



January 7, 2009

Glenn Hackbarth, J.D.  
Chairman  
Medicare Payment Advisory Commission  
601 New Jersey Ave., NW  
Washington, DC 20001

Dear Glenn,

The Federation of American Hospitals (“FAH”) is the national representative of investor-owned or managed hospitals in urban and rural areas throughout the United States. Our members include full-service community hospitals, teaching and non-teaching, long-term care, inpatient rehabilitation, psychiatric, and cancer hospitals. We appreciate the opportunity to comment on the Medicare Payment Advisory Commission’s (“MedPAC”) draft 2010 recommendations, presented at its December 4, 2008 meeting, regarding market basket payment updates for acute, inpatient rehabilitation (IRH), and long-term care hospitals (LTCH).

FAH respectfully requests that the Commission adopt final recommendations to Congress that acute and inpatient rehabilitation hospitals receive a full market basket increase in 2010, and to the Secretary of Health and Human Services that long-term care hospitals also receive a full market basket increase in 2010.

Recent Medicare margin numbers reported by MedPAC staff clearly demonstrate both the inadequacy of current Medicare payments and the compelling need for a full market basket update in 2010 to enable hospitals to meet the needs of Medicare patients. Chronic underpayment has led to a 2009 projected margin of negative 6.9 percent for acute hospitals - a stunning seventh consecutive year of negative and falling Medicare margins for acute hospitals.

LTCH hospital margins, subject to sustained arbitrary payment policies imposed by the Centers for Medicare and Medicaid Services, have fallen very far, very fast, and are projected to be virtually zero in 2009, at .5 percent. In fact, even that margin estimate may be overstated because the analysis excludes Medicare Advantage patients, who are

not in the administrative data set, and there are reports of a higher than average patient case mix among those MA patients who are being transferred appropriately to LTCHs. In addition, the growth of LTCHs has halted, as MedPAC has previously documented, and admissions are flat.

IRH margins are projected to be 4.5 percent in 2009, a 62 percent drop in just two years, and certainly not an unreasonable number that warrants the complete elimination of an inflation update. Moreover, there are strong reasons to believe that this margin projection for IRHs is overly optimistic. By the end of 2009, through a combination of Congressional action and administrative fiat, IRHs will have received virtually no net payment update for three years. Eliminating the market basket update for 2010 would make that four years. Yet, the IRH cost structure continues to grow. IRH patient acuity has clearly become more intense and complex, resulting in more costly care. Coupling those escalating costs with early evidence that IRH admissions continue to fall in response to the 75 percent rule results in higher unit costs of care.

It is important also to keep in mind that, and this applies to all hospitals, not just IRHs, the care these institutions provide is very labor intensive, which limits their fiscal flexibility, particularly in light of the well-documented current and projected health care workforce shortage. Skilled physical therapists, for example, the lifeblood of an IRH, are in increasing demand, and the market must respond accordingly, with higher wages and benefits, even in a time of growing joblessness and wage erosion in the broader economy.

Finally, IRHs have been pressured by a relentless stream of medical review denials from Medicare contractors. These denials, often based on obsolete standards of medical care or erroneous interpretation of existing medical guidelines rendered by individuals without sufficient professional expertise in acute rehabilitative care, disrupt cash flow, admissions, and operations. Appeals, which have a relatively high success rate, take time and drain diminishing resources away from hands-on patient care.

Beyond the Medicare margin numbers, however, is the troubling cascade of economic events in the general economy that threatens the fiscal health of all hospitals, with clear negative implications for Medicare beneficiary access. The relative swift and sudden change in the fiscal climate for hospitals suggests that 2007 data, the most recent data relied on to assess current payment adequacy, has limited utility as a reliable benchmark, and, further, that projections on what 2009 holds are on unusually shaky ground.

The financial turmoil and deepening economic recession has not spared the hospital sector, and the effects on hospitals will grow worse over time. Recovery in the sector will likely lag a prolonged recovery in the broader economy, which many believe is unlikely until at least 2010. Analysts expect that the full impact of the economic meltdown on the hospital industry will not be known for at least another 12 -24 months as the cycle of consumers losing jobs and health coverage runs full circle, and hospital finances continue to deteriorate. More and more people will postpone health care, so that when they do seek care, often in distress in an already overburdened hospital emergency

room, their health status will have deteriorated and their condition will be more acute, requiring more intensive and expensive medical intervention.

Increasing unemployment, loss of insurance and lack of consumer confidence are already directly impacting the number and mix of patients seeking care, pressuring hospitals with fewer than expected admissions and a growing caseload of uninsured patients and uncompensated care. Compounding these difficulties is the increasing number of states cutting Medicaid benefit coverage, eligibility, and provider payments, all of which will have a negative impact on hospitals.

The crisis in credit markets generally has already forced hospitals to abandon or postpone indefinitely critical capital infrastructure projects to replace obsolete facilities, deploy life-advancing technologies and modernize health care delivery systems with, for example, health information technologies that promise to increase efficiency and improve quality. This, in turn, will impair the ability of hospitals to invest in productivity-enhancing practices, and suggests that the Commission should reconsider whether to adjust a market basket increase on the expectation of improved productivity, as was the case with the draft LTCH update recommendation.

In addition, there is a growing loss in investor confidence across all hospital sectors, another signal of payment inadequacy. Equity analysts and bond-rating agencies continue to downgrade the industry, with negative repercussions including higher costs of capital, where it is even available, not just for capital goods but for access to credit to finance operations. Moody's Investor Service, for example, in December 2008, reportedly downgraded from stable to negative the healthcare sector, including hospitals.

In a December 19, 2008, note to investors, Deutsche Bank reaffirmed Hold ratings for all acute hospital companies and further revised downward already recently reduced earnings estimates, highlighting "lousy hospital fundamentals," among which are "Medicare and Medicaid reimbursement exposure" (some fifty percent of total revenue), "rising unemployment and ...bad debt", "slowing commercial volumes", and "higher deductibles/cost-sharing." Stock prices for the two largest publicly-traded hospital companies, by revenue, dropped some sixty and seventy-six percent, respectively, in 2008. This is especially noteworthy because these equity values and their underlying trends offer a transparent, "real-time" proxy for the fiscal health of hospitals generally. Equally important, because the stock market is often called a forward-looking "discounting" mechanism, they inform on future expectations of hospital financial health.

The financial uncertainty facing hospitals – acute, inpatient rehabilitation, and long term care, alike -- going forward cannot be overstated. In this unprecedented environment, until we know more about the trajectory of the economy and its effects on hospitals and are better able to project casemix and margins, the prudent course of action is to permit hospitals to receive a full Medicare inflation update – which will likely be a modest sum in a slowing inflationary environment-- rather than risk aggravating the deteriorating financial condition of hospitals, with potentially negative consequences for beneficiaries.

Finally, as MedPAC considers its update recommendation during this unique time of economic turbulence, arguably it would do well to consider factors that may appear to be outside its immediate payment framework and recognize that the health of our economy and the fiscal health of our hospitals are inextricably entwined. Specifically, as Congress and the incoming administration of President-elect Obama explore every avenue to provide a broad fiscal stimulus for the economy – and hospitals, in addition to their health and healing mission, are critical economic engines in communities across the country-- denying hospitals a full Medicare update would seem to be counterproductive to that broad economic goal, while at the same time weakening hospitals. Indeed, the American Recovery and Reinvestment Act of 2009 will reportedly include relief for States and Medicaid providers serving safety net patients. It is no less important that Medicare provide hospitals serving seniors with a full market basket update in 2010.

Again, I want to thank you for this opportunity to share our thoughts, and to reiterate our request that you recommend a full inflation update for acute, inpatient rehabilitation, and long term care hospitals in 2010.

Sincerely,

A handwritten signature in black ink, appearing to be "Andrew M. Rosenthal", written in a cursive style.