American Hospital Association™
Advancing Health in America

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Michael Chernew, Ph.D.
Chairman
Medicare Payment Advisory Commission
425 I Street, N.W., Suite 701
Washington, DC 20001

Dear Dr. Chernew:

The Medicare Payment Advisory Commission (MedPAC, or the Commission) will vote this month on payment recommendations for 2022. 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 before making final recommendations the following issues that would have significant impacts on hospitals, health systems, other providers and Medicare patients.

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

- **Urge the Commission to consider the longer-term impact of the COVID-19 crisis on health care providers, including staffing and supply costs, evolving patient needs and ongoing financial instability;**
- **Urge the Commission to recommend at least the current law market-basket updates for the hospital inpatient and outpatient prospective payment systems (PPS), in light of the sustained and substantial negative Medicare margins hospitals face;**
- **Support the concept of appropriately linking quality performance to payment, but continue to have significant concerns about the design of the Hospital Value Incentive Program (HVIP); and**
- **Urge the Commission to recommend a current law market-basket update for the long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs) and hospital-based skilled nursing facilities (SNFs).**

Our detailed comments on these issues follow.

THE CONTEXT OF COVID-19

The COVID-19 crisis has put unprecedented pressure on America's hospitals and health systems, with about 130,000 patients currently hospitalizatized from COVID-19, never-before-seen ICU bed occupancy, and financial losses expected to exceed $323 billion through 2020. While recent progress on COVID-19 vaccines is very encouraging, health care providers remain on the front lines of fighting this powerful virus, with many hospitals across the country battling new surges and implementing costly treatments. At the same time, these providers are continuing to meet patient needs outside of COVID-19, including primary care, deliveries, chronic disease management and surgical procedures. As the hospital field moves forward both with caring for COVID-19 patients and safely delivering needed health care services to others, providers still will need assistance to ensure that the nation can successfully coexist with COVID-19. As Chairman Chernow stated during the December meeting, "during a pandemic or not, … hospitals are a critical part of the nation's health care infrastructure, and paying them in a way that allows them to provide the care that we need is an important goal."

We agree with MedPAC commissioners who have cautioned against an overly optimistic view of how hospitals will fare over the next year. Hospitals will experience persistent costs and have to tackle new challenges, including those discussed below, as a result of the pandemic. **We urge MedPAC to consider the changing health care system dynamics, including those described below and other longer term effects of the COVID-19 pandemic, on hospitals while the Commission makes payment recommendations for 2022 and beyond.**

First, as mentioned by several commissioners, labor and supplies (e.g., vaccine storage, personal protective equipment (PPE)) will continue to be a challenge. While the full impact of COVID-19 on labor and supply markets is not yet known, it is crucial that MedPAC monitor and account for increases in hospital input costs.

Second, hospitals will have to contend with evolving patient care demand, including increased attention to behavioral health needs and the ramifications of delayed or forgone care in 2020. Indeed, Commissioner DeSalvo noted that hospitals will have to address "pent-up demand from people who haven't been able to attend to chronic disease or get screened for malignancies and … rising rates of mental health and substance use disorder that we're already seeing in the background."

Third, hospitals will continue to face economic instability as the public health emergency continues. For example, growth in the uninsured as a result of COVID-19-related unemployment will put additional and sustained pressure on hospitals' finances. In addition, several financial aids provided to hospitals to battle the virus will end in the near to mid-term, and the future of financial relief remains uncertain. For example, the elimination of the Medicare sequester ends on March 31, 2021, and most hospitals will begin repaying their accelerated payments in April 2021. These changes are expected to put even more stress on a field that has already seen more than three dozen

hospitals entering into bankruptcy and 17 hospital closures in 2020. Even when COVID-19 cases decline in the future, hospitals will continue to grapple with the cumulative impact of the pandemic.

Taken together, these shifts in the health care environment will put enormous, continued strain on hospitals and health systems. We strongly urge the Commission to consider these potentially long-lasting changes to the context within which payment recommendations are made.

HOSPITAL INPATIENT AND OUTPATIENT UPDATE RECOMMENDATION

The AHA urges MedPAC to consider a payment recommendation for both the hospital inpatient and outpatient PPS for 2022 that is at least equal to current law. In addition, in light of concerns we have regarding the HVIP, which are described further below, we also urge the Commission to recommend a full update that is not contingent on the establishment of the HVIP. As Commissioner Thompson noted during the December meeting, Medicare payments have remained far below the cost of providing care for many years. Specifically, the Medicare program has not fully covered the costs of serving Medicare patients since 2002, a staggering 18 years, according to the 2010 MedPAC data book**. Slight improvements in overall Medicare margins during the past few years do not offset the longstanding trend of substantially negative Medicare margins.** In fact, if future years experienced the same small uptick of 0.6% that was observed from 2018 (-9.3% margin) to 2019 (-8.7% margin), *it would take 15 years* for hospitals to have even a slim positive Medicare margin on average. Such data do not offer encouragement that hospitals may soon expect payment that would adequately compensate for Medicare services.

In addition, negative aggregate margins may obscure the breadth and depth of financial losses associated with Medicare payment for individual hospitals. According to the 2020 MedPAC data book, for example, *a quarter of hospitals had a Medicare margin of negative 19.2%* or lower in 2018. In the same year, among nearly 5,200 hospitals surveyed by AHA, approximately two-thirds – more than 3,400 hospitals – lost money caring for Medicare patients. Such widespread, sustained low margins make it very difficult for providers to meet emergency demands, such as the current public health emergency, or maintain access to care for Medicare patients and their communities over the long term. **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 necessary.**

Moreover, for the fourth 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 and deeply negative margins for nearly two**

decades are not acceptable, particularly in the face of the low-cost growth hospitals have kept to for roughly 10 years.

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 strongly negative margins overall, 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, as mentioned above, 17 rural hospitals closed in 2020, *during a pandemic*. Such closures underscore the extreme financial vulnerability many hospitals are facing, and the need for adequate Medicare payments to help sustain access to care.**

HOSPITAL VALUE INCENTIVE PROGRAM

The AHA again urges the Commission to reconsider the proposed HVIP and 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 current law market-basket update for LTCHs in FY 2022, which would support their considerable efforts in treating

those with or recovering from COVID-19. LTCHs are playing an invaluable role in the pandemic, while also undergoing major payment reforms. Specifically, LTCHs have continued their unique and valuable role by treating the highest-acuity, long-stay Medicare beneficiaries and other patients. They also have made significant contributions to patients, local hospitals and other health care partners in their communities in the fight against COVID-19 – especially in virus hotspots. Their expertise in treating the highest complexity patients – including ventilator patients – positioned the field to offer targeted services for patients with active COVID-19, as well as those recovering from the virus who still required high-level care, such as the "long-haul" patients who no longer had the virus, but experienced ongoing and often multiple, related clinical complexities.

The LTCH field has been in significant flux since 2015 when LTCH site-neutral policy implementation began. The policy continues to produce major operational shifts due to overall declining case volume and facility closures during the phase-in of the policy, which concluded last year. In fact, AHA has estimated that from FYs 2016 through 2019, Medicare payment of LTCH site-neutral cases declined by more than $1 billion. Indeed, average Medicare FFS margins have dramatically dropped under this policy. For example, for 2019, MedPAC estimates an average LTCH margin of 2%.

In addition, when considering the FY 2022 recommendation for LTCHs, we ask the Commission to consider Medicare payment adequacy for the field as a whole, rather than payment adequacy only for those LTCHs treating a high share of standard LTCH PPS cases, which have a higher 2019 margin of 3.2%. If MedPAC used the same criteria as last year to identify "high-share" LTCHs, we estimate that this category accounts for only 17% to 47% of the field.[1] **This subset is not reflective of the field as a whole. Disregarding the margins of the remaining 53% to 83% of LTCHs – which account for the majority of the field and have a *negative* 1.6% margin – is not appropriate.**

As such, prior to the final vote on the FY 2022 recommendation to Congress, we urge staff to share with the commissioners and stakeholders the exact number of facilities included in their various LTCH margin calculations, including the number of providers excluded from the "high-share LTCH" category. **If the margin data for the field as a whole show a negative or near-negative margin, it is clear that a full market-basket update for LTCHs in FY 2022 should be considered.**

INPATIENT REHABILITATION FACILITIES

In December, the commissioners considered a draft recommendation to reduce FY 2022 IRF PPS payments by 5%, relative to FY 2021 levels. However, given the ongoing

[1] Last year, the Commission identified LTCHs with at least 85% of cases paid a standard LTCH rate, rather than a site-neutral rate, as "high share." Applying this criterion against the FY 2021 LTCH PPS final rule impact file results in 17% of LTCHs as high share. Using the 2021 LTCH cost reports – for which 133 LTCHs had thus far submitted data – results in 17% of LTCHs as high share.

stresses of the COVID-19 pandemic and its nationwide impact, including the proliferation of virus hotspots in every state, now is a difficult time for providers to absorb additional burdens. **Instead, we ask MedPAC to help maintain the operational stability needed during the pandemic by supporting a current law update for IRFs in FY 2022.**

Many IRFs have played an important role in either treating COVID-19-positive patients or post-COVID-19 patients who require extended care during their recovery from the virus. Further, some recovering patients are being well served by the physician-led medical and rehabilitation teams in IRFs. They also have provided an important "overflow" space for general acute-care hospitals facing an intense influx of COVID-19 patients, which results in a need to relocate their patients to another hospital site such as an IRF or LTCH. In addition, to optimize contributions to the local continuum of care, some IRFs have constructed COVID-19 units that include negative pressure rooms to prevent viral transmission, converted double-occupancy into single-occupancy rooms, and/or made staffing adjustments needed to ensure that safety and quality of care are achieved for both patients and staff. These modifications have, of course, required unanticipated expenditures. Moving forward, policymakers should support these IRFs as the nation struggles with the intermittent surges in hospital and related COVID-19 admissions.

With regard to average margins for Medicare FFS payments reported in December, we note the highly varied margins across the IRF field. In fact, analysis by AMRPA of the Centers for Medicare & Medicaid Services' (CMS) FY 2021 rate setting files found that 42% of all IRFs have margins below 5%. Thus, the MedPAC draft recommendation would reduce four out of 10 IRFs to a negative Medicare margin. This margin disparity should be better understood, as suggested during the December meeting discussion.

In addition, we note that during the December meeting, some commissioners' comments seemingly treated IRFs and SNFs as fully interchangeable. This is neither accurate nor appropriate. For example, in its FY 2021 rulemaking, CMS proposed to reduce IRF minimum qualifications for its medical personnel by allowing non-physician practitioners (NPP) to lead the inter-disciplinary teams that are mandated for all IRFs. However, in its final rule, CMS withdrew the proposal based on the recognition that such a change would result in an overall reduction in the quality of care and qualitative inconsistencies in the scope of IRF services provided across the nation. With this conclusion, CMS essentially affirmed that IRFs maintain a level of clinical resources and oversight that far exceeds those found in SNFs.

HOSPITAL-BASED SKILLED NURSING FACILITIES

The COVID-19 pandemic has been greatly challenging for SNF patients and providers. The field's response to the pandemic has been quite mixed as freestanding SNF/nursing homes have struggled to control community-spread that resulted in COVID-19 infections and deaths. Hospital-based SNFs have played an important role in the pandemic response as their host hospitals struggled to deal with surges in COVID-

19 admissions across the country. Based on their proximity and inter-connections with their hosts, as well personnel and mix of services – which focused on treating the highest shares of medically-complex patients – hospital-based SNFs have supported their communities in a variety of ways during the pandemic. These strengths and flexibilities also helped hospital-based SNFs manage the stresses of their concurrent implementation of the new SNF PPS case-mix system, known as PDPM.

Given their ongoing role in treating higher-acuity patients, which proved valuable in supporting their COVID-19 response, and their historic underpayment, payments to hospital-based SNFs warrant a current-law-market-basket update for FY 2022, 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.

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 Joanna Hiatt Kim, vice president of payment policy, at 202-626-2340 or jkim@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development