American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

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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 2023. 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 — as well 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 significant impacts 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:

- **Urge the Commission to consider the longer-term impact of the COVID-19 crisis on health care providers, including staffing and supply costs, as well as the ongoing financial instability;**
- **Appreciate the draft 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;**
- **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**
- **Support the draft recommendation for a current law market-basket update for long-term care hospitals (LTCHs), and urge the Commission to make the same recommendation for inpatient rehabilitation facilities (IRFs) and hospital-based skilled nursing facilities (SNFs).**

THE CONTEXT OF COVID-19

The COVID-19 crisis has put unprecedented pressure on America's hospitals and health systems, with never-before-seen ICU bed occupancy and continued financial losses expected to exceed $50 billion in 2021, even after accounting for federal COVID-19 relief funds.[1] Health care providers remain on the front lines of fighting this powerful virus, with many hospitals across the country once again battling new surges due to the Delta and Omicron variants, and hospitalization rates have increased once again. For example, in the week ending on Jan. 1, hospital inpatient COVID-19 utilization increased nearly 30% compared to the previous week.[2]

We agree with MedPAC commissioners who have commented on the lasting and durable impacts of the COVID-19 pandemic on the healthcare system. Hospitals will experience persistently higher costs and face new challenges as a result of the pandemic. **We urge MedPAC to consider the changing health care system dynamics, including those described below, and their effects on hospitals. Taken together, these shifts in the health care environment will put enormous, continued strain on hospitals and health systems. We urge the Commission to consider these long-lasting changes when making payment recommendations for 2023 and beyond.**

First, as mentioned by several commissioners, labor and supplies will continue to be a challenge. Expenses are rising across the board, as hospitals face increasing costs for labor, drugs, purchased services, personal protective equipment (PPE), and other medical and safety supplies needed to care for patients. For example, a study found that labor expenses per adjusted discharge are up 14% compared with pre-pandemic levels, and supply expenses are up 17%.[3] These estimates are far greater than the estimate currently used to forecast the market basket update at 3.1%. 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 for the long-term.

Second, hospitals will continue to face economic instability as the public health emergency continues. For example, hospitals and health systems must contend with rising inflation, which not only impacts wages and supply costs but also negotiated prices with insurers. In addition, several streams of government financial assistance 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, a phased elimination of the Medicare sequester ends on June 30, 2022. Most hospitals have started and will continue to repay their accelerated payments throughout this year, and the majority of funds from the Provider Relief Fund and American Rescue Plan Act have been distributed as of late 2021. Thus, there will be even more stress on a field that had already seen more

[1] https://www.kaufmanhall.com/insights/research-report/financial-effects-covid-19-hospital-outlook-remainder-2021
[2] https://beta.healthdata.gov/Health/COVID-19-Community-Profile-Report/gqxm-d9w9
[3] https://www.kaufmanhall.com/insights/research-report/financial-effects-covid-19-hospital-outlook-remainder-2021

than three dozen hospitals entering into bankruptcy and 19 rural hospital closures in 2020.[4]

HOSPITAL INPATIENT AND OUTPATIENT UPDATE RECOMMENDATION

The AHA agrees with MedPAC that current law updates for both the hospital inpatient and outpatient PPS are absolutely necessary in 2023. We appreciate the Commission's continued recognition that Medicare payments have remained far below the cost of providing care for many years. Specifically, according to the MedPAC data book, the Medicare program has not fully covered the costs of serving Medicare patients since 2002.

Furthermore, slight improvements in overall Medicare margins during the past few years have not brought hospitals into positive territory and do not offset the longstanding trend of substantially negative Medicare margins. Moreover, some of these improvements have been due to policies outside of Medicare — not improvements to Medicare payments. For example, the small uptick of 0.2% that was observed from 2019 (-8.7% margin) to 2020 (-8.5% margin) occurred because COVID relief funds were accounted for in 2020. Without these temporary relief funds, overall Medicare margins would have fallen to a staggering -12.6%.

In addition, even MedPAC's cohort of "efficient" hospitals had overall Medicare margins that were negative when relief funds are not accounted for, 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 should not be considered adequate, particularly in the face of the low cost growth hospitals have kept to for nearly a decade.**

Furthermore, these negative aggregate margins may obscure the breadth and depth of financial losses associated with Medicare payment for individual hospitals. According to the 2021 MedPAC data book, for example, *a quarter of hospitals had a Medicare margin of -18%* or lower in 2019. In the same year, among nearly 5,200 hospitals surveyed by AHA, almost two-thirds lost money caring for Medicare patients.[5] 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 consider a higher-than-market-basket increase for inpatient and outpatient hospital services as necessary to start to bring Medicare payments back to the level where they cover costs and ensure patients have adequate access to care.**

HOSPITAL VALUE INCENTIVE PROGRAM

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

[4] https://www.aha.org/fact-sheets/2020-11-09-fact-sheet-covid-19-pandemic-results-bankruptcies-or-closures-some-hospitals
[5] https://www.aha.org/fact-sheets/2020-01-07-fact-sheet-underpayment-medicare-and-medicaid

"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.

LOW-VOLUME HOSPITAL POLICY

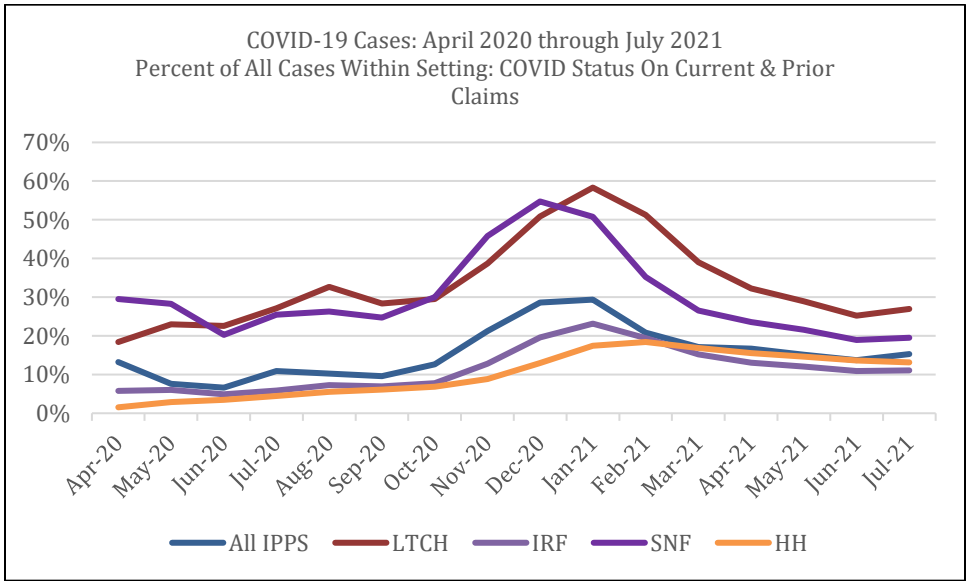
The AHA appreciates the Commission's work detailing the impacts of the changes to the low-volume hospital (LVH) payment adjustment required by the Balanced Budget Act (BBA) of 2018. The LVH adjustment aims to support low-volume and isolated hospitals that lacked economies of scale and thus have higher standardized costs per stay. **Thus, we are concerned with the Commission's discussion about allowing the BBA's modifications to expire, thus reverting to the original 2005 criteria with a narrower volume eligibility.** Specifically, the current volume criterion of less than 3,800 all-payer inpatient stays would be reduced to less than 800 all-payer inpatient stays. This reversion would severely undermine the financial stability of rural providers at a time when substantial additional funding, not less, is needed to bolster care in these communities. For example, while approximately 600 hospitals currently are eligible for the LVH adjustment, under the original 2005 criteria, approximately ten hospitals received the adjustment each year. Thus, if the reversion were to take effect in 2023, it would mean that nearly all rural hospitals that currently are eligible would lose their funding – about $300 million. This would occur at a time when rural hospitals face unprecedented challenges. While COVID-19 relief funds have financially sustained certain rural hospitals in 2021, we agree with Commissioner Barr's concern of a "tsunami of [rural] closures" in the near future. **Therefore, we urge MedPAC to support policies that help rural communities maintain their access to care and refrain from allowing current LVH modifications to expire.**

POST-ACUTE CARE UPDATE RECOMMENDATIONS

Throughout the pandemic, the four PAC settings — long-term care hospitals (LTCH), inpatient rehabilitation hospitals (IRF), skilled nursing facilities (SNF) and home health

(HH) agencies — have substantially contributed to the COVID-19 pandemic response by treating patients with active COVID-19, as well as patients recovering from the virus. Additionally, referring hospitals continue to transfer patients to PAC facilities that correspond with their clinical competencies in order to open more space for those requiring immediate care. In some areas, COVID-impacted patients are even bypassing a stay in a general acute care hospital to streamline care protocols in response to pandemic pressures. In fact, some hotspots have experienced COVID-driven waitlists for certain PAC care.

The trends shown below illustrate that PAC providers have responded to the PHE in sync with referring inpatient PPS hospitals, shown in blue. Specifically, the chart shows each settings' rate of COVID-19 patients, with LTCHs (shown in red) and SNFs (shown in purple) exhibiting the highest concentrations.



Source: Medicare fee-for-service claims, Centers for Medicare & Medicaid Services, Chronic Conditions Data Warehouse, www2.ccwdata.org/web/guest/home.

In addition, PAC providers experienced substantial decreases in case volume at the same time that patients' clinical needs greatly increased, as indicated by increases in case-mix index, average length of stay and ICU days during the prior hospital stay. We note that all of these indicators demonstrate the prominent trend of far sicker patients being treated in PAC, especially in the HH and LTCH settings.

Inpatient PPS Discharge Destination Data
Rate of Change from Pre-PHE to PHE Period*

Inpatient Hospital Discharge Destination	Case Volume	Case-mix Index	Average Length of Stay	Average Number of ICU Days
All Inpatient PPS Discharges	**-18.2%**	**6.9%**	**8.8%**	**12.6%**
HH	-6.9%	5.0%	9.2%	10.1%
SNF	-30.8%	3.2%	8.8%	7.4%
IRF	-11.2%	3.6%	8.4%	6.9%
LTCH	-15.0%	8.5%	15.0%	15.2%

Source: Medicare fee-for-service claims, Centers for Medicare & Medicaid Services, Chronic Conditions Data Warehouse, https://www2.ccwdata.org/web/guest/home.

A comparison of the PHE period of Jan. 27, 2020 to March 31, 2021 (approximately 14 months) versus the pre-PHE period of Nov. 23, 2018, 2019 to Jan. 26, 2020 (approximately 14 months).

Long-term Care Hospitals. **The AHA appreciates and supports MedPAC's recommendation for a current law market-basket update for LTCHs in FY 2023, which recognizes their considerable, ongoing efforts in treating those with or recovering from COVID-19.** LTCHs continue to play an invaluable role during the prior and latest surges of pandemic. In addition, at the end of the PHE, they will return to the pressures of major payment reform that would have been fully implemented in FY 2021 if not for pandemic waivers. In particular, the LTCH site-neutral payment policy will resume, which AHA estimated cut LTCH payments by more than $1 billion in total from FYs 2016 to 2019. Indeed, the related drop in LTCHs' Medicare FFS margins has been reported in recent years by MedPAC staff. The full implementation of the site-neutral policy following the PHE will exacerbate these trends even though LTCHs will likely still face elevated, post-PHE personnel and other costs without the benefit of support from relief funds.

Inpatient Rehabilitation Facilities. In December, the commissioners considered a draft recommendation to reduce FY 2023 IRF PPS payments by 5%, relative to FY 2022 levels. Given persistent PHE stresses, **we urge MedPAC to help maintain the operational stability needed during the pandemic by supporting a current law update for IRFs in FY 2023.** As shown above, IRFs also have experienced a major increase in the clinical needs of its patient population during the pandemic. Additionally, in some instances, they have — at least in part — adapted to treat general acute-care hospitals patients, which greatly aids local referring hospitals and the overall community response to pandemic surges.

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 American Medical Rehabilitation Providers Association (AMRPA) of the Centers for Medicare &

Medicaid Services' (CMS) FY 2022 rate setting files found that 45% 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 disparity should be better understood, as suggested during the December meeting. In addition, we note that in its FY 2021 rulemaking, CMS affirmed the unique role filled by IRFs relative to SNFs when it recognized IRFs' much higher level of physician and other clinical resources. This distinction was further illustrated during the PHE by the contrast between IRFs' ability to step forward and treat a sicker patient population while nursing homes struggled with infection control and other patient safety challenges.

Hospital-based Skilled-nursing Facilities. In December, commissioners discussed a draft recommendation to eliminate the SNF market basket for FY 2023. As is widely recognized, the COVID-19 pandemic has been greatly challenging for SNFs and nursing home patients and providers. The field's response to the pandemic continues to be quite mixed. Freestanding SNFs/nursing homes have struggled to control community-spread that resulted in COVID-19 infections and deaths. However, hospital-based SNFs have continued to play an important role in the pandemic response as their host hospitals struggle to deal with ongoing surges in COVID-19 admissions. Based on their proximity and inter-connections with their hosts, as well their personnel and mix of services — which focused on treating the highest shares of medically-complex patients — hospital-based SNFs are strongly supporting their communities' pandemic responses. **Given both their historic and ongoing role in treating higher-acuity patients, as well as their historic underpayment, we urge you to consider providing hospital-based SNFs with a current-law-market-basket update for FY 2023.** 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, which increased even more during the pandemic. MedPAC has noted that this negative 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 during the PHE.

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 Shannon Wu, AHA's senior associate director of policy, at 202-626-2963 or swu@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development

Cc: James E. Mathews, Ph.D.
MedPAC Commissioners