American Hospital Association

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January 9, 2012

Glenn M. Hackbarth, J.D.
64275 Hunnell Road
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Dear Mr. Hackbarth:

The Medicare Payment Advisory Commission (MedPAC) will vote this week on payment recommendations for fiscal year (FY) 2013. Before making final recommendations, we ask you to consider the following issues that have a significant impact on hospitals, other providers and beneficiaries.

Hospital Update Recommendations

For FY 2013 Medicare payments for inpatient and outpatient hospital services, Commissioners discussed a draft recommendation to update payments by 1 percent. According to MedPAC projections, overall Medicare margins for hospitals – including the costs of inpatient, outpatient and post-acute care services – will reach *negative* 7.0 percent in FY 2012. Analyzing American Hospital Association (AHA) annual survey data, a staggering 53 percent, or 2,661 hospitals, lost money in 2010 serving Medicare patients. ***Thus, we believe a full market basket increase for inpatient and outpatient hospital services is warranted and necessary.***

In December, Commissioners discussed a draft recommendation to eliminate the FY 2013 payment update for Medicare inpatient rehabilitation facility (IRF) services. In 2010, the Centers for Medicare & Medicaid Services (CMS) implemented stringent IRF patient and facility criteria that, in combination with the "60% Rule," resulted in more restrictive patient selection for IRF admission. As reported by Commission staff in December, average clinical severity of IRF patients continues to increase while performance on IRF quality measures is steadily improving. Since 2004, overall Medicare payments to IRFs have remained relatively flat; since 2003, Medicare margins for IRFs have dropped by 53 percent and plateaued at far lower levels. IRFs continue to provide a unique and valuable clinical service for beneficiaries while demonstrating cost growth that is consistent with the sicker case-mix of patients treated in IRFs. Based on these patterns, **the AHA urges the Commission to support a market basket increase to enable IRFs to continue providing high-quality care to the targeted population of beneficiaries who require both hospital-level medical management and intensive rehabilitation.**

For FY 2013 Medicare payments for long-term care (LTCH) hospital services, Commissioners discussed a draft recommendation to eliminate the payment update. The AHA agrees with MedPAC and other policy makers that LTCHs need patient and facility criteria to distinguish them as serving a group of high-acuity, long-stay patients. AHA data analysis shows that LTCHs treat a patient mix with a far higher severity of illness than is found in general acute hospitals, which is consistent with MedPAC findings that LTCHs provide value for severely ill patients. Given that LTCH Medicare margins were projected by Commission staff to decrease in 2012 to 4.8 percent and that the LTCH "25% Rule" is scheduled to resume for cost reporting periods starting on July 1, 2012 and that other major LTCH cuts will resume during FY 2013, **the AHA urges the Commission to support a market basket increase for LTCHs in FY 2013**.

Medicare Payments for Evaluation and Management Services

The AHA remains strongly opposed to the draft MedPAC policy recommendation to equalize Medicare payment rates for evaluation and management (E/M) services between hospital outpatient departments (HOPDs) and physician office settings by reducing payments for E/M clinic visits by more than 70 percent. Hospitals are already underpaid for these services and making additional reductions of this magnitude is excessive and harmful. We are concerned that the policy will reduce patient access to hospital-based outpatient care that is not otherwise available in the community and will undermine the ability of hospitals to adequately fund their emergency standby capacity. Further, the AHA believes that moving forward with this policy is premature given that its assumptions and impacts have not been adequately analyzed and confirmed. We believe that rushing to put this untested policy into place is not justified when one considers that HOPDs only account for 7.3 percent of these E/M visits and this share has only increased by about 2 percent in past six years. Indeed, while such a moderate trend may deserve further analysis by the Commission over time, it certainly does not justify an immediate and extreme payment reduction that would be applied to all HOPD E/M clinic services. **If, despite these substantial concerns, MedPAC decides to move forward to approve such a policy, then given all the remaining questions regarding potential impact, the Commission should include both a multi-year transition and implement the policy in a budget neutral manner within the outpatient prospective payment system (OPPS) by redistributing any amount removed from the E/M services to other services in the OPPS.**

Further cuts in outpatient payment are untenable. This proposal would result in significant payment reductions to an outpatient payment system that is already significantly underfunded. At the December MedPAC meeting, staff stated that 2010 Medicare margins were *negative* 9.6 percent for outpatient services, *negative* 1.7 percent for inpatient services and *negative* 4.5 percent overall. MedPAC's proposal would result in additional cuts to outpatient payments, which would endanger Medicare and Medicaid beneficiary access to these services. Implementing this policy would result in an additional 3 percent cut to outpatient payments, thereby reducing Medicare outpatient payments to 87 percent of cost, or a margin of about *negative* 13 percent. This will harm hospitals' abilities to continue to maintain emergency stand-by capacity and capability, which is not a situation that can be resolved or justified through cost-shifting when the inpatient, outpatient, and overall Medicare margins are all negative.

Further, the proposed recommendation interferes with health care delivery system reform efforts to achieve better clinical integration through incorporation of physician practices into hospital systems. This policy would hamper integration efforts by creating even greater shortfalls in Medicare funding. In fact, those hospitals participating in the Pioneer Accountable Care Organization (ACO) demonstration program would see an average 5.2 percent reduction in their Medicare OPPS payments under the proposed MedPAC recommendation. This short-sighted proposal would disproportionately harm the very type of accountable care organization models that we are striving to foster through healthcare reform.

MedPAC draft recommendation would put access to care at risk. This reduction in outpatient Medicare revenue to hospitals would threaten beneficiary access to critical hospital-based services that are not otherwise available in the community, such as care for low-income patients and services for medically complex patients with multiple co-morbid conditions. The impact on vulnerable patients who depend on hospital-based services, especially public hospitals and teaching hospitals, would be devastating. MedPAC's draft recommendation would reduce total OPPS payment in major teaching hospitals by 5.8 percent (about $458 million estimated for 2012) and reduce total OPPS payment in urban public safety net hospitals by 4.9 percent (or about $220 million estimated for 2012). These hospitals provide primary care and specialty services in a variety of clinics, many of which serve primarily low-income patients. They are vital safety net providers of outpatient services, providing a growing amount of timely, integrated and culturally competent care to vulnerable patient populations. These services are not commonly offered by free-standing physician practices.

Other hospital-based clinics serve patients with complex illnesses or multiple co-morbidities in clinics such as diabetes clinics, pain clinics, and cancer clinics. The costs in all these hospital-based clinics are higher due to more severely ill patient populations requiring greater use of resources, greater regulatory requirements, stand-by capacity costs related to offering emergency department and other services 24/7 and 365 days a year, and also the costs of unreimbursed "wrap-around" services needed to support these vulnerable patient populations, such as transportation, case management, and translation services.

While the overall impact of MedPAC's draft recommendation on rural hospitals – a 2.6 percent reduction in total OPPS payment (or about $138 million in 2012) – is close to the national average reduction of 2.8 percent, this is exacerbated by rural hospitals' high Medicare share, high outpatient share and their limited cash flow. Therefore, this draft recommendation also would have a significant impact on rural access to care.

An AHA analysis of Medicare data demonstrates that average patient severity for E/M clinic visits is nearly 24 percent higher in HOPDs than in physician offices (see table below), as measured using hierarchical condition categories (HCC) scores weighted by numbers of E/M visits.

Weighted HCC Risk Scores

All E/M Clinic Visits	Physician Office E/M Clinic Visits	HOPD E/M Clinic Visits
1.696	1.672	2.067

Free-standing physician practices often refer more complex patients to hospital-based clinics for safety reasons, as hospitals are better equipped to handle complications and emergencies. These services, which are generally not available in free-standing physician practices, cannot be supported by payments set at a residual of the physician fee schedule amount, as proposed by MedPAC. Cuts of the magnitude described by MedPAC's proposed policy would make it difficult for hospitals to continue to support existing clinics and a disincentive to create new clinics to support the growing needs of these populations.

Recommending policy is premature in light of questions and unknown impacts. The AHA believes that it is premature to recommend moving forward with the proposed E/M payment policy without adequate analysis of unanswered questions that have been raised by MedPAC commissioners and the public. For instance, much more information is needed about the trend that MedPAC staff note around hospitals purchasing free-standing physician practices – how many hospitals are purchasing physician practices and for what purposes? Are these physicians being integrated into the hospital setting? What proportion of these practices is being converted into a HOPD and billing under the OPPS versus continuing to bill as a physician office under the PFS? For those that become newly minted HOPDs, do they merely continue to provide the same type of services to the same patient population or are they transformed and furnishing safety net or other needed services that are not otherwise available in the community? Are these physicians being fully integrated into the hospital setting?

There is also much more work needed to better understand the issue of packaging of supplies and services under the OPPS versus the physician fee schedule, especially if MedPAC expands their recommendation beyond E/M services. However, even for E/M services the questions are relevant. Which types of HOPDs have the highest amount and percentage of packaged services included in their clinic visits and what kind of patients are they serving? What items and services are being packaged in E/M services and how will these costs be reimbursed under the MedPAC proposal since they are often paid separately in the physician office?

MedPAC commissioners have also questioned the impact that the E/M proposal will have on the relative weights under the OPPS. Under the OPPS, the hospital mid-level clinic visit is central to establishing the relativity of all the APC payment weights. With the MedPAC proposal, the weights will instead be derived from the much lower residual costs derived from physician office services. How will this impact the OPPS and will this lead to distortions in the outpatient APC relative weights? How will this affect hospital charges for E/M and other OPPS services?

Another unanswered question involves how MedPAC's proposal can be reconciled with the fact that current procedural terminology (CPT) E/M codes as used in physician offices are not defined to be equivalent, in terms of the amount and intensity of resources, to those used in HOPDs. CMS policy dictates that the CPT codes used to represent E/M visit services are different in HOPDs than in physician offices, and therefore one cannot assume that comparable service levels are being provided when a particular CPT code is billed across settings. In fact, the E/M code billed by the hospital is often different than the E/M code billed by the physician for the same patient, because of the different resources used and different definitions. Given these differences, how can MedPAC's proposal be equitably applied?

Before moving forward with this proposed recommendation, it is imperative that the Commission conduct due diligence by answering all of the above questions and any others that Commissioners may raise. Otherwise MedPAC's policy could result in multiple unexpected and harmful impacts on the nation's hospitals.

We appreciate your consideration of these very important issues and we urge you and your fellow commissioners to reject this draft recommendation. If you have any questions, please feel free to contact me at (202) 626-4628 or Joanna Kim, senior associate director for policy, at (202) 626-2340.

Sincerely,

Linda E. Fishman
Senior Vice President, Policy

cc: Mark Miller, Ph.D.