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American Hospital Association

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Dear Mr. Hackbarth:

At its September meeting, the Medicare Payment Advisory Commission (MedPAC) discussed both the Physician Fee Schedule Sustainable Growth Rate (SGR) formula and rural payment adjustments. In further considering these topics, and before moving forward with recommendations, we ask that you consider the following issues, which have a significant impact on hospitals, other providers and beneficiaries.

SGR REPEAL

The commission discussed a draft recommendation to repeal the SGR formula and replace it with a 10-year path of legislated fee schedule updates. Under this path, payments for primary care physicians' primary care services would be frozen; specialist services would be cut by 5.9 percent for three consecutive years and then frozen. The recommendation would cost about \$200 billion over 10 years, and the commission discussed \$235 billion in offsets to this cost, consisting almost entirely of cuts to other health care providers.

As hospitals employ more than 200,000 physicians across the nation, the AHA supports the repeal of the SGR. However, offsetting the cost of the repeal with Medicare cuts to hospitals and other providers is merely "robbing Peter to pay Paul" and is the wrong approach. Making cuts to providers, such as hospitals, that, according to MedPAC itself, are already seeing negative Medicare margins, could endanger beneficiary access to those providers. Physician payment reform offsets should not come from other health care providers, who are themselves working to provide high-quality, innovative and efficient care to beneficiaries in their communities and experiencing negative margins under the Medicare program.

Perhaps an even more significant concern to us, however, is the commissioners' potential willingness to offer proposals to offset the costs of repealing the SGR, particularly savings ideas upon which MedPAC has not formally voted. Only about \$50 billion of the cuts MedPAC included in its draft offset package stem from actual MedPAC recommendations. The remaining \$180 billion comes from other sources, such as the Congressional Budget Office and MedPAC staff. Until now, MedPAC has followed a very rigorous process for developing recommendations that allows all commissioners the opportunity to fully deliberate recommendations and consider all their impacts, both intended and



unintended, before voting. **It is inappropriate for the commission to suggest such impactful cuts when commissioners have not fully deliberated, received public comment or voted on these policies.**

If, however, MedPAC stays the course and suggests cuts that it has not fully researched or discussed, it is inappropriate for the commission to take on the challenge of fully offsetting its SGR recommendation while at the same time limiting itself to only Medicare provider cuts. While we understand that MedPAC's main statutory charge is to review and recommend improvements in Medicare payment policy, part of its charge is also to assess the implications of changes in health care delivery and the general health care market on the Medicare program. Many activities in the general health care market affect the Medicare program and could be used to address the current problems with physician payments. For example, the high costs associated with the current medical liability system not only harm hospitals and physicians, but also patients and their communities. Across the nation, access to health care is being negatively impacted as physicians move away from states with high insurance costs or stop providing services that may expose them to a greater risk of litigation. The increased costs that result from the current flawed medical liability system not only hinder access to affordable health care, they also threaten the stability of the hospital field, which employed 5.3 million people in 2009, and continues to be one of the largest sources of private-sector jobs. An estimated \$50 to \$100 billion is spent annually on defensive medicine – services not provided for the primary purpose of benefiting the patient, but rather to mitigate the risk of liability. To help make health care more affordable and efficient, the current medical liability system must be reformed.

In addition, for more than two years, MedPAC has been developing an ongoing body of work around benefit design and beneficiary cost sharing. It has aimed to create incentives for beneficiaries to use high-value services and weigh their use of discretionary care without discouraging needed care. The commission has pulled several offset suggestions from this body of work, such as the institution of a copayment for the home health benefit. We suggest that the commission look to this work for further offset suggestions, such as eliminating first dollar coverage for MediGap plans or raising the Medicare eligibility age.

We support incentives for physicians to participate in coordinated care as part of accountable care organizations (ACOs), bundling, and other systems of care. As such, we support the commission's draft recommendation to increase shared savings opportunities for those in the more risk-based track of the ACO program. We also urge the commission to consider that pay-for-performance via physician-hospital incentives would serve the purpose of both enabling a performance-based payment program and reducing Medicare spending. It also would allow physicians to earn more without increasing Medicare spending. For example, in the Medicare Gainsharing Demonstration program in New Jersey, the average physician incentive was approximately \$5,000, while another gainsharing program in New York averaged over \$9,000 per physician. These are significant savings as you consider how to pay physicians more than under current law. A gainsharing arrangement is relatively simple to construct, but is blocked by existing regulatory barriers, specifically in Civil Monetary Penalty, Anti-kickback and "Stark" physician self-referral laws.

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RURAL PAYMENT ADJUSTMENTS

As part of its mandated report on rural health care, at its September meeting, MedPAC discussed rural payment adjustments. Much of the discussion focused on the commission's assertion that not all rural hospitals are isolated. Specifically, staff presented analysis that 16 percent of critical access hospitals (CAHs) are located less than 15 miles from another hospital. However, there was no discussion of the full story of how these hospitals became CAHs, which is important contextual information.

Currently, to become a CAH, a hospital must be located either more than 35 miles from the nearest hospital or CAH or more than 15 miles in areas with mountainous terrain or only secondary roads. However, prior to January 1, 2006, this requirement was waived if a hospital was state-certified as a "necessary provider" of health care services to residents in the area. This provision provided governors, who are much more knowledgeable about and in touch with the health care delivery systems in their states, the flexibility to waive the "one size fits all" mileage requirement if they recognized that certain hospitals were absolutely essential to their communities.

We are concerned that MedPAC is using a one-size-fits-all consideration of these hospitals – viewing them only through the lens of proximity to the nearest hospital without any additional considerations. **In reality, there are many unique circumstances that MedPAC must take into account when analyzing CAH location, including distance to the next nearest hospital, availability of post-acute care services, size of the hospitals, size and location of the surrounding population centers, weather, geography and posted speed limits.** Each rural community is unique and should be considered as such when discussing payment policy.

The commission also discussed the current low-volume adjustment and asserted that it is duplicative with the sole community hospital (SCH) adjustment. **We strongly disagree with this conclusion.** The low-volume adjustment is obviously intended to account for the higher costs associated with treating a lower volume of patients – such providers frequently cannot achieve the economies of scale of their larger counterparts. The SCH adjustment, however, helps preserve access to care by targeting hospitals with higher-than-average costs given their circumstances. As MedPAC itself found in its June 2001 report, SCHs' higher costs persisted after adjusting for certain factors, such as low volume, case mix and teaching activity. The commission stated that the higher costs could be due to other factors than scale, such as longer lengths of stay linked to an inability to place patients into appropriate post-acute care. Thus, the two adjustments address two different challenges faced by small, isolated hospitals.

We appreciate your consideration of these very important issues. If you have any questions, please feel free to contact me at (202) 626-4628 or Joanna Hiatt Kim, senior associate director for policy, at (202) 626-2340.

Sincerely,

/s/

Richard J. Umbdenstock
President & Chief Executive Officer

cc: Mark Miller, Ph.D.