaid eligibility for each PAC setting-specific groups of peers. In addition, an explicit position was stated against using functional status and other patient assessment data collected by the provider. Further, it was noted that in the future, a patient experience and possibly other items could be added.

PAC PPS VIP Withhold. The Commissioners extensively discussed various approaches related to the size of a PAC PPS VIP withhold and, in general, seemed to support a phase-in approach, in line with the approach used in HH and for physician VBP programs, to a pool that would be large enough to affect provider behavior. Several Commissioners suggested that a pool of approximately 5% - the withhold amount initially to be modeled by MedPAC – might be an appropriate target. Likewise, **the AHA also would support a phase-in approach; however, a 5% withhold would be excessive. A larger withhold raises concerns because of the lack of reliable data influencing outcomes, as discussed below. For comparison, the hospital VIP program withhold is set at 2%.**

Claims Used for VIP Determinations. With regard to sample size, in light of the many low-volume PAC providers, there was significant discussion regarding the pros and cons of using multiple years of data to determine eligibility for a VBP reward. On the one hand, pooling data would make additional smaller providers eligible to participate in the VBP, but still leave many ineligible. On the other hand, relying, in part, on 3-year old data may demotivate providers to improve. In addition, several commissioners expressed support for weighting the withhold amount based on provider volume.

The AHA does not support using data pooled across multiple years. Medicare claims data are already subject to significant lags, so assessing performance on old data does not provide an accurate evaluation of quality of care and makes it difficult for providers to make changes to their protocols.

VIP Measure Selection. Several commissioners expressed concern that under the initial three measures, providers may be subject to double-jeopardy, as, for example, a hospitalization would automatically increase MSPB. Staff noted that such double impact is suitable as both are bad outcomes.

The AHA is concerned about using MSPB as a measure for a VIP program, especially when used as one of only a few measures. The basic performance attribution approach lacks a "line of sight" from provider actions to measure performance, since the measure attributes *all* Medicare Parts A and B costs for a beneficiary during the defined episode to a single provider, even though the measure purposefully captures actions for a multitude of health care entities (and multiple PAC

providers). Thus, the ability for any single provider to influence overall measure performance will vary significantly depending on local market factors.

In addition, the measure is not an assessment of actual cost *per se*. Rather, it is a measure of what Medicare decides to pay each PAC facility rolled into a single score over a 30-day timeframe. As a result, the only way to improve measure performance is to lower the utilization of services; this may be inappropriate for highly complex patients, who have higher cost and are prevalent in many PAC settings.

Accounting for Social Risk Factors. The incorporation of Medicaid eligibility in a VIP was widely supported among the commissioners, along with the acknowledgment of the limitations of this measure and the need for ongoing, proactive work by MedPAC and other policymakers to develop stronger indicators of socio-economic status.

We agree that adjustment for social risk factors is vital to both uncover disparities and ensure that providers caring for vulnerable patients are not unfairly penalized and thus face greater challenges to improve care. "Incorporating" Medicaid eligibility – potentially by stratifying providers by proportion of dually eligible beneficiaries served, as is done in the Medicare Hospital Readmissions Reduction Program – is a good first step. **We would encourage MedPAC to consider, now and in the future, other ways to incorporate social risk factors in a value-based care program.** For example, in the Merit-based Incentive Payment System (MIPS) programs, CMS implemented a "complex patient bonus."

Trade-off of Data Uniformity versus Accuracy. At numerous points during the September discussion, apprehension was expressed regarding the VIP's proposed use of uniform measures for all four PAC settings. Specifically, many were concerned with the trade-off resulting from the use of truly uniform measures, i.e., while uniform measures increase opportunities to compare outcomes and move the field toward a truly uniform payment system, they also reduce the model's ability to capture patient distinctions – especially for highest-acuity patients. In addition, some commissioners were worried that using uniform measures could fail to capture the strengths of providers specializing in treating sicker patients, which only could be accomplished with setting-specific measures. On a related note, several commissioners expressed support for rewarding providers that, as a result of their specialization, produce higher-quality outcomes – especially as patients are the ultimate benefactors of such specialization. It was noted that such specialization requires additional capital investment, technology and other resources to support other competencies required to treat patients with greater severity of illness. Likewise, it was stated that rather than treating such PAC specialization as a problem, such investments should be encouraged by a VIP.

Distinctiveness of Home Health (HH). **The AHA shares the multiple concerns raised regarding the ability of a PAC PPS VIP to account for the unique profile of HH patients, relative to those in other PAC settings, including their much lower acuity levels and cost of care.** In addition, the bifurcated HH patient population also was flagged as requiring unique accommodations by a VIP. (Two-thirds of HH patients

originate from the community, with the remainder receiving post-hospital care.) One commissioner questioned whether the HH field would ever treat patients who are very similar to institutionalized PAC patients. Another suggested that by removing community-originating HH patients, the HH sample would become more comparable to the broader PAC patient population. Staff agreed that they would investigate differences between post-acute and community-originating HH patients.

Limitations of PAC Data. **The AHA shares the commissioners' concerns related to the limitations of PAC data.** Specifically, strong concerns were raised about the significant variation within and across PAC settings for the VIP outcomes and resource-use measures under consideration. The extensive disparities found among these data produced commissioners' doubts since they felt that it is likely that, at least in part, they are caused by providers' inconsistent data metrics and collection protocols versus actual differences in quality. One commissioner cautioned that if the physician referring a patient to PAC cannot trust these data, then perhaps they should not be used as a basis for issuing rewards.

Further, several concerns were raised regarding the reliability of available PAC data, especially for higher and highest-acuity patients. For example, several voiced doubts that available data could reliably differentiate sicker patients from others with the same condition. Likewise, there was doubt regarding the ability to accurately risk-adjust to account for their greater resource needs. Of great concern, these limitations were flagged as possible drivers of reduced access to care for medically complex patients.

Again, we thank you for your consideration of our comments. Please contact me if you have questions or feel free to have a member of your team contact Erika Rogan, senior associate director of policy, at (202) 626-2963 or erogan@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development