



**American Hospital
Association**

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

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Glenn M. Hackbarth, J.D.
64275 Hunnell Road
Bend, OR 97701

Dear Mr.Hackbarth:

The Medicare Payment Advisory Commission (MedPAC) will vote next week on payment recommendations for fiscal year (FY) 2014. On behalf of our nearly 5,000 member hospital, health systems and other health care organizations, the American Hospital Association (AHA) asks that commissioners consider the following issues that have a significant impact on hospitals, other providers and Medicare beneficiaries before making final recommendations: hospital inpatient and outpatient update recommendations, including consideration of documentation and coding changes; post-acute hospital update recommendations; and site-neutral payment policy.

HOSPITAL INPATIENT AND OUTPATIENT UPDATE RECOMMENDATIONS

In December, commissioners considered a draft recommendation to increase hospital inpatient and outpatient payments by 1 percent in FY 2014. Since the commission's last meeting, Congress, in the recently enacted *American Taxpayer Relief Act (ATRA)*, directed the Centers for Medicare & Medicaid Services (CMS) to cut hospital inpatient payments an additional \$11 billion between FY 2014 and FY 2017. This would mean an average reduction of about 2.4 percent in each year. Combined with the current marketbasket update projection of 2.6 percent and with an estimated reduction of 0.8 percent already mandated by the 2010 *Affordable Care Act (ACA)*, the AHA estimates an inpatient hospital update of *negative* 0.6 percent **before the impact of sequestration**. The commission's consideration of a 1 percent update at its December meeting does not take into account the impact of sequestration policies from the *Budget Control Act of 2011*, which will decrease all Medicare payments by 2 percent beginning in April. In making recommendations for FY 2014 Medicare payments – whether on hospital payment updates, document and coding adjustments or site natural payment policy – commissioners should consider that the recent actions of Congress, coupled with mandated ACA payment reductions, result in negative updates for inpatient and outpatient hospital payments.

The AHA believes a positive update for both hospital inpatient and outpatient payments in FY 2014 is absolutely essential. According to data presented at the last meeting, Medicare margins continue to be negative and fell sharply in 2011. Overall Medicare margins fell from negative 4.7 percent in 2010 to negative 5.8 percent in 2011 – a drop of 1.1 percentage points.



This means that, across all service lines, Medicare paid only 94 cents on the dollar of cost to treat Medicare beneficiaries. For outpatient services, Medicare paid 89 cents on the dollar (a margin of negative 11.0 percent), and for inpatient services, Medicare paid only 96 cents on the dollar (a margin of negative 4.0 percent). The staff projection for 2013 was even lower, at negative 6.0 percent. According to the MedPAC chart book, Medicare has not fully covered the costs of caring for Medicare beneficiaries since 2002. Payments that result in such negative margins over more than a decade cannot be considered adequate, particularly in the face of the low cost growth hospitals have sustained since 2009.

Further, at its December meeting, MedPAC staff identified 14 percent of hospitals that it considered “relatively efficient” based on specific efficiency and quality criteria that were applied over three years. During discussion, staff indicated that as many as 40 percent of these “relatively efficient” providers could have negative overall Medicare margins. If true, this would suggest that MedPAC staff could find only 8 percent of hospitals that met the efficiency and quality criteria and covered their costs of treating Medicare patients over three years. A finding that so few hospitals can meet the quality benchmarks used in the analysis and have a positive margin would suggest that current payment rates are well below the actual costs of efficient delivery of services, and should be increased considerably.

Other policies will also affect total payments to hospitals, but the impact will vary across facilities. Both the hospital readmission reduction program and cuts to Medicare disproportionate share hospital payments will reduce the total pool of payments in the inpatient prospective payment system (PPS) in FY 2014. The Medicare electronic health record (EHR) incentive program will add limited funds, but be followed by penalties that begin in FY 2015. The incentives in FY 2014 will not make up for an insufficient payment update, particularly given the large price tag hospitals face to purchase and implement certified EHRs. And, of course, the rationale for the incentives was not to offset other payment cuts but to partially offset the significant costs that hospitals and physicians bear to implement EHRs.

DOCUMENTATION AND CODING CUTS

As noted above, Congress directed CMS to remove \$11 billion in inpatient PPS payments to account for alleged overpayments associated with documentation and coding changes. The AHA firmly believes that no additional adjustments for documentation and coding should be considered. In particular, we disagree with MedPAC staff’s assertion that changes in documentation and coding related to the move to Medicare Severity Diagnosis-Related Groups (MS-DRGs) inflated payments in FY 2010.

MedPAC recommended, and CMS adopted, the MS-DRGs to improve payment accuracy across hospitals by better capturing patient severity of illness. The initial transition to MS-DRGs was made in a budget-neutral manner, and CMS has made multiple payment cuts to recoup alleged overpayments due to changes in documentation and coding in 2008 and 2009, the two years following introduction of MS-DRGs.

Based on a flawed analysis, MedPAC alleges that additional overpayments were made in FY 2010. Specifically, to determine coding change for FY 2010, CMS and MedPAC took the FY

2010 claims and calculated the case mix using the new, more accurate MS-DRG GROUPER and compared it to the same set of claims with case mix determined by the FY 2007 DRG GROUPER. Any difference was called “coding change.” **Assuming that case mix under the old DRG GROUPER and the new, more accurate MS-DRG GROUPER should be equal makes no attempt to separate out real case mix change from documentation and coding changes, as was required by statute.**

Using this same flawed methodology, MedPAC and CMS actually maintained that real case mix was *negative* during the initial years following the implementation of MS-DRGs. However, numerous other indicators suggest that Medicare patients are getting sicker in ways that were not appropriately accounted for under the old DRG system. As identified in the attached *TrendWatch* report, rates of chronic conditions are rising. According to data from CMS, four out of five Medicare beneficiaries suffer from chronic disease and two-thirds of them have two or more chronic diseases. These multiple chronic conditions all must be managed during an inpatient stay. The prevalence of obesity among Medicare beneficiaries has doubled since 1987, reaching 38 percent in 2009-10. Diabetes among seniors has increased from 18 percent in 2002 to nearly 27 percent in 2010. Medicare populations that use the most services – the disabled, those dually eligible for Medicare and Medicaid, and those with end-stage renal disease – account for an increasing share of those who receive inpatient care. Similarly, the use of intensive care unit (ICU) beds is increasing.

Other composite measures of patient severity, such as the health risk score used to risk-adjust payments under Medicare Advantage, show that Medicare patients admitted to the hospital were, on average, sicker in 2010 than they were in 2006. **In fact, applying the more accurate MS-DRG system to historical claims shows a steady increase in case mix even before its implementation and any associated incentives to improve coding. Taking these trends into account in differentiating real case mix change from documentation and coding improvement indicates no further adjustments are warranted, including the \$11 billion cut just enacted in the ATRA.**

POST-ACUTE HOSPITAL UPDATE RECOMMENDATIONS

INPATIENT REHABILITATION FACILITIES (IRF)

The clinical role filled by IRFs is unmatched by other settings. No other hospital or post-acute setting provides the intensity or scope of hospital-level medical and therapy services. **We urge the commissioners and staff to acknowledge the substantial tightening of IRF admission practices that has been underway for almost 10 years, which has produced a distinct and valuable IRF role in treating beneficiaries needing specialized care following a brain injury, spinal cord injury, stroke, amputation or other acute medical event. Thus, we ask the commissioners to support a positive update for inpatient rehabilitation units and hospitals.**

CMS has implemented significant policy changes that have reduced IRF volume by 24.4 percent since CMS changed the “75% Rule” policy in summer 2004 – from 355,030 discharges (for the 12-month period ending June 2004) to 268,357 discharges (for the 12-month period ending June 2012). In addition to the impact of the 75% Rule change, the 2010 tightening of IRF patient and facility criteria heightened further the distinctions between IRFs’ physician-led care and skilled nursing facility (SNF) services. This distinction was validated by CMS in the FY 2012 final rule for the SNF PPS:

*Finally, as one commenter highlighted, shifting IRF patients toward SNF care does not necessarily improve the quality of care provided to the beneficiaries... 81.1 percent of IRF patients were discharged to home, compared to 45.5 percent of SNF residents. Additionally, IRF patients appeared to have shorter lengths of stay, averaging approximately a 13-day stay, compared to the average 36-day stay for a SNF resident. Finally, when patients discharged from each setting were reviewed 24 weeks after discharge, IRF patients had consistently better outcomes and displayed a faster rate of recovery. **Given these findings, we do not agree with those commenters who would assume that shifting patients from the IRF setting to a SNF setting is necessarily more beneficial to the patient or the Medicare Trust Fund.** (Emphasis added.)*

LONG-TERM CARE HOSPITALS (LTCH)

The AHA agrees with MedPAC’s call for more stringent LTCH patient and facility criteria, which began in 2004. In fact, the AHA is pursuing a legislative effort to implement such criteria, which will enhance the already substantial distinction in the case mix treated by LTCHs relative to other hospitals, specialized hospital units such as ICUs, hospice and other post-acute care providers. **We urge MedPAC to support a positive update for LTCHS in FY 2014 to enable LTCHs to carry out their specialized role of treating the sickest long-stay beneficiaries – a role not filled by any other setting.**

LTCHs Treating Highest Acuity Case Mix. LTCHs already treat the highest-acuity case mix, which is supported by two metrics on severity of illness – the general acute hospital severity of illness discharge data and MS-DRG claims data. Data from FY 2011 show that hospital physicians are referring to LTCHs a mix of patients who are very sick, and far sicker than the population treated in hospital ICUs or referred to other settings, including hospice.

To address the December discussion on whether LTCHs are admitting patients who should instead be treated in a hospice, we note that it can be very difficult for physicians to predict whether or when some complex patients will die. AHA analysis of data on Medicare hospitalizations shows that LTCH patients who die have far higher levels of comorbidities and complications relative to the overall LTCH population, ICU patients and hospice patients; and greater complexity than the general acute hospital and ICU cases that end in death.

LTCHs and SNFs are Not Acting as Substitutes. Two analyses cited in the March 2012 MedPAC report found that LTCHs and SNFs are not serving as substitute settings. June 2011 research by RTI, Inc., found “little evidence of a substitution effect between SNFs and LTCHs...”

SNF stays were the same or *longer* for LTCH users compared to non-users in five out of the seven condition groups.” In addition, MedPAC’s March 2012 SNF chapter found that the presence of an LTCH does not affect the case mix of SNFs in the area. These timely and credible analyses refute the hypothesis that LTCHs are commonly admitting patients who should have been referred to a SNF.

SITE-NEUTRAL PAYMENT POLICY

After the December meeting, MedPAC staff disclosed to AHA and other national associations the 71 ambulatory payment classifications (APCs) included in its analysis of Medicare payment differences across hospital outpatient departments (HOPDs) and physician offices and were very gracious in providing time to discuss their methodological approach. These APCs represent services that would be cut if MedPAC were to recommend expanding its site-neutral payment policy from evaluation and management codes to additional services that meet specific criteria. After receiving the list of APCs from MedPAC and estimating their impact, the concerns we expressed in our letter of Dec 3, 2012 remain. These cuts would further reduce already negative Medicare margins for hospital outpatient services, and completely destroy the logic of the outpatient PPS.

If the commission were to recommend that hospitals be paid a portion of the Medicare physician fee schedule (PFS) amount for these 71 APCs, payments under the outpatient PPS would be reduced by 2.6 percent, or \$1.1 billion in a single year; over 10 years, the reduction would be \$12.2 billion. The resulting payment cuts to individual services from this policy are also significant, and go as deep as reducing the payment rate for an APC by 92 percent. The table below estimates the impact on select APCs that would experience the greatest change in either total payments or the payment rate. As we noted in our Dec. 3 letter, the policy would pay hospitals only a residual amount that is less than the practice expense payment a physician receives when the service is performed in a physician’s office.

Analysis of Estimated Impact of Site Neutral Payment on Select APCs

APC	Title	Estimated Cut to 2013 Payment Rate for APC	Estimated Cut to Overall Payments for APC
0269	Level II Echocardiogram without Contrast	- 67%	- \$275.0 m
0207	Level III Nerve Injections	- 32%	- \$108.0 m
0209	Level II Extended EEG, Sleep, and Cardiovascular Studies	- 32%	- \$82.0 m
0238	Level I Repair and Plastic Eye Procedures	- 83%	- \$13.0 m
0365	Level II Audiometry	- 92%	- \$6.9 m
0382	Level II Neuropsychological Testing	- 86%	- \$1.9 m

Source: Preliminary analysis of the 2010 Medicare 5% Standard Analytic File, the 2010 Final Outpatient Rate-setting data, addendum and tables from the CY2013 Final OPSS Rule by The Moran Company.

Note: Analysis incorporates methodological notes taken during conversations with MedPAC staff but is not an exact replication. Analysis attempted to follow the general policy and methodology as described by MedPAC.

These cuts would be applied to a payment system that is chronically underfunded relative to the costs of providing care. HOPDs are different from physician offices and provide a wide range of essential acute-care and diagnostic services, support public health needs, and provide access to care to vulnerable patient populations that is not otherwise available in the community. They also provide 24/7 access to emergency care and standby capacity for emergency response that is not separately funded and must be built into payments for all services.

In addition, the complexity of both the payment system itself and the MedPAC staff methodology used to identify candidate APCs means that any number of small technical and methodological decisions will change the outcome significantly. As a result, despite considerable effort, the AHA cannot replicate the analysis leading to these 71 APCs. For example, in our analysis, APC 0269, Level II Echocardiogram, would not meet the criteria for inclusion in the policy because it is performed with an emergency department (ED) visit 20 percent of the time. The commission's criteria would include only APCs performed with an ED visit less than 10 percent of the time. This single APC represents a quarter of the overall payment impact.

We further note that each APC contains multiple Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) codes and the composition varies significantly each year. Further, the definitions of the HCPCS/CPT codes also change over time as technology and clinical practice evolve. For example, in 2011, CMS moved CPT code 93307 from APC 0697, Level I Echocardiogram without contrast, to APC 0269. This same code was also redefined in 2009. It is not clear whether or how MedPAC staff accounted for these changes in their analysis, or in their data on volume changes for echocardiography presented at the December meeting. In the presentations, MedPAC staff noted changes in APC volumes for select echocardiography services from 2010 to 2011, and implied that the changes were due to change in setting. However, such changes also could be due to changes in the composition of the

Glenn M. Hackbarth, J.D.

January 4, 2013

Page 7 of 7

APCs, changes in the definitions of the HCPCS/CPTs, or changes in practice that stem from advances in technology. We also note that, overall, the great majority of cardiac imaging services (around 75 percent) were still performed in physician offices in 2011.

The fact that each APC contains multiple HCPCS codes makes it challenging to determine what the actual payment rate to the hospital would be under this policy, as under the PFS each HCPCS has a unique payment rate that changes annually based on relative value units for work, practice expense and malpractice. It is also unclear how the payment rates for all outpatient services would be updated over time, since the site-neutral policy would destroy the central mechanism of the outpatient PPS, which sets relative payments across services provided in the HOPD, and annually places clinically related services into APCs based on whether they have similar costs.

We appreciate your consideration of these concerns. Ensuring adequate payment for hospital services will ensure Medicare beneficiaries continue to have access to high-quality, innovative and effective care in their communities, including standby capacity and emergency response. If you have any questions, please feel free to contact me or Chantal Worzala, director of policy, at (202) 626-2313 or cworzala@aha.org.

Sincerely,

/s/

Linda E. Fishman

Senior Vice President, Public Policy Analysis and Development

Cc: Mark Miller, Ph.D.

MedPAC Commissioners

Enclosure