

December 2, 2021

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

Dear Dr. Chernew:

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) would like to share our thoughts, suggestions and concerns on several items discussed at the Medicare Payment Advisory Commission's (MedPAC) November 2021 meeting. We appreciate the important and thoughtful work performed to date by the chair, commissioners and staff related to these topics, including policies to support safety-net providers, align payment rates across ambulatory settings and the future of telehealth services.

Regarding the discussions during the November 2021 meeting:

- AHA appreciates MedPAC's work on safety-net providers, including the recognition that more can be done to support these providers; we suggest three considerations for further deliberations.
- We discuss our strong concerns related to the alignment of payment rates across ambulatory settings. *MedPAC's proposals would cut rural and government hospitals' Medicare outpatient revenue by almost 25%.* Our concerns stem from sustained hardship hospitals would experience under these very large cuts and policies.
- AHA strongly supports MedPAC's continued conversations on the future of telehealth policies and we offer additional thoughts for consideration.

Our detailed comments on these issues follow.



SAFETY-NET PROVIDERS

In the November 2021 meeting, MedPAC staff presented a comprehensive analysis of the patient needs served by safety-net providers. Commissioners followed the presentation with a robust discussion of the purpose and tradeoffs associated with MedPAC's definition of safety-net providers and Medicare payment policies. **The AHA supports MedPAC's consideration of Medicare payment policy options that help sustain safety-net providers, and we thank the Commission for recognizing that more can and should be done.**

Many of these providers serve as a critical access point for primary care and specialized health care services, including trauma and burn care, neonatal and pediatric intensive care, substance use disorder treatment and HIV/AIDS care. Beyond medical services, they are often trusted community partners, working closely with area schools, civic and religious organizations, and community leaders to reach historically-marginalized populations and improve community health. During the COVID-19 pandemic, many took on an expanded public health role, standing up COVID-19 testing operations, vaccination clinics and organizing public health awareness campaigns that benefit the entire community. These hospitals are more than simply four walls and a roof; in reality, they serve as anchor organizations for their community.

However, despite safety-net hospitals' vital roles and the complex needs of the patients they serve, many face significant financial challenges. The patients served often have more complex health needs, or need more care than other populations. They are disproportionately covered by Medicare or Medicaid, which reimburse less than the cost of care. These hospitals also provide significant care for the uninsured, including in outpatient settings. This is a critical role because, despite coverage gains, the uninsured rate remains at nearly 9% nationally. Other coverage gaps also persist, including in states that have expanded Medicaid.

At the same time, the cost of providing care is rising. The COVID-19 pandemic has disrupted everything from labor markets to supply chains. Evidence of this can be seen in rising costs for labor, prescription drugs, and other supplies: year-to-date total expense per adjusted discharge is up nearly 17%, compared to 2019.¹

These factors create serious financial headwinds for safety-net hospitals; we thank MedPAC for recognizing these concerns and the vital role these hospitals play in our national safety-net. As the Commission continues to deliberate on this issue, we would like to raise three specific considerations:

First, we urge commissioners to consider uncompensated care as a defining characteristic of safety-net providers. In its analysis, MedPAC explores the relationship of dually eligible individuals to hospital closures and margins. We believe

¹ https://www.kaufmanhall.com/sites/default/files/2021-10/national-hospital-flash-report_oct-2021_final.pdf

that the amount of uncompensated care provided also may be correlated with hospital closures and should be considered as a defining characteristic of safety-net providers.

Second, we ask MedPAC to consider defining safety-net providers based on standard characteristics of the organizations that provide care. The AHA appreciates the MedPAC analysis, including the emphasis on avoiding eligibility cliffs that often result from classification based on organizational characteristics. On the other hand, as many commissioners noted during discussion, variation in state policy may create substantial eligibility inequities. For example, variation in state Medicaid policy means an individual may only be eligible for Medicare in some states, and eligible for Medicare and Medicaid coverage in others. Moreover, defining “safety-net” by organizational characteristics, such as geographic location, allows the commissioners to choose metrics that reflect the complex health needs of all patients, regardless of their source of coverage.

Finally, as MedPAC embarks on considering additional support for safety-net providers, we strongly urge it to consider the effects *all* of its policy recommendations would have on safety-net providers. For example, safety-net providers typically provide a substantial amount of outpatient care. Therefore, any additional support the Commission recommends for safety-net providers risks being offset by its potential continued and expanded reductions from site-neutral payment policies. Multiple and conflicting recommendations that result in net revenue neutral or negative payment policies for these providers, and which make the Medicare program even more complex, is not a desirable outcome.

ALIGNMENT OF PAYMENT RATES ACROSS AMBULATORY SETTINGS

At the November 2021 meeting, Commissioners also discussed a new approach to establishing site-neutral payment rates across ambulatory settings. Specifically, staff proposed that those ambulatory payment classifications (APCs) furnished the majority of the time in physician offices would be paid at a rate that is the residual difference between the physician fee schedule (PFS) nonfacility practice expense (PE) payment and the facility PE payment in hospital outpatient departments (HOPDs) and ambulatory surgery centers (ASCs). For APCs that are performed the majority of the time in ASCs, the HOPD payment rate would be reduced to the ASC payment rate. In addition, the Commission discussed applying stop-loss policies intended to reduce the impacts of the cuts on hospitals that serve a relatively high share of structurally-marginalized populations and communities.

MedPAC stated that hospitals’ overall Medicare revenue would decrease by 4.5% under these policies. However, the impact would be greater for rural hospitals and government hospitals, which would see the highest percent decrease: 7.6% and 5.3%, respectively. Even with the stop-loss policy, rural and government hospitals would experience substantial cuts in overall Medicare revenue: 5.8% and 3.9%, respectively.

The AHA continues to strongly oppose site-neutral cuts. The proposals MedPAC staff discussed at the November 2021 meeting would be devastating, particularly to rural and other hospitals that serve patients and communities with sustained hardship. Existing site-neutral payment policies have already been a significant blow to hospital financial stability, particularly with regard to the COVID-19 pandemic. Hospitals have been on the front lines for over 20 months, enduring historic financial challenges from forced shutdowns and a slow resurgence of non-emergent care, as well as increased costs associated with preparing for the pandemic and treating COVID-19 patients, as referenced above. Despite the advent of multiple COVID-19 vaccines and a growing number of Americans who have been vaccinated, the pandemic continues to take its toll. A Kaufman Hall analysis projected that hospitals will lose up to \$54 billion in net income with approximately a third of all hospitals slated to operate in the red by the end of 2021. This comes after unprecedented losses in 2020.² **Now more than ever, hospitals need stable and adequate government reimbursements for what is likely to be a highly challenging environment, even as COVID-19 cases diminish.**

The AHA conducted an analysis of the impact MedPAC’s proposed site-neutral changes would have on hospitals’ Medicare total margins, both with and without the stop-loss provision. In the table below, we provide key results of the analysis for all outpatient prospective payment system hospitals. We applied MedPAC’s revenue reduction assumptions to fiscal year (FY) 2019 baseline revenues, assuming costs would not change.

Hospital Type	Actual Medicare Total Margin, FY 2019	Simulated Medicare Total Margin, MedPAC Proposed Site-neutral Policy	Simulated Medicare Total Margin, MedPAC Proposed Site-neutral Policy, including Stop-loss
All Hospitals	-8.4%	-13.5%	-12.7%
Urban	-8.3%	-13.1%	-12.3%
Rural	-24.2%	-34.5%	-31.9%
Nonprofit	-8.5%	-13.8%	-12.9%
For Profit	-1.7%	-5.2%	-5.0%
Government	-20.7%	-27.4%	-25.6%

The results above show the devastating impact that MedPAC’s proposed policies would have, particularly on rural and government-owned hospitals. Specifically, rural hospitals’ already substantially negative margins would decrease by another 10 percentage points under MedPAC’s proposed policy, or by another almost 8 percentage points when the stop loss is considered. Government hospitals’ similarly substantially negative margins would decrease by an additional almost 7 percentage points, or by another almost 5 percentage points

² Financial Effects of COVID-19: Hospital Outlook for the Remainder of 2021, <https://www.aha.org/guidesreports/2021-09-21-financial-effects-covid-19-hospital-outlook-remainder-2021>

when the stop loss is considered. And, these cuts are to Medicare total margins – thus, they represent an extremely high amount of actual dollars that would be cut from patient care.

Although the analysis above is on Medicare total margins, MedPAC’s proposed cuts are to the outpatient system. Therefore, we also conducted an analysis of the effect they would have on Medicare outpatient margins. **The results below show that MedPAC’s proposal would cut rural hospitals’ already-negative outpatient margins by another 36 percentage points to negative-64%.** The cut is another 25 percentage points to negative-53% when the stop loss is considered. Government hospitals would also see large cuts – almost 25 percentage points, and 17 percentage points with the stop loss. **While MedPAC has historically expressed concern regarding outpatient margin calculations given overhead allocation issues, cuts of this magnitude cannot be dismissed as accounting artifacts. For better or worse, the hospital safety-net and emergency stand-by role are funded through the provision of all outpatient services. If this funding continues to be eroded, particularly to the degree shown above, so too will these critical services continue to be eroded.**

Hospital Type	Actual Medicare Outpatient Margin, FY 2019	Simulated Medicare Outpatient Margin, MedPAC Proposed Site-neutral Policy	Simulated Medicare Outpatient Margin, MedPAC Proposed Site-neutral Policy, including Stop-loss
All Hospitals	-15.5%	-35.4%	-31.7%
Urban	-15.4%	-34.2%	-30.5%
Rural	-28.2%	-64.1%	-53.6%
Nonprofit	-16.4%	-36.2%	-32.2%
For Profit	-6.7%	-22.5%	-21.4%
Government	-27.0%	-51.7%	-44.0%

In fact, much erosion has already occurred, due in no small part to existing site-neutral policies. As spurred by the steady decline in Medicare margins over the past two decades, and as documented by the [North Carolina Rural Health Research Program](#), 137 rural hospitals have closed since 2010. These closures serve as the initial indicators that we are beginning to reach a tipping point where private payers are no longer willing to fund, and hospitals can no longer sustain, operations on the cost-shift that such considerable Medicare underpayments, particularly those under OPPIs, necessitate.

Expanding site-neutral cuts to the degree discussed by MedPAC, on top of the financial impacts U.S. hospitals and health systems face due to COVID-19, would endanger the critical role that HOPDs play in their communities, as well as access to care for beneficiaries, including the most medically complex. Therefore, the

AHA urges MedPAC to abandon further recommendations regarding site neutral payment policies.

TELEHEALTH SERVICES

MedPAC also discussed the future of telehealth policy following the COVID-19 public health emergency (PHE), as it has done in several prior meetings. **The AHA supports MedPAC's continued conversations of the post-pandemic future of telehealth policy.** The increased use of telehealth since the start of the PHE is producing high-quality outcomes for patients, closing workforce gaps, and protecting access for patients who cannot risk infection. This shift in care delivery could outlast the PHE if the appropriate statutory and regulatory framework is established. The Commission has recognized that to do so, there are several policy questions that must be answered. The AHA stands ready to assist MedPAC in these discussions in any way that would be helpful.

Delivery of Telehealth across the Nation. As MedPAC discussed at length at its November 2021 meeting, one of the most salient benefits of telehealth is the access to care it creates for broad swaths of patients. Telecommunications technology connects patients to vital health care services through videoconferencing, remote monitoring, electronic consults and wireless communications. It increases patient access to physicians, therapists and other practitioners. This is especially important in areas of the country where recruiting and retaining providers is challenging, such as in rural areas, and in areas where structurally-marginalized populations often lack an entrance point to the health care system.

During the pandemic, hospitals and health systems have utilized critical flexibilities that the Centers for Medicare & Medicaid Services (CMS) established to allow telehealth services to reach even more patients. Providers received extremely high patient satisfaction ratings and observed greatly improved health outcomes for patients who no longer cancelled or missed their appointments due to the ability to connect with their providers remotely. **Given the millions of successful telehealth encounters that have occurred since the COVID-19 pandemic began – and in the years prior – the AHA urges the Commission to recommend elimination of the 1834(m) geographic and originating site restrictions. This would allow all patients to receive telehealth services wherever they are located, including in their homes, residential facilities and other locations.** Without this change, much of the progress that has been made to significantly increase patient access to care will disappear, since the status quo limits telehealth to rural areas of the country and requires patients to be at certain types of facilities to receive care. The PHE clearly demonstrated the need for access to telehealth in non-rural areas including in the safety of patients' homes, and the importance of being able to reach patients who are completely removed from the health care system, such as individuals in homeless shelters. **Thus, we urge the Commission to ensure that its recommendations for federal policy reflect the realities of today's health care environment.**

As MedPAC continues to conceptualize the future of Medicare-covered telehealth, we wish to underscore that any expansion of telehealth should be implemented with the explicit goal of addressing health equity and reducing health disparities. We are mindful that even though our recommended actions would protect access to care for millions of patients, challenges remain for the nation's historically-marginalized communities. As such, telehealth must be employed with supporting policies, such as access to broadband and end-user devices, to reach these populations.

We also encourage and support the Commission in addressing two unsolved issues for the long term expansion and implementation of telehealth: state licensing barriers and requirements for in-person visits for ongoing telehealth coverage. The nationwide patchwork of state licensure requirements continues to stymie the most useful and efficient application of telehealth. While CMS granted some licensure flexibilities during the pandemic, they will expire when the PHE declaration ends. Additionally, these flexibilities related only to Medicare coverage and reimbursement; they did not address differences in states' licensure requirements for the actual practice of medicine. Thus, the AHA appreciates MedPAC's continued discussion of this complicated issue.

In the meeting, MedPAC also discussed requiring periodic in-person visits for continued coverage of telehealth services. This topic arose from the recently finalized calendar year (CY) 2022 physician fee schedule (PFS) rule, in which CMS implemented provisions of the Consolidated Appropriations Act that require an in-person visit within six months prior to an initial telehealth visit for certain mental health services newly authorized to be delivered via telehealth. CMS also implemented a requirement for subsequent in-person visits every 12 months to maintain telehealth coverage. The Commission discussed at length the threat such in-person requirements could pose to access to mental health services, given the great dearth of behavioral health providers in numerous pockets across the nation. **We agree with the very real nature of these risks and with Commissioners who pointed out that in certain areas of the country, requiring in-person visits for continued telehealth coverage could sever access to other, non-behavioral health services. Thus, as the Commission continues to assess how Medicare should cover non-behavioral telehealth services after the PHE, we encourage MedPAC to ensure any recommendations regarding in-person visits do not exacerbate current access challenges that some beneficiaries face.** Similarly, we urge MedPAC to explore ways to expand the types of providers that can deliver and bill for telehealth services, beyond physicians and limited non-physician practitioners. This, too, could alleviate barriers to accessing services that plague many areas of the country.

Coverage and Reimbursement for Audio-only Services. As in prior meetings, MedPAC discussed the continuation of Medicare coverage and payment for audio-only telehealth services. **The AHA enthusiastically supports coverage and reimbursement for audio-only services.** This flexibility has enabled our members to maintain access to care for numerous patients who do not have access to broadband internet or video-

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conferencing technology. It also has protected the continuity of care when a video connection fails, a situation with which the nation is now intimately familiar due to the COVID-19 pandemic. In those situations, if a provider and patient are connected via audio/video technology, and their video connection fails, they can default to an audio-only visit and pick up right where they left off. Additionally, audio-only behavioral health services have become extremely popular with patients who are more comfortable without face-to-face visits, as CMS recognized in the CY 2022 PFS rule. **The AHA also supports MedPAC conducting more in-depth analysis – as was mentioned at the November 2021 meeting – as to how coverage for audio-only services can contribute to reducing inequities in access to telehealth.**

Payment for Telehealth Services. For providers to be able to continue delivering improved patient care through telehealth and other virtual services, they need adequate reimbursement for the substantial upfront and ongoing costs of establishing and maintaining their virtual infrastructure, including secure platforms, licenses, IT support, scheduling, patient education and clinician training. **Thus, we encourage MedPAC to conduct a thorough and complete accounting of the costs that go into providing virtual visits and how such expenses relate to the need to maintain capacity for in-person services.** Without adequate reimbursement of these costs, providers will be forced to decrease their telehealth offerings, thus shrinking a potential opportunity for providers to address certain inequities in care. Adequate reimbursement for virtual services also is key to ensuring providers have the means to invest in HIPAA-compliant technologies and to deliver these services with the highest attainable quality of care. **Therefore, we support the Commission’s ongoing exploration of how to establish the “right” amount of reimbursement for telehealth services to ensure its use is not exploited by too much reimbursement, nor discouraged by too little.**

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 Shannon Wu, AHA’s senior associate director of policy, at swu@aha.org or 202-626-2963.

Sincerely,

/s/

Ashley B. Thompson
Senior Vice President, Public Policy Analysis and Development
American Hospital Association

Cc: James E. Mathews, Ph.D.
MedPAC Commissioners