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

January 3, 2023

Michael Chernew, Ph.D.
Chairman
Medicare Payment Advisory Commission
425 I Street, NW, Suite 701
Washington, D.C. 20001

Dear Dr. Chernew:

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) appreciates the opportunity to share our comments and asks that commissioners consider the following issues before making their final payment update recommendations.

The decisions you reach on hospital payment updates will not only greatly affect America's hospitals and health systems, but also other providers and the patients and communities we serve. In response to the discussions during the December meeting and the commission's draft recommendations, we:

- **Appreciate your draft recommendation to provide a current law market-basket update plus an additional 1% for the hospital inpatient and outpatient prospective payment systems (PPS), but urge the commission to recommend a higher update for hospitals in light of the sustained and substantial financial pressures and negative Medicare margins they face;**
- **Urge the commission to recommend current law updates for inpatient rehabilitation facilities (IRFs) and hospital-based skilled nursing facilities (SNFs) given the pivotal role they play for the entire health care continuum; and**
- **Support the recommendation to increase physician reimbursement, as well as the proposal for add-on payments, but encourage the commission to consider a higher update that more fully accounts for the impact of inflation, as well as the release of additional analysis on the distribution and amount of add-on payments for safety net clinicians.**

Our detailed comments on these issues follow.

HOSPITAL UPDATE RECOMMENDATIONS

The AHA appreciates MedPAC's draft recommendation to increase hospital inpatient and outpatient PPS payments by the current-law market basket plus an additional 1% for 2024. An update above and beyond current law is absolutely necessary, and we thank the commission for recognizing this. However, an additional 1% is insufficient to account for providers' current financial pressures combined with the sustained and substantial negative margins that hospitals have faced for almost two decades. Simply put, Medicare's payments to hospitals are inadequate.

Therefore, we urge the commission to recommend a higher payment update. Specifically, we urge it to recommend an update of market basket plus the difference in what hospitals received in 2022 and what they should have received, based on the *projected* versus *actual* market basket for 2022.[1] This difference is approximately 2.8% for the inpatient and outpatient PPS hospitals and 2.7% for long-term care hospitals (LTCHs).[2]

As we detailed extensively in our November letter, the current inflationary economy and ongoing workforce challenges have put unprecedented pressure on America's hospitals and health systems. Health care providers continue to struggle with persistently higher costs and additional downstream challenges because of the lasting and durable impacts of high inflation and the pandemic. Appropriately, accounting for recent and future trends in inflationary pressures and cost increases in the hospital payment updates is essential to ensure that Medicare payments for hospital services more accurately reflect the cost of providing care.

Medicare payments have remained far below the cost of providing care for many years — a fact that the Commission recognizes. **Specifically, according to the MedPAC data book, the Medicare program has not fully covered the costs of serving Medicare patients since 2002.** In fact, on average Medicare only pays 84 cents for every dollar hospitals spend providing care to Medicare beneficiaries.[3] Slight

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[1] See AHA's letter to MedPAC in November and AHA's letter to CMS June. https://www.aha.org/lettercomment/2022-12-01-aha-urges-medpac-consider-current-financial-challenges-faced-hospitals-and-health-systems; https://www.aha.org/lettercomment/2022-06-17-comments-cms-its-fy-2023-proposed-inpatient-prospective-payment-system

[2] IHS Global, Inc.'s (IGI's) forecast of the IPPS market basket increase, which uses historical data through first quarter 2022 and second quarter 2022 forecast. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData

[3] https://www.aha.org/fact-sheets/2020-01-07-fact-sheet-underpayment-medicare-and-medicaid

improvements during the past few years have only made margins slightly less negative — never mind providing an adequate margin for capitalization — 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 2021 Medicare margin of -6.2% occurred because COVID-19 relief funds were accounted for in 2021. Without these temporary relief funds, overall Medicare margin for 2021 remained depressed at -8.2% after hitting a staggering low of -12.3% in 2020, according to MedPAC.[4] Similarly, overall Medicare margins for LTCHs were less than the cost of care from 2017 through 2019, but reached 3.6% in 2020, solely due to temporary, public health emergency-related increased payments.

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 2020, among nearly 5,200 hospitals surveyed by AHA, two-thirds lost money caring for Medicare patients.[5] Such widespread, sustained low margins make it very difficult for providers to meet emergency demands or maintain access to care for Medicare patients and their communities over the long term. Indeed, MedPAC estimates that Medicare margins will remain depressed at -10% for 2023. 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 maintained for nearly a decade. Negative margins, let alone those in the realm of negative 8.2%, are not acceptable, particularly when accompanied by the expectation that hospitals will always be there, ready to care, in any and all emergency situations. **We continue to urge the commission to start to bring Medicare payments back to the level where they cover the cost of providing care to and ensure patients have adequate access to care.**

The commission also discussed its safety-net index (SNI) proposal at the December meeting, proposing to redistribute disproportionate share hospital (DSH) and uncompensated care funds through the SNI with an additional $2 billion to be added into the SNI pool. **The AHA thanks the commission for recognizing that more should be done to stabilize the financial health of safety-net hospitals and for including additional funds to help support these providers that care for vulnerable communities.** However, we urge it to further consider the implications of redistributing existing Medicare DSH and uncompensated care funds. Medicare DSH and uncompensated care payments are intended to bridge the gap between the cost of

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[4] https://www.medpac.gov/wp-content/uploads/2021/10/Tab-C-Hospital-Updates-8-Dec-2022.pdf
[5] https://www.aha.org/fact-sheets/2020-01-07-fact-sheet-underpayment-medicare-and-medicaid

providing care to certain patients and low Medicare payment rates. However, inflation and costs have skyrocketed in 2022, making this one of the most financially challenging years for hospitals since the pandemic began and only exacerbating this gap. In fact, outlooks for not-for-profit hospitals remain negative for 2023, with Moody's citing continued difficult operating conditions related to labor shortages, high inflation, and supply chain challenges.[6] Revenue reductions to hospitals that score low on the proposed safety-next index would have significantly negative implications for Medicare beneficiaries and other patients served by these already financially fragile hospitals.

We also urge the commission to increase transparency around its SNI proposal. The commission has discussed at the aggregate level the types of hospitals that would benefit or be disadvantaged by this proposal, but there are still many unanswered questions about how specific hospitals may be affected. **At both the November and December meetings, several commissioners, including Ms. Barr, Dr. Riley and Dr. Jaffery, expressed concern that this proposal would actually adversely affect many hospitals typically recognized as safety-net hospitals, such as large county or other public hospitals.** For example, staff cited that hospitals that rank low on the SNI index would see their Medicare margins decrease from -12.4% to -15.7%, even after an additional $1 billion is added for distribution under the proposal. It is difficult for us to understand the rationale behind a proposal that would cut Medicare margins so significantly to such an unacceptable level, particularly when so little is known about what type of hospitals would see these cuts**.** As Dr. Jaffery stated, "There's a pretty significant impact on that 5th percentile […] I'm not sure I fully understand what that five percent looks like, who they are, where they are, what the impact will be on them." We agree, and it is critical to understand the impact of this proposal on hospitals during such a financially unstable time. Making the methodology more transparent would allow others to model the proposal and could better inform future policy discussions.

POST-ACUTE CARE UPDATE RECOMMENDATIONS

Post-acute care (PAC) providers continue to play a critical role in supporting the nation's health care system in responding to the COVID-19 PHE. As MedPAC has recognized in previous discussions, PAC providers have helped alleviate acute-care hospital capacity issues, as well as rehabilitated COVID-19 patients facing continued challenges in their recovery. Far from winding down, PAC providers continue to provide critical support to their acute-care partners as the country faces a potential "tripledemic" of COVID-19 and other respiratory illnesses.[7] In fact, just this month, Health and Human Services Secretary Xavier Becerra made clear to state leaders that they should utilize COVID-19

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[6] https://www.moodys.com/research/Moodys-Not-For-Profit-Healthcare-2023-Outlook-Remains-Negative-as--PBM_1351244
[7] https://www.cnn.com/2022/12/08/health/hospitals-full-not-just-covid/index.html

waivers and flexibilities as these other emerging threats combine with COVID-19 to strain their states' health care resources.[8]

The data below illustrate that the trend of increased patient case-mix, average lengths of stay and ICU days among patients cared for in PAC settings that began at the beginning of the COVID-19 PHE has continued into 2022. These sicker, more debilitated patients, combined with the ongoing workforce shortages and inflationary pressures discussed in our November letter, have put enormous strain on PAC providers. We encourage MedPAC to consider these unprecedented challenges faced by PAC settings alongside the pivotal capacity these settings provide for the entire health care continuum when finalizing its recommendations for each sector.

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

Inpatient Hospital Discharge Destination	Case-mix Index	Average Length of Stay	Average Number of ICU Days
All Inpatient PPS Discharges	**7.5%**	**10.3%**	**12.8%**
HH	4.9%	10.7%	10.6%
SNF	3.2%	10.8%	7.4%
IRF	4.1%	10.0%	7.7%
LTCH	9.2%	17.5%	17.0%

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 COVID-19 PHE period of Jan. 27, 2020 to March 31, 2022 (approximately 26 months) versus the pre-COVID-19 PHE period of Nov. 23, 2017 to Jan. 26, 2020 (approximately 26 months).

Inpatient Rehabilitation Facilities. During MedPAC's December meeting, the commissioners discussed recommending a 3% reduction to fiscal year (FY) 2024 IRF PPS payments. For the reasons discussed herein, **AHA urges MedPAC to support a current law update for IRFs in FY 2024.** As MedPAC has previously acknowledged, IRFs have played a critical role during the COVID-19 PHE. Through important regulatory waivers, they have been able to treat a broader array of patients, which in turn has increased capacity for acute-care hospitals. As shown above, IRFs also have seen patient case-mix and other indicators of resource-intensive care remain elevated relative to pre-pandemic levels. These factors, combined with the expected continued

[8] https://www.hhs.gov/about/news/2022/12/02/letter-us-governors-from-hhs-secretary-xavier-becerra-covid-19-flu-rsv-resources.html

financial strain on hospital-level providers into 2023, warrants a payment update that ensures IRFs are sufficiently resourced to meet the needs of their communities.

AHA appreciates that several commissioners noted the widely varying margins in the IRF sector. As we previously shared, an 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%. Therefore, a 3% cut would create negative or very low margins for nearly half of all IRFs. In addition, during the COVID-19 PHE, IRFs have been caring for Medicare patients that otherwise might not be eligible for IRF care, such as those who might not meet the "3-hour rule" criteria. Therefore, current financial outcomes likely will not carry forward once the COVID-19 PHE ceases, when numerous patient types will no longer be treated in IRFs.

Finally, we are eager to examine a report referenced, but not disclosed to the public, during December's public meeting that analyzes recent case-mix changes in IRFs relative to historical trends. During MedPAC's discussion, there was some implication that provider behavior may have contributed to changes in case-mix among IRFs. However, we are unclear as to how MedPAC accounted for the major change in the IRF PPS in 2019 that replaced long-used FIM™ instrument with the IRF-PAI to determine payment grouping. As we noted in our comment letters to CMS regarding this change, many of the IRF-PAI indicators can result in different levels of function from their counterparts in the FIM™, and therefore this change in case-mix would be expected even absent any behavioral changes. This is especially relevant since providers only had a little more than a year to use of this new instrument prior to the COVID-19 PHE, and many providers are still adjusting to this change.

Hospital-based Skilled-nursing Facilities. In December, commissioners discussed a draft recommendation to lower SNF payments by 3% for FY 2024. However, such a reduction would be harmful to the entire care continuum, but in particular to hospital-based SNFs and their host hospitals. As discussed previously, PAC providers have stretched beyond their usual capacity to support their acute-care counterparts and maximize care for their communities. While doing so, freestanding SNFs in particular have struggled to control community-spread that resulted in COVID-19 infections and deaths. Hospital-based SNFs, meanwhile, have continued to focus on treating medically-complex patients and alleviating capacity for the rest of their host-hospital. In addition, these hospital-based SNFs have historically seen massively negative margins (-50% in FY 2020), but have nonetheless maintained higher quality indicators than freestanding SNFs.[9] **Therefore, AHA encourages MedPAC to recommend a current law update for SNFs, especially hospital-based SNFs, in order to ensure they can meet the expected challenges of this coming year as well as continue to provide critical care capacity for their communities.**

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[9] https://www.medpac.gov/wp-content/uploads/2021/10/mar21_medpac_report_ch7_sec.pdf

PHYSICIAN UPDATE RECOMMENDATIONS

The AHA appreciates the commission's report and presentation on assessing adequacy and updating payments for physician services and supporting Medicare safety-net clinicians. As cited in the presentation and commissioners' comments, the impacts of inflation and rising input costs continue to outpace the reimbursement for services covered by the physician fee schedule (PFS). Not only are rates decreasing due to reductions in reimbursement like the PFS conversion factor cut of 2% in the calendar year (CY) 2023 and around 3% for 2024, but also costs are increasing in an unprecedented manner due to supply chain disruptions and workforce shortages, for example. The widening gap between PFS updates and increases in the Medicare economic index (MEI) puts some numbers to this crisis, which poses significant threats to patient access and provider financial stability, particularly safety-net providers.

While the staff presentation cited that access to care for fee-for-service beneficiaries remains higher than beneficiaries in private plans, there are concerns regarding the percentage of beneficiaries having problems finding a new primary care provider or specialist (6% and 8% of all beneficiaries respectively), as well as the number of beneficiaries foregoing care in the last year (18% total, with 4% of all beneficiaries reporting it was due to not being able to get an appointment). The presented solutions focused on 1) updating physician reimbursement for 2024 to account for rising input costs (outside of budget neutrality) and 2) providing an add-on payment for PFS services provided to low-income beneficiaries (also outside of budget neutrality). Updates to physician reimbursement were recommended at 50% of MEI (or 1.25%), and add-on payments for safety net providers were recommended at 15% and 5% respectively for primary care and specialty care.

The AHA directionally supports the draft recommendations to increase physician reimbursement outside the parameters of budget neutrality, and to make add-on payments for safety-net primary care and specialty care clinicians outside budget neutrality. **However, we urge MedPAC to recommend a higher update to physician reimbursement, one which more fully accounts for the impact of inflation and recent PFS cuts. We also ask the commission to release additional analysis on the distribution and amount of add-on payments for safety-net clinicians under its proposal.**

Specifically, the recommendation to increase PFS rates by 50% of MEI will not fully offset the impact of rising input costs; indeed, it will not come close to offsetting the 2% cut in reimbursement that will occur in 2023 and estimated 3.25% cut in 2024. **In fact, data from the Medicare Trustee's Report indicate that physician reimbursement**

has dropped over 20% over the last 20 years when accounting for inflation.[10] The staff presentation also highlighted the widening gap in MEI and projected spending. This suggests that the proposed increase of 1.25% will be insufficient to compensate for the longitudinal decrements in reimbursement and projected gap between MEI and spending.

In terms of add-on payments for care delivery to low-income beneficiaries, we acknowledge the challenges safety-net providers, in particular, face in remaining financially viable. As such, we directionally support MedPAC's proposal. However, we agree with many of the commissioners' comments that more analysis is necessary, including on the amount of payments necessary for primary care and specialty care. Indeed, data from the commission's 2022 survey indicate that in aggregate, more patients were looking for a specialist (26%) compared to a primary care physician (PCP) (11%), and additionally were unable to find a specialist (8%) compared to a PCP (6%). This suggests that there may be particular challenges in access to specialty care, rendering the 5% proposed add-on payment for specialty care insufficient to support clinicians and ensure access in this portion of the care continuum.

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 swu@aha.org or 202-626-2963.

Sincerely,

/s/

Ashley B. Thompson
Senior Vice President
Public Policy Analysis and Development

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

[10] https://www.beckershospitalreview.com/hospital-physician-relationships/the-stark-reality-of-physician-reimbursement.html