MEDICARE PAYMENT ADVISORY COMMISSION'S ANNUAL MARCH REPORT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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U.S. HOUSE OF REPRESENTATIVES

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MEDICARE PAYMENT ADVISORY COMMISSION'S ANNUAL MARCH REPORT

THURSDAY, MARCH 1, 2007

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:06 p.m., in Room 1102, Longworth House Office Building, Hon. Fortney Pete Stark (Chairman of the Subcommittee), presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
February 22, 2007
HL–2

CONTACT: (202) 225–3943

Chairman Stark Announces a Hearing on MedPAC's Annual March Report with MedPAC Chairman Glenn M. Hackbarth

House Ways and Means Health Subcommittee Chairman Pete Stark (D–CA) announced today that the Subcommittee on Health will hold a hearing on the Medicare Payment Advisory Commission's (MedPAC) annual March report on Medicare payment policies with MedPAC Chairman Glenn M. Hackbarth. **The hearing will take place at 2:00 p.m. on Thursday, March 1, 2007, in Room 1100, Longworth House Office Building.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from the invited witness only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

MedPAC advises Congress on Medicare payment policies. MedPAC is required by law to submit its annual advice and recommendations on Medicare payment policies by March 1, and an additional report on issues facing Medicare by June 15. In its reports to the Congress, MedPAC is required to review and make recommendations on payment policies for specific provider groups, including Medicare Advantage, hospitals, skilled nursing facilities, physicians, and other sectors, and to examine other issues regarding access, quality, and delivery of healthcare.

In announcing the hearing, Chairman Stark said, **"Through its annual reports, MedPAC provides the careful analysis that Congress needs to make appropriate adjustments to Medicare payments. MedPAC's recommendations help Medicare remain a reliable partner to providers, while also assuring that beneficiaries and taxpayers are getting the best value for their money."**

FOCUS OF THE HEARING:

The hearing will focus on MedPAC's March 2007 Report to Congress.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "*110th Congress*" from the menu entitled, "*Committee Hearings*" (*http://waysandmeans.house.gov/Hearings.asp?congress=18*). Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record*." Once you have followed the online instructions, completing all informational forms and clicking "submit" on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You ***MUST REPLY*** to the email and ***ATTACH*** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business **Thursday,**

March 15, 2007. **Finally**, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, and telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov*.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman STARK. We will begin. We will welcome Glenn Hackbarth, the Chairman of the Medicare Payment Advisory Commission, known as MedPAC. Glenn, it is good to have you back with us, and we look forward to your analysis. I am sure we each look forward to some of your recommendations, and we appreciate the work that your staff and the commissioners do in advising us and how you remain as objective as you can in this area. We really do appreciate it.

I am not going to say a lot. I am going to ask you to go through your recommendations and I am going to ask my colleagues to indulge me. We will have a vote, I think, around 2:30, a couple of them. Five votes, okay, but I am going to suggest that Members, as Mr. Hackbarth goes through the recommendations—I will be happy to indulge them in making an inquiry as he goes along, but I really want to hold it to an inquiry, like 30 seconds for a technical question; no speeches about does red wine improve your health.

Mr. THOMPSON. This is Congress.

Chairman STARK. I know, all right. We will save the speeches, as we go through, almost like a walk-through. Glenn has suggested that he would accommodate us in that. Maybe that will help us as we move along.

So, without further ado, I recognize Dave Camp for any comments he would like to make, and then we will look forward to Mr. Hackbarth's statement.

Mr. CAMP. Well, thank you, Mr. Chairman. I know we have got a vote coming up, and in the interest of getting started, I will submit my statement for the record, but I do want to welcome Chairman Hackbarth. Thank you for joining us to discuss MedPAC's annual report. I also want to thank Mark Miller and the staff for their hard work on this report as well.

We do rely on your payment recommendations for Medicare providers. Also we have seen recent and rapid growth in Medicare in past years. So, I look forward to hearing your analysis and want to thank you again for appearing before the Committee.

Thank you, Mr. Chairman.

Chairman STARK. Glenn, why don't you proceed any way you would like?

STATEMENT OF GLENN M. HACKBARTH, J.D., CHAIRMAN, MEDICARE PAYMENT ADVISORY COMMISSION

Mr. HACKBARTH. Thank you, Chairman Stark and Mr. Camp, other Members of the Committee. It is a pleasure to be here to talk about our annual March report to Congress on Medicare.

Before I start into the substance, let me just second what you said about the MedPAC staff. It is a terrific staff, and a real resource not just for me but for the Congress and more broadly. We are all very lucky.

Before briefly reviewing the recommendations and findings, I would like to just quickly remind you about the Commission and who sits on it. As you know, we have 17 members on the Commission. Seven of the members are trained as clinicians, either physicians or nurses. We have eight members who have executive level or board experience in healthcare delivery organizations, five with executive level experience in healthcare purchasing organizations, and seven of us have high-level Government experience, either in Congress or at support agencies or the executive branch. Some of us have more than one of these credentials.

In short, we have a longstanding interest, each of us, in the Medicare program, a stake in its success as well as considerable experience with it. The diversity of the Commission is one of its strengths. It also presents a challenge, and that is to weave the various points of view and expertise into consensus recommendations.

As Chairman, I strive very hard to do that, and believe that a consensus recommendation is much more useful to you, the Congress, than one that reflects a narrow majority. Of the recommendations in this year's March report, and there are nine of them, we had a total of 126 recorded votes by individual commissioners, only two of those were dissenting votes and one abstention. So, we have succeeded again this year to a very substantial degree in providing you with consensus recommendations from this diverse commission.

Seven of the nine recommendations in our March report relate to payment updates. As you well know, that is one of our basic responsibilities under our governing statute. One of the recommenda-

tions pertains to payment, the Indirect Medical Education Payment to hospitals, and one pertains to collecting uncompensated care data which could guide reform of the Disproportionate Share Hospital (DSH) payment adjustment for hospitals.

In addition, in our March report we review past recommendations from MedPAC on Medicare Advantage and Part D as well as present some new data on those aspects of the Medicare program.

Let me just talk for a minute about how we approach the task of recommending payment updates each year. In formulating those recommendations, we assess Medicare's payment adequacy for each of the respective provider groups, hospitals, physicians, dialysis facilities, post-acute providers and so on. We assess adequacy by reviewing all of the available data we can find on issues like access to care for Medicare beneficiaries, the quality of that care, changes in the volume of services provided, access to capital for the providers of the services and Medicare margins where those data are available.

As required by our governing statute, we seek to recommend rates that are adequate for "efficient providers of service." Consistent with that efficient provider requirement, we begin our analysis with an expectation that healthcare providers should improve productivity each year. Thus very often, although not always, our recommendations are cast in terms of increasing rates by the relevant measure of input price increases minus a productivity adjustment.

Our seven update recommendations in this year's report are as follows. For physicians and dialysis facilities, our recommendation is the increase in market basket minus productivity adjustment. For post-acute care providers, specifically skilled nursing facilities, home health agencies and long-term care hospitals, we recommend no update in the rates. Then for inpatient rehab facilities, a one percent increase. Finally, for hospitals we recommend a full market basket increase in the rates, but also recommend that concurrently that we should move to implement a pay-for-performance program for hospitals.

Finally, with regard to the Indirect Medical Education adjustment, we recommend that that adjustment be reduced by one percentage point, concurrent with implementation of a credible severity adjustment system in the Medicare hospital payment system.

Then finally, the last recommendation is that the Centers for Medicare and Medicaid Services (CMS) collect uncompensated care data which might subsequently be used to guide reform of the disproportionate share of hospital payment adjustment.

So, that is a very quick summary, Mr. Chairman. I would be happy to take your questions.

[The prepared statement of Mr. Hackbarth follows:]

Prepared Statement of Glenn M. Hackbarth, J.D., Chairman, Medicare Payment Advisory Commission

Chairman Stark, Ranking Member Camp, distinguished Subcommittee Members. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this afternoon to discuss MedPAC's March Report to the Congress and our recommendations on Medicare payment policy.

The Commission has become increasingly concerned with the trend of higher Medicare spending without a commensurate increase in value to the program. (An

increase in value would be, for example, beneficiaries receiving higher quality services with no increase in spending.) That trend, combined with the retirement of the baby boomers and Medicare's new prescription drug benefit, will, if unchecked, result in the Medicare program absorbing unprecedented shares of the GDP and of Federal spending. Policymakers need to take steps now to slow growth in Medicare spending and encourage greater efficiency from healthcare providers, while assuring access and maintaining or improving quality.

In our March report to the Congress, we review Medicare fee-for-service payment systems for eight sectors: hospital inpatient, hospital outpatient, physician, outpatient dialysis, skilled nursing, home health, inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). The Commission recommends changes to payment and other policies designed to make payments more accurate and to improve the value received by beneficiaries and taxpayers for their expenditures on healthcare.

Our March report also reviews recent findings and past recommendations on the Medicare Advantage (MA) plans beneficiaries can join in lieu of traditional fee-for-service Medicare, and the private plans offering the new prescription drug benefit. We express our support for the MA program, but also our concern that payments for private plans are higher than the amount traditional Medicare would have spent on the same beneficiaries. We also provide information on the enrollment, benefits and premiums of the plans offering the new prescription drug benefit, both the stand-alone prescription drug plans and the prescription drug plans affiliated with MA plans.

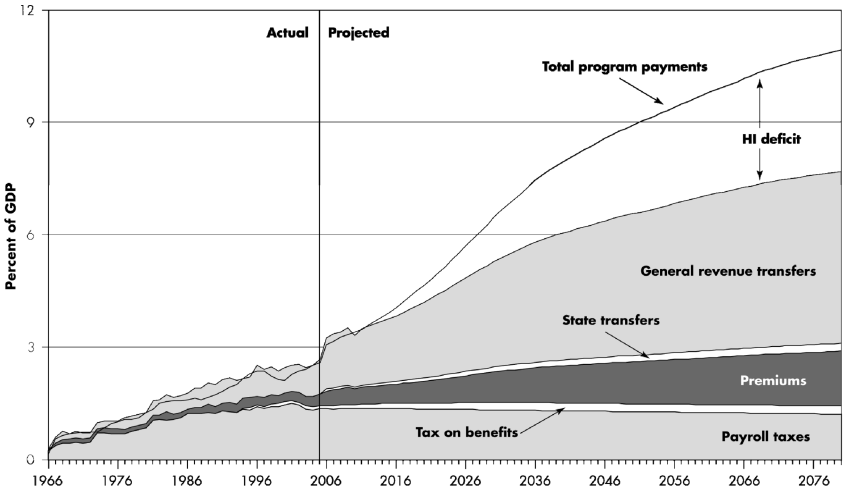
Medicare should exert continued financial pressure on providers to control their costs, much as would happen in a competitive marketplace. We have found, for example, that hospitals under financial pressure tend to control cost growth better than those that have non-Medicare revenues that greatly exceed their costs. In all sectors, Medicare should also adjust payments for quality, paying more for high quality and less for poor quality. The Commission is striving to pursue innovative means to increase value in Medicare while maintaining financial pressure in all of its payment systems to restrain costs.

Context for Medicare payment policy

Medicare was designed to help ensure access to medically necessary care for the aged and disabled. Many analysts give Medicare credit for improving the economic position of its beneficiaries. Today, however, Medicare and other purchasers of healthcare in our nation face enormous challenges for the future. One challenge relates to the wide variation in the quality and use of services within our healthcare system, with quality often bearing no relationship or even a negative relationship to spending. Analysts point to geographic variation in spending as evidence of inefficiency and waste. Although spending is rising it is not clear that beneficiaries are seeing commensurate increases in the quality of their care or their health. A second challenge is that, as is true for other purchasers of healthcare, Medicare's spending has been growing much faster than the economy. In Medicare, forces such as the broad use of newer medical technologies and enrollment growth will likely push future spending higher. Because of these forces, the Commission warns of a serious mismatch between the benefits and payments the program currently provides and the financial resources available for the future.

Figure 1 shows the Medicare trustees view of the future of Medicare financing. Total expenditures for Medicare will take up an increasing share of the nation's GDP and quickly exceed dedicated financing. In their most recent report, the Medicare trustees project that, under intermediate assumptions, the hospital insurance (HI) trust fund (which finances Part A of Medicare) will be exhausted in 2018. Because Medicare cannot pay for Part A services once the HI trust fund is exhausted, either those expenditures will have to cease or some new source of financing will have to be found. For other parts of Medicare (Part B and Part D), general tax revenues and premiums automatically increase with expenditures. Those automatic increases will impose a significant financial liability on Medicare beneficiaries, who must pay premiums and cost sharing, and on taxpayers in general. For example, if income taxes remain at their historical average share of the economy, the Medicare trustees estimate that the program's share of personal and corporate income tax revenue would rise from 10 percent today to 24 percent by 2030 and to 40 percent by 2080.

Figure 1. Medicare faces serious challenges with long-term financing



Note: GDP (gross domestic product), HI (Hospital Insurance). Tax on benefits refers to income taxes that higher income individuals pay on Social Security benefits that are designated for Medicare. State transfers (often called the Part D "clawback") refer to payments from the States to Medicare for assuming primary responsibility for prescription drug spending.
Source: 2006 annual report of the Boards of Trustees of the Medicare trust funds.

Strategies to help ensure a more sustainable Medicare program include using payment policy to obtain greater value (that is, higher quality using fewer resources or restraining unnecessary spending), increasing the program's financing, and restructuring Medicare's benefits and supplemental coverage. Policymakers will need to use a combination of approaches to address Medicare's long-term sustainability. Since Medicare heavily influences many aspects of healthcare, policymakers should keep in mind that the program could play a leading role in initiating some types of change. At the same time, broad trends in the healthcare system affect the environment in which it operates, and Medicare needs to work in collaboration with private sector payers who face similar pressures from growth in health spending.

Assessing payment adequacy and updating payments in fee-for-service Medicare

The Commission recommends payment updates for 2008 and other policy changes for fee-for-service Medicare. An update is the amount (usually expressed as a percentage change) by which the base payment for all providers in a prospective payment system is changed. To help determine the appropriate level of aggregate funding for a given payment system, the Commission considers whether current Medicare payments are adequate by examining information about beneficiaries' access to care; changes in provider supply and capacity; volume and quality of care; providers' access to capital; and, where available, the relationship of Medicare payments to providers' costs. Ideally, Medicare's payments should not exceed the costs of the efficient providers. Efficient providers use fewer inputs to produce quality services. We then account for expected cost changes in the next payment year, such as those resulting from changes in input prices.

Improvements in productivity reduce providers' costs in the coming year. Medicare's payment systems should encourage providers to reduce the quantity of inputs required to produce a unit of service by at least a modest amount each year while maintaining service quality. Thus, in most cases where payments are adequate, some amount representing productivity improvement should be subtracted from the initial update value, which is usually an estimate of the change in input prices. Consequently, we apply a policy goal for improvement in productivity (the 10-year average of productivity gains in the general economy, 1.3 percent for 2008). This factor links Medicare's expectations for efficiency to the gains achieved by the firms and workers who pay taxes that fund Medicare. Competitive markets demand continual improvements in productivity from these workers and firms; as a prudent purchaser, Medicare should expect the same of healthcare providers.

Hospital inpatient and outpatient services

Most indicators of payment adequacy for hospitals are positive. More Medicare-participating hospitals have opened than closed in recent years. Inpatient and outpatient service volume continues to increase but at reduced rates of growth in 2005 and into 2006. The quality of care hospitals provide to Medicare beneficiaries is generally improving. Spending on hospital construction increased substantially in recent years while the median values of several financial indicators (such as measures of debt service coverage) reached their best value ever recorded in 2005.

Hospitals with consistently lower Medicare margins (the excess of payments over costs divided by payments) over the last 3 years tend to have higher private payer payments. Those higher payments allow those hospitals to continue to have higher costs, and thus they are under less pressure to control costs. Table 1 shows that hospitals with consistently low Medicare margins over the last 3 years had revenues from non-Medicare payers that were 1.16 times the hospitals' costs for providing the services. Conversely, hospitals with consistently high Medicare margins had non-Medicare revenues just under their costs. Those hospitals were under pressure to control their costs and did so more successfully, with costs increasing at a lower rate and length of stay decreasing at a faster rate than hospitals with consistently low margins. The result was that in 2005 hospitals with low Medicare margins were less competitive with nearby hospitals and those with high Medicare margins more competitive. Excluding hospitals with consistently high standardized costs (about 17 percent of hospitals) would raise the industrywide Medicare margin by 3 percentage points.

Table 1. Hospitals with consistently low or high adjusted overall Medicare margins face different cost pressures

	Hospitals' adjusted Medicare margins:	
Indicators:	**Consistently low**	**Consistently high**
Non-Medicare ratio of revenues to costs (2005)	1.16	0.99
Average annual increase in inpatient cost per case (2002–2005)	6.3%	5.2%
Annual change in Medicare length of stay (1997–2005)	−2.3%	−3.1%
Standardized cost per case (2005):		
Subject hospital	$6,203	$4,527
Hospitals within 15 miles	5,742	5,103

Note: Hospitals with consistently low or high margins had adjusted overall Medicare margins (margins calculated excluding indirect medical education and disproportionate share payments over empirically justified amounts) from 2002 to 2005 that were in the top or bottom third each year. Per cases costs are standardized for wages, case-mix, severity, outlier cases, and teaching intensity. Median values shown.

Source: MedPAC analysis of data from the Centers for Medicare & Medicaid Services.

Lack of pressure to control costs because of high non-Medicare revenues may have also contributed to an increase in the growth in costs per unit of service in 2006, leading to the negative Medicare margin (−5.4 percent) we project in 2007.

Balancing positive indicators and negative margins, the Commission recommends that the Congress update both inpatient and outpatient services by the hospital market basket, with this increase implemented concurrently with a quality incentive payment program. A pay for quality performance program would pay those hospitals with higher quality more than the basic payment rate. Although such a program would operate separately from the update, a hospital's quality performance would likely determine whether its net increase in payments in 2008 would be above or below the market basket increase.

Part of the funding for a quality incentive payment policy for all hospitals should come from reducing indirect medical education (IME) payments. Our analysis finds that more than half of the IME add-on payment is unrelated to the additional cost of care that results from the intensity of a hospital's teaching program (measured by the ratio of residents per bed). The Commission recommends that the Congress reduce the IME adjustment by 1 percentage point to 4.5 percent per 10 percent increment in the resident-to-bed ratio, concurrent with implementation of a system for adjusting payments for severity of illness. Teaching hospitals as a group already

have better financial performance than non-teaching hospitals under Medicare. They will also benefit from the severity adjustments to hospital payments that CMS is considering for proposed regulation and which are necessary to help improve the accuracy of the payment system.

Our recommendations on the update and IME payments, along with the contemplated severity adjustments and a focused pay-for-performance initiative, should be viewed as a package that would improve the accuracy of Medicare's acute inpatient payments while creating an incentive for improving the quality of care.

For several years, policymakers have been considering options for the Federal Government to help hospitals with their uncompensated care. We found little evidence of a relationship between the disproportionate share payments hospitals receive and the cost of caring for Medicare patients or the amount of uncompensated care they provide. If policymakers desire to provide a Federal payment for uncompensated care, it should be distributed on the basis of each hospital's uncompensated care not as an add-on to a Medicare per case payment rate. To provide the necessary data, the Commission recommends that CMS improve its instrument for collecting information on uncompensated care. The Commission has previously suggested specific changes to help CMS revise its data collection instrument.

Physician services

Our analysis finds that most indicators of payment adequacy for physicians are stable. Beneficiary access to physicians is generally good with few statistically significant changes in recent years. We find that the number of physicians providing services to Medicare beneficiaries has more than kept pace with growth in the beneficiary population in recent years, and per beneficiary service volume grew at a rate of 5.5 percent in 2005. Our claims analysis shows small improvements in the quality of ambulatory care. The ratio of Medicare payment rates to private payment rates was essentially unchanged.

In consideration of expected input costs for physician services and our payment adequacy analysis, the Commission recommends that the Congress update payments in 2008 for physician services by the projected change in input prices less the Commission's expectation for productivity growth. Physicians, like other providers and the taxpayer and firms that fund Medicare, should be expected to increase their productivity each year.

Although the recently passed Tax Relief and Health Care Act directs additional funds to physicians in 2008, the sustainable growth rate (SGR) formula continues to call for substantial negative updates through 2015. Though currently we do not see overall access problems, the Commission is concerned that consecutive annual cuts would threaten beneficiary access to physician services over time, particularly those provided by primary care physicians. As a mechanism for volume control, the current national SGR has several problems, which the Commission examines in its mandated report to the Congress: *Assessing Alternatives to the Sustainable Growth Rate System*.

Fee-schedule mispricing may be one factor contributing to disparities in volume growth among services. The Secretary could play a lead role in identifying mispriced services by measuring volume growth for specific services, while taking into account changes in the number of physicians performing the service and other factors. CMS or the Relative Value Update Committee (RUC) could use the results from these analyses to flag services for closer examination of relative work values. Alternatively, the Secretary could automatically correct such mispriced services and the RUC would review such changes during its regular 5-year review process.

Outpatient dialysis services

Most of our indicators of payment adequacy for outpatient dialysis services are positive. Beneficiaries' access to dialysis care is generally good; the number of facilities increased, capacity increased, and there do not appear to be access problems. The growth in the number of dialysis treatments kept pace with patient growth. Quality of care is improving for some measures; more patients are receiving adequate dialysis and more have their anemia under control. Yet, one quality measure—patients' nutritional status—has not improved during the past 5 years. Recent evidence about trends in opening new dialysis facilities suggests that providers have sufficient access to capital. Between 2003 and 2005, the cost per treatment for composite rate services and dialysis drugs fell, largely driven by decreases in drug prices. We project that Medicare payments will cover the costs of providing outpatient dialysis services to beneficiaries in 2007 with a margin of 4.1 percent.

Considering expected input costs and our payment adequacy analysis, the Commission recommends that the Congress update the composite rate for outpatient di-

alysis services in 2008 by the projected change in input prices less the Commission's expectation for productivity growth.

The Commission remains concerned that Medicare continues to pay separately for drugs and laboratory tests that providers commonly furnish to dialysis patients. Medicare could better achieve its objectives of providing incentives for controlling costs and promoting access to quality services if all dialysis-related services, including drugs, were bundled under a single payment. In addition to broadening the payment bundle, the Secretary should continue efforts to improve dialysis quality. The Commission has recommended that Medicare base a portion of payments on the quality furnished by facilities and physicians who treat dialysis patients. The Secretary also needs to continue to develop quality measures and to monitor and improve dialysis care. Together, these steps should improve the efficiency of the payment system, better align incentives for providing cost-effective care, and reward providers for furnishing high-quality care.

Post-acute care providers

The recuperation and rehabilitation services that post-acute care providers furnish are important to Medicare beneficiaries. In our March report the Commission analyzes payment adequacy for the four types of post-acute care (PAC) providers: skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs).

Prospective payment systems (PPSs) for each setting were developed and implemented separately. While the PPSs have changed the pattern of service use within each setting, we do not have adequate data to evaluate whether beneficiaries are being treated in the setting that provides the most value to them and the program. Three barriers undermine the program's ability to know if it is purchasing high-quality care in the least costly PAC setting consistent with the care needs of the beneficiary:

- Case-mix measures often do not accurately track differences in the costs of care.
- There is no common instrument for patient assessment across PAC settings, which makes it difficult to compare costs, quality of care, and patient outcomes.
- There is a lack of evidence-based standards of care.

Similar barriers limit our ability to compare differences in financial performance among the provider within each post-acute setting. We do not know if better financial performance results from higher efficiency or differences in the mix of patients chosen for treatment, but, as might be expected, we found that those facilities had consistently low unit costs, used fewer resources, and had higher occupancy.

Skilled nursing facility services

Our indicators of payment adequacy are generally positive for skilled nursing facilities (SNFs), but quality shows a decline. Beneficiaries have good access to SNF care, although those who need certain expensive services may experience delays in finding SNF care and end up staying longer in the hospital. The number of facilities providing SNF care to Medicare beneficiaries has remained almost constant. Spending and volume of days and stays increased in 2005, with cases continuing to shift to rehabilitation case mix groups, which receive higher payments. Two outcome measures for Medicare SNF patients show declining quality in recent years: average facility rates of avoidable rehospitalizations increased and discharges to the community declined. SNFs appear to have good access to capital. We project that Medicare payments will more than cover the costs of providing SNF care to Medicare beneficiaries in 2007 with margins for freestanding SNFs of around 11 percent.

The data suggest that skilled nursing facilities should be able to accommodate cost increases in 2008. Therefore, the Commission recommends that the Congress should eliminate the update to payment rates for SNF services for fiscal year 2008.

Some have argued that, although Medicare payments may be more than adequate, Medicaid payments to nursing facilities are inadequate and, therefore, Medicare should increase its payments to SNFs. The Commission rejects this argument for three reasons. First, Medicare payments should be set to cover the costs of an efficient provider, not to cover the additional costs of caring for non-Medicare patients. Second, increasing Medicare payments would target the wrong facilities; SNFs with more Medicare patients and fewer Medicaid patients would receive larger increases, and those with fewer Medicare patients and more Medicaid patients, would receive smaller increases. Third, if Medicare took this perspective, States might scale back their spending in response.

Home health services

Our measures for home health are positive. Access to care continues to be satisfactory; more than 99 percent of beneficiaries live in an area served by a home

health agency (HHA) in 2006. The number of beneficiaries using the benefit increased substantially, the number of HHAs participating in Medicare also continues to increase rapidly, but the growth in new HHAs varies among regions with two States accounting for two-thirds of the growth. For most measures quality has increased slightly, but the rate of hospital readmissions and of unplanned admissions to emergency rooms has not changed. Between 2004 and 2005 average cost per episode grew at a rate of under one percent yielding a margin for freestanding agencies of over 16 percent. We project that Medicare payments will more than cover the costs of providing home healthcare to Medicare beneficiaries in 2007 and project margins remaining over 16 percent.

The data on access, quality, volume, and financial performance suggest that agencies should be able to accommodate cost increases in 2008, hence, the Commission recommends that the Congress should eliminate the update to payment rates for home healthcare services for calendar year 2008.

Inpatient rehabilitation facility services

Judging payment adequacy for inpatient rehabilitation facilities, which has been robust in recent years, is now more difficult because of a major change in Medicare policy. The change was CMS's modification of the 75 percent rule, which requires IRFs to have 75 percent of admissions with one or more of a specified list of conditions, and 2005 was the first full year the new rule took effect. Medicare is the principal payer for IRF services, accounting for about 70 percent of discharges.

The number of IRF cases increased rapidly after the introduction of the PPS but decreased as the 75 percent rule started to be phased in. Medicare spending followed the same trends, increasing rapidly from 2002 to 2004 but decreasing from 2004 to 2005. Our other indicators show that the supply of IRFs was stable in 2005, the patients treated by IRFs in 2005 were more complex than those who shifted to alternative settings, and quality indicators for all IRF patients and for those who were discharged home improved slightly. Most IRFs are hospital-based units that access capital through their parent institutions, which have good access.

As expected, in response to the modified 75 percent rule growth in costs per case accelerated between 2004 and 2005. This is because the volume of cases declined, and the patient mix became more complex as patients with lesser needs were treated in other settings. Aggregate Medicare margins for 2005 were high, around 13 percent. We estimate that margins in 2007 will be lower, largely because of the effect of the 75 percent rule. We estimate that the margin will range between 0.5 and 5.5 percent, depending on the ability of the IRFs to control their costs to compensate for the drop in volume.

In this time of transition from historically high margins and growth to lower margins and volume declines, the Commission recommends that the Congress update payment rates for IRFs for 2008 by 1 percent.

Long-term care hospitals

Our indicators of payment adequacy for long-term care hospitals (LTCHs) are largely positive. Medicare is the predominant payer for LTCH services and accounts for more than 70 percent of LTCH discharges. The number of LTCH providers increased between 2004 and 2005, with the number of LTCH hospitals within hospitals (HWHs) growing twice as fast as the number of freestanding facilities. The number of cases increased 10 percent annually from 2003 to 2005 and Medicare spending grew at almost triple that pace during the same period. The rate of growth slowed in 2006. The evidence on quality is mixed. Risk-adjusted rates of death in the LTCH, death within 30 days of discharge, and one of four patient safety indicators (PSIs) showed improvement between 2004 and 2005. But more patients were readmitted to acute care and three PSIs worsened. Rapid expansion of both for-profit and nonprofit LTCHs demonstrates good access to capital for this sector.

LTCHs' Medicare margins for 2005 were high, almost 12 percent, but CMS has made a number of policy changes that will reduce payments. We estimate the margin in 2007 to be between 0.1 and 1.9 percent with the magnitude depending on how LTCH–HWHs respond to the 25 percent rule (this rule pays less for certain patients these facilities admit from their host hospitals).

The Commission is concerned about growth in long-term care hospitals because we are not certain that this high-cost service is being used only on patients who need it. LTCHs have shown themselves to be very responsive to changes in payments and should be able to accommodate cost changes in 2008. These findings, as well as the other factors the Commission considers, which are almost all positive, lead us to recommend that the Secretary should eliminate the update to payment rates for LTCH services for 2008. The Commission recommends limiting growth in payments per case until the industry and CMS agree on patient and facility criteria

to better define these facilities and the patients appropriate for them, as we previously have recommended.

Update on Medicare private plans

In our March report the Commission presents recent findings on the Medicare Advantage (MA) plans beneficiaries can join in lieu of traditional fee-for-service Medicare, and the private plans offering the new prescription drug benefit.

All beneficiaries will be able to join an MA plan in 2007, and enrollment in MA plans grew substantially in 2006 with the percentage of beneficiaries enrolled in MA plans reaching 17 percent, a level close to its all-time high. Almost half the growth in 2006 was in private fee-for-service MA plans. In addition, our analysis of MA payments shows that the benchmarks (which are the reference level for plan bids and the maximum program payment) now average 116 percent of traditional Medicare fee-for-service (FFS) levels, and payments average 112 percent.

The ratio of benchmarks and payments varies by plan type, although it exceeds the expected Medicare FFS expenditures for those beneficiaries for all types of plans. Table 2 shows that payments to HMOs are 110 percent of expected FFS costs. Payments for PFFS plans are 119 percent of expected Medicare FFS costs as they are located in areas of the country where benchmarks are much greater than FFS. The amount returned to beneficiaries in the form of extra benefits and reduced premiums varies as well. For example, PFFS plans returned a much lower share of plan payments to beneficiaries in the form of extra benefits and reduced premiums than HMOs.

Table 2. Medicare Advantage benchmarks and payments in 2006 exceed expected Medicare fee-for-service expenditures for all types of plans

Type of plan	Enrollment as of July 2006 (in thousands)	Benchmark relative to FFS cost	Payments relative to FFS cost
HMO	5,195	115%	110%
Local PPO	285	120	117
Regional PPO	82	112	110
PFFS	774	122	119

Note: FFS (fee-for-service), PPO (preferred provider organization), PFFS (private fee-for-service). Payments relative to expected FFS costs for the beneficiaries enrolled in Medicare Advantage plans.

Source: MedPAC analysis of data from the Centers for Medicare & Medicaid Services on plan bids, enrollment, and benchmarks.

The Commission has always supported a private plan option in Medicare, and has recommended a policy of financial neutrality between private plans and traditional Medicare fee-for-service. Financial neutrality includes setting payment benchmarks at 100 percent of fee-for-service costs and removing duplicative payments for indirect medical education. In addition to financial neutrality between MA and FFS, the Commission has also recommended neutrality between types of MA plans, including eliminating the stabilization fund for PPO plans and making bidding rules consistent across plan types. Further, the Commission has recommended a pay for quality performance program for MA plans, and calculating clinical measures for the FFS program that would permit CMS to compare quality in the FFS program with that in MA plans.

The report also provides information on the enrollment, benefits, and premiums of the plans offering the new prescription drug benefit, both the stand-alone prescription drug plans and the prescription drug plans affiliated with Medicare Advantage plans. Our analysis of Part D plan offerings for 2007 shows that about 30 percent more plans entered the market for 2007 than in 2006 and that the typical beneficiary has a choice of over 50 stand-alone drug plans. More plans are including coverage in the gap for generic drugs. (The gap is that part of drug spending where the basic benefit provides no coverage.) Looking at average premiums unweighted by plan enrollment, those for basic plans are lower in 2007 than in 2006, and those for plans with enhanced coverage are higher.

Plans bid to provide Part D coverage, and current law calls for weighting Part D plan bids for 2007 with plans' 2006 enrollment when calculating the national average bid (called enrollment weighting). Because enrollees tended to choose lower premium plans, enrollment weighting would have led to a lower government subsidy, which would mean lower Medicare payments to plans and higher enrollee pre-

miums. Similarly, the law also calls for enrollment weighting in the formula for calculating each region's low-income premium subsidy amount for 2007. CMS chose not to fully enrollment weight bids in either case. This action means that enrollees will pay lower premiums and more low-income enrollees will be able to remain in their current plan. However, it also does not allow the full benefits of competition to be realized and thus, the cost to Medicare will increase.

CMS is using its general demonstration authority to transition to enrollment weighting over time. The Commission is concerned that CMS is using its demonstration authority to provide higher payments rather than demonstrate policy options. The Commission has previously recommended that the Secretary should use his demonstration authority to test innovations in the delivery and quality of healthcare, not as a mechanism to increase payments. The Commission has also previously recommended that the Secretary have a process for timely delivery of Part D data to Congressional support agencies. CMS has proposed a regulation that supports the intent of that recommendation. MedPAC supports that proposed regulation and urges CMS to make it final.

Chairman STARK. Okay. This one is on. Dave, do you want to start out here? I can come back to you.

Mr. CAMP. I noticed that you—first of all, thank you for your testimony. I noticed—obviously I just want to talk about Medicare Advantage a little bit.

You note that the plans are paid 12 percent more than the traditional fee-for-service. Did that analysis take into account the additional services that Medicare Advantage plans may provide to beneficiaries?

Mr. HACKBARTH. The 12 percent is the amount paid on behalf of enrollees in the various types of private plans. So, it is a total of all of the payments going on behalf of those beneficiaries. So, it includes the additional benefits provided by some plans to beneficiaries.

Mr. CAMP. Yes, but the value of those plans—obviously, the payment to the Advantage Plan covers all those plans. My question is, did that amount take into account the value of those plans, which I am not sure I heard you address.

Mr. HACKBARTH. Yes. Well, let me approach it from a little bit different perspective and see if we can come together. As you know, there are various types of private plans participating in Medicare Advantage. There are Health Maintenance Organizations (HMOs), local preferred provider organization (PPOs), regional PPOs and private fee-for-service. Those plans are located in different parts of the country. So the amount that they are paid varies according to where they are located.

Of those types of plans there is only one of them, the HMOs, where the amount going to the—the plans bid for Medicare Part A and B services—is less than it costs traditional Medicare to provide the same service, but when you add the amount paid to those plans, it is passed on to beneficiaries, and added benefits reduce premiums. The combined total takes the HMO payments above the traditional fee-for-service expense.

For all the other plan types, local PPOs, regional PPOs, private fee-for-service, the bids of those plans on Part A and B Medicare are higher than it costs traditional Medicare to provide the same services.

Mr. CAMP. Yes, but what I think that I hear you saying is that that finding did not take into account the value of the additional

services outside of traditional fee-for-service Medicare, nor does it take into account the value of a lower copayment and deductible to a beneficiary. Am I accurate in making that statement?

Mr. HACKBARTH. Well, not exactly. The amount we are paying on behalf of each enrollee exceeds the amount that Medicare would spend on behalf of the same people. Now, in fact, the private plan enrollees often get additional benefits or lower premiums as a result of that additional payment. So, that is unquestionably real value and benefit to many of your constituents.

The evidence from the bidding process suggests that those plans are not delivering even the Medicare A and B services more efficiently. So, we are using an inefficient mechanism to provide additional benefits to beneficiaries.

Chairman STARK. Would the gentleman yield?

Mr. CAMP. Yes, I would be happy to.

Chairman STARK. Glenn, let me try it this way. Let us just take Plan A and let us say that fee-for-service Medicare in that community would be $6,000. What you are suggesting is that we are paying $6,720 on average to that plan, so we are paying $720 more than what we would normally pay for A and B services.

Mr. HACKBARTH. Right.

Chairman STARK. I think where David and I are curious to go is would the $720 extra, would that be eaten up, if you will, by eyeglasses, hearing aides, reduced monthly premiums, et cetera, on average? In other words, for the extra 12 percent, are the beneficiaries getting that much extra value?

Mr. HACKBARTH. We don't know what the plan's cost structure is for providing the eyeglasses and the other things that you mentioned. So, for that $720 the beneficiary is getting additional benefits.

Chairman STARK. But you don't know what they are worth?

Mr. HACKBARTH. Right. I don't know what they are worth. The second point that is critical is that if we want to pay more through traditional Medicare, you could also buy additional benefits for beneficiaries, and in many cases at a significantly lower cost than it costs the private plans to do the same.

Chairman STARK. So, if the policy goal is more benefits or more support to lower income patients, those are reasonable policy goals, but let us use the most efficient vehicle, which often will be traditional fee-for-service Medicare not the private plan.

Mr. CAMP. Well, thank you. What we are trying to get at is comparing values, and what is interesting is HMO plans, for example, which have the highest enrollment, did 3 percent less than traditional Medicare, but we are trying to compare the value of the plan that recipients receive.

Obviously in Medicare Advantage they receive a little bit more, but is it enough to make the extra payment valuable? We are just trying to determine that, and so the conclusion that Medicare Advantage plans are paid more I think we all accept and understand and agree to, but the question is, is it a wise use of taxpayer dollars to pay those plans more to go into these areas that—to have lower deductibles, to have these extra benefits? That is the bottom line we are trying to get to.

Mr. HACKBARTH. Well, I think that the question about whether we are getting good value is an important question to ask. The way the current payment mechanism works, because the payment rates are generous and the private plans are able to provide additional benefits, lower premiums for that, we are basically sucking more and more Medicare enrollees into private plans that cost more than traditional Medicare to provide the Part A and B benefit package.

Mr. CAMP. Except that doesn't explain the HMO plans.

Mr. HACKBARTH. The HMO plans, of the types, the HMO plans are the only type that, on average, the bid for Part A and B is less than what it costs traditional Medicare to provide the same package. For all the other plan types the average bid is higher than traditional Medicare.

Mr. CAMP. Thank you. I see my time has expired. Thank you, Mr. Hackbarth.

Chairman STARK. Yielding to Mr. Thompson.

Mr. THOMPSON. Thank you, Mr. Chairman. Could you just tell me, I am wondering if you did any analysis on the issue of private pay margins in hospitals, urban versus rural? I know you talked about how the Medicare margins of rural and urban hospitals compare. I am talking about just the private component. Did you do anything with that? How do they compare?

Mr. HACKBARTH. Well, as you know, Mr. Thompson, we do focus on the Medicare margins of hospitals principally, not the private margins. We do know that the total margins, which is a combination of Medicare and of private, for rural hospitals tend to be higher on average than for urban hospitals.

Mr. THOMPSON, but you didn't break out the specific categories?

Mr. HACKBARTH. Well, I can infer. Right now, the average Medicare margin of rural hospitals and urban hospitals is very close. Rurals are actually somewhat higher at this point. Let us say they are even, so if their total margins are higher, the private margins therefore must be higher.

Mr. THOMPSON. But you didn't separate them out? You didn't——

Mr. HACKBARTH. No.

Mr. THOMPSON. Okay. I just wanted to know that. On the critical access hospitals, some of the problems that we are facing, especially out in California where, like every place else, hospitals are getting old and they are trying to build new hospitals, but in California we have the seismic hurdle that we are trying to clear, and it is pretty significant. I don't know if you know the numbers, but it costs more to seismically retrofit the hospitals in California than the equity in all the hospitals in California. Some of these guys are trying to consolidate, and some are trying to build new maybe five miles up the road from the old, and they can't get any guarantee from CMS that they can stay a critical access hospital. Have you taken any position on this?

Mr. HACKBARTH. We have not. We have discussed the issue.

Mr. THOMPSON. Would you, please?

Mr. HACKBARTH. Well, I come here to represent the Commission and there is no formal Commission position on that issue. We

did talk about recommending that CMS have the ability to allow mergers without losing designation as critical access.

Mr. THOMPSON. I didn't hear the last part of your statement.

Mr. HACKBARTH. I am sorry. We did talk about recommending to CMS that they allow mergers of critical access hospitals without the hospitals losing their designation, but we did not make a formal recommendation on it.

Mr. THOMPSON. When you say you talked about, you talked about it in the positive?

Mr. HACKBARTH. Generally speaking, yes. As with almost everything we talk about, there are pros and cons, but in general the feeling was that it could be positive. The other part of the discussion was that at that point in time at least we did not have an indication that there was a widespread interest in doing such mergers. So, we could take a look at it.

Mr. THOMPSON. There is a pretty widespread interest—and I can't speak for everyone here who represents rural areas, but I know that in my area there is. I am sure that the seismic issue probably pushes it a little bit, but this is really important for a lot of folks, and it is going to mean whether or not some of these hospitals are able to rebuild or not.

I would appreciate any work you can do on that.

On the Geographic Practice Cost Indices (GPCI) issue, does your report or the Surgeon General's Report (SGR) do any work on some of the things that you have talked about before? I know in your 2005 report you made some findings that it was time to revisit the boundaries of payment localities. Localities likely do not correspond to market boundaries, and you said that Medicare is probably underpaying in some geographic areas because of this. Probably most of us here can point to examples in our own districts where this is the case. I am wondering if your report or the SGR report dealt with this and if not when are you going to complete your work and will you be making recommendations?

Mr. HACKBARTH. Yes, we have talked at some length about this issue with specific regard to some areas in California where there seem to be particularly acute issues with the boundaries.

I would make a couple points. First of all, this sort of geographic adjustment to reflect underlying difference in costs is pervasive in the Medicare Program. The purpose of doing it, of course, is to try to match payments with the cost of doing business in particular areas.

It is not an easy thing to do. Drawing these lines almost inevitably leads to people feeling unhappy about where the line is; they are on the wrong side.

Mr. THOMPSON. I don't think anybody is suggesting it is easy, but in a lot of areas it is just patently unfair and it is hurting in the delivery of healthcare and we need to try to figure this out.

Mr. HACKBARTH. So, with specific regard to California, we think that there are some places in California where the problems are particularly severe and our advice to CMS has been to look at how those boundaries can be redrawn.

Mr. THOMPSON. With all due respect, and my time has run out. I ask to be indulgent for a second. We have been talking about this forever. Ever since I have been here we have been talking about

this and you guys have told us that you are going to make recommendations, and I would just like to know when the recommendation will be forthcoming. Thank you.

Mr. HACKBARTH. May I answer the question? What I was describing is our view of the issue, Mr. Thompson, and that is that CMS ought to look at redrawing. We do agree with CMS that redrawing of the boundaries ought to be budget neutral within the State. In addition to that, as CMS reviews this sort of line drawing, they ought to be willing to respect the wishes of States where there has been an agreement to have a single area in the whole State. So, those are our thoughts on the issue.

Chairman STARK. Mr. Ramstad.

Mr. RAMSTAD. Thank you, Mr. Chairman. Chairman Hackbarth, good to see you again. I appreciate your testimony. I certainly agree that we need a thorough analysis of Medicare Advantage payments, and I certainly also appreciate MedPAC's recommendations, but I have this distinct feeling of deja vu.

I remember 1997 when we enacted the Balanced Budget Act (P.L. 105–33) and made significant changes to Medicare Managed Care, and certainly these changes did achieve some savings, but they also caused many private plans to desert the market entirely. Of course this diminished the number of overall choices for Medicare beneficiaries many places, including my home State of Minnesota.

So, then we spent the next few years trying to undo some of those reforms. Today in my hometown of Minnetonka, Minnesota, we have 42 Medicare Advantage plans available. Six of the 42 plans have $0 premiums and 11 have monthly premiums less that $30. Nearly half allow a beneficiary to see any willing physician. Thirty plans offer vision—eye benefits. Eleven offer dental benefits and 35 offer physical exams. In the aggregate, 35 percent of Medicare beneficiaries enrolled in Medicare Advantage plan in my district, which by the way is the second lowest percentage only to my distinguished Chairman, Mr. Stark, who has the highest percent on the Subcommittee.

Anyway, in cataloguing these virtues, reading the litany of the result of these reforms really, my concern is—and I think the key question we have to ask, if we limit payments to Medicare Advantage plans, won't these seniors in Minnetonka, Minnesota be deprived of these benefits? That is what the seniors are asking me, and that is their big concern, understandably so.

Mr. HACKBARTH. I certainly understand their concern. Let me sort of go back to square one for a second. MedPAC, over a period of many years, has repeatedly expressed its support for giving Medicare beneficiaries the option of enrolling in private health plans. That is something that we believe very strongly in.

Chairman Stark will remember that when I was deputy administrator of the Health Care Financing Administration (HCFA) in the Reagan Administration too many years ago, that this was an issue that we felt very strongly about, worked with Congress to enact legislation at that point to allow HMOs to participate in Medicare. I was Mr. Private-Health-Plan-Option within the CMS, then HCFA, at that point in time. In addition, in my own career, I was

CEO of Harvard Vanguard Medical Associates, a very large, multi-specialty, practice that is overwhelmingly prepaid group practice.

I believe, and I have worked in the field, and I think this is critically important for Medicare beneficiaries. On the other hand, Medicare has severe long-term financing issues. We want private health plans in Medicare, the private health plans that will help deal with the long-term challenges facing the programs, not plans that will help drive up the cost still further and create impossible choices for this Committee in the future.

Our concern about the current structure, the Medicare Advantage program, is that through these overly generous payment rates which are translated for beneficiaries into very attractive with added benefits, and lower premiums, and free choice of physician, we are going to be sucking millions of additional beneficiaries into private health plans that are demonstrably less efficient than traditional Medicare.

Once we get millions, and millions and millions of people in those plans, changing course on this policy is going to become impossible. So, we see a very clear and imminent risk from this overpayment that is going to put the Committee, the Congress and the country on hold in an untenable position.

Private plans that are more efficient? Absolutely, I am all in favor. Private plans that are going to drive up Medicare costs are a mistake for the program.

Mr. RAMSTAD. Well, let me just—I see that time is waning both for our floor vote and here. Let me just ask a final question very directly. It should be a pretty simple answer and it concerns pay for performance. I think you are an advocate, as I have been for a long time, of pay for performance if it is done right. It seems to me that if we want to effectively implement MedPAC's pay-for-performance proposal that Congress needs to accompany that with a comprehensive information technology (IT) bill. Do you agree?

Mr. HACKBARTH. I certainly agree that clinical IT is very, very important for the advancement of a broad health policy agenda, including pay for performance.

I mention my experience with Harvard Vanguard. Harvard Vanguard has had a computerized medical record since 1974. It is one of the leaders in the field. I have seen the benefits of computerized medical records firsthand. So, yes, we need to build that infrastructure.

Mr. RAMSTAD. Thank you, Mr. Chairman. Dr. Hackbarth, thank you.

Chairman STARK. Thanks very much. Ms. Tubbs-Jones.

Ms. TUBBS JONES. Mr. Chairman, I was getting ready to say if we are getting ready to recess I want to say hi, and welcome and I will see you next time, but since we are not, let me real quick—maybe somebody else will get a chance to ask questions before votes as well, Mr. Kind over here. I will only take 2½ minutes, Mr. Kind.

I represent the city of Cleveland, great hospital systems. Can you tell me what you think the impact of you imposing controlling costs will have on the ability of urban hospitals who tend to have larger healthcare costs or delivery costs or have on their ability to deliver service?

Mr. HACKBARTH. Well, our goal in making recommendations about the hospital payment system is to ensure that Medicare pays adequately for the cost of the efficient provider of those services. There are two aspects to that, one is the level of the payment and the other is how it is adjusted for different types of patients. So we spend a lot of efforts trying to make our payment rates fair to all providers, both urban and rural.

Ms. TUBBS JONES. Can I stop you just for one minute and ask you what a "different type of patient" is? What is that?

Mr. HACKBARTH. Different diagnoses, for example a heart patient as opposed to a patient with knee surgery.

Ms. TUBBS JONES. Just so the record is clear, we are not talking about the type of patient, we are talking about the type of service——

Mr. HACKBARTH. The diagnosis, the clinical needs of the patient.

Ms. TUBBS JONES. Okay.

Mr. HACKBARTH. So we do think our recommendations are adequate to finance the Medicare operations of efficiently run urban and rural hospitals.

Ms. TUBBS JONES. Is there a differentiation between an urban hospital and a rural hospital in terms of cost?

Mr. HACKBARTH. The system uses a wage index to adjust for differences in the cost of hiring people in urban areas versus rural areas or among different types of urban areas. So, the system is fairly complex in making adjustments for those costs.

Ms. TUBBS JONES. So, the fact, for example, that diabetes or high blood pressure or other diseases such as that predominate in many urban areas and many minority areas, is that factored into your decisionmaking with regard to cost?

Mr. HACKBARTH. Well, we pay on a per case basis. If diabetes, for example, is more common and there are more hospital admissions unfortunately for diabetes, then the hospital gets paid for each of those cases. So, if the prevalence of the disease is higher in a particular community there will be a higher volume of patients and a higher volume of payments to the hospital.

Ms. TUBBS JONES. I could ask you a thousand more questions, but in the interest of making sure that my colleague, Mr. Kind has an opportunity to ask questions before we break, I am going to end with that.

I may submit some questions in writing. My greatest concern is that we deliver quality healthcare, my greatest concern.

Chairman STARK. Mr. Kind, would you like to take some time?

Mr. KIND. Yes, thank you Mr. Chairman. I will try to get right to the point. Thank you, Chairman Hackbarth, for your testimony here today. We appreciate the work you put in.

I come from a district not unlike Mr. Ramstad's, western Wisconsin, and we, for a very long time, have been dealing with some of the regional reimbursement disparities. I am sure you are familiar with the Weinberg study or the Dartmouth Atlas study highlighting this issue.

Getting the MedPAC recommendations on pay for performance, do you think that is one way of being able to deal with these regional disparities that exist today?

Mr. HACKBARTH. Perhaps indirectly. As you know, some of the areas that have low cost on a per-beneficiary basis actually have higher quality on average than the high-cost areas in the country.

Mr. KIND. That is right.

Mr. HACKBARTH. So, to the extent that we are adjusting payments for performance, there will be rewards for those States that are low cost and high quality which don't exist in the current system.

Mr. KIND. I am new to the Committee, and obviously we will be getting into this in greater detail, but that always has been a puzzlement for many of my constituents back home, the fact that we are one of the lower reimbursed areas, yet still consistently one of the highest quality as far as performance outcome is concerned. I also agree with—I think it was Mr. Ramstad that raised the issue with health information technology (HIT) and the importance of trying to get to that promised land as soon as possible.

I haven't had a chance to obviously review MedPAC's recommendations, but are you making any specific recommendations to incentivize getting HIT nationwide that we should be looking at?

Mr. HACKBARTH. Briefly, our general view of it is that the best way to encourage clinical information technology is to reward performance, in particular reward high quality of care. There is lots of capital in the U.S. healthcare system. There is lots of investment going on every day, in fact in the hospital world record-breaking investment in new facilities and upgrades and the like.

So, there is lots of money around. The problem is, right now, there is not a return on investment because we don't reward higher quality. So if you are a hospital executive and you look into invest money, you put it into things like scanners that have a rate of return. Higher quality doesn't have a rate of return in today's healthcare system.

If you pay more for quality, you will get more——

Mr. KIND. Let me ask you, there are really two approaches. We could either offer a bonus payment for those that get there, make the investment and do it, or threaten payment reimbursement if they don't do it.

Mr. HACKBARTH. Yes. The approach that we caution against is to say, well, we will give you money to buy computer systems and not link that payment to results. It is easy to go out and buy a computer system and have boxes in offices. What we want is for them to use it to improve care. So, pay for the outcome, and that will provide an incentive to invest in the tools, don't just pay for the tools and leave the outcomes——

Mr. KIND. Let me ask you real quick in regards to the recommendation on home health services, MedPAC is recommending eliminating the update to the payment rates. It seems to me that this should be the direction we should be advocating, more home health services. It is better for the patient and I think ultimately better for the taxpayer too. A lot of the home health agencies that are around my neck of the woods have been experiencing some pretty tough times. So, I am concerned in regards to the rate. I am wondering if you could offer a brief explanation of why you are recommending this.

Mr. HACKBARTH. Yes. The brief explanation is that there is plenty of money in the home health system right now. On average the margin, Medicare margin for home health is about 16 percent. For rural providers, as I recall, it is about 13 percent. It is a few points lower than the average but still very healthy. So we don't think the problem in home health right now is a lack of money.

We do think that there are some issues in the case mix adjustment system and whether we pay adequately for all types of patients. So we have made some recommendations on improving that case mix adjustment system. There is plenty of money in the bank.

Mr. KIND. Well, I have a similar concern in regards to the recommendation on skilled nursing facilities, nursing homes back home. Again, I have heard a lot from them throughout the years in regard to how tight their budget is, and while Medicare reimbursement may be their one shining star in the revenue portfolio, they are telling me that with insufficient Medicaid payments, which is the bulk of their reimbursement, that they are just barely staying even. So, if they see a hit on Medicare reimbursement, that is going to put them in even a tougher spot.

Let me ask, in the report do you take into consideration Medicaid reimbursement?

Mr. HACKBARTH. We do not. The reason for that—first of all, the Medicare margin for skilled nursing facilities is also quite healthy. We do not take into account Medicaid because we think it would be a very inefficient way to deal with the Medicaid payment problem if there is one.

Just think about this for a second. If the problem is Medicaid patients, the skilled nursing facilities with the most problems are the ones that have the most Medicaid patients and the fewest Medicare patients. So, if we increased Medicare payments for those institutions with a very high Medicaid proportion, they are not going to get a lot of assistance. The skilled nursing facilities that will be helped are the ones that already have a high Medicare share relative to Medicaid.

So, if you pump up Medicare payments, it is not going to go to institutions with a heavy Medicaid burden. So, it is misdirected and it is just not an effective way to deal with the Medicaid payment problem.

Mr. KIND. Thank you again. Thank you, Mr. Chairman.

Chairman STARK. You are welcome. Glenn, I am going to ask—I know this is going to send Mark into a tailspin, but if we could keep the record open, I think we will conclude the hearing. We have got 45 minutes or more of voting.

I know it will only take Mark that long to answer all the letters that we will submit to you to add to the record. Thank you, and as I said, I know we have got a lot more questions, but I don't think it is quite fair to keep all of you guys hanging around now. We will revisit this again.

Thanks very much for your help.

Mr. HACKBARTH. Okay. Thank you.

Chairman STARK. Bye-bye.

[Whereupon, at 2:46 p.m., the hearing was adjourned.]

[Questions submitted by the Members to the Witness follow:]

Questions Submitted by Mr. Stark to Mr. Hackbarth

Question: Private Fee for Service. Private Fee for Service appears, based on your data, to be the most overpaid of all the Medicare Advantage plans, with payments to private fee-for-service at 119 percent of what we pay in fee-for-service Medicare. What is the range of overpayments to private fee-for-service plans? Can you tell us what a beneficiary gets from joining a private fee-for-service plan? What care coordination services do they typically provide? How are they different from fee-for-service Medicare? Are there other additional benefits that a beneficiary receives from a private fee-for-service plan?

Answer: Our data do indicate that private fee-for-services (PFFS) plans receive program payments that are 119 percent of what Medicare Program expenditures would have been for the enrollees of these plans if they had been in traditional fee-for-service (FFS) Medicare. The 119 percent figure is weighted by actual enrollment in PFFS plans as of July 2006. That is, the 119 percent figure is higher than for other plan types, such as HMOs, because PFFS plans draw their enrollment from counties where the benchmarks are relatively higher than other counties. Generally, PFFS plans are drawing their enrollment from counties that have benchmarks that reflect statutorily set floor levels that exceeded historical fee-for-service expenditures levels (the floors established in the Balanced Budget Act 1997 and in the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000).

The table below shows the range of MA program payments to PFFS plans and the enrollment in each range.

Range and distribution of Medicare Advantage program payments to private fee-for-service plans in relation to Medicare fee-for-service expenditures, weighted by enrollment, July 2006		
MA program payments to PFFS compared to FFS	**Percentage of PFFS enrollment in this range**	**Enrollment-weighted average MA program payment for this range**
≥140%	2%	142%
≥130, <140	9	134
≥120, <130	34	125
Subtotal of enrollment in counties with payments at or above 120 percent of FFS	**45**	
≥110, <120	42	115
≥105, <110	10	108
<105	3	103

In our analysis of benchmarks and program payments in MA in 2006, we found that level of rebates in PFFS plans was about 10 percent of FFS expenditure levels, on an enrollment-weighted basis. Thus, PFFS plans are providing enrollees with extra benefits financed by rebate dollars (75 percent of the difference between plan bids and the benchmarks in their service areas). The majority of the rebates are used to finance reductions in cost sharing for Medicare Part A and Part B services that beneficiaries would otherwise be responsible for—about 70 percent of rebate dollars are used for this purpose in PFFS plans. About 20 percent of rebate dollars finance enhancement of the Part D drug benefit, and/or a reduced premium for that benefit; and about 9 percent of the rebate dollars are used to finance extra benefits, such as hearing, dental and vision care not covered by Medicare. (A very small percentage of rebate dollars were used in 2006 to finance reductions in the Part B premium for PFFS enrollees—under 1 percent.)

While the availability of extra benefits and reduced cost sharing is something that would attract beneficiaries to PFFS plans, being able to use any provider appears to be an important consideration.

We do not have information on the degree to which PFFS plans might coordinate care for their plan members. A number of PFFS plans have reported that they use

nurses to perform care coordination functions for their enrollees, but we do not have data on how prevalent that is. Currently all PFFS plans pay providers using Medicare's fee-for-service payment rates. They rely on Medicare's administered pricing system and do not negotiate rates with providers or set up networks (as they are permitted to do under the statute).

We would also note that 90 plans require an enrollee to notify the plan if the beneficiary is going to be admitted to the hospital, and these plans impose an additional charge for the hospital stay if the plan is not notified. It is possible that, on being notified of a hospital admission, the PFFS plan will coordinate hospital care.

Although PFFS plans are allowed to form networks of providers, as far as we are aware, none of the PFFS plans has a network. Thus, beneficiaries can use any Medicare provider that is willing to accept the terms and conditions of the PFFS plan.

Question: IME Payments to Medicare Advantage Plans. Medicare currently pays teaching hospitals directly for the indirect medical education (IME) costs associated with Medicare Advantage beneficiaries and we also make IME payments to the Medicare Advantage plans. Are MA plans using the portion of their payments attributable to IME to enhance payments to teaching hospitals? Is there anything preventing Medicare Advantage Plans from diverting these dollars to other purposes, such as plan administrative or marketing costs?

Answer: MedPAC staff has consulted with plans and hospitals in the past and we have been told by both sides that plan payments to hospitals are determined by negotiation between the parties. The teaching hospitals have told us that they must compete with community hospitals and that plans do not recognize teaching costs separately. Plans tell us that they need to include the teaching hospitals in their networks in order to attract enrollees seeking care in prestigious institutions. The plans claim that the teaching hospitals have all the leverage in negotiations and thus they pay the teaching hospitals more than non-teaching community hospitals. The plans further claim that the teaching hospitals do not give them credit for Medicare teaching payments for the plans' enrollees.

Question: Future analysis of Part D. What type of data does MedPAC need to analyze the Part D program? Are there issues with the proprietary nature of private plan data that will preclude you from doing certain analyses?

Answer: The Commission must report to the Congress about the effects of Medicare payment policies on cost, quality, and access. We need detailed data on enrollment, prices, payments, and the performance of individual plans in order to develop policy recommendations for the Part D program. For example, we would need detailed data to:

- Look at how plan benefit designs, cost-sharing requirements, and formularies affect the use of prescription drugs by enrollees. This would help us evaluate the effects of proposals to change Part D's standard benefit, other coverage rules, and monitor how well plans control drug spending for both the program and enrollees.
- Evaluate whether plan features are related to a beneficiary's compliance with drug therapy and with use of Part A and Part B services.
- Analyze the characteristics of plans that have higher quality measures or lower costs than other plans.

The types of data we need include:

- Information describing plan benefit designs, formularies, and bids;
- Prescription drug events that can be linked to claims for Part A and Part B services provided to the same beneficiary. These data identify the plan, the prescriber, and the pharmacy that dispensed the product, as well as the drug dispensed and amounts paid by the patient, plan, and other payers.
- Levels of enrollment and disenrollment in individual plans, including numbers of enrollees who receive low-income subsidies.
- Data on drug prices and negotiated price concessions aggregated in such a way as to conceal proprietary information.
- Information for plan payment adjustments based on health status, reinsurance payments, and risk corridor payments.
- Other plan-level data on rates of prior authorizations, nonformulary exceptions, appeals, coordination of benefits for out-of-pocket determination, call-center operations, grievances, and consumer satisfaction.

Of course, plan-level data are often proprietary. The Commission has a history of negotiating data use agreements and taking measures to protect the security and confidentiality of person-level and plan-level data. Nevertheless, stakeholders consider it more important to prevent disclosure of certain types of data, such as rebates from pharmaceutical manufacturers. Without access to data on aggregate price concessions, the Commission will not be able to examine program costs thoroughly. However, even in the absence of rebate information, the Commission could still address relationships between plan features and drug utilization so long as we obtain access to other types of data such as Part D claims.

The Commission is concerned that congressional support agencies do not now receive Part D claims data. In MedPAC's *June 2005 Report to the Congress*, the Commission recommended that the Secretary should have a process in place for timely delivery of Part D data to congressional support agencies to enable them to report to the Congress on the drug benefit's impact on cost, quality, and access.

Under the law, CMS has clear authority to collect Part D claims and other data for purposes of making payments. Until CMS issued a proposed regulation last October, it was less clear whether the agency had authority to use Part D data for other nonpayment purposes. It has also been unclear whether CMS has legal authority to provide claims and other Part D data to other Federal agencies, to congressional support agencies, and to private researchers. CMS's proposal would allow the agency to share Part D data with Federal agencies and researchers under the same safeguards that exist for the release of other Medicare data. If this regulation goes forward, it will address many of our concerns about gaining access to Part D claims. However, if the regulation or new legislation authorizing release of Part D claims does not move forward, that outcome would severely inhibit the Commission from carrying out its duty to provide policy recommendations to the Congress.

Question: Growth in number of Part D plans. The number of stand alone prescription drug plans and MA prescription drug plans grew exponentially in 2007. Why has this growth occurred? Does MedPAC intend to track the Medicare margins of these plans like you do for other providers?

Answer: The Commission's analysis of plan offerings for 2007 in MedPAC's *March 2007 Report to the Congress* shows that sponsors are offering about 30 percent more stand-alone prescription drug plans (PDPs) and 25 percent more Medicare Advantage Prescription Drug (MA–PD) plans this year. New PDPs for 2007 emerged in every region of the country, and the median number of plans offered in each region rose from 43 in 2006 to 55. A number of factors account for this new plan entry.

Several organizations began offering nationwide plans in 2007. Nationwide plans refer to the same plan name that a sponsor offers in each of the country's 34 PDP regions. In 2007, 17 organizations are offering at least one nationwide PDP in each region, and those organizations together account for 80 percent of all stand-alone plans. In 2006, 10 organizations had at least one nationwide plan, and those organizations offered 62 percent of all PDPs. Some of the new nationwide plan offerings were from organizations that operated plans in nearly all PDP regions for 2006. In other words, these near-national organizations chose to expand their presence to all PDP regions for 2007. Other organizations were entirely new entrants into the Part D market for 2007. Some of those organizations had sponsored Medicare drug discount cards during the period after the prescription drug law was passed in 2003 but before Part D began in 2006.

As is also true for Medicare Advantage plans, the Commission cannot measure margins of Part D plans as we do for other providers in Medicare's fee-for-service (FFS) payment systems. The reason is that while most FFS providers submit cost reports to CMS, private plans do not.

Question: The Need for a Common Assessment Tool for Post-Acute Care. Mr. Hackbarth's testimony discusses the need for a common instrument for patient assessment across post-acute care settings. How would care for Medicare beneficiaries be improved by the development and use of a single assessment tool for post-acute care? Do you have concrete recommendations that can move us forward in a meaningful way on this front?

Answer: Until a common instrument gathers patient assessment information across settings, it is impossible to compare the value of services furnished to beneficiaries. Without diagnosis and co-morbidity information, we can not compare the care needs, service use, costs, and outcomes. We do not know, for example, if providers with high costs treat more complicated patients or whether their higher costs are associated with inefficiencies. Without comparable outcomes measures, we can not determine whether high service use produced better patient outcomes or wheth-

er the additional services added little of clinical value to the patient. Outcomes information that is adequately risk-adjusted would allow the program to compare practice patterns across settings and their relative effectiveness at treating specific types of cases, especially in settings where there is overlap in the types of patients treated, such as post acute care. In settings with poor case mix adjustment methods for the prospective payment systems, such as SNFs and HHAs, more detailed clinical information could also be used to improve the patient classification systems used for risk adjustment and payment.

Providers and clinicians could also use comparable diagnosis and outcomes information to develop evidence-based guidelines for treating patients with specific clinical conditions. Providers could use data-based guidelines to predict a patient's expected care needs and establish anticipated outcomes. Evidence-based benchmarks could delineate typical resource use by condition and indicate over and under provision of services.

Section 5008 of the Deficit Reduction Act of 2005 required that the Secretary establish a 3-year demonstration program by January 1, 2008 to develop and gather uniform patient assessment information for use at hospital discharge and across post acute care settings. In March 2007, CMS and its contractor convened a technical advisory panel to gather feedback on a draft of the tool. Participants will be recruited this spring and testing of the tool is planned for the summer. The demonstration will begin in one market in January 2008 with broader implementation planned for April 2008. The Commission is watching this demonstration with great interest.

Questions Submitted by Mr. Doggett to Mr. Hackbarth

Question: In June 2006, MedPAC reported in the chapter on outpatient therapy services that CMS needs more outcomes data before it can develop an alternative to the therapy caps. Contractors working for CMS have already recommended four outcome measurement tools—including the NOMS database which has patient outcome data on speech-language pathology, but has not taken further action. Would you support CMS moving quickly in implementing a pilot program that would gather data through these four recommended measurement tools?

Answer: In its report to CMS, researchers at Computer Sciences Corporation (CSC) suggested that four patient assessment tools—the Patient Inquiry® Tool, the National Outcomes Measurement System (NOMS), the Outpatient Physical Therapy Improvement in Motion Assessment Log (OPTIMAL), and the Activity Measure—Post Acute Care (AM–PAC)—be evaluated for use in an alternative payment system. While each tool is appropriate for evaluating the patients it was designed to evaluate, none could be used to evaluate all types of outpatient therapy (physical and occupational therapy and speech-language pathology services), for all patient conditions in every outpatient setting. For example, the NOMS evaluates only speech-language-pathology (SLP) services, the OPTIMAL evaluates only physician therapy (PT) services, the AM–PAC does not fully evaluate patients' swallowing difficulties, and the Inquiry® tool does not evaluate SLP services. Looking at the performance of these tools is a good thing for CMS to do. One of the goals of the pilot would be to assess how each of these tools performs in a variety of settings, across a wide range of patient conditions, and for which types of therapy; however, the concern is that such a pilot would not produce an assessment tool that works in all settings.

Question: In MedPAC's 2006 report, it specifically discussed the fact that we cannot gather data on speech-language pathologists because they do not have a Medicare supplier number that can be tracked. Since that report, another event has taken place that has made this issue even more relevant. In December, Congress passed legislation allowing Speech-Language pathologists (and others) to voluntarily participate in the pay-for-reporting program. However, without a supplier number, speech-language pathologists have little incentive to participate because the bonus payment will go to the entity holding the supplier number—not to the speech-language pathologist. Given MedPAC's interest in this latest report in pay-for-performance, shouldn't we make sure that providers who are eligible for the bonus program have an incentive to participate in it?

Answer: We haven't taken up this particular question in the Commission; however, it touches on a larger question regarding the administration of pay-for-performance programs: Must pay-for-performance bonuses be awarded at the individual

provider level to improve quality, or could the bonuses also be effective when directed at the provider's affiliated organization?

On the one hand, pay-for-performance initiatives may be most successful when they direct bonuses to the provider most responsible for administering the care in question. Under this theory, removing the provider from the direct receipt of the bonus could dilute the desired behavioral response (i.e., improved performance).

On the other hand, the parent entity, such as the hospital or skilled nursing facility, that receives payment for the service has an incentive to establish a system to reward its employees or contractors who report data and provide high quality care. It is possible that such systems may have a wider effect on the general delivery of care, than if rewards were exclusively between Medicare and individual providers.

Question: In CMS's latest 5-year review of Part B billing codes, payment for evaluation and management (E&M) services were increased, and as a result, payment for work relative value units (RVUs) were all depressed by 10% to offset the increase to E&M services. For psychologists and social workers who provide mental health services, this cut is especially harmful as they cannot bill for E&M services that are within their scope of practice. Would MedPAC support removing psychologists and social workers from the 5-year review cuts? Alternatively, would MedPAC support allowing psychologists and social workers to bill for E&M services?

Answer: The Commission has not taken up this question.

Questions Submitted by Mr. Pomeroy to Mr. Hackbarth

Question: When calculating Medicare margin's for Home Health providers, I understand that the Medicare Payment Advisory Committee's analysis excludes over 1600 agencies that are classified as "hospital-based" from the margin calculation. I also understand that in some locations, like North Dakota, these agencies are either the sole source of home health services or the primary provider. Isn't it necessary that these agencies be incorporated into any evaluation on the impact of a payment rate freeze on access to care? What would be the simple average margin, across all agencies large and small, if these agencies were included?

Answer: In 2005, the aggregate margin for all agencies was 13.8 percent, a number which includes hospital-based agencies. (The margin for freestanding providers was 16.7 percent.) Previous research suggests that the discrepancy between hospital-based and freestanding margins is not attributable to factors that would cause the margins of efficient providers to differ. Given this analysis, we do not think the margins should be combined into a single average.

Hospital-based data shows higher costs in part because hospitals shift overhead costs to the hospital-based home health provider; if this cost shifting did not happen, the hospital-based margin would be higher. Furthermore, there is nothing we see in the patient or other economic characteristics of hospital-based home health agencies that would explain these higher costs. A review of 2001 data found that hospital-based providers were similar to freestanding ones in many respects, such as case mix, average reimbursement per agency, volume of patients, and average number of visits (MedPAC 2004). Of course, hospital-based and freestanding providers deliver care in the same setting—the beneficiary's home—so the differences we see in costs are not due to different settings.

Questions Submitted by Mr. Ramstad to Mr. Hackbarth

Question: CMS's assumes that all imaging equipment is in use about 50% of the time. In its June 2006 report, MedPAC presented survey results that showed that MRI equipment was in use more than 90% of the time and CT equipment was in use 70% of the time. MedPAC suggested that imaging procedures may be paid more than twice the appropriate amount, based on these survey results. Independent analysis of the MedPAC survey shows that less than 1% of the independent diagnostic testing facilities nationwide responded to the survey. The survey did not cover x-ray or ultrasound equipment, or many other imaging modalities. How would you characterize the MedPAC findings which are based on survey responses from 80 physi-

cian offices and testing facilities in 6 selected geographic areas, and only surveyed use of MR and CT equipment?

Answer: CMS assumes that imaging machines (and all other medical equipment) are used 50 percent of the time a practice is open for business, which may overstate the cost of equipment. In order to test this assumption, we surveyed imaging providers in six markets (Boston; Miami; Greenville, South Carolina; Minneapolis; Phoenix; and Orange County, California) to find out how frequently they were using MRI and CT machines. We focused on MRI and CT machines because of their high cost and the rapid spending growth for MRI and CT services.

In our June 2006 Report to the Congress, we acknowledged that the survey is not nationally representative because it is based on six markets. We did not intend for it to be representative—the data was meant to help the Commission and CMS focus on the issue. However, all providers in one of those markets that submitted a Medicare claim for an MRI or CT service in 2003 had the same chance of being selected for the survey.

The survey found that providers were using these machines significantly more than 50 percent of the time, which should lead to lower costs per use. The survey results raise questions about whether CMS currently underestimates how frequently these machines are used. Therefore, we suggested that CMS revisit its assumption that *all* equipment is used 50 percent of the time. In its final rule on the 2007 physician fee schedule, CMS agreed that the 50 equipment utilization assumption should be examined for accuracy.

The Commission did *not* suggest that imaging procedures may be paid twice the appropriate amount. Rather, we estimated that increasing the equipment use assumption to 90 percent and using a more updated interest rate assumption would lower equipment price per service by 50 percent. In addition to equipment, there are other parts of practice expense payments: nonphysician clinical staff, supplies, and indirect costs. We did not model the impact of changing the equipment use assumption on total practice expense payment rates.

It is important to note that the American Medical Association (AMA)/specialty society Relative Value Update Committee recommended that CMS use a rate higher than 50 percent for all equipment, while permitting specialty societies to present evidence that specific items are used less frequently. The AMA and specialty societies are about to field a new multi-specialty survey of physician practice costs that will include questions on how frequently practices use high-cost equipment.

Please feel free to follow up with me or Mark Miller, MedPAC's Executive Director (202–220–3700) on any of these issues. Again, we appreciate the opportunity to testify on our March 2007 report and appreciate the Committee's interest in this area.

[Submissions for the Record follow:]

Statement of Alliance for Quality Nursing Home Care

The Alliance for Quality Nursing Home Care (the "Alliance") represents seventeen of the nation's largest providers of long term and post-acute care and services. The roughly 2,000 skilled nursing facilities ("SNFs") owned and operated by Alliance companies care for more than 300,000 older Americans and employ more than 300,000 people in 49 States. As compared to Medicare-certified SNFs as a whole, Alliance members disproportionately provide skilled nursing care to Medicare beneficiaries.

The quality of care Medicare beneficiaries receive today—and the quality of care many of us will require in the decades ahead—relates directly to the Federal Government's payment policies, particularly Medicare and Medicaid. The Alliance is deeply concerned that, all too frequently, the Federal Government's approach to funding for Medicare and Medicaid conflicts directly with its goals of sustaining and improving the quality of patient care. When Medicare funding for skilled nursing services is stable, quality of care and services improves. When Medicare funding is inconsistent and unstable, our nation's long term care infrastructure deteriorates, to the detriment of every senior today and every retiree tomorrow.

At a time when Congress and the Centers for Medicare and Medicaid Services ("CMS") increasingly look to develop a more rationale post-acute Medicare benefit, an objective that the Medicare Payment Advisory Commission ("MedPAC") has long championed, we remain concerned that MedPAC's restrictive view of Medicare payments to SNFs undermines not only care and services for Medicare beneficiaries,

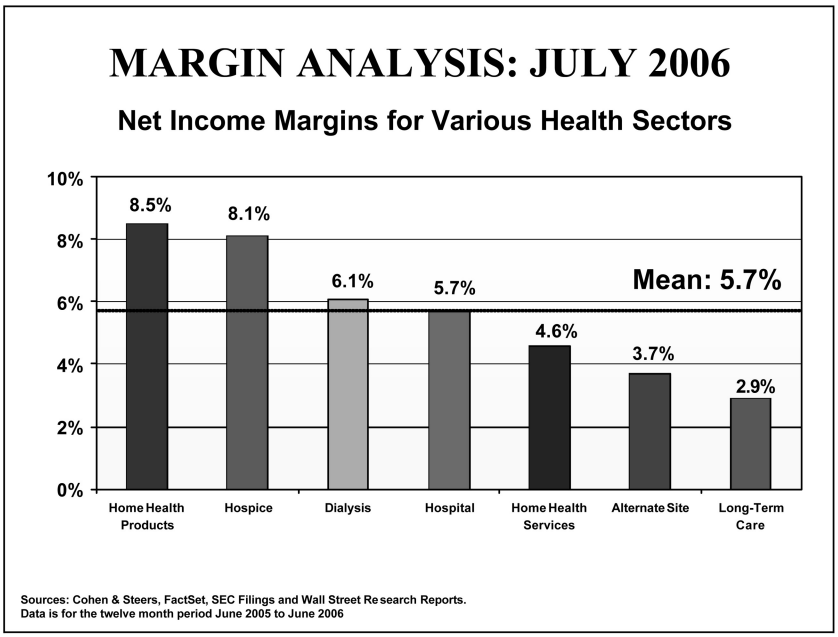
but for all nursing home patients as well. In addition, we are concerned that MedPAC's short-term recommendations undermine its long-term goal of a more rational and unified post-acute benefit.

MedPAC's sole recommendation is that SNFs receive no market basket adjustment in FY 2008. Its March 1, 2007 report notes that, if Congress were to adopt this recommendation, payments to SNFs would be $250 million to $750 million less next year than the Medicare baseline otherwise would allow. Given that the President's proposed FY 2008 budget also eliminates the market basket increase for SNFs and scores the impact at $1 billion, it seems likely that the impact will be at least $750 million. We respectfully submit that this recommendation is short-sighted and urge that Congress reject it in favor of a more expansive view to assure that all SNF patients continue receiving high quality care and services.

The Relationship between the SNF Marketplace and Medicare Payments

A fair evaluation of MedPAC's recommendations requires an appreciation for the economic realities for SNF operations. In SNFs today, Medicare pays for 12% of patients but represents 26% of revenues, Medicaid pays for 66% of patients but represents only 50% of revenues and private sources (commercial insurance, long term care insurance and out-of-pocket expenditures) pay for 22% of patients but represent 24% of revenues. While MedPAC estimates that SNFs **Medicare** operating margins in 2007 will be 11%, MedPAC does not acknowledge that **Medicaid** operating margins are *negative 7%* and private payment operating margins are less than 2%.[1]

As a result, according to independent analysis, overall after-tax operating margins for SNFs were only 2.9% in July 2006, the lowest overall operating margins of any Medicare Part A provider group.



Given these economic realities, robust and positive Medicare operating margins effectively subsidize negative Medicaid operating margins. The Medicare and Medicaid programs, moreover, pay for three of every four SNF patients. While Medicare cross-subsidization of Medicaid may not be optimal policy in the long run, is it is necessary at least until the inadequacy of Medicaid payments is addressed effectively.

Over the past decade, moreover, Medicare funding for SNFs has been volatile. The Balanced Budget Act of 1997 ("BBA") slashed Medicare payments to SNFs and

[1] Source: The Lewin Group analysis of Lewin survey data from multifacility organizations.

forced 20% of SNFs into bankruptcy. In 1999 and 2000, Congress enacted temporary additional payments to help SNFs overcome the most severe consequences of BBA. Thereafter, CMS made certain administrative changes designed to maintain some stability in Medicare payments. Ultimately, in 2006, all Congressional add-ons expired and CMS refined the payment system to better recognize the growing intensity of rehabilitation services Medicare beneficiaries now receive in SNFs.

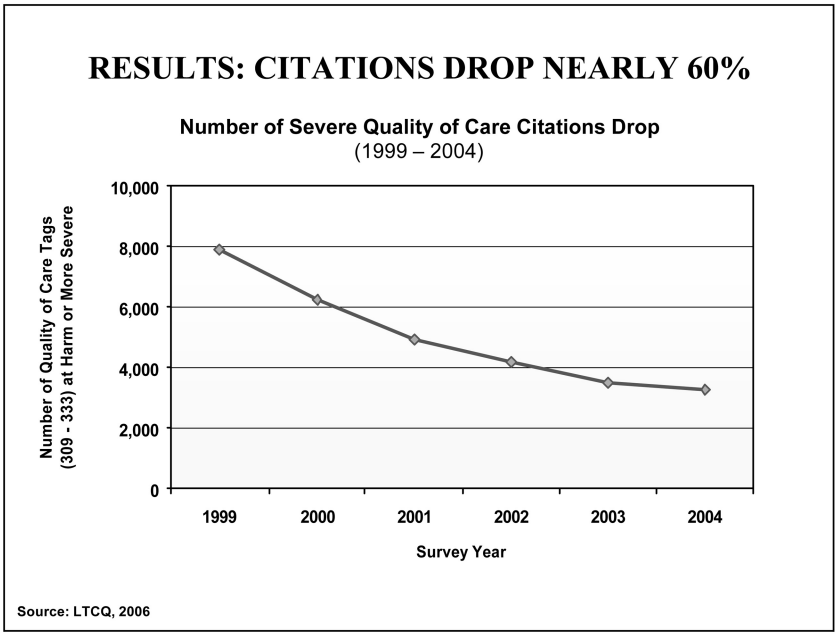
The net effect of these changes is that, only in 2006 did average Medicare payments to SNFs return pre-BBA levels. In 1998, average per diem payments were $367. In 2006, average per diem payments were $366.[2]

Nursing Home Quality Has Improved Significantly

It is noteworthy that America's SNFs have led the quality movement despite comparatively low overall operating margins and volatile Medicare payments. The sector's leadership—which includes the Nursing Home Quality Initiative (a partnership between CMS and providers), the Quality First initiative (a voluntary provider effort) and most recently the Advancing Excellence in America's Nursing Homes campaign (a partnership among providers, consumers, unions, private foundations and CMS)—has helped to improve the overall quality of care in our nation's nursing homes.

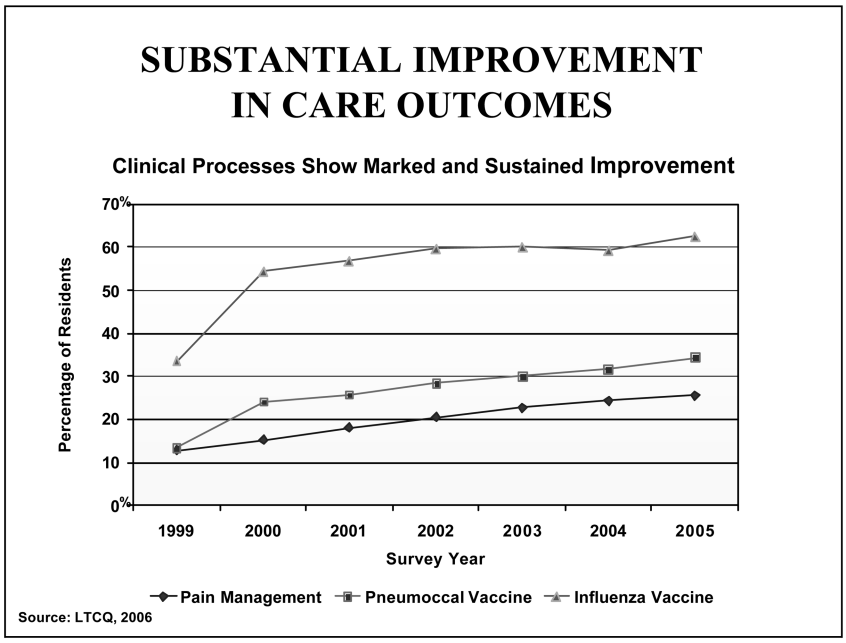
As part of CMS' Nursing Home Quality Initiative, the agency now reports comparative clinical data for use by consumers in choosing SNFs and by SNFs to benchmark and improve performance. Quality First was the first nationwide, publicly articulated pledge by providers in any healthcare sector to voluntarily establish and meet quality improvement targets. The Advancing Excellence campaign, which was launched in September 2006 and is modeled on the recently completed "100,000 Lives" campaign in the acute care sector, seeks to improve quality in eight clinical and operational domains over a 2-year period. Taken together, these efforts underscore that SNFs are committed to accountability for the quality of care and services they provide, as well as prudent use of government resources.

Perhaps more importantly, these efforts are showing positive outcomes. For example, from 1999 to 2004, the number of severe quality of care citations in America's nursing homes dropped by almost 60%.



[2] United BioSource analysis of Alliance database.

Similarly, over the same period, clinical processes like pain management and vaccination rates showed marked and sustained improvement as well.



Consumer satisfaction with nursing home care also reflects noteworthy quality improvement. In 2005, 80% of nursing home patients and their families found the care SNFs provided to be excellent or good. By contrast, 80% of Americans rate their overall healthcare as excellent or good.

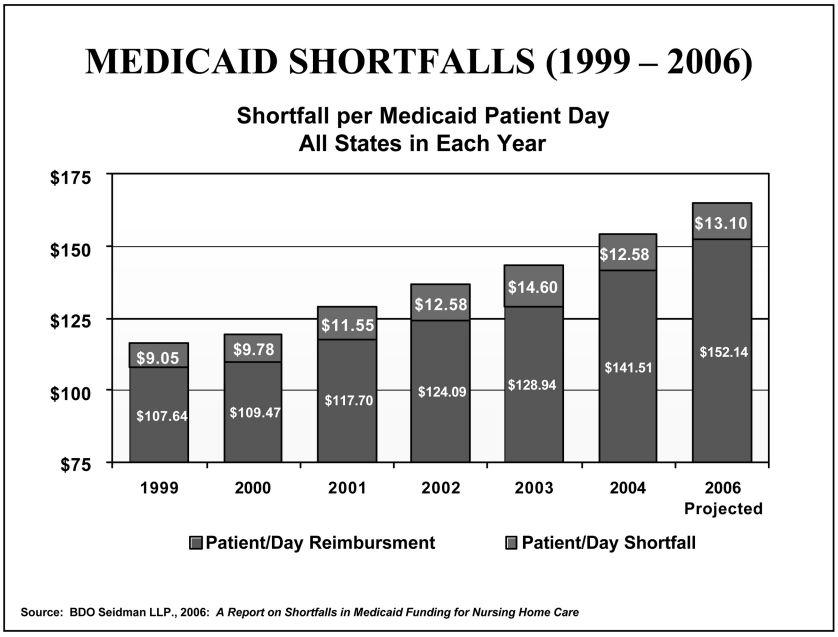
The Alliance remains committed to sustaining these quality improvements for the future. However, sustained quality improvement depends on maintaining the stable Medicare funding which the sector has begun to enjoy in the past few years.

Congress Should Reject MedPAC's Recommendation for FY 2008

MedPAC specifically acknowledges that its recommendation that SNFs receive no market basket increase in FY 2008 is based solely on its evaluation of Medicare payments to SNFs. Consequently, MedPAC directly rejects any consideration of overall operating margins in formulating its recommendation.

While this may be consistent with MedPAC's legislative charter, Congress certainly is not so limited. Congress should base its decision not only on budgetary concerns with respect to the Medicare program, it also should assess the impact on the provision of care and services overall. Given the recent history of volatility in Medicare payments to SNFs, the importance of robust Medicare margins to overall SNF operating margins and therefore to assuring that SNFs have the resources necessary to continue quality improvement efforts, Congress should reject MedPAC's recommendation that Congress forego the market basket increase that current Medicare law otherwise would afford to SNFs.

MedPAC's March 1 report does attempt to address the effect of Medicaid payments on overall margins. Its arguments, however, are unpersuasive. First, MedPAC asserts that Medicaid payment rates are adequate because, since the elimination of the Boren Amendment in 1998, Medicaid payments to SNFs have risen and State revenues in 2006 and 2007 have grown. In fact, Medicaid payment rates prior to repeal of the Boren Amendment were inadequate, such that growth since 1998 does not reflect adequacy of Medicaid payments. Indeed, the gap between the reasonable cost of care and Medicaid payments to nursing facilities has grown consistently since 1999.



The fact that State revenues increased in 2006 and 2007, moreover, ignores the fact that, earlier in the decade, State revenues were severely threatened and, as a result, Medicaid payments were undermined, particularly given that, in more challenging economic periods, Medicaid enrollment swells. While overall Medicaid expenditures may increase in such circumstances, this does not reflect more robust payments for services. Rather, it reflects more enrollees, which places even greater strain on State Medicaid budgets and prompts even more aggressive cost containment initiatives.

It is noteworthy that historic reports from the Kaiser Commission on Medicaid and the Uninsured, the very group whose work the MedPAC report cites in support of its argument, has a long history of reports to the contrary.[3] Congress itself recognized the financial straits States faced earlier in the decade, and the adverse impact on Medicaid programs, by temporarily increasing the Federal Medicaid matching rate in the Federal Fiscal Relief Act.[4]

MedPAC also argues that paying nursing facilities higher Medicare rates misdirects resources because facilities with higher Medicare census benefit from additional payments but such payments should be directed to facilities with higher Medicaid census. This claim misapprehends the ownership structure of a majority of America's nursing homes. Most nursing homes are not owned independently as freestanding facilities. Rather, they are part of multi-facility organizations. Within multifacility structures, providers cross-collateralize across all facilities. Operating losses in facilities with higher Medicaid census are offset by operating gains in fa-

[3] See, e.g., the following Kaiser Commission reports, State Fiscal Conditions and Health Coverage: An Update on FY2004 and Beyond (September 2003), Medicaid Spending: What Factors Contributed to the Growth Between 2000 and 2002? (September 2003); The Current State Fiscal Crisis and Its Aftermath (September 2003); States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment (September 2003); State Responses to Budget Crisis in 2004: An Overview of Ten States (January 2004); Is the State Fiscal Crisis Over? A 2004 State Budget Update (January 2004), States Respond to Fiscal Pressure: A 50–State Update of State Medicaid Spending Growth and Cost Containment Actions (January 2004); The Role of Medicaid in State Economies: A Look at the Research (April 2004), State Fiscal Conditions & Medicaid, April 2004 (April 2004), Medicaid and the 2003–05 Budget Crisis—State Case Studies (August 2005), available at www.kkf.org/statepolicy/budgets.cfm.

[4] Kaiser Commission on Medicaid and the Uninsured, Financing the Medicaid Program: The Impact of Federal Fiscal Relief, April 2004 Fact Sheet (April 2004), available at www.kff.org/statepolicy/budgets.cfm.

cilities with higher Medicare census. The facility-by-facility approach MedPAC suggests is not in keeping with the operating realities of the nursing home financial environment.

In addition, MedPAC's recommendation for FY 2008 threatens its longer-term objective to develop a unified and more rational post-acute benefit. As part of this objective, MedPAC has encouraged policy changes that create incentives for Medicare post-acute patients to receive care and services in the least costly setting consistent with appropriate quality outcomes. CMS has acted on these recommendations in various ways, including refinements to the Resource Utilization Groups ("RUGs") payment system for SNFs effective in FY 2006. These refinements have encouraged SNFs to care for higher acuity patients, particularly those patients requiring short-term rehabilitation care.

Eliminating the Medicare market basket increase in FY 2008 would deprive SNFs of resources necessary to continue expansion of care for these beneficiaries, undermining the effort to rationalize the post-acute benefit. Since SNFs frequently are the lowest cost settings in which such services may be provided, the intermediate- and long-term impact could well be to increase overall Medicare post-acute spending by continuing to provide post-acute care in higher cost settings. For example, based on CMS data for FY 2004, the average cost to Medicare for an episode of care in a SNF was $7,000, while the average cost to Medicare for a comparable episode of care in an Independent Rehabilitation Facility was $12,525, or 78% higher than the cost per episode of care in a SNF. Slowing the trend toward SNFs treating a growing percentage of Medicare post-acute patients similarly slows efforts to rationalize the post-acute system and better control Medicare spending growth in the future.

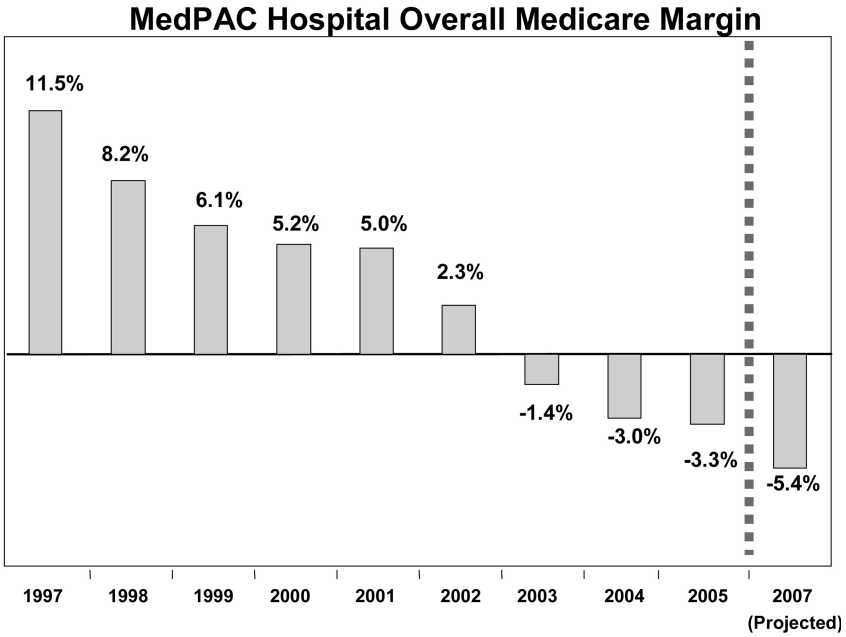
In conclusion, the Alliance respectfully urges Congress to reject MedPAC's recommendation that SNFs receive no market basket increase in FY 2008.

Statement of American Hospital Association

The American Hospital Association (AHA), representing nearly 5,000 member hospitals, health systems, networks and other providers of care, is pleased to submit this statement for the record regarding the hearing on the Medicare Payment Advisory Commission's (MedPAC) Annual March Report to Congress.

Inpatient and Outpatient Update. The AHA commends MedPAC for recommending at its January 2007 meeting that Congress implement a full market basket update, currently estimated at 3.1 percent, for both the inpatient and outpatient prospective payment systems (PPS) in fiscal year (FY) 2008. A full market basket update is essential if America's hospitals are to keep up with inflation and fulfill our roles of caring for patients, preserving the safety net, being ready for unexpected emergencies and disasters, and modernizing the healthcare system.

According to MedPAC estimates, hospitals' overall Medicare margins—including the costs of inpatient, outpatient and post-acute care services—will reach a 10-year low in 2007 at negative 5.4 percent.



Sources: Healthcare Spending and the Medicare Program: A Data Book December 2006 MedPAC Meeting. (June 2006).

According to AHA annual survey data, a staggering 65 percent, or more than 3,000 hospitals, lost money in 2005 serving Medicare patients. These statistics clearly indicate that Medicare payments are inadequate and full market basket increases for both inpatient and outpatient hospital services are critical.

Despite MedPAC's recommendation, the president's FY 2008 budget request would reduce hospital inpatient PPS reimbursements by $13.8 billion and outpatient PPS payments by $3.4 billion over 5 years. These cuts would jeopardize the ability of hospitals to serve their patients and their communities and should be rejected by Congress.

In addition to recommending a full market basket update for inpatient and outpatient hospital services, MedPAC made a series of other payment recommendations.

Inpatient Rehabilitation Facilities Update. The Commission recommended an update of only 1 percent for inpatient rehabilitation facilities—only about a third of the actual expected 3.1 percent increase in costs due to inflation. These facilities are run by specially trained doctors and staff who treat both patients' rehabilitation and medical needs. While the number of inpatient rehabilitation facilities is stable, the strict enforcement of the "75% Rule," which sets key conditions a facility must meet to qualify for reimbursement under Medicare, reduced patient volume by 10 percent and increased the severity of patients seen by 6 percent in 2005. The 75% Rule, even at a transitional level, has already changed the course of inpatient rehabilitation facility payment. To avoid further erosion of beneficiary access to quality inpatient rehabilitation care, a full market basket update to account for inflation is warranted.

Indirect Medical Education. In January, the Commission recommended that Congress reduce the indirect medical education adjustment in FY 2008 by 1 percentage point—from 5.5 percent to 4.5 percent—concurrent with the Centers for Medicare & Medicaid Services' efforts to implement a payment system based on severity-adjusted diagnosis related groups. However, it is not clear at this time what, if any, adjustments will be made for patient severity, the size of these changes or how these changes will affect the indirect medical education adjustment.

The AHA opposes this recommendation, as a one percentage point reduction equates to a 20 percent cut in indirect medical education payments.

The indirect medical education adjustment is intended to help compensate teaching hospitals for the higher costs of training physicians, research-related patient care costs, treating sicker patients and providing more complex and costly services. Many teaching hospitals have trauma centers, transplantation services, and most use cutting-edge new technologies. In addition, teaching hospitals are also preparing to be first-line responders in the event of a flu pandemic, or biological or chemical attack.

Arbitrarily targeting indirect medical education payments for reductions may lead to reduced access to high-caliber medical education for our future physicians. We urge Congress to consider the benefits provided by teaching hospitals and reject any cuts to indirect medical education.

We appreciate the opportunity to submit this statement for the record and look forward to working with members of the Subcommittee and the MedPAC commissioners to ensure that Medicare reimbursement keeps pace with inflation and the changing needs of our healthcare system. Americans depend on hospitals to be there, ready to serve, 24 hours a day, 365 days a year. Reversing the dramatic decline in hospitals' Medicare margins is essential to ensuring hospitals' ability to fulfill this expectation.

Statement of Mid-Florida Cardiology Specialists, Orlando, Florida

It is imperative that we receive a voice every time you are meeting on the healthcare issues that are so greatly affecting our practice. First let me express our great appreciation for averting the 5% cut by your congressional action of December 8, 2006. But the effects of the other budget adjustments have taken a heavy toll on cardiology practices in the Central Florida area. We are experiencing lay offs of personnel and searching for other areas to save a few pennies to be able to continue to provide services to the Medicare population of Florida.

Two areas have had great impact on this cardiology group. First the imaging cap for the technical component of the global service provided by our office. These codes affected by this imaging cap will have a very detrimental effect on services provided to the Medicare patients in our office. The nuclear stress test reduced $55.94 which is 6%. It would be incomprehensible to imagine what the 5% averted cut would have added to this already devastating reimbursement system. This test is only one of the imaging services that we provide.

We have a total of three fee schedules to consult to try to figure out what our reimbursement is going to be in 2007. There is a 2007 Fee for Service Participating Physician Fee Schedule. Then there is a fee schedule for the imaging caps. Then there is another fee schedule for the "carrier priced" codes. It is challenging at best.

The second area where we are greatly affected is the work relative value decrease which was lowered to maintain budget neutrality. Each code for 2007 decreased by 0.8994% for the relative work value portion of the code. The majority of our codes decreased with very few increasing. Out of the 217 codes we have priced in our system, only 22 codes increased.

With every committee meeting that you have, you hold the very future of many practices in your hands. I have been with this practice for 19 years and these physicians provide excellent and compassionate care to our Medicare population. We can not continue to do so at the current reduction rate of reimbursement. We have been unable to find a "bandage" large enough to cover the wound this constant downward spiral is opening. I know this is a challenge, but to continue to cut the physician's fee schedule is NOT the answer.

Statement of National Association for Home Care and Hospice

The National Association for Home Care and Hospice (NAHC) is the largest national home health trade association. Among our members are all types and sizes of Medicare-participating care providers, including nonprofit agencies such as the VNAs, for-profit chains, public and hospital-based agencies and free-standing agencies.

NAHC is pleased to submit this statement for the record to the Committee on Ways and Means Subcommittee on Health on the Medicare Payment Advisory Commission's (MedPAC) recommendations and report to Congress on home care payment adequacies. In January 2007, MedPAC voted to recommend that Congress eliminate the home health market basket update for calendar year 2008. The MedPAC recommendation is based upon a number of factors including access to

care, supply of providers, volume of services, quality of care, access to capital, and payment and costs.

NAHC believes that MedPAC's recommendation fails to address the true financial status of home health agencies. The recommendation is based on an incomplete analysis of Medicare cost report data that excludes a significant segment of home health agencies, ignores essential home care service costs, and relies on a methodology that treats home health services as if it were provided by one agency in just one geographic area. If accepted, the MedPAC recommendation will severely compromise continued access to care.

In specific response to the recommendation, we note the following:

- The Medicare home health prospective payment system (HHPPS) has been found to be seriously flawed and extremely ineffective at predicting the costs of care delivery. As a result, care for some types of patients can be reimbursed at significantly higher rates than agencies' care costs while Medicare reimbursement for other patients is woefully inadequate. MedPAC has found that the payment distribution system of HHPPS fails in over 75% of the case categories to fairly set rates in relation to the level of care. Payment is either significantly lower or greater than justified for the level of care. These and other findings have lead Medicare to undertake a wholesale revision of HHPPS that is expected to take effect in January 2008.
- The considerable shortcomings in the home health PPS are further illustrated by a dramatic range in profits and losses among home health agencies (HHAs). About 31.0% of all HHAs experienced financial losses under Medicare in 2002; that figure increased to 33.0% in 2004. A 5-year freeze would increase the number of agencies with Medicare margins of zero or below to around 60%. These figures actually understate losses because Medicare cost report data excludes the costs of numerous items that are legitimate care expenses, such as telehealth services and respiratory therapy.
- MedPAC's financial analysis of Medicare home health agencies, alleging a 16% margin, is unreliable. First, it does not include any consideration of the 1723 agencies (21%) that are part of a hospital or skilled nursing facility. In some States, hospital-based HHAs make up the majority of the providers (MT 63.2%; ND 65.4%; SD 60.5%; OR 58.3%). These HHAs have an average Medicare profit margin of negative 5.3%. Second, the MedPAC analysis uses a weighted average, combining all HHAs into a single unit, rather than recognizing the individual existence and local nature of each provider. This approach fails to portray the real status of HHAs that are experiencing a wide range of financial results. Third, MedPAC fails to evaluate the impact on care access that occurs with the current wide ranging financial outcomes of HHAs. Instead, it sees a single national average profit margin as indicative of over 8,000 very diverse HHAs. When all HHAs are included in the analysis, the true average Medicare profit margin is 3.12%.
- With the existing HHPPS, an agency's mix of patients (case-mix) can result in significant profits or losses unrelated to efficiency or effectiveness of care Losses exist for agencies of all sizes and in all geographic locations that are a result of the flawed HHPPS. These agencies are essential care providers in their communities. An across-the-board cut or freeze would do tremendous financial damage to those agencies that are at break-even or losing money on Medicare. Further, it would interfere with Medicare's effort to solve payment rate concerns with a reformed HHPPS in the near term.
- Home health agencies are already in financial jeopardy as a result of Medicaid cuts and inadequate Medicare Advantage and private payment rates. Ongoing study of home health cost reports by the National Association for Home Care & Hospice indicates that the overall financial strength of Medicare home health agencies is weak, and expected to diminish further. In 2002, the average all-payor profit margin for freestanding HHAs was 2.53%. A more recent cost report data analysis indicates that the average all-payor profit margin for 2004 dropped to 1.55%.
- Current reimbursement levels have failed to adequately cover the rising costs of providing care, which include: increasing costs for labor, transportation, workers' compensation, health insurance premiums, compliance with the Health Insurance Portability and Accountability Act and other regulatory requirements, technology enhancements including telehealth, emergency and bioterrorism preparedness, and systems changes to adapt to the prospective payment system (PPS).
- A loss of the market basket inflation update could leave home health providers no alternative but to cut down on the number of visits per episode or avoid cer-

tain high-cost patients, which could have potential adverse consequences on a patient's clinical outcome. It would be difficult for HHAs to continue to lower visit frequency without compromising quality of care. Outcome Concept Systems, a national home health benchmarking firm, has found, in general, that reductions in average visits below 20 visits per episode (the current average is around 18) result in lower outcome scores.

- Medicare home health services reduce Medicare expenditures for hospital care, inpatient rehabilitation facility (IRF) services, and skilled nursing facility (SNF) care. For example, a study by MedPAC shows that the cost of care for hip replacement patients discharged to home is $3500 lower than care provided in a SNF and $8000 less than care provided in an IRF, with better patient outcomes.
- Home health agencies have already experienced a disproportionate amount of cuts in reimbursement as a result of the Balanced Budget Act of 1997 (BBA). For example, under the BBA, Congress expected to reduce Medicare home healthcare outlays in FY 2006 from a projected $40.4 billion to $33.1 billion. The Congressional Budget Office (CBO) now estimates that home health outlays for FY 2006 were $13.1 billion. This reduction is far in excess of the reduction originally envisioned by Congress, and already has had a profound impact on beneficiary access to care and home health agency (HHA) financial viability. Home healthcare as a share of Medicare spending has dropped from 8.7 percent in 1997 to 3.2 percent today. By 2015 it is projected to drop to 2.6 percent of total Medicare spending.
- Over the past 10 years, the Medicare home health benefit has been cut nearly every year placing serious financial strains on home health agencies:

Year	**Impact**
FY 1998–1999	Home health interim payment system (IPS) was implemented. During 2 years under IPS Medicare spending for home healthcare dropped from $17.5 billion to $9.7 billion and the number of Medicare beneficiaries receiving home health services dropped by 1 million. Over 3,000 home health agencies closed their doors.
FY 2000	Home healthcare's inflation update was cut by 1.1 percent.
FY 2002	Home healthcare's inflation update was cut by 1.1 percent.
FY 2003	Home healthcare total expenditures were cut by 5 percent off previous year's rates.
CY 2004 (¾ of year)	Home healthcare's inflation update was cut by 0.8 percent.
CY 2005	Home healthcare's inflation update was cut by 0.8 percent.
CY 2006	Home healthcare's inflation update of 3.3 percent was eliminated.

NAHC recommends that Congress reject any efforts to reduce the home health inflation adjustment and support a full market basket update for Medicare home health services. NAHC suggests that relying on the ongoing efforts to reform the Medicare Home Health Prospective Payment System is a better approach to address any concerns with payment rates. Those efforts are intended to target payment changes in a manner that more closely aligns the rate to the level of service required by the patient avoiding excess reimbursement unrelated to patient care. Those efforts are expected to be implemented in January 2008.

Mr. Chairman, NAHC appreciates the opportunity to provide these comments to the Committee on Ways and Means Subcommittee on Health on Medicare home care payment adequacy. We look forward to working with the Subcommittee as it studies and considers NAHC's recommendations on MedPAC's report to Congress

Statement of Bruce Yarwood

Chairman Stark, Ranking Member Camp, and Members of this Committee, thank you for allowing us the opportunity to outline our views—based on our direct experience—that the Federal Government's approach to funding Medicare and Medicaid all too often conflicts directly with our shared goal of sustaining and improving the quality of patient care for America's seniors and people with disabilities.

The matter at hand is relatively simple. When Medicare funding for skilled nursing services is stable, quality of care and services improves. When Medicare funding is inconsistent and unstable, our nation's long term care infrastructure deteriorates, to the detriment of every senior today and every retiree tomorrow.

We are appreciative of comments voiced in the past by Members of this Committee that considering Medicare and Medicaid funding policies in isolation is shortsighted. We agree, and believe the Medicare Payment Advisory Commission's (MedPAC's) recommendation that there should be no annual inflation update is ill-advised, fails to accurately assess long term care funding necessities, and will contribute to the deterioration of our nation's long term care system at a time when every stakeholder can least afford it. Federal Reserve Board Chairman Ben Bernanke testified on Capitol Hill just yesterday that Congress "must budget for the rising costs of retirement and medical benefits or face a 'fiscal crisis' in coming decades."

Unfortunately, the Administration's proposed FY 2008 Budget incorporates MedPAC's most recent recommendation regarding the market basket adjustments for skilled nursing facilities. As a result, the proposed overall budget would cut Medicare funding for skilled nursing care by $10 billion over 5 years. Cutbacks of this magnitude will not only threaten the progress we have achieved working with the Federal Government to improve care quality, but could impact seniors' access to much-needed quality long-term care.

In addition, the Congressional Budget Office's (CBO's) new "Budget Options" report to Congress also warns that reducing update factors "might lead to certain patients having difficultly obtaining post-acute care." The report also states, "To the extent that patients faced limited access to post-acute care, they might either remain longer in a short-stay hospital, return home without receiving post-acute care, or be discharged to receive long-term care not covered by Medicare. By reducing the revenue of providers, this option might also limit their ability to provide high-quality care."

It is noteworthy, Mr. Chairman, that America's nursing home providers have led the quality movement. Our sector's leadership—which is reflected in the Quality First Initiative and our partnership with the Federal Government's successful Nursing Home Quality Initiative (NHQI) and recently launched Advancing Excellence in America's Nursing Homes campaign, has helped to improve the overall quality of care in our nation's nursing homes. We remain committed to sustaining these quality improvements for the future.

MedPAC's Recommendations Would Jeopardize Quality of Care

We fear implementation of MedPAC's recommendations would seriously jeopardize ongoing quality improvement because, among other negative variables, operating margins would be driven to dangerously low levels. Skilled nursing facilities already have the lowest operating margins of all major healthcare provider providers.

Given the dramatic cost increases we face in key areas including labor, energy, liability and capital, not providing an annual update is wholly inadequate to maintaining our gains in care quality, especially as these cost increases stem from factors beyond providers' control. For example, the shortage of nurses and other direct care workers coupled with the fact that long term care must compete with other employers both within and outside the healthcare sector for these employees, contributes significantly to increasing labor costs. In addition, we must adjust to the ripple effect that the minimum wage increase will surely have throughout our profession. So, when operating margins are further reduced, we are far less able to recruit and retain qualified care givers, modernize and refurbish aging physical plants and equipment, acquire and implement new technologies to accommodate advances in medical practices, and meet the increasingly complex care needs of an aging population.

MedPAC Must Also Consider Medicaid

MedPAC's exclusive focus on Medicare margins in the long term care sector does a disservice to those poor frail, elderly and vulnerable individuals who receive care and services in America's nursing homes. By ignoring Medicaid operating margins, MedPAC's analysis and recommendations do not present an accurate picture of the

long term care marketplace. Medicaid is responsible for funding the care for 66% of patients in America's nursing homes, and those nursing homes lose an average of $13 per Medicaid patient, per day.

MedPAC's continuing and exclusive focus on Medicare ignores the real and growing interdependence between Medicare and Medicaid. While 66% of skilled nursing facility patients receive Medicaid benefits, those benefits account for only half of nursing facility revenues. Given that the prevalence of Medicaid patients in our nation's nursing facilities is four times that of the acute care sector, special consideration of the relationship between Medicare and Medicaid seems particularly relevant to nursing facility care. While MedPAC does not include Medicaid as a determinant in recommending government funding policy, the millions of Medicaid patients who rely upon the care we provide do not have the luxury of ignoring the broken funding relationship between both programs.

MedPAC's Recommendations for Skilled Nursing Facilities Should Be Rejected

It is a public policy error for MedPAC to dismiss the Medicare-Medicaid "cross subsidization" issue as irrelevant to the debate at hand—despite the fact it has specifically acknowledged this phenomenon in the past—which is certainly noteworthy. On that basis, MedPac's recommendations should be rejected, and we make the following recommendations:

- Congress should reject MedPAC's recommendations for skilled nursing providers, and should maintain the full market basket for FY 2008.
- Congress should amend MedPAC's charter to require the Commission to consider operating margins of all government payers and the adequacy of all government funding in making its recommendations. This approach will enhance economic stability and quality improvements.
- Congress should require that MedPAC factor into its recommendations long term care's progress in improving quality. Funding volatility undermines providers' ability to remain focused on continuous quality improvement.

Mr. Chairman, America's seniors cannot afford another setback generated by the continuing failure in Washington to recognize the tangible, growing relationship between payment policies and quality objectives. Our recommendations concerning MedPAC offer an approach that avoids such a negative scenario, and properly prepares the nation's long-term care infrastructure for the challenging task ahead.

Thank you for the opportunity to offer these comments on behalf of millions of professional, compassionate long-term caregivers and the millions of frail, elderly, and disabled Americans they serve each day.