American Hospital Association

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January 2, 2009

Mr. Glenn M. Hackbarth
Chairman of the Commission
64275 Hunnell Road
Bend, OR 97701

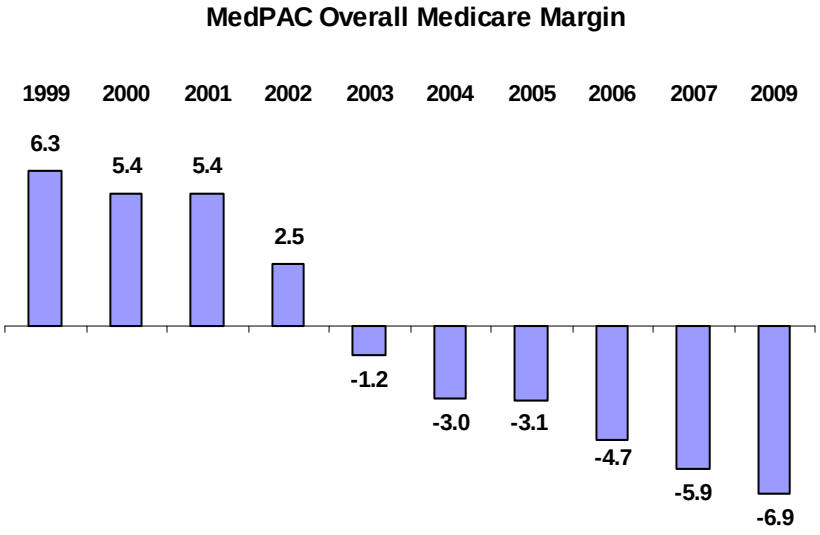
Dear Mr. Hackbarth:

At the January meeting, the Medicare Payment Advisory Commission (MedPAC) will vote on payment recommendations for fiscal year (FY) 2010. Before making final recommendations, we ask that you consider the following issues that have a significant impact on hospitals, other providers and beneficiaries.

Medicare Payments to Hospitals Are Inadequate

According to MedPAC estimates, overall Medicare margins — including the costs of inpatient, outpatient and post-acute care services — will reach a ten-year low in 2009 at ***negative*** 6.9 percent. Even when looking at MedPAC's analysis of "efficient" hospitals from the December meeting, overall Medicare margins for the most efficient hospitals were barely positive and inadequate.

Looking at American Hospital Association (AHA) annual survey data, a staggering 58 percent, or 2,840 hospitals, lost money in 2007 serving Medicare patients. This clearly indicates that Medicare payments are woefully inadequate and ***a full market basket increase for inpatient and outpatient hospital services is absolutely necessary.***



Sources: MedPAC: Healthcare Spending and the Medicare Program (June 2008). December 2008 MedPAC meeting.

Payments to LTCHs

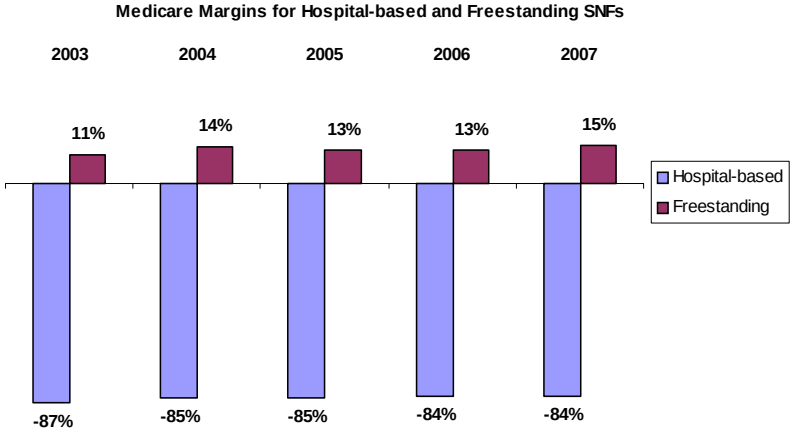
Long-term care hospitals (LTCHs) provide care to beneficiaries who have clinically complex problems and need hospital care for extended periods of time. The number of LTCH facilities has remained steady, but Medicare spending for LTCHs declined in 2007. In addition, Medicare margins have been on a downward trajectory since 2005 and are projected to reach 0.5 percent in 2009, meaning that Medicare payments will only just cover the costs of providing care to Medicare beneficiaries. In order to halt the decline in margins and preserve beneficiary access during the current economic volatility that threatens LTCHs and other hospitals, ***a full market basket increase to account for inflation is needed.***

Payments to IRFs

Inpatient rehabilitation facilities (IRFs) are run by specially trained doctors and staff who treat both their patients' *rehabilitation* and *medical* needs. The field has experienced significant change since 2007 and payment adequacy is on a steep downward trend. Specifically, strict enforcement of the 60 Percent Rule has reduced patient volume and increased the severity of IRF case mix. In addition, IRFs have been subject to an 18-month payment cut that runs through FY 2009. Many IRFs are also facing the pressure of aggressive medical necessity audits that require them to undertake costly appeals to recover funding – appeals which are being decided in favor of IRFs at a high rate. **A *full market basket increase is needed to maintain payment adequacy.***

Payments to Hospital-based SNFs

Hospital-based skilled nursing facilities (SNFs) provide a fundamentally different model of care than freestanding SNFs. They treat sicker patients who require more extensive services and higher nurse staffing ratios per bed than freestanding SNFs. The complexity of these patients is not well accounted for in the SNF payment system; as a result, at the December meeting, MedPAC reported that these patients are experiencing delays in being placed into a SNF. We support the Commission's prior recommendations for redesigning the SNF prospective payment system, as these changes would greatly improve access for medically complex patients. However, aggregate Medicare margins for hospital-based SNFs were *negative* 84 percent in FY 2007, compared to positive 15 percent margins for freestanding facilities. With deplorably low margins and hospital-based SNFs continuing to retreat from the market, ***a full market basket update is critical to preserve the high level of care provided by hospital-based SNFs.***



Sources: MedPAC: Healthcare Spending and the Medicare Program (June 2008). December 2008 MedPAC meeting. AHA analysis of Medicare cost reports.

Indirect Medical Education Payments

During the last meeting, the Commission discussed repeating its recommendation to reduce the inpatient indirect medical education (IME) adjustment from 5.5 to 4.5 percent per 10 percent increment in the intern/resident-to-bed ratio – a 20 percent reduction in IME payments. The commissioners also emphasized that more analysis is needed to understand graduate medical education financing and the contribution of Medicare IME payments to covering the operating costs incurred by hospitals in training physicians, serving as settings for clinical research and providing care to disadvantaged populations. When coupled with the elimination of the capital IME adjustment, this recommendation would reduce overall IME funding to teaching hospitals by about 25 percent. The AHA believes that, in the current economic environment, it is not an appropriate time for the Commission to make a recommendation to reduce IME payments by one percentage point. Such a substantial cut would negatively affect the education, clinical care and research missions of teaching hospitals, including their ability to train high-quality physicians. ***We urge the Commission to reject IME cuts, and withhold a recommendation on the level of the IME adjustment. Instead, the Commission should continue its deliberations and conduct thorough analyses on how IME payments are used.***

We appreciate your consideration of these very important issues. If you have any questions, please feel free to contact me or Joanna Hiatt at (202) 626-2340.

Sincerely,

Rick Pollack
Executive Vice President

cc: Mark Miller, Ph.D.