American Hospital Association™
Advancing Health in America

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April 4, 2023

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

Re: Comments on March 2023 Public Meeting Topics — Wage Index, Alignment of Payment Rates Across Ambulatory Settings and Part B Drugs

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) appreciates the opportunity to share our comments on three topics that were discussed during the March 2023 Medicare Payment Advisory Commission (MedPAC) public meeting: the hospital wage index, alignment of payment rates across ambulatory settings and Medicare Part B drug payments.

We appreciate your thoughtful discussions on these topics. The AHA:

- **Agrees that the current wage index system is flawed, but continues to have concerns about the use of non-hospital data in an alternative wage index system;**
- **Recommends that the commission reject modifications to the current average sales price (ASP)-plus-6% methodology; and**
- **Urges the commission not to recommend additional site-neutral payment cuts.**

Our detailed comments on these issues follow.

WAGE INDEX

At the March meeting, the commission continued its discussion related to Medicare's hospital wage index policies. First, commissioners and MedPAC staff discussed concerns over the source of the current wage data and its circularity in setting wage indices. Second, they discussed labor market areas and the resulting wage index "cliffs." They also discussed the increasingly burdensome and complicated processes for adjustments. Finally, staff set forth an alternative wage index system that could potentially address these concerns.

The AHA has conducted extensive policy work on the wage index. As a result of that work, we and our members agree that it is greatly flawed in several respects. However, as we have iterated to MedPAC in our October 2021 and September 2022 letters, **we continue to have serious concerns over the proposed alternative wage index system and the disruption it could cause, particularly when considered in the broader context of the financial instability hospitals continue to face.** For example, we have concerns over the proposed use of Bureau of Labor Statistics (BLS) data rather than hospital-reported data from the Medicare cost reports. There continues to be critical differences between the two data sets that should be carefully evaluated. We refer you to the above letters for additional details.

In addition, hospitals face large and ongoing financial instability and will continue to face challenges, including acute workforce shortages and supply chain disruptions, after the end of the public health emergency. Hospitals and health systems had their worst financial year in 2022 since the pandemic started, experiencing negative operating margins for most of the year with approximately half of the nation's hospitals ending the year in the red.[1] The outlook for not-for-profit hospitals remains negative for 2023, with Moody's citing continued difficult operating conditions related to labor shortages, high inflation and supply chain challenges.[2] Introducing additional instability in the form of wage index reform will only exacerbate these challenges.

MEDICARE PART B DRUG PAYMENTS

Also at the March meeting, commissioners discussed three proposed recommendations to address the high and increasing prices of Medicare Part B drugs and biologicals. The AHA appreciates the commission's continued attention to this critical issue over the last six years, as achieving sustainable drug pricing is a critical priority. We have previously submitted extensive comments on the recommendations being considered; thus, we briefly reiterate our views on the commission's policy options below. For additional

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[1] https://www.kaufmanhall.com/insights/research-report/national-hospital-flash-report-january-2023
[2] https://www.moodys.com/research/Moodys-Not-For-Profit-Healthcare-2023-Outlook-Remains-Negative-as--PBM_1351244

context and details, we refer you to our letters from November 2021, September 2022 and February 2023.

AHA supports:

- **Maintaining the ASP-plus-6% payment methodology for Part B drugs;**
- **Exploring a payment model that expands the inflation rebate policy enacted under the Inflation Reduction Act by extending inflation caps and rebates to generic Part B drugs; and**
- **Establishing a value-based approach focused on first-in-class drugs approved under the Food and Drug Administration's accelerated approval pathway in which Medicare could cap payment for such drugs with excessively high launch prices and uncertain clinical benefit — using the criteria proposed by the commission.**

ALIGNMENT OF PAYMENT RATES ACROSS AMBULATORY SETTINGS

Commissioners also discussed a proposed recommendation to establish site-neutral payment rates across ambulatory settings. Under this approach, payments for certain services currently paid under the outpatient prospective payment system would be reduced either to the residual difference between the physician fee schedule's non-facility and facility practice expense payment rates or to the ambulatory surgical center payment rate, depending on the setting in which the service is generally furnished. The recommendation would not make any adjustments for patient severity. We have previously submitted extensive comments on the recommendations being considered; thus, in this correspondence, we briefly reiterate our views on this topic. For additional context and details, we refer you to our letters from December 2021 and November 2022.

The AHA continues to strongly oppose site-neutral payment cuts. As we have discussed, these proposals would be devastating, particularly to rural and other hospitals that serve patients and communities with sustained hardship. For many hospitals and health systems, continued financial viability is becoming increasingly difficult as they manage the aftermath of the most significant public health crisis in a century, as well as the incredible challenges of deepening workforce shortages, broken supply chains and historic levels of inflation that have increased the costs of caring for patients. **Now more than ever, hospitals need stable and adequate government reimbursements in order to ensure access to care in this highly challenging environment.**

In addition, Medicare payment already fails to cover the costs of caring for Medicare beneficiaries — a fact that the commission itself acknowledges. This substantial underpayment is due in part to existing site-neutral payment policies that have significantly cut reimbursements; further site-neutral cuts would only exacerbate this gap, which is completely unsustainable. As mentioned above, 2022 was the worst financial year for hospitals since the start of the COVID-19 pandemic. Indeed, historic

inflationary cost pressures pushed hospital expenses up over 20% compared to pre-pandemic levels.[3] Between 2010 and 2021, 136 rural hospitals have closed, and 19 of these closures occurred in 2020, the most of any year in the past decade.[4] As the bulk of rural hospital revenue comes from government payers, of which Medicare comprises nearly half, MedPAC's additional site-neutral policies that would cut rural hospital payments by an additional 2.5% would result in even more financial hardship and closures, and with devastating impacts to the communities they serve.[5]

Moreover, as noted by several commissioners at the March 2023 meeting, the cost of care delivered in hospitals and health systems, including hospital outpatient departments (HOPDs), is fundamentally different than other sites of care and takes into account the unique benefits that only they provide to their communities. This includes maintaining standby capacity for natural and man-made disasters, public health emergencies, other unexpected traumatic events, and the delivery of 24/7 emergency care to all who come through their doors, regardless of ability to pay or insurance status. HOPDs also provide services that are not otherwise available in the community for vulnerable patient populations. Since the hospital safety-net and emergency standby role are funded through the provision of all outpatient services, expanding site-neutral cuts to additional HOPDs and the outpatient services they provide would endanger the critical role that they play in their communities, including access to care for patients, especially the most medically complex.

Indeed, a recent report (attached below) found that patients receiving care in HOPDs had higher clinical complexity than those in ambulatory surgery centers and independent physician offices. For example, Medicare patients in HOPDs were more likely to enter into the Medicare program due to disability or end-stage renal disease than those in independent physician offices; were more likely to be dual-eligibles; had higher likelihood of having at least one major comorbidities and complications; and were also more likely to have had an emergency department visit or inpatient hospital stay in the prior 90 days.

The AHA continues to strongly urge the commission *not* to adopt the recommendation for additional site-neutral payment cuts. This policy greatly endangers the critical role that HOPDs play in their communities, including providing access to care for the most medically complex beneficiaries.

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.

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[3] https://www.kaufmanhall.com/sites/default/files/2023-02/KH-NHFR_2023-02.pdf
[4] https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/
[5] https://www.aha.org/system/files/media/file/2022/09/rural-hospital-closures-threaten-access-report.pdf

Sincerely,

/s/

Ashley B. Thompson
Senior Vice President
Public Policy Analysis and Development

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