December 8, 2016

Francis J. Crosson, M.D., Chair
Medicare Payment Advisory Commission
425 Eye Street, N.W.
Washington, D.C. 20001

Dear Dr. Crosson:

On behalf of our 200 member hospitals and 50 health systems, the Illinois Health and Hospital Association (IHA) supports the Commission’s dedication to improving Medicare payment policies. As stated in our previous MedPAC letters, IHA hopes that you will look to us as a vital resource while Medicare payment deliberations continue. This letter contains three sections:

I. IHA comments on specific December meeting agenda items;

II. A summary of IHA’s Transformation of Rural Healthcare activities — a follow-up to the Commission’s discussions on the availability of emergency services in rural communities; and

III. A summary of IHA’s continued opposition to the Commission’s site-neutral policy.

I. IHA COMMENTS ON SPECIFIC DECEMBER MEETING AGENDA ITEMS:

As the Commission begins its deliberations of Medicare payment adequacy and recommended payment updates for federal fiscal year (FFY) 2018, IHA offers the following relating comments:

• Assessing payment adequacy and updating payments: Hospital inpatient and outpatient services. In the past, the Commission has reviewed the current Medicare payment methodology for both hospital inpatient acute and hospital outpatient payments. It has often recommended annual increases lower than the market basket rate of inflation, irrespective of the 2 percent reduction applied to Medicare payments as a result of the sequestration legislation included in the Budget Control Act of 2011. One justification that the Commission has used for its recommendation is its conclusion that hospitals still experience high Medicare profit margins. IHA has always maintained that development of Medicare payment policy should not be influenced by financial margins, positive or negative, but should be dictated by sound patient care approaches.
Based on our most recent projections, Illinois hospitals, in the aggregate, will experience only a 1.1 percent increase in their Medicare hospital inpatient payments, and an increase of 2.1 percent in their 2017 Medicare hospital outpatient payments. However, the estimated outpatient payment increase does not include the Medicare hospital outpatient department site-neutral payment reductions (as legislated by the Bipartisan Budget Act of 2015), that will be implemented beginning in January. For most of those services, that payment is the Medicare Physician Fee Schedule in which rates are significantly lower than the hospital OPPS Ambulatory Payment Classification (APC) amounts. And those estimates do not include the additional 2 percent sequestration reduction, applied to all Medicare service levels.

In order to ensure continued access to these outpatient services for Medicare beneficiaries, we urge the Commission to rethink its position on hospital-acquired, off-campus physician practices, and recommend to Congress that Centers for Medicare & Medicaid Services’ (CMS’) current policies implementing the legislation must be revised, or in the very least, delayed.

- Assessing payment adequacy and updating payments: physician and other health professional services. In 2015, the Medicare and CHIP Reauthorization Act of 2015 (MACRA) repealed the sustainable growth rate (SGR) payment formula, and in its place legislated an annual 0.5 percent payment increase through calendar year (CY) 2019. However, this increase is scheduled to sunset beginning in CY 2020 and be replaced by payment adjustments based on physicians’ performance on various quality of care measures. IHA supports the continued emphasis of the Medicare payment methodology based on the quality of care provided to Medicare beneficiaries, and for Medicare physician payments as well.

During 2016, CMS solicited feedback from the healthcare field on the process of implementing the Merit-Based Incentive Payment System (MIPS) beginning in 2017, initially affecting payments in CY 2019. In conjunction with CMS’ efforts, IHA strongly recommends that MedPAC, in its discussions on payment adequacy for physician services, be cognizant of the fact that the MIPS regulations should reflect and be supported by sound physician clinical practices versus strict budgetary incentives.

However, we stress that any future improvements to the current Medicare Physician Fee Schedule (PFS) payment system must not be financed through the reduction of Medicare payments made to hospitals or to other post-acute service providers. Our Illinois
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providers simply cannot endure further payment reductions in a system that has already seen significant legislative and regulatory changes primarily from the enactment of the Affordable Care Act (ACA). We encourage the Commission to continue to review and discuss reforms to the current Medicare physician fee schedule payment system, but in doing so, hold other Medicare providers harmless from further cutbacks.

- **Assessing payment adequacy and updating payments:**
  **Ambulatory surgical centers (ASCs):** As mentioned earlier, the hospital outpatient site neutral payment policy will be implemented in CY 2017. This policy will also be applied to off-campus, hospital-acquired ambulatory surgical centers, resulting in reduced Medicare payments to those facilities. IHA recommends that any ASC payment recommendations put forth by the Commission take the negative impact of this policy into consideration.

- **Assessing payment adequacy and updating payments:** **Other Services.** MedPAC will be discussing Medicare payment adequacy for other services, including skilled nursing, inpatient rehabilitation, home health, hospice and long-term acute care. In the past, the Commission has recommended no increase (0 percent) for these services, citing analyses that conclude that profit margins for these services are high. IHA recommends that the Commission revisit its data for these services, in particular the hospital-based programs, which tend to treat patients with more complex conditions. The result is higher costs per treatment (when compared to free-standing facilities) and consequently, in many situations, operational losses. For each of these services, specifically, IHA offers the following:

  - **Skilled Nursing Facility Services:** The Commission has indicated that it welcomes recommendations on how the Medicare payment system for skilled nursing facility services can be improved. Consequently, IHA reiterates its support of a previous Commission’s recommendation that an outlier policy for those services be implemented in FFY 2018.

  - **Inpatient Rehabilitation Services:** The Commission’s own supporting information indicates that margins for hospital-based rehabilitation units have been steadily declining on an annual basis. However, the Commission justified its 0 percent update for hospital-based facilities by stating that those facilities are able to cover their direct costs. We estimate a 1.6 percent profit margin for our members that provide rehabilitation services, *before the application of the sequestration reduction*. This is hardly adequate to cover inflationary increases in direct costs, much less the
total costs of the facility.

As hospital-based rehabilitation units continue to serve Medicare patients needing highly specialized care, IHA strongly recommends that the Commission support a positive update. Simply covering direct costs is not a valid reason for limiting payment increases. Hospital-based programs, in particular, incur greater overhead costs than their free-standing counterparts, including costs of technology, 24-hour access and services, patient billing, and building and equipment expenses and depreciation.

- **Home Health Services:** In previous meetings, MedPAC has concluded that Medicare payments for home health services appeared to be more than adequate due to comparatively low capital needs and double-digit profit margins in previous years. Consequently, the Commission recommended no increase (0 percent) for home health services last year. Our experience in Illinois, however, does not support MedPAC’s conclusions regarding home health agency profitability. Our projections for CY 2017 for Illinois home health agencies conclude that in the aggregate, our member hospital-based, home health agencies are estimated to experience a 1.2 percent increase in Medicare payments under current law, but that increase **does not include the additional 2 percent sequestration reduction.**

IHA respectfully disagreed with the Commission’s previous recommendations for home health payment increases and continues to recommend a minimum increase of the full market basket for 2017. Our reasons are twofold: First, home health agencies have already faced payment reductions legislated through the ACA or enacted as CMS regulatory reductions (i.e., the documentation and coding reduction). More importantly, Congress should act to encourage the growth of home health services, as these are cost-effective alternatives to inpatient care. Limiting the amount of Medicare payment increases for these services discourages that potential for growth.

- **Hospice Services:** IHA is pleased to see that the Commission is examining the adequacy of Medicare payments for hospice services. Hospice services are much less costly alternatives to inpatient hospitalization, and have proven to be a preferred setting of treatment by patients and their families. At the same time, reimbursement must be equitable, and IHA believes that a
full market basket percentage in Medicare payments is appropriate.

- **Long-Term Care Hospital (LTCH) Services:** Last year, the Commission had recommended a 0 percent update for inpatient long-term care facilities last year, based on profit margin data. Our experience in Illinois, however, does not support MedPAC’s conclusions regarding long-term care hospital profitability. Our projections for FFY 2017 for Illinois long-term care facilities conclude that in the aggregate, our member hospital-based, long-term care hospitals are estimated to experience a 4.5 percent decrease in Medicare payments under current law. Much of that decrease can be attributed to a site-neutral payment policy that was implemented beginning in 2016. *And this decrease does not include the additional 2 percent sequestration reduction.* Therefore, IHA believes that the Commission should recommend a full market basket update, as these facilities continue to treat Medicare patients with highly specialized and critical needs, and our Illinois LTCHs are not seeing the proliferation of profits that MedPAC believes exist.

II. **AVAILABILITY OF EMERGENCY SERVICES IN RURAL COMMUNITIES:**

During its October 2015 meeting discussions, the Commission indicated it recognized that inpatient services at many small, rural hospitals have declined significantly, resulting in financial strains for those hospitals. IHA would like to point out that some CMS rules and requirements have contributed to physicians referring patients away from rural and critical access hospitals. This could be partially resolved by eliminating unnecessary “Direct Physician Supervision” of therapy services (such as chemotherapy and blood transfusions) that have safely been provided in rural hospitals. In addition, the 96-hour attestation requirement strongly encourages individual physicians to refer away patients or not accept patients who may require a length of stay that could exceed 96 hours. Assisting our rural hospital members in their transformation of the delivery of healthcare services in their communities, and throughout the state, is a high priority of our association. IHA is pleased that the Commission has discussed the needs of rural hospitals in today’s changing environment of healthcare delivery and hopes that it will continue to do so.

III. **IHA’S CONTINUED OPPOSITION TO SITE-NEUTRAL POLICIES:** Addressing MedPAC’s recommendations on CMS’ HOPD site-neutral policies, IHA reiterates its objection to the Commission’s four components of the “site-neutral” payment policy which proposes that:

- a. Medicare payment for outpatient evaluation and management
(E&M) office visits provided in hospital outpatient departments (HOPDs) be reduced to the level of payment made for those same visits to a private physician’s office;

b. Medicare payment for 66 specified Ambulatory Payment Classifications (APCs) be made based on the Medicare PFS amount;

c. Medicare payment for 12 Ambulatory Surgery APCs be made at the Medicare rate currently paid to free-standing ASCs; and

d. Medicare payment for certain inpatient rehabilitation services be made at the rate currently paid to skilled nursing facilities for those same services.

Based on our most recent impact estimates of all of the site-neutral payment adjustments, in the first year alone, Medicare payments to Illinois hospitals and rehabilitation facilities would be reduced by approximately $200.5 million. **Over a 10-year period, the reduction compounds to almost $2.2 billion.** Additionally, we have estimated that the six-year (2010 – 2015) impact of Medicare reductions already implemented to Illinois hospitals and health systems, including the Affordable Care Act and sequestration, is approximately $2.9 billion. **Our member hospitals simply cannot withstand further reductions.**

Of current concern is the spread of the Zika virus in the United States. For the same reasons that hospitals required funding to treat the previous Ebola crisis, in the event of a national outbreak of Zika, hospitals will be required to invest comparable amounts of staff training and financial resources to address this national health threat. Zika will only accelerate in the months and years ahead, and our hospitals will need resources to be prepared to deliver care to patients and their families. Reductions in Medicare outpatient payments resulting from the implementation of the site-neutral policy will threaten those hospitals’ ability to provide these resources.

It is important to point out that hospitals are economic engines for their local communities, serving as catalysts for job growth and community vibrancy. The potential impact of the loss of healthcare services and jobs, not only in those hospitals, but also in the communities in which they serve, will result in a diminishing availability of much-needed healthcare services for Illinois’ most vulnerable citizens, requiring the elderly and the handicapped to travel unnecessarily further for their care and services.

Dr. Crosson, IHA appreciates the difficult task before MedPAC to recommend changes to Medicare payment policies in an environment with constant pressures to reduce healthcare spending. We hope that as MedPAC continues to discuss policy improvements to transform the Medicare payment system through incentives for clinical integration
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strategies and quality care across the continuum of services, we can continue our dialogue with you.

Sincerely,

A.J. Wilhelmi, President & CEO

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