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

March 30, 2021

Michael Chernew, Ph.D.
Chairman
Medicare Payment Advisory Commission
425 I Street, N.W., Suite 701
Washington, DC 20001

Dear Dr. Chernew:

At its March meeting, as well as in several prior meetings, the Medicare Payment Advisory Commission (MedPAC, or the Commission) discussed potential recommendations for changes to the Indirect Medical Education (IME) program, which supports patient care and resident training at teaching hospitals, as well as to Medicare payment policy for certain outpatient drugs. 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) asks that commissioners consider the following issues as they recommend changes that would have a significant impact on hospitals, health systems and the Medicare patients we serve.

Medicare Payments to Teaching Hospitals

MedPAC at its March meeting discussed a draft recommendation to require that the Centers for Medicare & Medicaid Services (CMS) transition to empirically justified IME adjustments for not only inpatient, but also outpatient Medicare payments. We appreciate the Commission's work to help ensure that teaching hospitals are accurately reimbursed for their costs. **However, we are concerned that the draft recommendation would not accomplish MedPAC's articulated goals.** Specifically, it presented no data or analysis demonstrating that the recommendation would revise IME payments to "better reflect teaching hospitals' costs" as the Commission stated it aimed to do. Indeed, without such data and analysis, the possibility remains that the recommendation would actually result in less accurate IME payments to individual teaching hospitals than are made under the current system. Similarly, MedPAC did not present any evidence supporting the view that its draft recommendation would shift more resident training into outpatient settings, which was an implied goal.

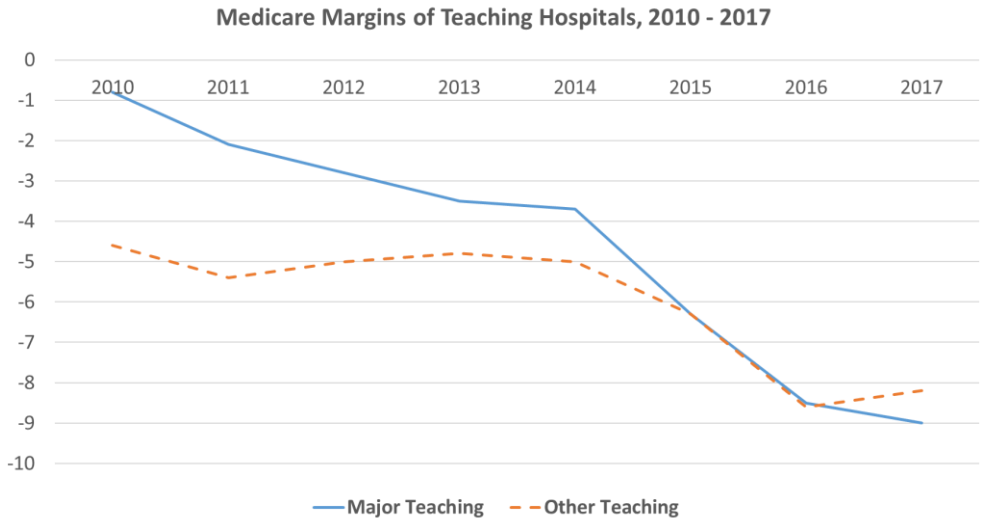
Lack of Data Demonstrating Improved Accuracy. MedPAC has stated that it wishes to revise IME payments to better reflect teaching hospitals' costs. However, it has not set

forth any *hospital-level* analysis demonstrating either that the current system is deficient in this respect, or that the draft recommendation would represent a substantial improvement. Thus, MedPAC appears to be asserting that its recommended changes would result in more fair and accurate payments simply by virtue of the fact that they consider outpatient care. But, without appropriate data analysis, this hypothesis remains only theoretical. Indeed, we believe that the draft recommendation may be a solution in search of a problem.

Specifically, the Commission presented evidence that the recommended changes would result in an improved empirical justification of IME payments. However, while this may be true at an *aggregate* level, there was no discussion or data analysis of the accuracy of *hospital-level* payments. The only impact data presented showed the distribution of teaching hospitals by percent change in fee-for-service (FFS) Medicare payments – which doesn't speak to accuracy at all. While we did attempt to model and analyze the recommended changes ourselves, there was simply not enough detail released on MedPAC's methodology to allow us to do so. Therefore, absent more information, the possibility remains that MedPAC's draft recommendation would actually result in *less accurate* IME payment adjustments at an individual hospital level as compared to the current system.

As mentioned above, MedPAC did analyze the impact of its draft recommendation on hospital payment levels. That analysis showed that its draft recommendation would lead to approximately 6% of teaching hospitals seeing a decrease of *at least* 2% in their inpatient and outpatient Medicare FFS payments. For the average teaching hospital, a 2% cut would equal about $2 million; however, the average IME payment is about $8.5 million. ***Therefore, MedPAC's draft recommendation that results in a cut of at least 2% in inpatient and outpatient payments for these hospitals equates to a cut of at least 25% in their IME payments.*** Yet, the characteristics of these 6% of hospitals remain unknown; those that stand to see such large decreases – cuts of at least a quarter of their IME payments – may very well be the exact hospitals that provide the most-highly specialized care or serve the most complex, vulnerable patients. **As requested by several commissioners, a more granular assessment of the hospital-level impacts is needed in order to fully understand what any modifications to the IME program would mean for teaching hospitals and the communities they serve.**

Decreases to Medicare payments of the magnitude discussed during the March meeting could compromise the financial stability of teaching hospitals, particularly as we continue to face a global pandemic. According to our analysis of cost report data, in fiscal year (FY) 2018, the approximately 1,200 teaching hospitals had an inpatient and outpatient Medicare margin of *negative 9%*. Moreover, margins for both major and other teaching hospitals have been negative and on the decline for nearly a decade, as shown below.



Additionally, we are concerned that the Commission is debating such a significant change during a once-in-a-century global pandemic that has severely strained the medical community. **Indeed, further reducing Medicare underpayments would exacerbate the financial challenges hospitals are already facing, and limit hospitals' ability to provide state-of-the-art clinical care and train the next generation of practitioners, even further exacerbating clinician burnout.** Now, more than ever, stable, predictable payments and an adequate margin are needed to ensure hospitals can maintain their ability to provide essential public services, continue to serve as society's ultimate safety net, protect their patients, and serve their communities.

Recommendation Would Not Incentivize Shift to Outpatient Training. In discussing its draft recommendation, MedPAC implied that a secondary goal was to incentivize hospitals to provide more resident training in outpatient settings. **However, the assertion that Medicare payment policy drives, or even influences, residency training program decisions is flatly incorrect.** Rather, these decisions are driven by the Accreditation Council on Graduate Medical Education (ACGME), individual specialty boards and residency review committees. It is a fundamental misunderstanding to think that hospitals have flexibility with regard to where their residents train based on the types of Medicare IME payments being made. Indeed, our members have made it clear to us that they have never made these types of changes in response to Medicare payment policy.

Separately Payable Outpatient Drugs

MedPAC, at two recent meetings, has examined the complex nature of hospital outpatient perspective payment system (OPPS) policies for separately payable drugs, and, in particular, the overlap and financial incentives that may exist in the policies governing pass-through drugs and separately payable non-pass-through (SPNPT) drugs. New drugs that qualify for pass-through status are paid at the rate of Average Sales Price (ASP) + 6% for both 340B and non-340B hospitals and include drugs that

are the "reason for the visit" (e.g., certain cancer drugs), as well as drugs that are ancillary to other services (e.g., contrast media). The SPNPT policy, which includes only established drugs that are the "reason for the visit," pays separately for a drug if it exceeds an annually updated cost threshold. However, the payment rate for SPNPT drugs varies for 340B and non-340B hospitals where non-340B hospitals are paid at ASP+6% and 340B hospitals are paid at ASP-22.5%. Other non-pass through drugs, including those below the cost threshold and those that are ancillary, are packaged and paid as a part of another outpatient service.

MedPAC has expressed concerns that the policies described above are too complex and also may incentivize 340B providers to prescribe pass-through drugs in favor of SPNPT drugs due to the higher payment rate. Further, the Commission is concerned that the pass-through payment policy fails to adequately incentivize drug manufacturers to produce clinically superior drugs, particularly cancer drugs. This is because Medicare currently pays more for these drugs regardless of any "clinical superiority." As a result, the Commission put forth two draft recommendations:

1. The Congress should direct the Secretary to modify the pass-through policy in the hospital OPPS so that it includes only drugs and biologics that function as supplies to a service and applies only to drugs and biologics that are clinically superior to their packaged analogs.
2. The Secretary should specify that the separately payable non pass-through policy in the OPPS applies only to drugs and biologics that are the reason for a visit and meet a defined cost threshold.

Recommendation Would Limit Patient Access to Life-saving Drugs. These changes would remove all new drugs that are the "reason for the visit," including and particularly life-saving and life-sustaining cancer drugs, from qualifying for pass-through status and instead pay for these drugs under the SPNPT drug policy. **For 340B hospitals, this change would result in a nearly 30% reduction in payment (from ASP+6% to ASP-22.5%) for these life-saving drugs.**

The AHA supports MedPAC's interest in incentivizing drug manufacturers to produce clinically superior drugs for payment on a pass-through basis. However, we are very concerned that the proposed changes for separately payable drugs could harm 340B hospitals and the ability of their patients to access these drugs. MedPAC's proposed change would place more financial strain on 340B hospitals, which have already shouldered significant cuts in reimbursement due to prior Part B payment changes. Further, 340B hospitals have endured significant financial hardship as they remain on the front lines of the ongoing COVID-19 pandemic, and any proposal that seeks to cut payments to these providers is wholly misguided.

Lack of Data Supporting Rationale for the Recommendation. **Further, we are concerned about the lack of evidentiary and data analysis underlying the recommendation.** For example, MedPAC stated that its rationale for the recommendation is driven by its interest in removing financial incentives for 340B

hospitals to prescribe more expensive drugs that have pass-through status; yet, it presented no evidence to substantiate that claim. In fact, in 2019, MedPAC itself conducted an examination of whether 340B hospitals were incentivized to use more or more expensive oncology drugs and found no conclusive evidence that such behavior existed. In addition, part of Congress' intent in establishing the pass-through status for separately payable drugs was to incentivize their use by providers so that CMS could gain valuable volume, cost and pricing data for these new drugs on the market. As such, any proposal that seeks to discourage providers from prescribing pass-through drugs is contrary to the intent of the policy. Further, MedPAC did not attempt to quantify the financial impact that the proposed change would have on 340B hospitals and their patients – an analysis which is critical to understanding the proposal's far-reaching implications for patients and providers.

Given the significance of this policy recommendation and the implications for 340B hospitals, we urge that MedPAC defer its vote. Instead, we recommend that the Commission conduct a more thorough and deliberate review of the basis and implications of such a recommendation to ensure that 340B hospitals can continue provide access to life-saving treatments for the many vulnerable patients they serve.

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 Joanna Hiatt Kim, vice president of payment policy, at 202-626-2340 or jkim@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development