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HEARING ON MEDPAC'S MARCH REPORT ON MEDICARE PAYMENT POLICIES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

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HEARING ON MEDPAC'S MARCH REPORT ON MEDICARE PAYMENT POLICIES

WEDNESDAY, MARCH 1, 2006

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

The Subcommittee met, pursuant to notice, at 3:28 p.m., in room 1100, Longworth House Office Building, Hon. Nancy L. Johnson (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, 2006
No. HL–12

CONTACT: (202) 225–3943

Johnson Announces Hearing on MedPAC's March Report on Medicare Payment Policies

Congresswoman Nancy L. Johnson (R–CT), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on the Medicare Payment Advisory Commission's (MedPAC) March report on recommendations on Medicare payment policies. **The hearing will take place on Wednesday, March 1, 2006, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 3:00 p.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include Glenn Hackbarth, Chairman of MedPAC, as well as provider groups affected by the MedPAC recommendations. 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:

The MedPAC advises Congress on Medicare payment policies. The Commission 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, the Commission 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 health care.

In announcing the hearing, Chairman Johnson stated, "The MedPAC provides valuable advice to Congress on Medicare payments for providers, and this information is important as we continue to explore how to strengthen the Medicare program for our Nation's seniors. This hearing will offer the Subcommittee an opportunity to pursue the Commission's recommendations and various providers' responses to these recommendations."

FOCUS OF THE HEARING:

The hearing will focus on MedPAC's March recommendations on Medicare payment policies.

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 "*109th Congress*" from the menu entitled, "*Hearing Archives*" (*http://waysandmeans.house.gov/Hearings.asp?congress=17*). 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 Wednesday, March 15, 2006. **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, 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 JOHNSON OF CONNECTICUT. This hearing will come to order.

Welcome, Mr. Hackbarth. It is a pleasure to have you before us again.

This hearing is to discuss the report that the Medicare Payment Advisory Commission (MedPAC) has issued, proposing updates in every area for the next year. The Medicare Program is, as we all know, extremely complex, and the discussions made by policymakers must be well reasoned and based on accurate, timely information. We appreciate the hard work that you and your excellent staff do to provide us with that information, and we look forward to working with you to meet the challenges that we must meet in the next 6 months. The Commission reviews a variety of factors in making its payment recommendations, including providers' financial profitability, their access to capital, their cost, increase or decreases in the number of available providers, and beneficiary access to care.

In reviewing the Commission's analysis of the various payment systems, we need to ensure that we explore any potential inconsist-

encies or problem areas in the analysis and the views of the provider groups most directly affected by the recommendations, and we will hear from some of those provider groups today. Some that we aren't hearing from today, we aren't hearing from because we are going to have a series of hearings taking each provider community that is involved in post-acute care singularly, and so we will have a chance to go in depth on some of the issues affecting home health and other sectors that aren't represented here today. I want that to be clearly understood.

I do also want to mention in my opening comments that I do have concerns regarding the traditional factors that we have always considered, may not be giving us a clear enough picture of the state of the delivery system, that is, a picture that will enable us to make the policy decisions that we need to make at this time. We have so much happening between the nonprofit and for-profit sectors, the development of new technologies in both the diagnostic and treatment sectors, which our payment system doesn't very easily accommodate or reflect, and cost pressures on all of the groups we need to deliver care, like nursing salaries, fringe benefit costs, energy costs and malpractice costs, that it is hard for the system to capture this state of health of all of the actors in the delivery system, and particularly to distinguish or to understand the meaning of, in a sense, bad figures, or bad trends.

I feel myself like we need to talk more about—and we have talked a little bit about this, you and I—that we need to go beyond the study of industry's margins, to what are the interactions that are happening, and how do we move toward a system that does what the Medicare Modernization Act (MMA) envisioned, P.L. 108–173, which is swinging Medicare from entirely an illness-treatment model to a health management and preventive model. I think the responsible way to control Medicare's cost growth is through focusing on the 20 percent of the seniors who use the 80 percent of the dollars. They are all people with five or more chronic illnesses.

No fee-for-service has been skilled at dealing with the health problems of that type of population, and in the Medicare Modernization Act, we tried to set the predicate to move in that direction, both through mandates to the plans and through demonstrations in the fee-for-service arena.

We are going to have some testimony here today that will go directly to that issue of how do we move to a system that is capable of reimbursing for a more holistic approach to health care as opposed to illness treatment. Mr. Stark, welcome.

Mr. STARK. Thank you, Madam Chairman.

Chairman JOHNSON OF CONNECTICUT. If you would like to say a few words, then we will go directly forward to Mr. Hackbarth.

Mr. STARK. I would love to say a few works. Thank you for the hearing, which we haven't done for 3 years, and it used to be a routine. I hope it will start again.

Mr. Hackbarth, I hope you won't take the sparse attendance as an indication of our interest, but you just happened to pick a time when we quit early, and I think people scattered after the last vote. It would have been helpful to have the Centers for Medicare and Medicaid Services (CMS) here today instead of having them hide

behind your excellent report, and trying to get you to justify the cuts.

The President's budget took your name and many recommendations, I think, in vain, and extended policies for 3 years, and included a number of items that I am not sure you contemplated, or much less endorsed. I gather about a quarter of the President's proposed cuts are attributable to your recommendations, but the—it looks like they took the cuts in traditional Medicare and left off the recommendations which would have reduced payments to Heath Maintenance Organizations (HMOs) and Medicare, whatever that is called, aid, Medicare Advantage.

You have recommended, I think, since 2001, for 5 years, that we eliminate the HMO and Medicare Advantage, what I call overpayments, and I think you may classify them as that too. We discussed this last year, and I think we would have saved another 50 billion over 10 if we had followed your advice.

Without CMS here, we can't get a handle on this and discuss it, but I want to, as I say, welcome you here, and I hope it won't be your last appearance. I want to thank your staff. They have been extraordinary. I think Mark Miller will cringe, but I want to recognize him and thank him for his efforts at keeping us informed of what is going on, and I look forward to your testimony, and I know you will enlighten us on a whole host of issues that are rightly important to the Medicare Program. Thank you.

Thank you, Madam Chair, for having these hearings.

Chairman JOHNSON OF CONNECTICUT. Thank you, Mr. Stark. Mr. Hackbarth.

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

Mr. HACKBARTH. Thank you, Chairman Johnson, Mr. Stark, and the Members of the Subcommittee.

As MedPAC pursues its work, we come back over and over again to three basic themes. One is that we strive to assure that the Medicare payment systems pay fairly and accurately for the services provided. By fairly and accurately, we mean that the rates paid, for example, reflect the complexity of a patient or the risk assumed by a private health plan. You are familiar with recommendations we have made in that spirit to refine the payment system for hospitals, the Diagnostic Related Group (DRG) refinement proposals that were in our specialty hospital report.

In this March report, published today, we have a series of recommendations about improving the physician payment system, the relative value system, to assure that those payments are more accurate. A second theme that we come back to frequently is that we want to reward improvements and quality, and you are well aware of the series of recommendations that we have made, encouraging pay-for-performance within Medicare. Third, we come back to a theme of encouraging improvement in efficiency in the delivery of care, and that is a very important aspect of our update analysis that is in this March report. To the extent that we can achieve these goals, we will increase the value of the Medicare Program both for Medicare beneficiaries and for taxpayers.

Now, the Commissioners bring to this task a wide range of experience and perspectives and political viewpoints. As you know, MedPAC has 17 members. Seven of our members are trained as clinicians, either physicians or nurses. Eight of us have experience as executives, high-level executives or board members of health care provider organizations. Six of us have high-level experience working with the Congress as senior staff, or in support agencies like CBO, or working in CMS. There are a number of us who have experience of all three types. I daresay that every one of us has at least one loved one who is a Medicare beneficiary. I emphasize this point just to highlight that we are all people with a stake in the welfare of the Medicare Program. We want it to work well. We all have a lot of experience with how it does operate, and we try to bring that to bear on your behalf.

In formulating our recommendations, I, as Chairman, have always sought to do that by consensus. I think it enhances the power of our work if we have substantial majorities in favor of our recommendations, not necessarily always unanimous recommendations, but very large majorities. In this case, in this March report, the one before you today, you will note that all of our recommendations are unanimous, so all 17 members of this diverse commission have supported these recommendations.

The March report, as Chairman Johnson indicated, is largely devoted to update recommendations for 2007, and thus, the related goal of improving efficiency in the program. In formulating our recommendations for updates, what we are trying to do is, through this administered price system, or a series of different administered price systems, mimic after a fashion what might happen in a competitive marketplace.

One of the important benefits of a truly competitive marketplace is that there is consistent, some would say, relentless, pressure to improve efficiency, and indeed, the taxpayers, who pay for the Medicare Program, experience that pressure all of the time, whether they are individual workers who experience it in terms of foreign competition for their jobs effecting their wages and benefits, or whether they have a job at all, or whether they are corporations who face those pressures on their profits in balance sheets. We believe it is entirely fitting that Medicare providers, through these administered price mechanisms, face that sort of relentless pressure to improve their efficiency. That is what fairness to the taxpayers requires.

I won't spend a lot of time going through the individual recommendations on updates. I will, obviously, be happy to talk about them in response to questions. I do want to highlight, however, that often our recommendations are cast as market basket minus some figure, so it is less than the market basket. Sometimes they are characterized as lower than the budget baseline, and we often hear that, oh, that is a cut that is being recommended by MedPAC. MedPAC is endorsing a cut in the hospital payments. Let me focus on hospitals. For example, our recommendation there is the market basket minus one half of our usual productivity expectation, and that works out to—based on the most recent projection of the market basket—to a 2.95-percent increase in rates. Where I come from

in Oregon, that is an increase, that is not a cut. I hope that is clear.

I also want to emphasize that although they are not included in our March report, we did make a series of recommendations about the Medicare Advantage Program in our June 2005 report. The theme of those recommendations was to achieve our longstanding goal, recommendation, that there be a neutral choice offered to Medicare beneficiaries between the traditional fee-for-service program on the one hand, versus enrollment in a private plan on the other.

Finally, I just want to highlight that in our March report, although it is largely devoted to update recommendations, we do have a couple recommendations related to refining the payment systems to assure fairness and accuracy. One State has to do with the physician payment systems, RVUs. There is also a very important recommendation for refining the payment system for skilled nursing facilities. I look forward to your questions.

[The prepared statement of Mr. Hackbarth follows:]

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

Chairman Johnson, Ranking Member Stark, 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. 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 health care providers. Medicare can and should take the lead in initiating changes to the health care system. But to encourage more thorough improvements in quality and efficiency, Medicare should work in collaboration with other payers.

Our March report to the Congress focuses on improving Medicare payment accuracy and calibrating payment adequacy to the efficient provider. The Commission reiterates its proposals to measure resource use and improve quality, to attain better value for the Medicare program. In this report, we review Medicare fee-for-service payment systems for eight sectors: hospital inpatient, hospital outpatient, physician, outpatient dialysis, skilled nursing, home health, long-term care hospitals, and inpatient rehabilitation facilities. Our analysis of payment adequacy for long-term care hospitals and inpatient rehabilitation facilities is the first for these sectors under their new prospective payment systems. The Commission's goal in all payment systems is for Medicare payments to cover the costs efficient providers incur in furnishing care to beneficiaries.

While this report focuses on Medicare's fee-for-service payment systems, our June 2005 report made recommendations on the Medicare Advantage program. Generally, these recommendations are intended to improve neutrality between the Medicare Advantage and fee-for-service program and among Medicare Advantage plans. The Commission strongly supports giving Medicare beneficiaries a choice to join private plans, because these plans have greater flexibility to improve the efficiency and quality of beneficiaries' health care services. The Commission has long recommended that the program should be financially neutral as to whether beneficiaries join private plans or remain in fee-for-service Medicare.

We also recommend improvements to the process for determining relative values in the physician payment system and continue to evaluate the relative payments for different services within other prospective payment systems (PPSs). Last year we made recommendations on improving payment accuracy within the inpatient hospital and skilled nursing facility PPSs. We reiterate our recommendations on the SNF PPS in this report. For the inpatient payment system we recommended in our March 2005 report on specialty hospitals four steps to improve payment accuracy:

refine the system to more fully capture differences in severity of illness, base relative weights on estimated cost instead of charges, base weights on the national average of hospitals' relative values, and adjust relative weights for prevalence of high-cost outlier cases.

Over the course of the last two years, the Commission has recommended that Medicare create incentives to improve quality through its payment systems. This approach builds upon the experience of private purchasers in designing and running pay-for-performance programs that reward health care providers for improving the quality of care. The Institute of Medicine and others have pointed to the quality gaps in the American health care system. While Medicare already has some programs in place to improve quality, these are not enough to orient the whole system towards improving quality; nor is it equitable for Medicare to pay a high quality provider the same as one that furnishes poor care.

Medicare should start differentiating among providers by paying more for higher quality performance and less for poor quality. This change to Medicare's payment systems is urgently needed. Currently, Medicare pays providers the same regardless of their quality. We have recommended pay-for-performance programs and that the Congress direct the Secretary to set quality standards for all providers who bill Medicare for performing and interpreting diagnostic imaging studies—which represents a major change in Medicare's payment policy. While some providers have raised concerns about aspects of a pay-for-performance program, these concerns must be weighed against the costs of not moving forward: allowing the program to reward poor care and not recognize quality care. Because Medicare is such an important part of the American health care system, it can be very influential in transforming the incentives in the broader health care system.

The Commission has concluded that pay for performance is ready to move forward in five settings—hospital, physician, home health, Medicare Advantage, and end-stage renal disease. The Commission has also recommended that Medicare measure resource use of physicians and feed this information back confidentially to them. The Commission is exploring measurement of resource use and evaluating its use in pay-for-performance programs. These are important steps to improving quality for beneficiaries and laying the groundwork for obtaining better value in the Medicare program.

While these recommendations will improve the current payment systems, as the new prescription drug benefit begins, new types of private plans enter the program, and new payment systems go into effect, new patterns of care will result. In particular, the Commission is conducting research on how beneficiaries learned about the drug benefit and what factors were important to them as they made decisions to enroll or not enroll in plans. We are also compiling baseline information on plan offerings for 2006 including: what organizations are offering plans; what type of plan they are offering (basic versus enhanced); and variations in premiums and benefit structures, including cost sharing and formularies.

In future work the Commission will analyze these changes and make recommendations to the Congress on how the new programs can be improved to increase their value.

Context for Medicare payment policy

Health care spending has been rising more rapidly than growth in national income for many decades, and all indications suggest that it will continue to do so into the future. The continuation of this trend, combined with the retirement of the baby boomers and Medicare's new prescription drug benefit, will lead the Medicare program to require unprecedented shares of GDP and federal spending.

Policymakers need to take steps now to slow growth in Medicare spending and encourage greater efficiency from health care providers. Delaying taking action will require more drastic changes to the program in the future. Strategies to address Medicare's long-term sustainability include constraining payment rates for health care providers, changing eligibility and benefits, increasing the program's financing, and encouraging greater efficiency from health care providers. The last strategy—increasing efficiency—is the most desirable because it would enable the Medicare program to do more with its resources. Even if policymakers succeed at moving providers towards greater efficiency, they may still need to make other policy changes to help ensure that the program is sustainable into the future.

Medicare and its beneficiaries are not alone in facing the challenges of rapid growth in health spending—all stakeholders in the U.S. health care system are confronting similar pressures. Medicare relies on providers and health plans that care for the entire population, not just Medicare beneficiaries, and thus broad trends in the health care system affect the environment in which the program operates.Medicare can and should take the lead in initiating changes to the health care

system. But to encourage more thorough improvements in quality and efficiency, Medicare should collaborate with other payers. For example, Medicare could use comparative-effectiveness analysis more readily if other payers do so as well, and a common set of measures for quality and resource use across payers would reduce the reporting burden on providers and magnify the impact of any public and private incentive programs.

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

We make update recommendations for one year at a time so that we can assess payment adequacy with the latest data each year. We answer the question of whether current Medicare payments are adequate by examining information about beneficiaries' access to care; changes in the capacity, volume, and quality of care; providers' access to capital; and, where available, the relationship of Medicare payments to providers' costs. Our assessment of the relationship between Medicare payments and providers' costs is influenced by whether current costs approximate those of efficient providers. Efficient providers use fewer inputs to produce quality outputs.

We then account for expected cost changes in the next payment year, such as those resulting from changes in input prices. As part of those considerations, we incorporate our expectation for improvement in productivity (0.9 percent for 2007). Medicare payment rates to health care providers should be set so that the federal government benefits from providers' productivity gains, just as private purchasers of goods in competitive markets benefit from the productivity gains of their suppliers. In developing its payment recommendations, MedPAC expects improvements in productivity consistent with the productivity gains achieved by the firms and workers who pay the taxes and premiums that support Medicare. The productivity factor is a policy objective, not an empirical estimate. To the extent that providers are unable to achieve this productivity target, that outcome would be revealed subsequently in MedPAC's analysis of payment adequacy, which is considered anew each year.

Hospital inpatient and outpatient services

Indicators of payment adequacy for hospitals present a mixed picture. Our assessments of beneficiaries' access to care, service volume growth, and access to capital are positive, while the results on quality are mixed. Regarding access to capital, hospital construction spending has been growing 15 percent annually since 1999 to an estimated $23 billion in 2005. However, the Commission is concerned that hospitals' overall Medicare margins are negative and that hospitals have had unusually large cost increases in recent years.

The rate of cost growth has been affected by unusual cost pressures, but it also has been influenced by the recent lack of financial pressure from private payers. Hospital costs appear to be influenced by cycles in private sector profitability. From 1986 through 1992, most insurers still paid hospitals on the basis of their charges, with little price negotiation or selective contracting. With limited pressure from private payers, the ratio of private-payer payments to hospitals' costs increased rapidly (Figure 1). In the mid-1990s, HMOs and other private insurers began to negotiate more vigorously for better prices and the payment-to-cost-ratio for private payers declined from 1993 through 1999. By 2000 hospitals had regained the upper hand in price negotiations due to hospital consolidations and consumer backlash against managed care and restricted networks. Private payer payment rates rose rapidly and the payment-to-cost ratio for private payers rose from 2000 to 2004.

TABLE 1 Growth in number of LTCHs, volume of cases, and Medicare spending

	2001	2003	2004	Average annual change 2001–2004
Number of LTCHs	273	319	357	9%
Number of cases	86,049	110,509	122,320	12
Medicare spending	$1.7 billion	$2.4 billion	$3.3 billion	25
Payment per case	$22,452	$25,076	$30,180	10
Length of stay (in days)	32.1	29.2	28.7	–4

Note: LTCH (long-term care hospital).

Source: MedPAC analysis of MedPAR data from CMS.

Cost growth during these same three periods followed the trends in private-payer profitability. In the last four years (2001 to 2004), increases in private-payer profit-

ability were accompanied by hospital costs rising at a rate faster than the market basket of input prices.

In addition, our analysis suggests that more efficient hospitals may not be performing as poorly as the industry's aggregate margin would suggest. High-cost hospitals have a significant effect on the industry's financial performance under Medicare. To illustrate, removing the roughly one fifth of hospitals with consistently high costs in both 2002 and 2004 raises the margin forecast by more than 2 percentage points. In addition, hospitals with consistently negative Medicare margins had above-average costs and cost growth, and these hospitals are not competitive in their own markets as evidenced by having higher costs and lower occupancy than neighboring facilities.

Balancing the payment adequacy indicators and concern about trends in margins and efficiency, the Commission recommends an update of market basket minus half of our expectation for productivity growth for both inpatient and outpatient hospital services. These updates should be combined with a quality incentive payment policy for hospitals and the improvements to the inpatient PPS relative values we recommended last year: refine the system to more fully capture differences in severity of illness, base relative weights on estimated cost instead of charges, base weights on the national average of hospitals' relative values, and adjust relative weights for prevalence of high-cost outlier cases. Although CMS has taken some steps to make payments more accurate for certain DRGs, ensuring payment accuracy across the board is necessary to make payments equitable and to lessen inequities resulting from selection.

Physican services

Our analysis of beneficiary access to physician care, physician supply, Medicare-to-private fee level comparisons, and the growth in physician service volume finds that many of these indicators are stable and shows that the large majority of beneficiaries are able to obtain physician care. Beneficiaries' access to physicians is similar to, or even better than, access for those with private insurance and has been stable. Averaged across all services and areas, the ratio of Medicare payment rates versus private payment rates rose slightly from 2003 to 2004. Additionally, the volume of services used per beneficiary continues to grow significantly, which has led to considerable spending increases. In consideration of expected input costs for physician services and our payment adequacy analysis, the Commission recommends that the Congress increase payments for physician services by the projected change in input prices less our expectation for productivity growth for 2007.

In contrast to this recommendation, current law calls for substantial negative updates from 2007 to 2011, under the sustainable growth rate (SGR) formula. The Commission does not support these sustained fee cuts because they could threaten beneficiary access to physician services. The Commission is especially concerned about the effect of rate cuts on access to services provided by primary care physicians and in the longer term about the attractiveness of primary care to new physicians. Furthermore, the Commission considers the SGR formula a flawed, inequitable mechanism for volume control. Over the next year, the Commission will examine alternatives to the SGR formula as mandated by the Deficit Reduction Act of 2005.

Valuing services in the physician fee schedule

Relative value units (RVUs) are a key element of Medicare's physician fee schedule. They determine how payment rates vary among the more than 7,000 services that physicians furnish to the program's beneficiaries. Periodic review of RVUs is important because the resources needed to perform a service can change over time. When that happens, the value of a service must be changed accordingly; otherwise, Medicare's payments will be either too high or too low.

Because the current system does a poor job of identifying overvalued services, we recommend improvements to the process for determining relative rates paid for services in the physician payment system. Inaccurate rates distort the market for physician services, and the Commission is concerned that in the long run they may affect the supply of physicians—in particular those providing primary care services. The Commission recommends improvements to the process that will help reduce the number of physician fee schedule services that are misvalued, thereby making payment more accurate.

The Commission recommends that the Secretary establish a standing panel of experts to help CMS identify overvalued services and to review recommendations from the American Medical Association's Relative Value Scale Update Committee (RUC), and that the Congress and the Secretary ensure that this panel has the resources it needs to independently collect data and develop evidence. In consultation with

this expert panel, the Secretary should initiate reviews for services that have experienced substantial changes in factors that may indicate changes in physician work and identify new services likely to experience reductions in value. Those latter services should be referred to the RUC and reviewed in a time period as specified by the Secretary. Finally, to ensure the validity of the physician fee schedule, the Secretary should review all services periodically.

Outpatient dialysis services

Most indicators of payment adequacy for outpatient dialysis services are positive. Beneficiaries are not facing systematic problems in accessing care. Providers are increasing capacity to meet patients' demand (as demonstrated by the increasing number of facilities and hemodialysis treatment stations), spending is increasing, and providers have sufficient access to capital. The quality of care is improving for some measures—dialysis adequacy and anemia status—and unchanged for others. Although most of the indicators for payment adequacy are positive, the Commission is concerned about the trend and level of Medicare margins for outpatient dialysis services. Balancing these considerations, the Commission recommends increasing the composite rate in 2007 by the projected rate of increase in the end-stage renal disease market basket less half of the Commission's expectation for productivity growth.

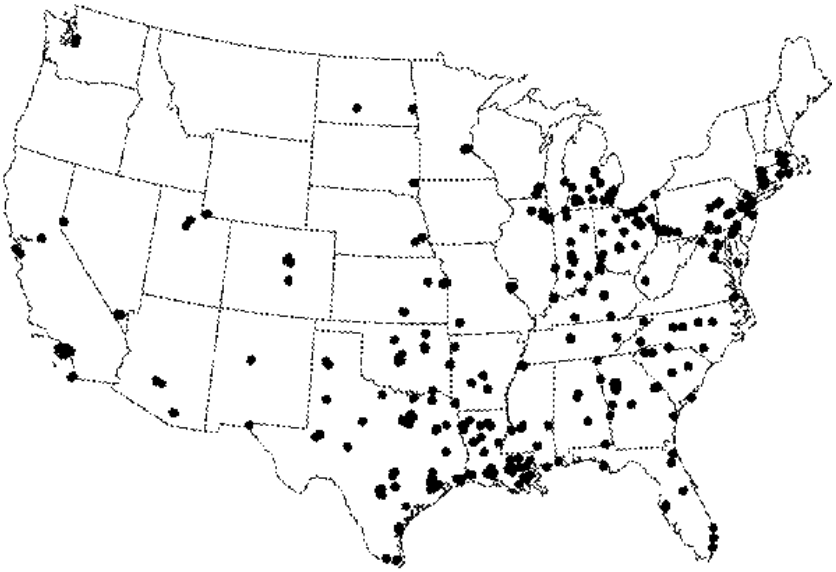
In addition to updating the composite rate, to improve equity in payments between provider types the Commission reiterates its recommendation that the Congress eliminate payment differences between freestanding and hospital-based facilities for composite rate services and combine the composite rate and the add-on payment.

Post-acute care providers

The recuperation and rehabilitation services that post-acute care providers furnish are important to Medicare beneficiaries. Medicare spending on post-acute care services totaled about $36 billion in 2004, accounting for more than 12 percent of total Medicare spending. After slowing in the late 1990s when CMS implemented the Balanced Budget Act of 1997, spending and the number of providers have risen (Figure 2). The number of home health agencies increased by 10 percent in the last year alone, and there were over 50 percent more long-term care hospitals in 2005 than in 2000. The rise in spending is the result of both higher payments and greater use.

FIGURE 1

Location of long-term care hospitals



Source: Online Survey, Certification, and Reporting System from CMS

We have analyzed payment adequacy for each of the four types of post-acute care providers: skilled nursing facilities (SNFs), home health agencies, long-term care hospitals (LTCHs), and inpatient rehabilitation facilities (IRFs). The payment systems for all four of these providers face similar issues:

- payments are not well calibrated to costs,
- services overlap among settings,
- the post-acute care product is not well defined, and assessment instruments differ among settings.

These issues make it difficult to get better value for Medicare spending across the spectrum of post-acute care.

New prospective payment systems for post-acute care providers have led to changes in the patterns of post-acute care use, which may not serve the program or beneficiaries well. We have called for action to slow payments refine the case-mix systems, and measure quality of care. However, even refining all of the case-mix systems would still not resolve issues of whether patients go to the right post-acute care setting or whether they need post-acute care at all. There is still a need for comprehensive payment system reform across all PAC settings.

Skilled nursing facility services

Most indicators of payment adequacy for SNFs—access to care, supply, spending, quality, access to capital—are stable, and the volume of services continues to increase. In addition, the Medicare margin for SNFs continues to be high and SNF payments appear more than adequate to accommodate cost growth. Therefore, the Commission recommends that the Congress eliminate the update to payment rates for skilled nursing facility services for fiscal year 2007.

CMS's refinements to the SNF case-mix system in 2006 did not address long-standing problems with the allocation of SNF payments. Therefore, the Commission once again recommends that the Secretary modify the SNF PPS to more accurately capture the cost of providing care to different types of patients. This new system should: reflect clinically relevant categories of patients, more accurately distribute payments for nontherapy ancillary services, improve incentives to provide rehabili-

tation services based on the need for therapy, and be based on more contemporary data than the current system. We will continue work to further define such a new system.

Currently, CMS has only three quality indicators for SNF patient care, all of which are limited. Medicare urgently needs quality indicators that allow the program to assess whether patients benefit from SNF care and to distinguish between facilities. The Commission recommends that CMS:

- collect information on activities of daily living at admission and at discharge;
- develop and use more quality indicators, including process measures, specific to short-stay patients in skilled nursing facilities; and
- put a high priority on developing appropriate quality measures for pay for performance.

Home health services

Evidence suggests that access to home health services is good: communities across the country have providers and more providers are entering the program. In addition, the quality of care continues to improve slightly, and the number of users and the amount of services that they use are rising. These factors, along with more than adequate margins, suggest that agencies should be able to accommodate cost increases over the coming year without an increase in base payments. Therefore, the Commission recommends that the Congress eliminate the update to payment rates for home health care services for calendar year 2007.

The Commission continues to be concerned about aspects of this payment system. There is some evidence that payments are not being distributed accurately within the system. The number of visits per episode and the mix of the type of visits (therapy, skilled nursing, and aide) have changed substantially since the payment system was developed and hence, the payment system may not now accurately predict the relative costliness of episodes. Ideally, the system's adjustments should bring payments closer to costs. The Commission will continue to investigate improvements to the payment system.

Long-term care hospital services

This year, for the first time under the new prospective payment system, the Commission assesses the adequacy of payment for long-term care hospitals. LTCHs provide care to patients with clinically complex problems who need hospital-level care for extended periods of time. Medicare is the predominant payer for long-term care hospital services.

Medicare payments for LTCH services are more than adequate. The supply of LTCHs, the volume of services, and the number of beneficiaries admitted to LTCHs have all increased rapidly since 2001. Changes in quality are mixed and access to capital is good. Moreover, Medicare spending for these facilities increased twice as fast as volume, and in 2004 alone, spending increased almost 38 percent. This increase is due in part to patients being assigned to higher payment categories—some because of increases in patient complexity and some because of coding improvements. Margins in this sector have been high.

The Commission concludes that long-term care hospitals should be able to accommodate cost changes in 2007 and therefore recommends that the Congress eliminate the update to payment rates for LTCH services for 2007.

Inpatient rehabilitation facility services

This year, also for the first time under the new prospective payment system, the Commission is assessing the adequacy of payment for inpatient rehabilitation facilities. IRFs provide intensive rehabilitation services. To be eligible for treatment in an IRF, beneficiaries must be able to tolerate and benefit from three hours of therapy per day.

Indicators of payment adequacy were generally positive through 2004. Supply and volume increased, quality was stable, and access to capital was good. Medicare payments grew rapidly from 2002 to 2004, resulting in high margins for IRFs. Regulatory changes and industry trends complicate analysis of this sector affecting both volume of services and financial performance. However, we estimate margins will still be more than adequate and that IRFs can accommodate price changes without an increase in payments. Therefore, the Commission recommends that the Congress eliminate the update to payment rates for inpatient rehabilitation facility services for fiscal year 2007.

Chairman JOHNSON OF CONNECTICUT. Thank you very much, Mr. Hackbarth. I wanted to first just ask in a general sense, when your information indicates that the average hospital has a negative 2.2 Medicare margin, which indicates to me that more than 50 percent of the hospitals have a negative Medicare margin. How then, under those circumstances do you rationalize a reduction in market basket for productivity? If I were losing 2 percent, I would be looking everywhere I could to increase productivity, and I wouldn't need another reimbursement cut from often a major payer, usually a major payer, to remind me that I needed to be more productive.

Mr. HACKBARTH. Well, the Commission, of course, is concerned by the trend in hospital margins. We have a number of hospital members on the Commission, and, of course, they share with us their experience and how things are going in their institutions. We don't take that lightly, but we do try to look behind that number, and assess why there has been this fairly significant decline in Medicare margins over the last several years. As we look at the data, what we see is there has been a very rapid—compared to historical experience—very rapid increase in cost per case.

Now, part of that has been attributable to factors that you well know, like increases in wages for nurses or malpractice insurance expense and the like. We believe another very important factor in the rate of increasing cost per case has been on the private side of the ledger, not what is going on with Medicare, but how hospitals have been interacting with private payers. What we have seen in the last five or 6 years, the years since the infamous, notorious backlash against managed care, is that there has been a dramatic change in our private payment to hospitals. In part that is because of changes in how private insurance is configured. They have gone to products that reduce the private payers' leverage in negotiating with hospitals. In part it is attributable to the fact that there has been a lot of consolidation within the hospital industry, and they are more powerful at the negotiating table.

For a combination of reasons, though, there has been a very significant acceleration in the rate of private payments to hospitals. Now, hospitals have responded to that increase in revenue by spending a lot of it, and it spills over into their Medicare cost structure. We think part of the increase is due to factors beyond a hospital's control. Part of it is due to factors within hospital control that are in turn influenced by private payment policies. We don't think Medicare should accommodate increases in cost that are driven by a relaxation of private payment policies.

A second piece——

Chairman JOHNSON OF CONNECTICUT. Go ahead.

Mr. HACKBARTH. Could I just go on for one moment?

Chairman JOHNSON OF CONNECTICUT. Yes.

Mr. HACKBARTH. The second piece of analysis that we conduct is in pursuit of a change in our statutory mandate that was included in the MMA. Our statutory mandate was amended to ask us to base our update recommendations on analysis that includes consideration of efficient hospitals, efficient providers of all categories. in a variety of ways we try to look not just at the average hospital, but assess the resources required by efficient hospitals.

One piece of analysis that we have done looks at the hospitals that consistently lose money under Medicare, and what we find when we look at those hospitals is that the consistent losers tend to have higher cost per case, more rapid increases in their cost, smaller reductions in average length of stay, compared to their peer hospitals in their same markets. In addition, they also have lower occupancy rates.

The consistent losers under Medicare seem to be performing less well compared to their own peers, and to the extent that that is the case, we shouldn't be gearing Medicare policy to assure that they make a profit, consistent with the efficient provider mandate.

Chairman JOHNSON OF CONNECTICUT. I thank you for that explanation. I think we need to look behind it though, because the need for our institutions to invest significant amounts of money in technology, significant amounts, hundreds of thousands in training people to use the technology, both medical technology and information technology—but the next round on the horizon is information technology—is extremely important to the future of the whole health care system. To have so many hospitals, the majority of your hospitals—in some of the testimony someone says 70 percent with negative margins—does indicate that we might slow that development which will both help control costs and certainly, by reducing medical errors and reducing administrative cost, but also in managing chronic disease, and keeping people out of the high-cost setting.

Although I hear what you are saying, I think, at least I don't know, maybe, but to what extent did you look at the state of the hospitals before the private sector reimbursement started going up? In other words, did they start going up because—I have seen examples of this. The hospital just couldn't take it any more and just said, "We are not going to serve you because we can't." In other words, between our reimbursement squeeze and the private sector's reimbursement squeeze, I saw a lot of deferred maintenance, I saw a lot of tensions growing, a lot of nurse personnel problems across the board. My view of the turnaround wasn't that all of a sudden they got up the courage to ask for luxurious reimbursements, but because they couldn't stay open if they didn't turn the thing around.

The higher payments from the private sector, I mean, I don't know. I hear you saying that you don't think so, but I don't see the data on which you base your thought that you don't think that the increase in private payments, which flowed over into public payments, was the result of actual need to run an institution that was state of the art, that had the latest technology, and so on and so forth. The picture that I got was—but I come from a State where the margins are—we have a CON and so on. We have high occupancy, but in my State, for over 10 years—and I don't know whether it is 12 or 14—the hospitals have run on plus or minus 1 percent.

Well, it is hard to run a big institution like that, and when you go through a period where everybody is pressing you, you don't buy the latest technology, and then you have to. You know, you defer maintenance and then you can't. Combined with the continue pressure from traveling nurses, malpractice and premium increases,

and so on, I don't interpret, though I think you do, the increase in private sector payments is somehow inappropriate, and is largely just profit. I see that as kind of saving the system.

This is a longer discussion, but I think in order to evaluate this you really have to go in and examine some of those hospitals that saw that severe turnaround, see what were the problems, how did it happen, and was it just that managed care became unpopular? I don't think it was just that managed care became unpopular, at least that is not what I saw in the instances that I am most familiar with.

This is a longer discussion, but I do worry, a lot, that the market basket minus this particular year with the majority of the hospitals minus, which are on the verge of health information technology and understanding how imperative it is to eliminating errors, to eliminating—to increasing quality, which you have been very good on pushing. I just fear that we are going to discourage the very one thing we know that could both improve quality and reduce cost.

I have been talking too long, and I am going to turn to Mr. Stark.

Mr. STARK. Thank you, Madam Chair.

Mr. Hackbarth, the March report does not address the Medicare Advantage payments, but your June report did, and you recommended that the payments to HMOs and other private plans be reduced so that they are——

Chairman JOHNSON OF CONNECTICUT. Mr. Stark, may I just intervene for a moment.

Mr. STARK. Yes.

Chairman JOHNSON OF CONNECTICUT. We do want to keep this, as much as possible, on this report because we are going to go back on those plans in a later hearing.

Mr. STARK. Okay. I just wanted to know when you first adopted the position of paying the private plans comparable rates to traditional Medicare. I believe it was 2001.

Mr. HACKBARTH. Thereabouts, yes.

Mr. STARK. Did the MMA go toward or away from your recommendations? Did we end up paying the plans more or less?

Mr. HACKBARTH. Under MMA, payments increased relative to fee-for-service levels.

Mr. STARK. Had we followed your recommendations—is $50 billion over 10 years a ballpark figure for the additional savings we might realize?

Mr. HACKBARTH. As you know, we don't do specific estimates of——

Mr. STARK. You have heard that number?

Mr. HACKBARTH. I have heard that number, yes, but I can't vouch for it.

Mr. STARK. All right. In 2004 or 2003, or whenever you recall, how many hospitals in the United States closed? Do you have any idea? Not mergers, but how many——

Mr. HACKBARTH. 2003, 2004, I don't know the exact number off the top of my head, but it is a relatively small number. There actually have been more hospitals opening than closing.

Mr. STARK. Closing, 10, 20 maybe?

Mr. HACKBARTH. Maybe a little bit higher than that. A few dozen, I think.

Mr. STARK. Okay. Let's say 25 or 30.

Mr. HACKBARTH. Yes.

Mr. STARK. Out of 6,000.

Mr. HACKBARTH. Yes.

Mr. STARK. Okay. On this figure of everybody with negative margins, they are talking about an average; the negative margin was minus 2, whatever it was.

Mr. HACKBARTH. Yes, that is our projection.

Mr. STARK. Do you know what the median was on that?

Mr. HACKBARTH. Again, I don't have that off the top of my head, but I can get you that.

Mr. STARK. What troubles me is if these guys are running along, it is my understanding that since 1985, when I first started to become aware of this problem of hospitals going broke, there has never been triple-digit numbers of hospitals closed—50, 20, 30, usually because the doctor dies or something happened. I mean, an insignificant number of hospitals closing relative to the approximately 6,000 in the country. Is that a fair statement?

Mr. HACKBARTH. The numbers have always been small. There have been periods when it has been higher.

Mr. STARK. What puzzles me, although you have suggested some of these areas, is that they are not going broke. They are continuing to build, as you said, many new fancy hospitals, and all of this on an average of a negative margin.

Now, can you explain that to me?

Mr. HACKBARTH. Well, in recent years, a big factor in that has been that their private payments have increased dramatically, and——

Mr. STARK. As you said earlier.

Mr. HACKBARTH. As I said earlier. In keeping with that, as you indicate, there has been a big increase in capital investment.

Mr. STARK. I think what I further heard you say is that you are not sure that we should be bailing out inefficiently run hospitals with tax dollars when you find that well-managed hospitals are able to survive.

Just one other quick question. On this 45-percent trigger, which now has been changed to be an automatic across-the-board cut if we exceed the 45-percent—is that not correct? The trigger is based entirely on part B spending, or non-A spending, to phrase it another way. Is that not correct?

Mr. HACKBARTH. Well, as I understand the provision, it is based on the share of the program finance, but general revenues.

Mr. STARK. General revenues, which is largely part B.

Mr. HACKBARTH. Right.

Mr. STARK. Therefore, if the hospitals screw up, if the doctors screw up, I mean, then we automatically have to cut the hospitals under the new law. I don't know whether people—do you think that across-the-board cuts are an efficient way to save money in the Medicare system, or that we ought to do it under the way you tend to recommend various areas that we overpay or underpay? Which do you think is a better system?

Mr. HACKBARTH. Well, we have not looked at the 45-percent trigger specifically. We have not had any specific recommendations on that. Certainly we share the goal of increasing the efficiency of the program and reducing the rate of increasing costs. We think that is very important for the program, for the taxpayers, and so forth.

As you point out, our general approach is very data-driven, and so as opposed to trying to predict what the right rate should be in 2009 or 2010, we want to look at the data within a reasonable period ahead, like a year, and make a recommendation based on those data at that time. We know very little about the circumstances that will exist in 2010, and so that is a very hard recommendation to make; what the rate should be that far out into the future.

Mr. STARK. Thank you very much.

Chairman JOHNSON OF CONNECTICUT. Mr. Hulshof?

Mr. HULSHOF. Thank you, Madam Chairman.

Chairman JOHNSON OF CONNECTICUT. Just a moment, before I recognize Mr. Hulshof, I did want to clarify for the record that the automatic trigger is not law. It is a proposal in the President's budget, because there has been some confusion as to whether that was involved in the last reconciliation act. Thank you.

Mr. Hulshof.

Mr. HULSHOF. Thank you, Madam Chairman. Mr. Hackbarth, thanks for the light reading.

Mr. HACKBARTH. Yes. You are welcome.

Mr. HULSHOF. I say this sincerely, because being on the Subcommittee and actually visiting with constituents, we were home this past week and there are a lot—I do not have the time to ask you the questions that have actually been put to me by constituents. For instance, I obviously, heard about the flawed Sustainable Growth Rate (SGR) formula and reimbursements and what is Congress going to do. We have heard about credentialing for imaging, which I know you address a bit. Oncologists were quick to talk about the average sales price. You do address the need for end-stage renal disease annual updates, which is in here.

Let me take just a couple of minutes, though, because it something that I have actually had a constituent's visit with Chairman Johnson about, and that is a brief discussion about post-acute care. You talk about—the way that I understand it, and especially Dr. Worsowicz—and for the reporter, I will get the spelling of Dr. Worsowicz. He is very passionate about this, focusing on what is in the best interests of the patient. You know, we had these silos of care, if you will, these silos for payment, and we drive care by putting money in these particular silos, when, in fact, would it not be—this is perhaps a rhetorical question. Would it not be in the best interest of that particular patient if you had somewhat of a continuum of care? It may be that, you know an Long Term Acute Care (LACT) might be the appropriate setting. It could be, in fact, I have a personal experience with my mother-in-law, who sort of reaches a plateau, but then, you know maybe home health works in that particular respect, but then there may be somewhat of a relapse and so you have to have more of a skilled nursing facility. We focus on four separate ways to deal with health, and you ad-

dress that in some regard because there is duplication of services in some regard.

Let me ask you: since Medicare reimburses are based on the setting rather than the needs, do you think that Medicare should move or maybe could move toward a site-neutral payment system for post-acute care?

Mr. HACKBARTH. I think that would be a very good goal. Having said that, we are quite a ways from it today. Our assessment of the situation is very much in line with what you describe. We think the fact that we have these four different payment systems based on a type of provider as opposed to patient need is a real problem in a variety of ways. It creates seams in the delivery of care. It creates incentives to try to get certain types of patients that are very profitable in certain types of settings when, in fact, they might be able to have their needs met as well or even better in a lower-cost setting. There is a lot that needs to be fixed.

In addition to that, within the individual payment systems, like for skilled nursing facilities or home health agencies, we see problems there as well, even if you are not looking across the different types. We are worried that, for example, the skilled nursing facility system does not properly allocate the available dollars across different types of patients. The case mix adjustment system, in other words, needs considerable refinement.

There are very big problems, as we see it, in post-acute payment policy. Getting to that site-neutral system that you describe, however, is not going to be an easy thing. Right now it is very difficult for us to even assess and compare across settings outcomes and costs. We have tried to do that in some particular cases and found it very difficult because the data don't support good analysis. We don't even have common assessment instruments.

Mr. HULSHOF. I, obviously, failed to mention the Employee Retirement Funds (ERFs) as the other silo of post-acute care. This is, in fact, the data collection—if there was a way to quantify and use some standard protocols, would this be at least, maybe, a baby step forward or a beginning step forward?

Mr. HACKBARTH. Yes. We have advocated for the development of a common assessment instrument, so we can compare outcomes and costs better than we do now. We think that an important step in getting better information may well be the demonstration project mandated by the Deficit Reduction Act of 2005 (P.L.109–171) of last year, where some head-to-head comparisons of these things will be done.

Mr. HULSHOF. The Chairman has been gracious in actually visiting with my constituent, Dr. Worsowicz, about perhaps, qualifying what we would need to do. I would like to continue this discussion further with you. My time has expired, but thank you very much.

Mr. HACKBARTH. Thank you.

Chairman JOHNSON OF CONNECTICUT. Thank you, Mr. Hulshof.

Mr. Thompson.

Mr. THOMPSON. Thank you, Madam Chairman. Thank you, Mr. Chairman, for being here. I would like to talk about the government Practice Cost Index (GPCI) issue and payment localities. I

represent a number of counties, but one of which, Sonoma County, is in a geographic locality that does not provide for the appropriate reimbursement to doctors. As a result, Sonoma County docs get about 8.2 percent less than what has been termed "optimal," and those are your numbers or Centers for Medicare and Medicaid Services (CMS) numbers, not mine. How long has it been since we have reconfigured the boundaries or we have updated the payment allocations.

Mr. HACKBARTH. It has been quite a while, something like 10 years.

Mr. THOMPSON. Ten years?

Mr. HACKBARTH. Yes.

Mr. THOMPSON. It is my understanding that California, although we have a couple of very egregious examples, isn't the only State where this is happening. I understand that you have got Maryland, Virginia, Georgia, Texas, some of them up to 13 percent. Is that fairly——

Mr. HACKBARTH. Yes, this is certainly not limited to California at all, but we are well aware of the issues that do exist in California. We think that the proper way to approach this problem is not to try to fix it just in California or Maryland, but the overall system needs to be reviewed, revamped, updated. In fact, that is a very important item on MedPAC's agenda for the relatively near future.

Mr. THOMPSON. What can I expect the relatively near future to be?

Mr. HACKBARTH. March or June report of next year is what we are looking at for an——

Mr. THOMPSON. For a fix?

Mr. HACKBARTH. For a national type look at this problem and what appropriate fixes might be.

Mr. THOMPSON. This has been going on in my situation for a number of years, and I guess, most recently, this last March, you stated that it would be fixed in the future. You were very specific. You said it was time to revisit the boundaries of payment localities; localities likely do not correspond to market boundaries; and Medicare is probably underpaying in some geographic areas because of this. We have heard a lot about it. As a matter of fact, Mr. Scully, when he was with CMS, was even out in my district and met with the docs. I have met with the Administration on this a number of times. Everybody admits there is a problem, but there has been a reluctance to move forward on it. Is it fair to—are you saying that the data that you are working on will be completed in March?

Mr. HACKBARTH. Well, our goal would be to have recommendations on how to revamp this system.

Mr. THOMPSON. In March?

Mr. HACKBARTH. March or June of next year.

Mr. THOMPSON. Next year.

Mr. HACKBARTH. Yes, this is our March report of 2007 that we are talking about.

I know this is an important issue, and I understand it has been going on a long time, and so I——

Mr. THOMPSON. Well, it is really impacting health care.

Mr. HACKBARTH. Yes, it is.

Mr. THOMPSON. It is something that everyone has—it has not just been going on a long time, but everyone has admitted there is a problem and there has been some very valiant attempts to fix it. We haven't had a lot of help from you guys.

Mr. HACKBARTH. Well, in the first instance, CMS, they are the people who make the decisions. We simply make recommendations, principally to you for legislation, although often, to CMS for things that they can do.

Mr. THOMPSON. Mr. Chairman, can you release the numbers before you release the recommendations?

Mr. HACKBARTH. Which numbers, sir?

Mr. THOMPSON. The data runs that you are supposedly working on to quantify——

Mr. HACKBARTH. Yes, well, as a matter—of course, we are happy to work with your staff, Committee staff, and give them updates on the work that we are doing, analysis as it is developed. We would be happy to keep you well informed about that.

Mr. THOMPSON. I would appreciate that.

Madam Chair, could I ask you to commit to me to work together on this? This has been going on for way too long.

Chairman JOHNSON OF CONNECTICUT. Yes, my understanding is that also we will be working on the hospital wage areas this year.

Mr. HACKBARTH. Yes.

Chairman JOHNSON OF CONNECTICUT. What we learn from that—and you might want to be involved in that because these are similar problems. I don't know whether there is any way of merging the considerations. We can do a seminar and begin to buildup the Committee's history and understanding of this. It is a very important problem. I am well aware of the situation in California and the fact that you are really losing physicians from some areas because of this specific weakness in the law. I will be happy to work with you and see if we can find a temporary fix before we go on.

Mr. THOMPSON. Thank you.

Mr. HACKBARTH. Mr. Thompson, I also mentioned that, unlike CMS, for example, all of our work is done in public, or the vast majority of it, so we have public meetings where there will be presentations on our work in progress, where data will be shared, and those materials are available to the public as well, and your staff is welcome to track that very closely.

Chairman JOHNSON OF CONNECTICUT. Will you be starting that work this year, I mean before, say, summer?

Mr. HACKBARTH. It probably will not happen until the fall. The staff will start doing the background work in the summer. It will first appear in our public meetings in the fall, September, October, thereabouts.

Chairman JOHNSON OF CONNECTICUT. Thank you.

Mr. McCrery.

Mr. MCCRERY. Thank you. Mr. Hackbarth, on the question of dialysis services, you have recommended or MedPAC has recommended that those services receive an update in the reimbursement for 2007, and it seems like every year we face this question and we conclude that, yes, an update is needed sometimes—and sometimes we do and sometimes we don't. As a consequence, there

is a lot of uncertainty from year to year as to what can be expected for reimbursement. Did you in your report talk about the question of having an automatic update as other sectors do? If so, what were your findings?

Mr. HACKBARTH. As you know, Mr. McCrery, we have recommended updates for dialysis facilities, certainly every year that I have been on the Commission, the last 6 years. We think it is important for dialysis facilities, as for other providers, to have an annual review of their rates and a recommendation for an appropriate update, taking into account all of the factors that Chairman Johnson mentioned at the outset.

As I said in my response to Mr. Stark, though, in general, we like to look a year ahead as opposed to multiple years ahead and say here is the right rate for some point way out into the future. We can understand why Congress has sometimes elected to do that legislatively and have updates for, a 2- or 3- or 4-year period into the future. For our sort of analytically driven work, we think the most consistent thing to do is look year by year, not just for dialysis but for hospitals, for physicians, for home health agencies, for all types of providers.

Given that, we have not taken a stance in favor of a formulaic update for dialysis or for any other provider. We have not advocated that. We are "step by step, year by year, let's crunch the numbers and make a recommendation" sort of group. Mr. MCCRERY. I understand that, and I have some sympathy for you in that regard. We have to work within our budget rules here in the Congress, and if there is not an automatic update in the baseline, then anything we add on; it costs us.

Mr. HACKBARTH. Right.

Mr. MCCRERY. It is harder in that sense to continually add an update that is not accounted for in the baseline than it is for us to take back an update that is in a baseline that we get credit for.

Mr. HACKBARTH. Yes.

Mr. MCCRERY. It might be helpful if you would ask your panel of experts to consider this question in that context: Should we put all providers or all sectors of the health care community on the same basis? Should they all have updates, or should they all not have updates and be subject to an annual re-examination?

Mr. HACKBARTH. Yes.

Mr. MCCRERY. Maybe there should be a change in the budget rules to allow us more flexibility to address this on an annual basis.You see my point that when one sector does not have an automatic update; I think they are disadvantaged in the context of our budget rules here in the Congress.

Another area that we are now treating on a year-to-year basis is the rural add-on for home health services. Did you all look at that in this report and make any recommendation—going forward on the 5-percent add-on?

Mr. HACKBARTH. Well, in years past, we have looked at that, and I can recall at least 1 year—I think maybe 2 years ago now—where we did recommend an extension of the add-on. However, as we look at the data now, we see that rural home health agencies as well as urban home health agencies are faring quite well under the Medicare Program and have quite healthy margins on average,

especially compared to hospitals and dialysis facilities. So we didn't think that recommending a continued add-on was appropriate or necessary to assure access to quality care for rural beneficiaries.

Mr. MCCRERY. Did you make a statement on that in your report, that you do not recommend that it be continued, or did you just——

Mr. HACKBARTH. No——

Mr. MCCRERY. Were you just silent on it?

Mr. HACKBARTH. Yes, we were silent on the issue in this report. When we have advocated in the past, we have added specific language saying we think that is appropriate to extend This year, under these circumstances, we did not say that.

Mr. MCCRERY. Okay. Thank you very much.

Chairman JOHNSON OF CONNECTICUT. Mr. Doggett?

Mr. DOGGETT. Thank you, and thank you so much for your work in leading this important effort. I am impressed, though I might not agree with every recommendation, with the fact that you do attempt to pursue this on a non-ideological basis, and also just from looking at the votes on these various recommendations, that you take a very broad-based, diverse group, and you get near unanimity. One of the areas that I would like to focus attention on that you have had near consistent unanimity on, I believe going back all the way to 2001, is this whole issue about whether or not we ought to have a slush fund to pay a lot more to the Medicare Advantage plans than to traditional Medicare.

If you look at that issue, is the effect of paying much more for traditional—for the Medicare Advantage plans than traditional Medicare, is one of the effects that it reduces the solvency of the Medicare trust fund?

Chairman JOHNSON OF CONNECTICUT. Mr. Doggett, if you would yield just a minute?

Mr. DOGGETT. Sure.

Chairman JOHNSON OF CONNECTICUT. We did point out before you came in that the hearing is focused on the current report——

Mr. DOGGETT. Sure, but this is intricately involved—I did hear your comment. I was here when you made that comment.

Chairman JOHNSON OF CONNECTICUT. Okay, and that was an earlier report. If you will recall, part of all that is they raised the rural floor, which the Congress adopted. This issue of whether there are overpayments is a complicated one and deserves a lot of attention on its own——

Mr. DOGGETT. When is that hearing set?

Chairman JOHNSON OF CONNECTICUT. Well, we have been talking about this series of hearings we are going to try to have this year.

Mr. DOGGETT. Well, I think this is so important that while he was here——

Chairman JOHNSON OF CONNECTICUT. There was an enormous of misinformation about it in the last public discussion of this matter, so I think it is important to straighten out.

Mr. DOGGETT. Right, and you got right to the heart of the misinformation in your earlier report where you had near unanimous agreement to the comment that for Congress to continue to pay

higher rates for Medicare Advantage than traditional Medicare—and I quote your report—"would be a disservice both to Medicare beneficiaries and, in these times of increasing budget deficits, the taxpayer." It affects not only seniors having to pay higher premiums when Congress insists on advantaging Medicare Advantage, but it also has a big effect on the taxpayer, does it not?

Mr. HACKBARTH. It does, yes.

Mr. DOGGETT. I believe Mr. Stark asked you about this, but it was not just anyone talking about this, but the Congressional Budget Office that said if we adopted all of your recommendations that you had near unanimous agreement on concerning Medicare Advantage, we would save $50 billion over 10 years.

Mr. HACKBARTH. Yes.

Mr. DOGGETT. Compared to some of the savings that you achieve in your recommendations, that is one of the biggest areas to make savings, isn't it?

Mr. HACKBARTH. Yes. We have been consistent, as you point out, over a period of years in advocating that there be a neutral choice between traditional fee-for-service and private plans. We have also been unanimous in believing that it is very important to the Medicare Program to have private plans offered. In fact, in my previous life, I came from that world——

Mr. DOGGETT. I am aware of that.

Mr. HACKBARTH. —and I think that private plans can often—not always, but often—offer things to Medicare beneficiaries that the traditional program cannot. we are trying to strike a balance.

Mr. DOGGETT. As you strike a balance, you are aware of the comments of the Actuary that the Medicare Advantage as currently modeled will not save money this year or next year or even over the 5, 10, or longer period of time. It costs the taxpayer money and it costs the Medicare—it costs the senior additional premiums.

Mr. HACKBARTH. Yes, although, as a result of MMA, there is a new dynamic that exists in the program where there is a competitive bidding process for the Medicare Advantage plans. I think at this point nobody knows precisely how that will play out and in turn, affect Medicare expenditures into the future.

Mr. DOGGETT. Thank you very much. Thank you, Madam Chairman.

Chairman JOHNSON OF CONNECTICUT. Thank you. I think it is important that the record note that it was the bipartisan Rural Caucus that fought hard over a long period of time to artificially inflate the rural floor, which has a lot to do with the subject that we were just talking about.

Mr. Camp.

Mr. CAMP. Well, thank you, Madam Chairman. I am a member of the Rural Caucus, but we won't go there. Really, I want to follow up on things Mr. McCrery said. You know, over the past several years, MedPAC has consistently called for an update for dialysis facilities, and I was glad to see that the Deficit Reduction Act (P.L. 109–171) did have the 1-year update, and I think it is important that in the context of legislating, it is a very heavy lift to each year try to address this issue from the context of our budget rules. I think he made a very important point. I just want to second that and associate myself with those remarks.

I would also like to discuss how MedPAC developed its data on home health agencies. I know that the information indicates that their profit margins are about 14.7 percent. I have to tell you, that is not the experience in my district because largely many of the home health agencies are hospital-based. I would tell you, 45 percent of the agencies in my district have a margin at or below zero, so it is almost half. I think what happens is those hospital-based agencies are included in the hospital-based rate, and so, therefore, this 14.7 percent number ignores about 30 percent of the agencies nationwide because they are put in another category, leaving the most profitable ones in the other basket, and so you can correctly point and say, gee, they are making such a high rate of return.

I just have to tell you, that is not the experience in large rural districts, as I have, particularly hospital-based home health agencies, because their rates are not as high. I just wanted to get your comment on that and how you think we might be able to address that inequity.

Mr. HACKBARTH. You are correct, Mr. Camp, that the analysis that we provide here in our report is based on the free-standing home health agencies and does not include the hospital-based agencies. The reason for that is that there are very important accounting issues, how costs are allocated when you have a home health agency being part of a larger enterprise like a hospital. In those accounting issues, how overhead is allocated can have a very large effect on the reported bottom line.

When we look at that line of business within a hospital or any other line of business within a hospital, like a hospital-based Skilled Nursing Facility (SNF), we are quite skeptical about the reported profitability because of the uncertainty about how overhead is allocated.

Second, as I said at the outset, what we are looking for is to pay at the level of efficient providers. If, in fact, a hospital is incurring higher costs in running its home health business than a free-standing competitor in the same market, we would not want to pay high enough to cover the costs of a less efficient provider. We would want to be paying at the lower cost in the interest of the Medicare Program and the taxpayers that fund it. Yes, the analysis doesn't include hospital-based, but we think there are sound reasons for the approach that we take.

Mr. CAMP. Well, you should know that in rural areas, in hospital-based home health agencies, there is not another alternative. If they exit the market, there will not be anyone delivering that service, unlike maybe a suburban or urban area, where there is a lot of competition and a lot of health care providers. I mean, just access is an issue.

Mr. HACKBARTH. Yes. Sometimes that is the case, although one of the unique characteristics of the home health business is that entry is exceedingly easy, doesn't require a lot of capital, and so it is relatively easy to start a home health agency. In fact, we have seen rapid growth in the number of home health agencies, we think in part because it is a very profitable business under Medicare.

Mr. CAMP. Thank you. Thank you, Madam Chairman.

Chairman JOHNSON OF CONNECTICUT. Mr. Emanuel?

Mr. EMANUEL. Thank you. Thank you, Mr. Hackbarth, for being here. Not in this hearing, but in another hearing, when the head of the Office of Management and Budget (OMB) was here, we talked about some of the recommendations from MedPAC. Now, this was from your other report; I know not today's report, but you had——

Chairman JOHNSON OF CONNECTICUT. Mr. Emanuel, if I may just intervene for a moment, we have talked about this twice during this hearing, that the hearing is focused on this report, and it covers every single sector of Medicare. If you could focus your questions on the significant issues this report raises, it would be very helpful. If you want to go back to another report, it is not germane to this hearing. Your colleagues have used their time that way. It is really unfortunate when there are so many reimbursement issues before us that you have so little——

Mr. EMANUEL. Is this coming out of my 5 minutes?

Chairman JOHNSON OF CONNECTICUT. No.

Mr. EMANUEL. Okay.

Chairman JOHNSON OF CONNECTICUT. That you have so little concern—didn't you notice that—I am the only one that has a clock, but you have so little concern about the seriousness of the issues raised by this report. I understand the politics of what you are talking about, but there is a lot of misrepresentation of information in the course of these discussions, and before the Subcommittee, I do not consider that valuable. You may proceed.

Mr. EMANUEL. I hope this had nothing to do with the way I spent my recess time. I do appreciate the guidance and counsel of your comments, and I was going to get to this report, Madam Chair. Obviously, look, if you wanted to say that—and I will just—and if you wanted to do that——

Chairman JOHNSON OF CONNECTICUT. That is fine if you want to proceed.

Mr. EMANUEL. I appreciate that.

Chairman JOHNSON OF CONNECTICUT. You have the right to proceed either way, but I am disappointed that some of your colleagues have used the time primarily to talk about something that is not in this report when, frankly, the issues raised in this report——

Mr. EMANUEL. Well, look, Madam Chair, you know what? I wasn't going to go there, but, if you want to do that, then I will say this: I am thoroughly disappointed you took a pass on $60 billion in savings. If you don't like it, I will take my 5 minutes, if that is okay with you.

Now, I was not going to do this. We have got a roomful of people. I had no interest in doing that, but I—and I have a lot of respect for you. If that is what you would like to do, I am sorry that you took literally the powder on $60 billion. You could have done something about it, and the MedPAC had recommendations for a PPO slush fund for $9 billion, eliminating double payments of $5.5 billion, equalizing payments for $30 billion——

Chairman JOHNSON OF CONNECTICUT. Mr. Ram, you——

Mr. EMANUEL. It is Mr. Emanuel and——

Chairman JOHNSON OF CONNECTICUT. Mr. Emanuel, sorry, Mr. Emanuel——

Mr. EMANUEL. It ain't "Ram," it is "Rahm."

Chairman JOHNSON OF CONNECTICUT. I am sorry. You——

Mr. EMANUEL. You know what? You—Madam Chair?

Chairman JOHNSON OF CONNECTICUT. There is so much to talk about——

Mr. EMANUEL. Madam Chair——

Chairman JOHNSON OF CONNECTICUT. In this report, I would like to urge you to focus your questions on the report, and the time is now yours and the clock is running.

Mr. EMANUEL. I know you meant no disrespect for Mr. "Ram" but he is not here. Mr. Emanuel is here, and it is "Rahm," for the record. I take a great deal of umbrage in the fact that you have no idea what my name is, having served here now 3 years with you. Now, may I reclaim my time?

Chairman JOHNSON OF CONNECTICUT. As I mentioned, the clock is running. It is your time.

Mr. EMANUEL. All right. Well, maybe at some point we will learn why $60 billion was passed on by this Congress, and you can maybe give some of us who are interested why you thought that happened and ways that we can deal with that $60 billion. Since $60 billion to some Members on this panel is nothing but a rounding error, I will now move on to the fact currently Medicare pays certain plans 115 percent over what traditional Medicare charges. What happens to the trust fund, part B premiums and general spending? Is that good enough, Madam Chair?

Mr. HACKBARTH. Well, in our world, we do not try to parcel out, Mr. Emanuel, what the effect is on the Part——

Mr. EMANUEL. It is "Rahm" for you. For others it is "Ram." Go ahead.

Mr. HACKBARTH. We do not try to parcel it out into the part A trust fund versus part B and so on. We just look at the aggregate expenditures, and you have seen from the report what we think the budget implications of our proposals would be.

Mr. EMANUEL. Your recommendations specifically, what would be the total loss in revenue? Obviously, this is a guess, so it is both high and low.

Mr. HACKBARTH. Yes. Well——

Mr. EMANUEL. A guess being not just a guess, but taking ranges.

Mr. HACKBARTH. The Congressional Budget Office (CBO) does the official projections, as you well know, for Congress, and what we publish in our reports are broad ranges of the potential savings from individual recommendations. We do that so that the Commissioners are aware of the budget implications of the recommendations we make, but we really try to avoid making very specific estimates because we do not have the expertise or the resources to do that. CBO does. For each of our recommendations on Medicare Advantage in the June 2005 report, you will see a range. I caution you against adding those numbers because there are interactions among the proposals, and so you cannot——

Mr. EMANUEL. You do not mind if we add them to the original $60 billion from the first report, do you?

Mr. HACKBARTH. Well, I think the $60 billion figure you are referring to may be a CBO estimate of our proposals. That, again, is not our number. That is somebody else's number.

Mr. EMANUEL. To some of us, $60 billion is real money. When you are looking for savings across the board, it is worth spending the time, whether that upsets people or not. I appreciate the time, Madam Chair.

Chairman JOHNSON OF CONNECTICUT. Thank you, Mr. Hackbarth. Your report is very provocative. There are a number of things that we did not get a chance to go into. I do want to call your attention to—I know that you are to advise on Medicare, but I do not see how we can continue without learning, thinking more about Medicaid, because so many of our reimbursement policies will not work when Medicaid is such a poor payer, and I think that is affecting us all across the country. we were not able to get into that. Would you comment on that? Members are interested.

Mr. HACKBARTH. On Medicaid?

Chairman JOHNSON OF CONNECTICUT. Well, this terrible situation——

Mr. MCCRERY. Well, on the question of not considering Medicaid—when you are looking at the appropriate level of reimbursement under Medicare, you do not take into consideration the sometimes low reimbursement rates of Medicaid. I think the Chairwoman is appropriately suggesting that maybe you ought to comment on that.

Mr. HACKBARTH. Yes, I would be——

Chairman JOHNSON OF CONNECTICUT. For example, in the area of SNF reimbursements, the crisis there is very real, caused by Medicaid. We no longer have a policy in that regard. This Committee does not have jurisdiction; you do not have scope; but, on the other hand, how can you continue to make recommendations even for hospital payments, the negative margins and what is the relationship between them and falling Medicaid reimbursements—that is certainly one thing we did not get to, and if Mr. McCrery would like to hear you comment, we would be happy to hear that.

Mr. HACKBARTH. I would be happy to. Of our statutory responsibility, you are correct, we do not look at Medicaid rates for SNFs. We have no official opinion about whether States are paying too high or too low. Of course, we often hear from people in the industry that they feel that the Medicaid rates are much too low, and that is an important financial burden. Let's stipulate that just for the sake of argument.

We think that increasing Medicare rates to offset any Medicaid shortfall would be a mistake for a couple reasons. First of all, if you increase the Medicare rates, what you are doing is making the Medicare patients even more attractive, relatively speaking, than the Medicaid, and so people would want to focus even more on Medicare and less on Medicaid.

Second, if you increase the Medicare rates, the SNFs that get the most out of that increase will be the ones that have the highest proportion of Medicare patients and the lowest proportion of Medicaid. The assistance will not go to the skilled nursing facilities with the highest Medicaid burdens and, therefore, the worst financial problems.

Third, we fear that if Medicare makes it known that it is our policy to offset Medicaid shortfalls—that is an invitation to State legislatures and Governors to cut their rates still further: Oh, Medicare will make up the difference, and we will do it out of the trust fund. For all three of those reasons, even if we assume as a given that Medicare rates are too low, we do not think increasing Medicare is the proper effective fix.

Chairman JOHNSON OF CONNECTICUT. I appreciate that, and I appreciate that answer. I think your comments in your report are weak by not having that rationale in there, not at least noticing the seriousness of the problem and the fact that adjusting Medicare rates or overpaying in Medicare does not solve the problem, but it is like the elephant in the room. In many sections of payments it is an elephant in the room.

The other thing, I just want to conclude with your recommendation for a standing panel, and I think that is a very good idea, to begin to better evaluate physician payments. I think we need to look at not just overvalued but undervalued, because earlier in your testimony you do recognize the problem of primary care, and we are going to have very good testimony on that, and I hope you will look at the testimony on the advanced medical home model.

Mr. HACKBARTH. Yes.

Chairman JOHNSON OF CONNECTICUT. Thank you for being with us.

Mr. HACKBARTH. Thank you.

Chairman JOHNSON OF CONNECTICUT. We will call the next panel now, please.

Welcome, and we will start with Mr. Evans, the President and chief executive officer of Clarian Health Partners of Indianapolis, Indiana.

STATEMENT OF DANIEL F. EVANS, JR., PRESIDENT AND CHIEF EXECUTIVE OFFICER, CLARIAN HEALTH PARTNERS, INDIANAPOLIS, INDIANA

Mr. EVANS. Thank you, Madam Chairman. I appreciate your personal invitation to me to be here, and I appreciated your presence the other day in the President's conference at HHS. I am flattered to be invited.

Chairman JOHNSON OF CONNECTICUT. Now, the rules are, of course, that you have 5 minutes.

Mr. EVANS. Yes, ma'am.

Chairman JOHNSON OF CONNECTICUT. All of your testimony will be included in the record, but the floor is now yours.

Mr. EVANS. Thank you. I sit every day at the vortex of what has been discussed today, as some of my co-panelists do. I started today like I do many days. I talked to the director of our Emergency. Yesterday we had 400 patients in the Emergency Department. The average daily census in our Emergency Department is 250. I know what happens in our community when access to health care is limited elsewhere in the community.

Madam Chairwoman, you referred to certain measures that have not been taken into consideration adequately in determining the costs. Rather than refer to my written comments, I would like to respond to those, if you do not mind. Last week, the signing bo-

nuses for nurses in Indianapolis, Indiana, increased 50 percent, from $5,000 to $7,500, after taxes. Our costs by virtue of that will go up $20 million in one fell swoop, just like that. Unless and until Congress and State policymakers deal with the workforce shortage in health care, our workforce issues will continue to eat up any efficiencies we are able to create elsewhere.

Secondly, despite the conclusions by MedPAC about productivity and profitability of hospitals that have a high loss in Medicare reimbursement—ours is 7 percent, by the way, so it vastly exceeds the national average; we are full virtually all the time. We are not a hospital that is half-empty, so we look for everything we can to be productive. We look for technology, clinical information, messaging, electronic intensive care, evidence-based medicine, positive patient ID, everything we can think of to improve productivity.

We just opened a new hospital on the north side of Indianapolis. The hallmark of that hospital is to be the highest tech that we can be. We have there positive patient ID, which is simply a bar code on the wrist of the patient, a bar code on the nurse, and a bar code on the drug. Interestingly, patients get that right away when they walk in because they are familiar with it.

Thirdly, we promote value, that is, transparency in cost and quality. We do that through technology, and last week, we actually published for the first time our own quality data on a website that the world can access. I asked before I came here today how many hits we got the first day, and it was 3,200. Most were in our community. The average person, believe it or not, spent 21 minutes on our website. It was clear, like most medical websites, they were looking for something important to them. They were looking pretty hard for it. Those individuals deserve the kind of transparency on cost and quality that heretofore has not been extant within the system.

Lastly, what we say to our people, no matter what they do, wherever they do it, at the end of the day it is about quality and the patient. That is what it is about. the testimony today about the very silos that patients have to go through to achieve care seems to me to beg the question of what the reimbursement system should be for those very same patients. This room is full of people my age who have octogenarian parents, who deal with the presence of silos every single day, and the absence of clinical messaging, the absence of communication between critical care hospitals.

Lastly, we are 31 percent Medicare and 20 percent Medicaid. We have a large children's hospital. The reason for our high percentage is acuity is going up. length of stay has actually bottomed out. The length of stay is not going down anymore. How we are trying to deal with the increase in acuity is acuity-based nursing and more skilled management of our Intensive Care Units (ICUs) so we can put people through the hospital and into rehab and long-term acute care facilities, skilled nursing facilities, so forth and so on. Those are my responses, Madam Chairwoman, to your specific comments earlier on rather than simply my testimony, which I have submitted in writing.

[The prepared statement of Mr. Evans follows:]

Statement of Daniel F. Evans, President and Chief Executive Officer, Clarian Health Partners, Indianapolis, IN

Madam Chairman and distinguished members of the Committee, good afternoon, and thank you for the opportunity to comment on MedPAC's proposed Medicare payment update formula. I am Dan Evans, CEO of Indianapolis-based Clarian Health Partners, a private, non-profit health center serving patients from across the state of Indiana through more than 73,000 annual admissions and over 1.3 million outpatient visits. Clarian is the state's only academic medical center, and is currently conducting 4,000 peer-reviewed research projects.

Clarian is Indiana's largest and most comprehensive health center and is one of the busiest hospital systems in the nation. Clarian employs nearly 13,000 people, and owns or is affiliated with 15 hospitals and health centers throughout Indiana. The Clarian-affiliated Indiana University School of Medicine educates the second largest medical student body in the United States. We have been ranked as one of the top American hospitals by *U.S. News & World Report* for the past eight years, and last year led the nation in solid organ transplant volume. Additionally, we operate one of the nation's top children's hospitals, and are one of only nine hospital systems nationwide to receive the coveted Magnet designation.

I'd like to begin by acknowledging the difficulties faced by federal legislators tasked with meeting the budget reform mandate, the challenges faced by MedPAC, and the balancing of multiple and sometimes competing interests on an annual basis. But I am here today to address the issue of Medicare payment updates from a provider perspective. Like many providers, Clarian receives a large amount of its funding—roughly one-third—from Medicare reimbursements via its almost 200,000 Medicare patients. The demand for Medicare-reimbursed services continues to rise annually, and as the members of this committee may know, almost 70 percent of all hospitals—including Clarian—lose money when treating Medicare patients. We therefore have a vested interest in the proposed payment reductions for FY07.

If approved, the proposed FY07 rate reductions will impact Clarian in real dollars. From 2007 to 2009, we project that the reductions would cumulatively amount to $8.3 million in lost inpatient revenue and $1.1 million in lost outpatient revenue. In addition, revenue will be lost to our home health providers in the amount of $400,000 and our hospice providers in the amount of $100,000. This, coupled with other changes to the Medicare system as proposed in the budget, will also cause us to forfeit an estimated $7.5 million in lost revenue from reduced transplant cost reimbursements, $7.1 million in lost revenue from reduced DRG payments, $7.1 million in lost revenue from phased-out bad debt payments, and $100,000 in lost revenue from reduced ambulance fees. These are significant losses to a system that, like others across the country, continues to face annual decreases in all forms of reimbursement and that struggles to continue serving as a safety net for the growing numbers of underinsured and uninsured.

I will not underemphasize the impact of these proposed reductions, and at least initially, they will constrain our current system of care delivery. But while these reductions will no doubt cause some growing pains, they will not impede Clarian's stated mission of providing high-quality services, excellence in research and education, and holding true to our values of providing charity, equality, and justice in health care. Clarian can, should, and will respond to any payment reductions by striving to offer our services in a more efficient manner, but not by compromising quality or service.

The difficulties facing academic, full-service medical centers like Clarian extend beyond the issue of Medicare reimbursement. They encompass the rising costs associated with pharmaceuticals, hospital supplies, nursing care, uncompensated care, and the national shortage of trained health professionals. The shortages also include the increasing number of employers that are dropping worker and retiree health coverage, our country's rapidly aging population, and the fact that our national health spending now exceeds $1.9 trillion annually. The challenge to control costs while continuing to provide quality care is upon us, and we must take immediate steps in order to stem the tide.

We must specifically begin to address the shortage of physicians that we are already experiencing nationally in more than 13 specialties, as well as the projected shortage forecasted by numerous studies of severe physician shortages by 2020 in nearly all specialties. It has been requested that Clarian and the Indiana University School of Medicine increase our education programs by 30 percent, but in order to do so the government must preserve and increase funding for graduate medical education.

While there is no panacea for this set of challenges, most would agree that an increase in the efficiency of the health care delivery system would go a long way

toward an overall decrease in cost. Legislators, insurers, and hospital providers must work together to find new and innovative ways to address efficiency and the larger health care issues of access and affordability. I support efforts by the government to reward providers that are agile and innovative; that address accessibility in health care; that empower consumers; that stress preventive treatment; that focus their efforts on quality and transparency; and that invest in technologies that maximize medical and information efficiencies, eliminate redundant processes and procedures, and minimize errors in medical diagnostics and information management.

I believe very strongly that an emphasis on quality, transparency, and consumer empowerment in health care can reduce costs, thereby aiding the federal government as it struggles to ration scarce dollars and remain accountable to taxpayers. Several weeks ago, I had the honor of participating in a panel discussion with President Bush and other leaders in the health care community regarding these very issues. We discussed how traditional health care delivery models obscure cost and quality data by limiting access to information that would allow a consumer to weigh a treatment's effectiveness. The rising health care consumerism movement, however, is leveling this playing field.

By empowering people to make decisions about their own health care, and by creating a transparent delivery system, we provide consumers with an incentive to become accountable and responsible health care purchasers. Consumers will reduce costs by seeking out and choosing qualified doctors and hospitals. Proactive consumers have hastened efficiencies and cost reductions in many other industries. For example, when I call Domino's to order a pizza, they answer the phone and say—before I identify myself—"Hello, Mr. Evans. Your medium sausage and mushroom pizza will be at your home in twenty minutes." This consumer-oriented company uses existing technologies to identify me, anticipate my needs based on past orders, and supply me with service in a timely fashion, all of which prompt me to choose this pizzeria instead of another.

Today's customers are driving a new paradigm of consumerism in virtually all industries, and informed consumers are increasingly basing their decisions—such as which car to buy, which university to choose for their children, or where to eat dinner—on quality and cost information published by consumer-focused, data-reporting groups like JD Power and Associates, the *U.S. News & World Report*, and Angie's List. Yet when we examine the purchase of health-related products and services, it is clear that those transactions are centered on the information needs of insurers and providers. Shouldn't health care customers be demanding the same transparency regarding quality and cost that is available to them when they purchase a washing machine or a pair of running shoes?

Consumers should demand and expect the same level of transparency and efficiency from the health care market that they receive from other private sector businesses, and the market seems to be heading in that direction. Step one has been the public's gradual but growing acceptance of health savings accounts (HSAs). These accounts pair a catastrophic insurance plan with a tax-free savings account, the funds from which are used to pay health care expenses. HSAs encourage consumers to play a more active role by giving them an incentive to closely examine the cost of care.

The explosion of technology-driven health solutions now being adopted by cutting-edge providers and insurers has powered the second part of the equation. Electronic medical records (already utilized by the U.S. Veterans Administration) allow physicians in separate facilities in different states to view a patient's history at the touch of a button; handheld PDAs update records in real time, and can be used to transmit prescription information directly to pharmacies, thereby reducing transcription errors; battlefield medics can scan microchipped dog tags, immediately accessing an injured soldier's medical history and providing appropriate treatment; and patients can examine online databases that list provider quality rankings and advise which facilities offer which procedures and at what price points.

These scenarios are not a projection of the future; the technology is available today. At Clarian, we're working to provide cost and quality data to all our patients, and we're partnering with insurers and other providers to ensure widespread data availability. Almost three thousand physicians in the Indianapolis area—more than 90 percent of the total—use the Indiana Health Information Exchange (IHIE), a messaging system that electronically provides physicians with clinical patient results via a secure platform; and Indiana's Regenstrief Institute is working with the IHIE to produce a model for a national health information network. We are on the cusp of a new culture of collaboration and information sharing, which is driven by one of health care consumerism's central tenets: that a patient's medical information belongs to the patient.

Let's now apply these principles to the issue of Medicare reimbursement. Medicare continues to comprise the largest percentage of health care costs, and many hospitals—including Clarian—depend on Medicare payments to maintain their current levels of service. A reduction in Medicare reimbursement rates will not only force Clarian to provide its services more efficiently, but should also be incorporated into a larger consumerism movement that provides incentives for consumers to do their part to rein in soaring health care costs by comparison shopping for the best value in health care.

This movement is gaining strength. Patients are using Internet-based services to comparison shop for lower-priced drugs, and are visiting walk-in clinics instead of emergency rooms for earaches and other minor maladies. Hospital systems are adopting payment schemes in which doctors are compensated based on the quality of their performance and receive bonuses when patients do not experience complications. Medical records are being stored and transmitted electronically in a secure fashion, allowing patient information to follow the patient and reducing the risk of medical error and therefore the risk of lawsuits.

Madam Chairman, it is true that Clarian and other hospitals will be greatly affected by a reduction in Medicare reimbursement rates, but we believe that these proposed reductions bring with them a tremendous opportunity for change. We ask that Congress join us in our efforts to address quality and access issues by focusing additional federal resources on investments in technology and consumer-driven care, thereby enabling providers such as Clarian to become more transparent, to empower their customers, and to work with other willing partners to reduce the costs associated with care.

Thank you very much for your time.

Chairman JOHNSON OF CONNECTICUT. Thank you very much. That was very provocative and helpful. Mr. Guillard of ManorCare from Toledo, Ohio. Nice to have you.

STATEMENT OF STEPHEN GUILLARD, EXECUTIVE VICE PRESIDENT, HCR/MANORCARE, TOLEDO, OHIO, ON BEHALF OF THE SKILLED NURSING FACILITY PROFESSION

Mr. GUILLARD. Thank you very much, Madam Chairman.

Thank you very much for the opportunity to testify today on the most recent MedPAC recommendations for post-acute providers. As mentioned, I am with ManorCare. We are the largest skilled nursing facility provider in the United States, with 275 nursing homes in 29 States. ManorCare also offers services across the post-acute continuum with services in home health and hospice in 24 States, assisted living in 13 States, and inpatient and outpatient rehabilitation throughout the country. In addition to my position at ManorCare, I am representing the Alliance for Quality Nursing Home Care as their immediate past Chairman and the American Health Care Association. Together, these organizations represent small as well as large, multi-State operators, nonprofit as well as for-profit, and the vast majority of skilled nursing providers throughout the country.

In discussing today's MedPAC recommendations, I would like to focus on three key elements: negative effect that implementation of MedPAC's recommendations would have on the quality of care delivered in America's skilled nursing facilities; the flaws that we perceived in MedPAC's analysis of SNFs; and the policy changes we support that will help ensure that MedPAC's recommendations protect taxpayers as well as the quality of patient care.

First, let me say that if MedPAC's recommendations as they affect skilled nursing providers would be implemented, they would have a devastating impact on quality of care. It is important to

note that SNFs have in particular led the health care quality movement in this country. We worked with CMS to create quality measures and to create systems of public disclosure. We launched the first industry-wide voluntary health care quality initiative, called Quality First, which continues today, and we continue to support linking Medicare payments to quality performance. We supported legislation introduced in this Congress by Representatives English and Tanner last year. As a result of this focus, SNF quality has improved dramatically since 1999. The number of severe deficiencies in quality has dropped 60 percent since 1999 when using inspection data. In that same period, we have seen similar improvements in clinical care, one of the most notable being the identification and treatment of patients in pain.

Since 1999, thanks to legislation enacted in 1999 and 2000, Medicare payments to SNFs have stabilized. We believe that this economic stability has contributed significantly to the quality gains we have seen. We believe that implementation of MedPAC's recommendations would lead to economic instability in this segment of health care, and would undermine our ability to sustain and expand on those quality improvements that we have demonstrated. Recognize that SNFs today have the lowest operating margins of any major provider group, and if MedPAC's recommendations of no market basket increase were adopted, our pre-tax operating margins as a sector would be a dangerously low 1.3 percent, and our post-tax margins would be less than 1 percent. Given rising costs, rapidly aging physical plants, and limited access to capital, any decrease in the current low margins that we see today would potentially precipitate another financial and operating crisis, as we saw in 1999.

Overall operating margins this low will make it impossible to sustain quality improvements, much less access the capital necessary to revitalize the post-acute infrastructure that today averages 30 years for every nursing home, with virtually no new construction in nursing homes across the country.

Second, MedPAC's analysis of SNFs is flawed because it fails to assess the overall market for nursing facility services. By focusing exclusively on Medicare margins, MedPAC ignores the reality of the economic model that we currently work under. Four out of five patients in nursing facilities are paid for by the government. Two of three are paid for by the Medicaid program. I thought your comments on Medicaid were very appropriate.

Although Medicare margins are positive, Medicaid margins are negative. Our Medicaid margins are at minus 7 percent, even when factoring in—not counting the full cost of capital costs that we incur. SNFs lose an average of $13 for every patient, every Medicaid patient, for every day we provide care. Medicare provides important and absolutely necessary support for the inadequate Medicaid funding that our sector provides. This cross-subsidization helps ensure that quality is provided for both Medicare and Medicaid patients.

I would like to just comment quickly in terms of my summary. First and foremost, Congress should reject MedPAC's recommendations as they related to 2007 skilled nursing facility payment policy, and they should maintain a full market basket adjustment in

2007. Congress should direct MedPAC, secondly, to consider operating margins from all government payers in all segments and sectors of post-acute to assure economic stability and thereby, protect quality.

Thirdly, Congress should direct MedPAC to consider the impact of economic stability on sustaining quality improvements in the skilled nursing sector. We believe that by requiring MedPAC to assess total government margins, Congress will receive more realistic and more useful analyses and recommendations.

Thank you very much for the opportunity to appear here today, and I am happy to answer any questions you may have.

[The prepared statement of Mr. Guillard follows:]

Statement of Stephen L. Guillard, Executive Vice President, HCR–ManorCare, Toledo, OH

Good afternoon Chairman Johnson, Ranking Member Stark and members of this subcommittee. Thank you for the opportunity to comment on the most recent Medicare Payment Advisory Commission (MedPAC) report on Medicare payment policies, as they pertain to long term care in general and skilled nursing facilities in particular.

As you know, my name is Stephen Guillard and I serve as Executive Vice President for ManorCare, which is based in Toledo, Ohio. ManorCare is the largest nursing home provider in America, with 275 nursing centers in 29 states. We also own and operate 65 assisted living residences in 13 states and offer home health care and hospice services in 24 states. In addition, we are one of the largest providers of rehabilitation services in both outpatient and inpatient settings. I am testifying on behalf of the Alliance for Quality Nursing Home Care, of which I am immediate Past Chairman, and the American Health Care Association.

We are grateful that you and your colleagues appreciate the unique characteristics of the long term care sector. While much of today's discussion will focus on financial and statistical analyses, ultimately we are concerned with the quality of care and services for some of our society's most vulnerable citizens.

The quality of care our 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. We are 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. 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 Administration are increasingly looking at the post-acute sector as a continuum of care, we remain concerned that the MedPAC commissioners' restrictive view of long term care effects not only skilled nursing facilities, but also to such post-acute segments as home health care and hospice care.

Chairman Johnson, we appreciate your previously comments that it is short-sighted to consider Medicare and Medicaid funding policies in isolation. From that standpoint, we believe the recommendations made by MedPAC are ill-advised, fail to accurately evaluate 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.

The President's proposed budget incorporates MedPAC's most recent recommendations regarding the market basket adjustments for skilled nursing facilities. As a result, the proposed budget would cut Medicare funding for skilled nursing care by $810 million in 2007. $660 million of this amount is due to MedPAC's recommended freeze in the market basket increase. Over five years, the budget proposal slashes $8.5 billion in Medicare funding for nursing home care, $5.1 billion of which is caused by market basket cuts. Cutbacks of this magnitude will threaten the progress we have achieved working with the federal government to improve care quality.

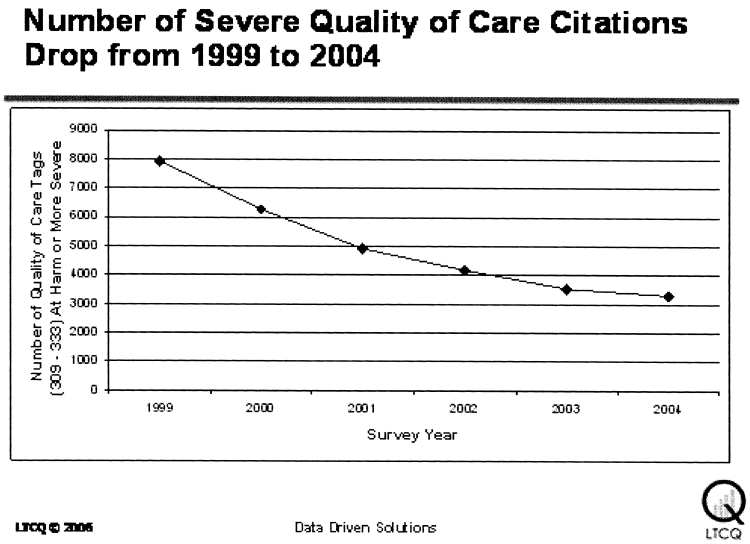
Nursing Home Quality Has Improved Significantly

It is noteworthy that America's nursing home providers have led the quality movement. Our sector's leadership—which is reflected in the Quality First initiative,

our partnership with the federal government on the successful Nursing Home Quality Initiative, our commitment to "pay for performance" concepts, and other programs—has helped to improve the overall quality of care in our nation's nursing homes.

Quality First, in fact, was the first nationwide, publicly articulated pledge by a community of health care providers to voluntarily establish and meet quality improvement targets. The watchword of our effort has been accountability; and taxpayers, consumers and lawmakers have every reason to expect government resources to be utilized in a manner that supports the provision of high quality long term care for every American. We are proud of our progress thus far—and remain committed to sustained improvement for the future.

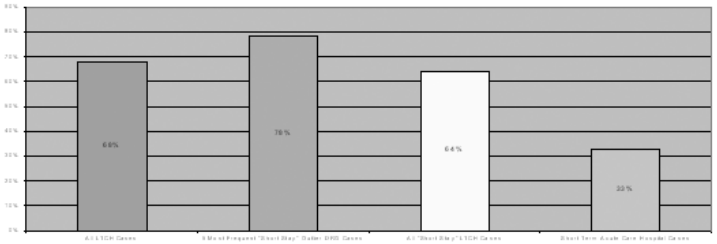
Our efforts are showing positive outcomes. For example, from 1999 to 2004, the number of severe quality of care citations in America's nursing homes dropped by almost 60%.



Similarly, over the same period, clinical processes like pain management and vaccination rates showed marked and sustained improvement as well. In fact, in most instances where skilled nursing facility providers partnered with Quality Improvement Organizations, patient outcomes improved.

Figure 1: LTCH Patients are Much Sicker than Average Short Term Hospital Patients

Percentage of Patients in the highest APR-DRG "Severity of Illness" Categories



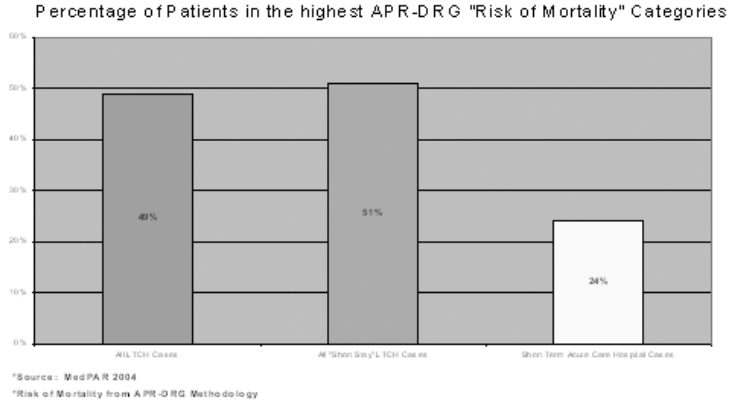
*Source: MedPAR 2004
*Severity of Illness from APR-DRG Methodology

We remain committed to sustaining these quality improvements for the future.

MedPAC's Recommendations Would Jeopardize Quality of Care

If MedPAC's recommendations were implemented, however, they would jeopardize continued quality improvement because operating margins would be driven to dangerously low levels. Skilled nursing facilities already have the lowest operating margins of all major health care provider providers. Adoption of the commissioners' recommendation to provide no annual update for skilled nursing facilities would, according to a recent analysis conducted by the Lewin Group, drive pre-tax operating margins down to just 1.32% and cause post-tax operating margins to plummet to 0.88%. We concur with the analysis' conclusion that this is "a level that is too low to support the future of the industry."

Figure 2: LTCH Patients Have a Higher "Risk of Mortality" than Average Short Term Hospital Patients



This is wholly inadequate to maintain our quality gains, particularly given the dramatic cost increases costs we face in key areas including labor, energy, liability and capital. Most of these costs are influenced by factors outside our control. For example, the shortage of nurses and other direct care workers, and the fact that we compete with myriad other employers both within and outside the health care sector for these employees, contributes significantly to increases in labor costs. When operating margins drop precipitously, 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 increasing complex care needs of an aging population.

MedPAC Must Consider Both Medicare and Medicaid

MedPAC's exclusive focus on Medicare margins in the nursing home sector does a disservice to those 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. This loss translates into a negative Medicaid operating margin of-7.06% in 2006, a negative margin that is expected to continue in 2007. Absent sufficient Medicare margins, the long term care sector would not be able to sustain economic viability, much less strive for continuing quality improvement. MedPAC's continuing and exclusive focus on Medicare ignores the real and growing interdependence between Medicare *and* Medicaid.

	Medicare Margins	Medicare as % of Revenue	Medicaid Margins	Medicaid as % of Revenue
2006	12.99%	27.30%	-7.06%	50.10%
2007:÷ Proposed	10.54%	26.70%	-7.06%	50.50%

Source: The Lewin Group analysis of Lewin survey of nursing facilities owned by Multifacility organizations.

While 66% of skilled nursing facility patients receive Medicaid benefits, those benefits account for only half of skilled nursing facility revenues. Given that the prevalence of Medicaid patients in skilled nursing facilities in four times that of the acute care sector, special consideration of the relationship between Medicare and Medicaid seems particularly relevant to skilled nursing facilities. 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 simply do not have the luxury of ignoring the relationship between funding for both programs. .

MedPAC's Recommendations for Skilled Nursing Facilities Should be Rejected

Chairman Johnson, your description of this situation in 2003 as "morally wrong" remains valid today. It is a tragic public policy error for MedPAC to dismiss the so-called "cross subsidization" issue as irrelevant to the debate at hand—despite the fact it has specifically acknowledged this phenomenon. Yet, to our typical Medicaid patient—an 85 year-old widowed female—the cross subsidization issue is real, it is tangible, and it is pertinent to her care needs. Similarly, for our typical Medicare patient—whose stay in a nursing home lasts less than 30 days—adequate funding to maintain and improve quality care is fundamental to provide them with the opportunity to return to the community and to maintain robust and active lives.

In addition, MedPAC's recommendations fail to consider the impact of very recent changes in Medicare and Medicaid policy. Effective January 1, the Centers for Medicare and Medicaid Services implemented the new Medicare payment system,(RUG–53) restructuring the reimbursement system for skilled nursing care. The Deficit Reduction Act also adopted sweeping changes to the nation's Medicaid asset transfer laws. Neither of these very significant policy changes is included in MedPAC's recent recommendations, adding further justification to rejection of those recommendations as they apply to skilled nursing facilities.

Recommendations

Therefore, Chairman Johnson and Ranking Member Stark, we make the following recommendations:

- Congress should reject MedPAC's recommendations for skilled nursing providers, and should maintain the full market basket for FY 2007.
- 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 our sector's progress in improving quality. Funding volatility undermines providers' ability to remain focused on continuous quality improvement.

At the outset of my testimony, I noted we must retain our focus on those we serve—the most vulnerable in our society—and we must sustain our ongoing commitment to quality care improvements. Chairman Johnson, Ranking Member Stark, and Members of this subcommittee, we continue to ask that you and your congressional colleagues, as well as President Bush, invest the resources needed to provide that quality care. America's seniors cannot afford another setback driven by continuing failures to recognize the relationships between payment policies and quality objectives or the division of oversight responsibilities for Medicare and Medicaid. Our recommendations concerning MedPAC offer an approach that avoids such a setback.

Thank you for the opportunity to speak with you today. I will be happy to answer any questions you may have.

Chairman JOHNSON OF CONNECTICUT. Thank you very much. Dr. Hedberg, welcome, from the American College of Physicians.

STATEMENT OF C. ANDERSON HEDBERG, M.D., PRESIDENT, AMERICAN COLLEGE OF PHYSICIANS, WINNETKA, ILLINOIS

Dr. HEDBERG. Thank you very much, Madam Chairman. My name is Dr. Anderson Hedberg. I am President of the American College of Physicians, and I am pleased to share with you the College's views on the 2006 report of the MedPAC. The College is pleased that the report calls attention to disparities in payments to primary care physicians. Unless immediate steps are taken to address these inequities, primary care medicine in the United States will collapse. Few young physicians are going into primary care and many established physicians are leaving. In 2005, among third year internal medicine residents, only 20 percent plan to practice primary care or general internal medicine compared to 54 percent in 1998. The rest plan to go into subspecialties.

A 2005 survey of internal medicine physicians found that 21 percent of those who were board certified in general internal medicine had left the field within 10 years of entering practice, compared with only 5 percent of those who went into subspecialties. The collapse of primary care will occur at a time when we need more primary care physicians to care for an aging population. General internists take care of the majority of Medicare patients. Within 5 years, 75 million baby-boomers will begin entering Medicare, many of whom will have or develop multiple chronic diseases.

The College supports the Commission's recommendations for improving the way that Medicare values services. Such improvements could begin correcting the disparities that disadvantage primary care. Overpriced services tend to be ordered more frequently, and may contribute to an increase in the total volume of services. the Sustainable Growth Rate (SGR), limits aggregate physician spending increases, the combination of mispriced relative values and volume mean certain types of services are capturing a larger share of Medicare spending, to the detriment of services provided by primary care physicians.

Specialties that derive a substantial amount of income from misvalued services have higher lifetime earnings than primary care physicians. The College specifically supports the Commission's recommendation that the Secretary establish a panel of experts to help identify misvalued services based on data that the physician work may have changed. Our support is predicated on maintaining the current rule that reductions in work values are put back into the total budget neutral relative value pool.

The College supports the Relative Value Scale (RVS) Update Committee, or the Relative Update Committee (RUC). The new expert panel should contribute to the work of the RUC and not replace it. We support the Commission's request that the RUC examine its composition. We applaud the Commission for recommending a 2.8 percent update for 2007 instead of a 5 percent SGR cut. The SGR is especially detrimental to primary care. It does not control volume, and creates barriers to physicians adoption of health information technology. We appreciate the fact that Congress reversed

the 4.4 SGR cuts for 2006, but further action is needed to avert more cuts in 2007.

In July 2005, the College endorsed Chairman Johnson's Medicare Value-Based Purchasing Act, H.R. 3617. We urge the Subcommittee to report legislation this year that would phase in pay-for-performance as the bill proposes. Performance-based payments should vary based on the individual physician's work and commitment to quality improvement. The College is proud to participate in efforts to develop performance measurements. We have worked with the Ambulatory Care Quality Alliance, and the American Medical Association's (AMA) Consortium for Performance Improvement to develop performance measures, and we commend the AMA for committing to the development of a starter set of quality measures for all specialties. We have also recommended that our Members consider participating in the CMS's present Voluntary Physician Reporting Program.

The College is pleased that the Commission is exploring ways to improve the care of patients with chronic diseases. We urge pilot testing of a new model we have developed for organizing and reimbursing care of patients with chronic diseases, called the Advanced Medical Home. Advance Medical Home practices would ensure that patients have a personal physician to partner with them to manage their chronic conditions, provide a full spectrum of patient-centered services, use health information technology to improve care, and be accessible through e-mail consultations. The physicians would be accountable for providing regular reports on quality, cost of care, and patient experience measures. The College is developing a reimbursement model that would recognize the value of care provided in the Advanced Medical Home.

In conclusion, the College applauds the Commission for its concern about the collapse of primary care and its proposals to improve the process of valuing services. These steps must lead to fundamental reforms. Such reforms should support the value of the patient's relationship with the primary care physician, provide incentives for physicians to organize their practices to improve care coordination and provide positive incentives for all physicians to report quality cost of care and patient experience measures. I would be pleased to answer questions.

[The prepared statement of Dr. Hedberg follows:]

Statement of C. Anderson Hedberg, MD, President, American College of Physicians, Winnetka, IL

I am C. Anderson Hedberg, MD, FACP, President of the American College of Physicians. The College is the nation's largest medical specialty, with 119,000 internal medicine physician and medical student members. Internists provide primary and subspecialty care to more Medicare patients than any other physician specialty. I appreciate the opportunity to share with the Subcommittee the College's views on the Medicare Payment Advisory Commission (MedPAC) 2006 report to Congress. My comments today will focus on the following:

1. The impending collapse of primary care medicine in the United States and the potential impact of the MedPAC recommendations on slowing or reversing such a collapse.
2. MedPAC's recommendations on the process used by the Centers for Medicare and Medicaid Services to determine and make changes in physician work relative value units that may be overvalued or undervalued.

3. The need to integrate the goal of linking Medicare payments to quality with broader reforms of a dysfunctional Medicare payment system and the College's work to create such reforms.
4. The urgent need to repeal the sustainable growth rate (SGR) and our suggested guidelines for evaluating any alternatives to the SGR that may be recommended by MedPAC or others.

MedPac's Recommendations and the Impending Collapse of Primary Care

The College is extremely pleased that the Commission's 2006 report to Congress, in the chapter "Valuing services in the physician fee schedule: The five year review" expresses concern about "*the disparities in remuneration between primary care and specialty care, and the implications of these disparities for the future of the physician workforce that will be necessary to meet the chronic care and other needs of Medicare patients*" *[emphasis added].*

The Commission's subsequent recommendations to address the misvaluing of physician services under the Medicare physician fee schedule (MFS) could begin to improve the economic environment for primary care. As the Commission notes, misvaluing of services can have an impact on physician workforce, because "*over time, if certain types of services become undervalued relative to others, the specialties that perform those services may become less financially attractive, which can affect the supply of physicians.*" We are also pleased that the Commission recognizes that its recommendations on mispricing services are only a first step to the broader reforms that will be needed to assure an adequate supply of primary care physicians, to improve quality, and to reduce the rate of growth in expenditures on physician services.

The Commission's concern about the future of primary care is well supported by evidence on trends in physicians' choice of specialty and demographic changes in the patient population. If anything, the 2006 report *understates* the impact of Medicare payment policies on physician workforce, and particularly, the impact that disparities in remuneration can have on driving physicians away from specialties, like internal medicine and family medicine, that are required to meet the primary care needs of an aging patient population with increased incidences of chronic disease.

Primary care, the backbone of the nation's health care system, is at grave risk of collapse due to a dysfunctional financing and delivery system. Immediate and comprehensivereforms are required to replace systems that undermine and undervalue the relationship between patients and their personal physicians. If these reforms do not take place, withina few years there will not be enough primary care physicians to take care of an agingpopulation with increasing incidences of chronic diseases. The consequences of failing to act will be higher costs, greater inefficiency, lower quality, more uninsured persons,and growing patient and physician dissatisfaction.

Demographic changes will require more primary care physicians:

- General internists and other primary care physicians are at the forefront of managing chronic diseases, providing comprehensive care and coordinated long term care. Yet, 45 percent of the U.S. population has a chronic medical condition and about half of these, 60 million people, have multiple chronic conditions. For the Medicare program, 83 percent of beneficiaries have one or more chronic conditions and 23 percent have five or more chronic conditions. Within 10 years (2015), an estimated 150 million Americans will have at least one chronic condition.
- Within the next decade, the baby boomers will begin to be eligible for Medicare. By the year 2030, one fifth of Americans will be above the age of 65, with an increasing proportion above age 85. The population age 85 and over, who are most likely to require chronic care services for multiple conditions, will increase 50 percent from 2000 to 2010.
- Among adults ages 80 and older, 92 percent have one chronic condition, and 73 percent have two or more. In 2000, physicians spent an estimated 32 percent of patient care hours providing services to adults age 65 and older. If current utilization patterns continue, it is expected that by 2020, almost 40 percent of a physician's time will be spent treating the aging population.
- It is anticipated that the demand for general internists will increase from 106,000 in 2000 to nearly 147,000 in 2020, an increase of 38 percent.

Unfortunately, there will not be enough primary care physicians to meet this increased demand:

- Over the past several years, numerous studies have found that shortages are occurring in internal medicine and family medicine. Factors affecting the supply of primary care physicians, and general internists in particular include exces-

sive administrative hassles, high patient loads, and declining revenue coupled with the increased cost for providing care. As a result, many primary care physicians are choosing to retire early. These factors, along with increased medical school tuition rates, high levels of indebtedness, and excessive workloads, have dissuaded many medical students from pursuing careers in general internal medicine and family practice.

- A recent study of the career plans of internal medicine residents documents the steep decline in the willingness of physicians to enter training for primary care. In 2005, only 20 percent of third-year internal medicine residents planned to pursue careers in general internal medicine compared to 54 percent in 1998. Among first-year internal medicine residents, only 13 percent planned to practice general internal medicine.
- A 2005 survey of internal medicine physicians who received their board certification in the early 1990s found that 21 percent of those who were practicing general (primary care) internal medicine have left internal medicine practice entirely, compared with only 5 percent of subspecialty internists who reported that they have left their subspecialty.
- More than 80 percent of graduating medical students carry educational debt. The median indebtedness of medical school students graduating this year is expected to be $120,000 for students in public medical schools and $160,000 for students attending private medical schools. About 5 percent of all medical students will graduate with debt of $200,000 or more. Studies show that students with the highest debt are the least likely to choose primary care.

Congress should be concerned about a collapse of primary care because it will result in higher health care expenses and lower health care quality:

- When compared with other developed countries, the United States ranked lowest in its primary care functions and lowest in health care outcomes, yet highest in health care spending.
- Studies have shown that primary care has the potential to reduce costs while still maintaining quality. Not only does early detection and treatment of chronic conditions play a vital role in the health and quality of life of patients, but it can also prevent many costly and often fatal complications when illnesses such as diabetes and cancer are diagnosed at a later stage. As expert diagnosticians, providing patient-focused, long-range, coordinated care, general internists play a significant role in the diagnosis, treatment and management of chronic conditions. It has been reported that states with higher ratios of primary care physicians to population had better health outcomes, including mortality from cancer, heart disease or stroke.
- States with more specialists have higher per capita Medicare spending. An increase in primary care physicians is associated with a significant increase in quality of health services, as well as a reduction in costs.
- Primary care physicians, including general internists, have been shown to deliver care similar in quality to that of specialists for conditions such as diabetes and hypertension while using fewer resources.
- The preventive care that general internists provide can help to reduce hospitalization rates. Studies of certain ambulatory care—sensitive conditions have shown that hospitalization rates and expenditures are higher in areas with fewer primary care physicians and limited access to primary care.
- Strengthening primary care may also result in more appropriate use of specialists. For example, patients receiving care from specialists for conditions outside their area of expertise have been shown to have higher mortality rates for community-acquired pneumonia, congestive heart failure, and upper gastrointestinal hemorrhage.

The College is aware that MedPAC has not found evidence that patients are currently experiencing widespread access problems. We believe that there are areas of the country where Medicare patients' access to primary care services has already declined, even if national surveys do not have enough locality-specific responses to show an overall access problem. Most importantly, a snapshot of current access trends is not a reliable predictor of how access will be affected in the future if Medicare continues to undervalue payments to primary care physicians at the same time that it continues to cut payments to all physicians because of the flawed sustainable growth rate (SGR) formula. The data on changing demographics and workforce trends that point to an impending collapse of primary care are far better indicators of potential future access problems than surveys of current beneficiaries' experiences.

Improving the Process for Valuing Physician Services

The College supports the Commission's recommendations for improving the process for valuing physician services under the MFS. We believe that the Commission's recommendations could help reduce the economic disincentive for physicians to practice in primary care specialties. Misvalued services contribute to the differentials that are undermining primary care in several ways.

First, there is evidence that services that are overpriced are ordered more frequently and may contribute to an increase in the total volume of services, which in turn, can trigger reductions in payments to all physicians—including primary care physicians—under the SGR formula.

Second, because the SGR limits the extent to which aggregate physician spending can increase, the combination of mispriced relative values and volume means that certain types of services are capturing a larger share of Medicare spending, to the detriment of evaluation and management services provided principally by primary care physicians.

Third, specialties that provide services that are overvalued are more likely to have higher overall earnings, while specialties that provide services, such as evaluation and management services, that are undervalued are likely to have lower overall earnings. This continued earnings disparity is a major reason why young physicians are not going into primary care while many older physicians are leaving primary care medicine.

The College would strongly oppose a process that results in reductions in the work RVUs for some procedures in order to achieve Medicare budget savings, since this would also make it impossible to redistribute the changes resulting from such revisions back into the services that are undervalued under the current MFS.

Specifically, ACP supports the recommendation that the Secretary should establish a standing panel of experts to help CMS identify overvalued services and to review recommendations from the American Medical Association (AMA)-Specialty Society Relative-value scale Update Committee (RUC). The group should include members with expertise in health economics and physician payment, as well as members with clinical expertise. The Congress and the Secretary should ensure that this panel has the resources it needs to collect data and develop evidence.

As the Commission envisions it, the expert panel would play a regular role in the process, particularly at the beginning when CMS is seeking to identify misvalued services. The panel would review the codes that CMS's data analyses identified as potentially misvalued and consider which services warranted further consideration by the RUC. The panel would then develop additional evidence providing support for correction, for example, by conducting its own provider surveys. This supporting evidence would then be forwarded to the RUC for RUC evaluation. To ensure that the panel has sufficient expertise in considering whether services are misvalued it should include representatives from CMS's network of carrier medical directors, experts in medical economics and technology diffusion, private payer plan representatives, and a mix of physicians, particularly ones that are not directly affected by changes to the Medicare physician fee schedule, such as those employed by managed care organizations or academic medical centers.

The College strongly supports the RUC process and believes that the RUC should maintain its primary role in advising CMS on the relative value units (RVUs) assigned to physician services in the MFS. Medical specialty societies have the best understanding of the work involved in the services provided by physicians in their specialties. The RUC has adopted rules and processes that assure that any recommendations that go forward to CMS are supported by at least two-thirds of the RUC members and are based on survey and other standards to assure that the recommendations are supported by evidence. CMS has consistently shown confidence in the strength and accuracy of the RUC's recommendations by accepting the vast majority of them.

We concur with the Commission's view, however, that the RUC, by itself, is not well-positioned to identify work values that may be too high. Because the recommendations that go to the RUC principally come from membership-based specialty societies, it is not surprising that specialty societies rarely suggest that some of the services that their own members provide may be overvalued. It is also difficult for specialty societies to identify services done by other specialties that may be overvalued. CMS itself lacks the internal expertise to identify work RVUs that may be too high. The expert panel recommended by MedPAC could play a valuable role in starting the process of identifying potentially overvalued services, while maintaining the RUC's essential role as the expert body that then evaluates the work RVUs recommended for review.

The College has several suggestions for improving the MedPAC recommendation for an expert panel. In addition to physicians who are employed by managed care organizations or academic medical centers, it is essential that the panel include representatives of physicians in small practices, most of who continue to practice in a fee-for-service environment. The reason is that carrier medical directors and physicians in academic centers or MCOs will have little or no direct experience with the impact of Medicare's valuation of services on running a small primary care practice or the work involved in taking care of patients with multiple chronic diseases.

Consideration should be given to including a member of the RUC on the expert panel in a liaison or observer capacity. It will also be important for the expert panel to operate in the open (public meetings), to solicit comments from specialties and the RUC, and to share the supporting evidence for any recommendations it makes relating to misevaluation of services. Should the expert panel disagree with a recommendation from the RUC, it should provide a clear explanation, with supporting data, on why.

The Commission's report also acknowledges a concern expressed by ACP and others that physicians who furnish primary care services are not represented adequately on the RUC. It calls on the medical community to propose changes in the composition of the RUC, states that it is aware that the AMA and physician specialty societies are having ongoing conversations about the composition of the RUC, and states that it intends to continue to monitor this issue.

The College agrees with the Commission that the RUC should re-examine its current composition to assure balanced and appropriate representation and expertise from all specialties, and we specifically have suggested to the RUC that it should revise its composition to better reflect measures of each specialty's contributions to care of Medicare patients. For instance, data on the percentage of Medicare Part B evaluation and management (E/M) services allowed and/or percentage of overall Medicare Part B allowed expenditures, could be accepted as proxies for determining how many seats that a particular specialty would have on the RUC. The College anticipates that such a review would lead to an absolute and proportionate increase in primary care representation in the RUC. The RUC should also review its existing criteria (as well as the revised membership criteria that would result from adoption of the above) to assure that it is consistently applied to specialties already on the RUC, as well as to additional specialties asking for membership. This would address concerns from some specialties that the RUC has applied a different standard for specialties that already have permanent seats on the RUC to those applying for seats.

The College believes that the RUC itself should consider the above recommendations, rather than having them imposed by CMS or by Congress. One of the important attributes of the RUC is that it is a private-sector body that has an informal advisory relationship with CMS; as such, the RUC makes its own rules. Therefore, the responsibility for changing its rules lies with the RUC itself. However, MedPAC and CMS should provide appropriate oversight and guidance to the RUC as it examines its composition. We are pleased that the chair of the RUC has expressed a commitment to call on the RUC to re-examine its composition and a willingness to keep MedPAC informed about the results.

The RUC finalized its recommendations on the E/M services in early February 2006. The College and other medical specialty societies originally asked CMS to include evaluation and management services in the Five-Year Review because we believe that there is compelling evidence that many of the services were undervalued as the physician work had increased over the 10-year period since they were last reviewed. CMS agreed to include the E/M codes in the Five-Year Review. The College then worked with the RUC to develop recommendations for the E/M service codes. We are unable to discuss the specific RUC recommendations because of the RUC's confidentiality policy, but we are able to inform the Subcommittee on Health that we support the RUC's recommendations on E/M services. The RUC has now sent all of its Five-Year Review E/M recommendations to CMS. The Subcommittee on Health, if interested, could likely obtain the specific RUC recommendations directly from CMS. The College will be urging CMS to assure that the MFS final rule for 2007 includes increases in the work RVUs for evaluation and management services commensurate with the evidence on increased patient complexity and physician work associated with such services.

The College also supports the following improvements in the process of reviewing relative work values as recommended by MedPAC:

- *The Secretary, in consultation with the expert panel should initiate the five-year review of services that have experienced substantial changes in length of stay,*

site of service, volume, practice expense, and other factors that may indicate changes in physician work.

- *CMS should institute automatic reviews of work relative values for selected new services after a specified period of time. The Commission's recommendation reflects the expectation that the work involved in furnishing many new services will change over time. The Secretary would initiate, after a specified period, reviews of the work relative values for selected recently introduced services. Where appropriate, services should be assessed by the RUC as soon as is practicable; reviews should not be postponed until an upcoming five-year review.*
- *CMS should also assess established services for which the newly introduced services are substitutes. As the use of newly introduced services grows, the type of patients using the established services could change.*
- *CMS should work with the RUC to review relative values established more than 15 years ago that have not since been examined by the RUC and that, as a result, may no longer reflect current medical practice.*

One of the original premises behind the resource based relative value scale (RBRVS) is that the physician work associated with a procedure or technology is often greater when it is first introduced, and few physicians have acquired the technical skills required to provide the procedure, than later on when its use has become widely accepted and the "learning curve" associated with providing it has decreased. The current processes have not been effective in identifying services whose work RVUs may decrease over time. The College believes that the Commission's recommendations are a reasonable way to trigger RUC review of services whose work may change over time.

As noted above, it is essential that any reduction in "misvalued" procedures be redistributed into the total budget neutral relative value pool instead of being used to achieve budget savings. Otherwise, there would no way for undervalued evaluation and management services to benefit from the redistribution that would result from reducing the work RVUs for overvalued procedures. Using the RUC and the new expert panel to identify procedures whose payments should be cut by CMS or Congress to achieve overall budget savings would undermine the support, credibility, and validity of the entire process for determining the value of physician work and lead physicians to question the fundamental fairness and accuracy of the RBRVS and the MFS.

Alternatives to the SGR

The College urges Congress to replace the SGR with an alternative that will assure sufficient and predictable updates for all physicians and be aligned with the goals of achieving quality and efficiency improvements and assuring a sufficient supply of primary care physicians. At a minimum, Congress should enact legislation to replace the 2007 SGR cut, estimated to be 4.6 percent, with a positive update. The College supports the Commission's recommendations for a 2007 Medicare fee schedule update based on the Medicare Economic Index, but recommends that further analyses be given to the assumption that the update should be lowered to reflect gains in physician productivity.

We appreciate that leadership shown by Chairman Johnson in seeking repeal of the SGR, and the role that this subcommittee played in getting legislation enacted to reverse the 4.4 percent SGR cut in 2006.

The SGR cuts payments to all physicians, but is especially detrimental to primary care physicians in small practices who already are under-reimbursed and have very low practice margins. The SGR does not control volume and, in fact, cuts payments without regard to the quality or efficiency of care provided by an individual physician. The SGR cuts also deprive physicians in primary care practices of the resources needed to invest in health information technology and quality improvements. It cuts payments for major surgical procedures and primary care services that have experienced lower volume growth by the same amount as procedures that have experienced higher volume growth.

First, Congress must enact additional legislation this year that would avert SGR cuts in 2007 and stabilize payments as a pre-cursor to legislation that would lead to a permanent replacement of the SGR formula no later than calendar year 2007.

Second, CMS, MedPAC and Congress should work with ACP and other medical organizations to develop a long-term alternative to the SGR. Key principles for this longer-term solution include:

- Separate physician fee updates from measures of per capita GDP
- Assure that the update formula is aligned with creating incentives for quality measurement and reporting and allow physicians to share in system-wide sav-

ings from quality improvement and coordination of patients with multiple chronic diseases
- Reflect increases in physician practice costs, including resources associated with acquiring health information technology to support quality improvement.
- CMS and Congress should also work with the College and other medical organizations to establish a process to address volume concern issues through a combination of encouraging adherence to evidence-based clinical measures through reporting and pay-for-performance, use of efficiency or cost of care measures, correcting mispricing of physician services under the Medicare fee schedules, addressing geographic variations in quality and cost through increased use of evidence-based guidelines and measures linked to financial incentives, and asking MedPAC to make recommendations regarding suspected inappropriate service/procedure-specific volume increases.

The College supports MedPAC's recommendation for a 2.8% MFS update in 2007 based on the Medicare economic index. We believe though that there should be further analysis of the productivity adjustment being recommended by the Commission. The Commission's view is that physician productivity has increased and that this should be factored into the update. The College questions the strength of the analysis to support this assumption. Studies and anecdotal reports from physicians indicate that as physicians incorporate electronic health records and quality measurement and reporting in their practices, the impact, at least in the early stages of adoption, is to reduce productivity, not increase it. We also question why the productivity adjustment for physicians is much higher than the productivity gains assumed for hospitals, when there is no evidence or reason to believe that physicians are achieving greater productivity gains than hospitals.

Linking Payments to Quality

The College continues to strongly support reforms to link Medicare payments to quality. We commend Chairman Johnson for her leadership on developing legislation to begin linking payments to quality. In July, the College was pleased to endorse Chairman Johnson's Medicare Physician Value Based Purchasing Act of 2005. We continue to support the bill, but we also recommend that the Subcommittee on Health consider a legislative framework that would go beyond grafting pay-for-performance on the current dysfunctional payment system to one that would create sufficient and sustained incentives for quality improvement, efficiency, and physician-directed coordination and management of care for patients with multiple chronic diseases.

Specifically, we recommend that legislation to link payments to quality be aligned with the larger goals of reforming the payment system based on the following framework:

- The longer-term goal should be to replace current payment system should be replaced with new methods of reimbursement that reward physicians who follow evidence-based standards and take on the responsibility of coordinating care for patients with chronic diseases. Pay-for-performance (P4P) incentive payments should reflect the level of work and commitment to quality, which will differ among physicians and across specialties.
- P4P systems should rely on valid and reliable clinical measures, data collection and analysis, and reporting mechanisms.
- The value of health information technology should be recognized in the performance-based payments.
- Potential P4P rewards should be significant enough to support continuous quality improvement, directed at positive—not negative—rewards, and be balanced between rewarding high performance and substantial improvement over time.
- Medicare P4P should enable physicians to share in system-wide savings (such as from reduced Part A hospital expenses) resulting from quality improvement.
- Adding an additional portion of reimbursement on top of the current dysfunctional payment system will not achieve the desired results.

ACP believes that Medicare pay-for-performance, if done correctly, can lead to improvements in reimbursement for primary care physicians while improving quality and lowering costs. The College has released a new position paper on "Linking Payments to Quality" (http://www.acponline.org/hpp/link_pay.pdf) that provides a framework for developing and implementing a Medicare pay-for-performance program that would recognize and support the value of care coordination and quality improvement by a patients' primary care physician. A key conclusion in this paper is that pay-for performance must be done in conjunction with other reforms to fix Medicare's dysfunctional payment system, including those described above, rather

than grafting it onto a system that rewards volume and episodic care over quality and physician-directed care coordination.

ACP believes that a Medicare P4P program will have to be supported by redistribution of funds among and across different geographic locations, health care professionals, and even among the College's own members on the basis of quality. It is, therefore, critical that, in providing rewards for physicians who commit to redesigning their practices to support quality improvement, the level of work and commitment involved should be recognized through differential payments. Basing incentives on effort assures that physicians who expend a disproportionately large amount of time and resources trying to improve quality and meet more complex measures, such as those who effectively manage patients with multiple chronic diseases, are recognized and rewarded accordingly. This is especially critical for the internist, whose ability to provide better care at lower costs through effective management of patients has been historically under-valued.

Redistribution of payments is only a small aspect of a larger issue that must be confronted before a system that rewards physicians for quality improvement can be effective: the dysfunctional physician payment system. The current reimbursement system is fragmented and episodic in nature, leading to enormous inefficiencies. Physicians are paid a standard fee regardless of the quality of their care, which discourages innovations, coordination, and practice improvement. The current system must be replaced with new methods of reimbursement that reward those who follow evidence-based standards of care.

The College realizes that designing a fair, credible, and effective P4P program is a challenging and complicated task. P4P is comprised of many aspects, including the development and selection of appropriate performance measures, the integration of acceptable methods of data collection and reporting, and an equitable determination of incentives. Within each of these categories are a set of unintended consequences that must be carefully monitored and reconciled. ACP also realizes that in the short-term, P4P programs may actually increase utilization of more effective but currently under-utilized treatments, thereby raising costs rather than reaping savings. As new systems of payment linked to performance are being explored, it is crucial that the right measures are used, that data collection is accurate and reasonable, that appropriate and adequate financial incentives are provided, and that quality—not just cost reduction—is always the overriding measure of success. The access-to-care problems that disadvantaged and severely ill patients may encounter, if P4P programs lead physicians to avoid sicker or non-compliant patients, must also be carefully monitored.

The College continues to be a leader in developing quality measures that could be incorporated into a program to link Medicare payments to quality. Although we initially had concerns about number and validity of some of the measures that CMS proposed for the Physicians Voluntary Reporting Program, we have since reached an understanding with CMS that physicians should begin by reporting on a smaller set of measures that are aligned with those approved by the Ambulatory Care Quality Alliance (AQA). The College has since urged our members to strongly consider participating in the PVRP. We continue to be an active participant in the AQA through our leadership in the AQA's steering committee and through the extensive commitment of time that our volunteer physicians and staff have given to the AQA's work groups on performance measurement and data aggregation and reporting. The College also strongly supports and participates in the AMA's Consortium for Performance Improvement. We commend the AMA for its decision to invest more resources in the Consortium and for the AMA's commitment and leadership to work through the consortium to develop a starter-set of evidence-based performance measures for all specialties that could be incorporated into a voluntary reporting program as early as 2007. We believe that the timeline for developing measures for all specialties as recommended by the AMA and the Consortium is reasonable and achievable.

Creating Incentives for Physicians—Guided Care Coordination

The College is pleased the Commission's work plan includes consideration of models for improving the care of patients with chronic diseases. We specifically urge the Commission and Congress to work with us to pilot test a new model for organizing and delivering primary and principal care that addresses the fact that the U.S. health care system is poorly prepared to meet the current, let alone the future health care needs of an aging population.

This model, called the advanced medical home model, is based on the premise that the best quality of care is provided not in episodic, illness-oriented, complaint-based care, but through patient centered, physician-guided, cost-efficient, longitudinal care that encompasses and values both the art and science of medicine.

Attributes of the advanced medical home include promotion of continuous healing relationships through delivery of care in a variety of care settings according to the needs of the patient and skills of the medical providers. Physicians in an advanced medical home practice are responsible for working in partnership with patients to help them navigate the complex and often confusing health care system. They provide the patient with expert guidance, insight and advice, in language that is informative and specific to patients' needs. In the advanced medical home model, patients will have a personal physician working with a team of health care professionals in a practice that is organized according to the needs of the patient.

Physician practices would apply for voluntary certification that they have met the standards to be listed as a qualified advanced medical home. Although the standards and certification process still need to be fully developed, ACP envisions that qualified practices will have the following kinds of services in place:

- Primary care physicians who practice in an advanced medical home would be responsible for partnering with the patient to assure that their care is managed and coordinated effectively.
- The practice would use innovative scheduling systems to minimize delays in getting appointments.
- Physicians in the advanced medical home would use evidence based clinical decision support tools at the point of care to assure that assure that patients get appropriate and recommended care.
- They would partner with patients to help patients with chronic diseases, like diabetes, manage their own conditions to prevent avoidable complications. Patients would have access to non-urgent medical advice through email and telephone consultations.
- The practice would have arrangements with a team of health care professionals to provide a full spectrum of patient-centered services.
- Advanced medical home practices will also be accountable for the care they provide, by using health information technology to provide regular reports on quality, efficiency, and patients' experience measures.

The advanced medical home is the way that most primary care doctors want to deliver care to their patients, and what most patients want from their physicians. It can only work, though, if Medicare and other payers develop and implement new ways of paying physicians that recognize the value of care coordinated by a personal physician. A revised reimbursement system would acknowledge the value of both providing and receiving coordinated care in a system that incorporates the elements of the advanced medical home model. Further, such a system would align incentives so physicians and patients would choose medical practices that deliver care according to these concepts. Physicians would elect to redesign their practices because the model is supported by enhanced reimbursement for system-based care in the advanced medical home, rather than the volume-based, episodic, fee-for-service system currently in place. Patients would select an advanced medical home based on service attributes such as the patient centeredness of a practice, improved access, and coordinated care—as well as value attributes as demonstrated by publicly available reports on quality and cost.

Pilot testing is crucial before the Advanced Medical Home model can be implemented nationwide. A pilot test would permit exploration of the model's applicability, reliability, strengths, weakness and identification of potential unintended consequences. The College recommends that the Subcommittee ask the Center for Medicaid and Medicare Services (CMS) to conduct a national pilot program in 2007 to determine the feasibility, cost effectiveness and impact on patient care of the advanced medical home in a variety of primary care settings. This effort should specifically address the advanced medical home model, but would complement ongoing and planned CMS pilot programs such as the Medicare Physician Group Practice Project, the Medicare Care Management Performance Demonstration (MMA Section 649), and Medicare Health Support Pilot (MMA Section 721) and Medicare Health Quality Demonstration Program (MMA Section 646). The College will also explore testing of this model with commercial payers.

Conclusion

The College applauds the Medicare Payment Advisory Commission for its willingness to recommend improved ways for valuing physician services, for its commitment to address the reimbursement disparities that are contributing to the collapse of primary care, for its work on developing new models for physician-directed care coordination, and for the leadership it has shown on linking Medicare payments to quality. We applaud Chairman Johnson for her outstanding leadership on advocating for a halt to the SGR cuts and for proposing a way to link Medicare payments

to quality that would gradually phase-in reporting of quality data and provide safeguards against unintended adverse consequences.

Although we are supportive of the specific recommendations made by the Commission for improving the process for valuing physician services, we also believe that more fundamental reforms of Medicare payment policies will be needed, including replacing the SGR with alternatives that provide positive updates to all physicians and that are aligned with the goals of creating incentives for continuous quality improvements and physician-guided are coordination. We urge the Commission and the Subcommittee on Health to work with us and other physician groups to reach agreement on a framework that would fundamentally change the way that we reimburse physicians to recognize the value of the patient's relationship with a personal physician who is working in systems of care, such as the advanced medical home, that are centered on patients' needs. Such fundamental reforms are essential, we believe, to prevent the impending collapse of primary care medicine and to assure that current and future beneficiaries have access to high quality and affordable care.

I would be pleased to answer any questions.

Chairman JOHNSON OF CONNECTICUT. Thank you very much, Dr. Hedberg. Mr. Thiry, welcome, from DaVita Patient Services, California.

STATEMENT OF KENT THIRY, CHIEF EXECUTIVE OFFICER, DAVITA INCORPORATED, EL SEGUNDO, CALIFORNIA; AND IMMEDIATE PAST CHAIRMAN, RENAL LEADERSHIP COUNCIL

Dr. THIRY. First, on behalf of all dialysis providers, thank you to the Committee for this opportunity.

Second, today I am specifically representing the Renal Leadership Council, the RLC, a group made up of providers who take care of over 70 percent of all of America's dialysis patients. That organization includes providers large and small, profit and not-for-profit.

Third, we heartily endorse the MedPAC recommendations and are grateful for the analytical rigor they brought to the task.

Fourth, we also recognize the Committee must consider those recommendations in a broader context, which perhaps could best be characterized by the question: are kidney care providers good citizens in the broader health care community? To that end we would answer four questions.

No. 1: Over the last 5 to 10 years have we demonstrably improved quality? No. 2: Over the last 5 to 10 years have we demonstrably improved productivity? No. 3: Over the last 5 to 10 years have we added a broader value to society and the community rather than just taking direct care? No. 4: Are we willing to be held accountable for our use of taxpayer dollars?

With respect to question no. 1, CMS, the Office of the Inspector General (OIG), National Institute of Health (NIH) and others agree, over the last 5 to 10 years there are few segments of American health care that can so clearly demonstrate improved quality for our patients.

With respect to question no. 2, have we demonstrably improved productivity, the two points that I typically make as a way of making the assertion that the answer is yes quite clear, is back in 1991 when I began, we had, roughly speaking, in most clinics two nurses for every tech. Now in most of our clinics we have two techs for every nurse, and in many instances we are at the statutory limit of one nurse per shift. The other fact we point out is that we pro-

vide 4 hours of hands-on technology intensive care three times a week to our patients. Those 4 hours of hands-on technology intensive care include dietician support, include most pharmaceuticals, include labs, and include social worker support, and the total cost is approximately $220 for Medicare for that 4 hours. We don't know of any comparably intensive therapy in America that can match that productivity.

The fourth and final question, are we willing to be held accountable as a community of care givers? The short answer is, yes, we are prepared to implement a truly substantive pay-for-performance in our community, and that is not just a provider speaking. The Renal Leadership Council is a Member of a broader group, the Kidney Care Partners Coalition, which includes most of the patient organizations, the nursing organization, the physician organization, device and pharma companies, and there is a tremendous consensus and significant substantive momentum toward proposing pay-for-performance mechanisms that would have real teeth and add real value for the patients and the taxpayer.

Hopefully, the answers to those four questions support the assertion that we are a good care-giving citizen within the context of the broader health care community.

The next question the Committee has to ask is, do we need this update? The short answer is yes, and the two things we would point out are, No. 1, we do need the level playingfield that has been referred to earlier by some of the Members of the Committee. Every single day we will lose a 6- or 7-year experienced wonderful nurse or technician to one of the other segments of American health care that receive an annual update, which we do not. We replace that person with a first- or second-year individual, and invest massively to train them, but at some point we cannot continue that trend.

Second, as MedPAC points out, we have a negative Medicare margin. That has historically been subsidized by our ability to increase private pay rates every year. That is no longer the case, and now we are regularly experiencing in fact decreases in private rates from the ever consolidating insurance sector.

We endorse the MedPAC recommendations, and we also endorse the fact that they believe there is room for improvement for patients and the taxpayer in the areas of vascular access, and the areas of nutritional therapy. We also endorse their recommendation that the whole issue of home dialysis be looked at very thoughtfully from a policy point of view in terms of cost, convenience, and impact on the overall system.

Thank you for this time.

[The prepared statement of Mr. Thiry follows:]

Statement of Kent Thiry, Executive Officer, DaVita Patient Services, El Segundo, CA Introduction

Introduction

Chairwoman Johnson, Congressman Stark, and distinguished Subcommittee Members, thank you for inviting me to discuss the Medicare Payment Advisory Commission's (MedPAC) recommendations regarding payment adequacy for providers that care for patients with end stage renal disease.

My name is Kent Thiry, and I am the Chief Executive Officer of DaVita Incorporated. I am also the Immediate Past Chairman of the Renal Leadership Council (RLC), and I am pleased to testify on the RLC's behalf.

The RLC is especially pleased to participate in this hearing given MedPAC's consistent support for improvements and modernizations to the outdated dialysis payment system, which has lagged far behind those of many other Medicare payment systems that receive payment updates each year on an automatic basis. We also appreciate MedPAC's longstanding support of policies that would level the playing field between hospital-based dialysis providers and freestanding providers, and policies that would improve quality and outcomes for our patients overall.

I am here today to discuss this year's MedPAC recommendations, and in so doing to answer four fundamental questions that shed light on our past, present and future commitments to our patients, and that offer a useful lens from which to view our comments on the recommendations. After providing a brief overview of our member companies and the patients we serve, I will take each of the following four questions in turn:

1. *Are we delivering high quality care and do we provide good value for the taxpayer dollars spent on health care?*
2. *Do we support pay-for-performance?*
3. *How important is an annual update to our ongoing quality improvement efforts?*
4. *Do we support the MedPAC recommendations?*

Brief Overview

The Renal Leadership Council is a coalition representing eight renal care organizations that provide care to over 70% of the dialysis patients in the United States. The RLC includes 2 non-profit providers, 3 small providers, 2 mid-sized providers, and 3 large providers. Our members operate more than 3,300 dialysis facilities in 48 states, Puerto Rico, and the District of Columbia, providing care to over 220,000 patients. We are: American Renal Associates, Inc., Centers for Dialysis Care, DaVita Inc., Fresenius Medical Care North America, Northwest Kidney Centers, Renal Advantage, Inc., Renal Care Group, Inc., and Satellite Healthcare.

Most of our patients are Medicare beneficiaries. Today, approximately 93% of the 309,000 dialysis patients in the United States are eligible for Medicare.[1] The illness occurs at the last stage of progressive impairment in kidney function and is a consequence of a variety of conditions, including diabetes, hypertension, glomerulonephritis, and cystic kidney disease. Diabetes is both the primary risk factor for ESRD and its most frequent underlying cause—the occurrence of diabetes in new ESRD patients was 55.7% in 2004.[2] The disease affects minorities in greater proportions than Caucasians, with African Americans being four times more likely to suffer from ESRD.[3] ESRD is fatal without regular dialysis treatments or a kidney transplant. Because of the limited number of organs available for transplantation, most patients receive dialysis treatments three times per week. Each of the blood cleansing treatments lasts from three to four and a half hours per session.

RLC members operate freestanding dialysis clinics and hospital-based centers in both urban and rural areas. Our members have 327 centers in the districts of the members of the Committee, with more than 6,900 employees serving more than 21,000 of patients. The RLC members have dialysis facilities in all the districts of this Subcommittee's Members. All of the RLC member companies are committed to working with Congress and the Medicare program to ensure good patient access to high quality dialysis services across the country.

Discussion

1. *Are we delivering high quality care, and do we provide good value for the taxpayer dollars spent on health care?*

Yes. Over the last ten years, dialysis providers have dramatically improved the quality of care for ESRD patients on dialysis, and continue to do so. In fact, dialysis providers are one of only three Medicare providers to report quality indicators to the Centers for Medicare and Medicaid Services (CMS) and to have that information

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[1] Medicare Payment Advisory Commission, *A Data Book: Health Care Spending and the Medicare Program,* Washington, D.C., at 183 (June 2005).

[2] United States Renal Data System, *USRDS 2005 Annual Data Report: Atlas of End-Stage Renal Disease in the United States*, at 82, National Institutes of Health, National Institute of Diabetes and Digestive Kidney Diseases, Bethesda, MD, available at www.usrds.org/atlas.htm (accessed 2006).

[3] United States Renal Data System, *USRDS 2004 Annual Data Report: Atlas of End-Stage Renal Disease in the United States*, at 32, National Institutes of Health, National Institute of Diabetes and Digestive Kidney Diseases, Bethesda, MD, available at www.usrds.org/atlas.htm (accessed 2006).

publicly available through the World Wide Web via the Dialysis Facility Compare website.[4]

Numerous metrics reflect a service sector that produces excellent clinical quality improvements year after year, and offers exceptional value for the taxpayer:

- The quality of delivered dialysis in the hemodialysis population has improved dramatically over the last decade. According to CMS' 2004 Report of the ESRD Clinical Performance Measures Project, the percentage of patients receiving adequate hemodialysis was 94%, compared to 85% in 1998. Likewise, the number of continuous ambulatory peritoneal dialysis patients receiving adequate dialysis increased by more than 15% over the same period of time.[5] These represent significant increases in patients achieving this goal.
- The industry's commitment to anemia management has resulted in the percentage of patients with hemoglobin levels greater than 11 gm/dl increasing from 43% in 1997 to 80% in 2003,[6] meeting the Kidney Disease Outcomes Quality Initiative (K/DOQI) target.
- The number of hospital days dropped 15% from 1993 to 2001, despite a substantial increase in the age and co-morbidities of patients on dialysis.[7] Similarly, Medicare spending for dialysis patients receiving adequate dialysis is about 15% lower than for those receiving inadequate dialysis. High quality and efficient outpatient dialysis leads to less frequent and less expensive hospitalizations and surgical interventions, reduced drug use, and overall better outcomes for patients.
- The use of fistulas to routinely provide access to the bloodstream for the purpose of providing dialysis treatments has increased from 27.8% in 1998 to 35.2% in 2002.[8] Fistula use is known to lessen complications from dialysis and improve patient outcomes, and is associated with lower per-patient Medicare costs.

Indeed, there have been continuous, demonstrable improvements in patient outcomes, patient safety, and quality of life for patients suffering from kidney failure.

Finally, RLC member companies have improved clinical performance and outcomes by increasing efficiencies and productivity in each treatment. RLC members provide intensive direct patient care services, for approximately four hours during each treatment. Patients are clinically evaluated before dialysis is administered; nurses and technicians spend one-on-one time ensuring patient safety, comfort and clinical effectiveness at each treatment; nutritionists work with patients to educate and improve their dietary habits; and social workers provide a broad range of lifestyle maintenance and counseling services. Facilities provide all of these services, including needed diagnostic tests and pharmaceuticals, to patients for an average per-treatment payment of $215-$220 from the Medicare program.[9] We believe this figure presents an exceptional value for beneficiaries, the Medicare program and the taxpayers who fund it, and could be a model for other financing systems in American health care.

2. *Do we support pay-for-performance?*

The kidney care community is supportive of and ready for pay-for-performance, especially a system that rewards providers who produce positive improvements in patient clinical outcomes, which ideally would be tied to an annual payment updating mechanism (as is done in other Medicare provider segments). As we have discussed, we have already achieved the quality outcomes that are the foundation of any pay-for-performance system. In addition, the Kidney Care Partners—an alliance of the broader kidney care community of which I am privileged to be the current

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[4] *See www.medicare.gov/default.asp*.

[5] Centers for Medicare and Medicaid Services, 2004 Clinical Performance Measures Project Report, (December 2004), available at http://www.cms.hhs.gov/ESRDQualityImproveInit/downloads/2004%20Report%20Describing%20the%20Data%20Collection%20Results.pdf.

[6] *Id*.

[7] United States Renal Data System, *USRDS 2003 Annual Data Report: Atlas of End-Stage Renal Disease in the United States*, at 104, National Institutes of Health, National Institute of Diabetes and Digestive Kidney Diseases, Bethesda, MD, available at www.usrds.org/atlas.htm (accessed 2006).

[8] United States Renal Data System, *USRDS 2005 Annual Data Report: Atlas of End-Stage Renal Disease in the United States*, at 24, National Institutes of Health, National Institute of Diabetes and Digestive Kidney Diseases, Bethesda, MD, available at www.usrds.org/atlas.htm (accessed 2006). A fistula is a surgically created connection between an artery and vein in the arm or leg.

[9] See generally, Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, Washington, D.C. (March 2005).

Chairman and in which the RLC pays a key role—is preparing for additional quality advances in the near future by mapping an ambitious quality improvement agenda—the Kidney Care Quality Initiative (KCQI)—which is charged with developing a consensus-based pay-for-performance program that includes clinical and quality of life measures and takes into account the unique needs of pediatric patients. The KCQI's goal is to develop a program that federal policymakers can implement immediately. We believe this program is ready for consideration now, and we are fully supportive of the efforts of this Committee and other federal policymakers to inject value-based purchasing models into the Medicare ESRD program and into Medicare's other payment systems.

3. *How important is an annual update to our ongoing quality improvement efforts?*

As we have discussed, dialysis providers must seek payment updates directly from Congress each year—an obligation unique to the dialysis payment among most other Medicare payment systems that receive payment updates automatically each year. While this process has resulted in Medicare payments that do not cover patient treatment costs, dialysis providers have continued to provide high quality health care to Medicare beneficiaries. We have been able to accomplish this, despite the Medicare deficits, by cross-subsidizing Medicare reimbursement with the higher rates from private insurance. However, this system is simply *not sustainable* for the future, as the numbers of private pay patients decline and as dialysis providers compete with other health care providers for qualified staff. An annual update mechanism is essential to fixing this unstable cross-subsidization once and for all, ensuring that Medicare pays its fair share for its beneficiaries, as required by the Social Security Act,[10] and allowing dialysis providers to continue providing high quality, cost effective care.

We believe an annual update to the dialysis payment system is a necessary foundation from which to build upon our quality improvements to date. A stable, predictable payment update is an essential step toward putting dialysis payment on equal ground with other Medicare payment systems. Dialysis providers believe in and are guided by the quality imperative, as are others, but in order to be fully competitive—to invest in new technology, commit to hiring high quality staff, and continue to improve productivity—we simply must be provided the same resources as other Medicare providers that work within a steady, seamless financing mechanism.

4. *Do we support the MedPAC recommendations?*

Yes. The RLC appreciates MedPAC's thoughtful analysis of our clinical and economic concerns related to dialysis, including the lack of an annual update mechanism. MedPAC's two payment recommendations from its January 2006 public meetings are appreciated and are generally supported by the RLC.

Recommendation 1: Congress should update the composite rate by the projected rate of increase in the ESRD market basket, less half the productivity adjustment, for services provided in calendar year 2007.

The RLC supports MedPAC's proposed update to the composite rate. We believe the proposed update is justified and imperative for 2007 because it takes steps to meet our real costs in operating clinics and providing clinical services with the newest, most appropriate technology and the most highly qualified staff. RLC members want to deliver the best possible care, and we are pleased by improvements in patient outcomes at many of our companies, but we cannot continue this progress indefinitely without an update formula that takes into account the high cost of new technologies, daily operating costs, and the cost of attracting and retaining high quality doctors, nurses and other clinical staff.

We are pleased with the proposed one year increase in the composite rate for 2007, and with similar proposed increases that preceded it. Given the fact that MedPAC has consistently recommended updates for the last five years, we believe a more comprehensive and consistent policy for updating dialysis services each year is warrantedand essential to our ongoing ability to provide quality dialysis services for our patients. Although the single year updates have helped to narrow the gap in our reimbursement, they have not eliminated our ongoing Medicare deficits. Thus, this payment situation is not viable going forward.

RLC supports an annual update formula modeled after the one currently used within the hospital prospective payment system. Under this model, the Secretary of

[10] *See* Social Security Act § 1861(v)(1)(A)(i) ("—the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs—.").

the Department of Health and Human Services (HHS) would have authority to increase the ESRD "market basket"—*i.e.*, the percentage by which the cost of the mix of goods and services included in the provision of dialysis services, appropriately weighted, exceeds the cost of such mix of goods and services for the preceding calendar year.[11] The Secretary would also take into account the increase in the cost of providing the services due to new technology, new service delivery methods, and other relevant factors. Another important component of this update formula would be to permit the Secretary to periodically review and update the items and services within the market basket.

For our patients, only 7% of whom are not eligible for Medicare, access and quality are directly related to Medicare reimbursement. For this reason, it is essential that Congress maintain its commitment to beneficiaries with ESRD by establishing an annual update mechanism for the dialysis services they need to stay alive.

Over the past five years, MedPAC has consistently called for annual improvements in dialysis payment policy, including upward adjustments to the composite rate, the establishment of quality incentive policies for physicians, and the elimination of unfair site-of-service payment differentials. We thank the Commission for its understanding of and commitment to these proposed policy changes. However, we urge the Commission to go further still and make recommendations to the Congress for the creation of an automatic annual updating mechanism for the dialysis payment, like those available to other Medicare payment systems.

Recommendation 2: Congress should direct the Secretary to (1) eliminate differences in composite rate payments between hospital and freestanding facilities and (2) combine the composite rate and drug add-on adjustment.

The RLC supports both aspects of MedPAC's second recommendation[12]—first, to eliminate the approximately $4 per treatment difference in the hospital-based facility and independent facility composite rates; and second, to combine the composite rate and drug add-on adjustment.

The RLC agrees with MedPAC that CMS should eliminate the differences between hospital-based and independent facilities in paying for composite rate services. There is no data or evidence to suggest that hospital-based facilities treat patients of greater acuity or incur additional, unique costs in treating their patients. Since there is no rationale for doing otherwise, CMS should pay the same rates for the same services, regardless of the treatment setting. In addition, payments should reflect the costs of efficient providers and be adjusted for costs that are beyond the providers' control, rather than allow inefficiencies to continue. If CMS were to maintain different composite rates, hospital-based providers would inappropriately continue to receive higher payments for providing the exact same services that independent facilities do. There is simply no economic or policy justification for this differential. Therefore, we support MedPAC's recommendation to eliminate these differences, and urge the Congress to mandate such action.

We also support the MedPAC recommendation to combine the composite rate and drug add-on adjustment, but note that such action must be done in a way that is consistent with Congressional intent in establishing the drug add-on adjustment. We believe that the proposed combination of composite rate services and the drug add-on adjustment is useful, but only if this combined payment amount is indexed to account for expected annual increases in drug spending, as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Finally, we would like to note that we continue to work with Commission Members and staff on patient nutrition, an issue that has been raised by the Commission. In our experience, one of the key issues that directly affects the quality of patient care and clinical outcomes in the ESRD program is nutrition. Approximately 30–40% of all dialysis patients are malnourished;[13] 6–8% are severely malnour-

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[11] The costs would include labor (including direct patient care costs and administrative labor costs, vacation and holiday pay, payroll taxes, and employee benefits); other direct costs (including drugs, supplies and laboratory fees); overhead (including medical director fees, temporary services, general and administrative costs, interest expenses, and bad debt); capital (including rent, real estate taxes, depreciation, utilities repairs and maintenance); and other allowable costs specified by the Secretary.

[12] Medicare Payment Advisory Commission, *Transcript of January 11, 2006 Public Meeting*, Washington, D.C., at 33–34 (January 2006); *Report to the Congress: Issues in a Modernized Medicare Program*, Washington, D.C., at 89, 91 (June 2005).

[13] Pupim LB, Caglar K, Hakim RM, Shyr Y, Ikizler TA., *Uremic Malnutrition Is A Predictor of Death Independent of Inflammatory Status*, Kidney Int., 2004 Nov; 66(5):2054–60.

ished;[14] and 3–4% fail to respond to conventional nutritional therapies.[15] Severe malnutrition is the best predictor of impending death for dialysis patients. We believe that dialysis providers and federal policymakers must address patient nutrition issues in ESRD care protocols.

I thank you for this opportunity to share the RLC's views with you today, and look forward to answering any questions you may have.

Chairman JOHNSON OF CONNECTICUT. Thank you very much. I appreciate the panel's testimony.

Dr. Hedberg, I particularly appreciate your going into detail about the Advanced Medical Home Practice model, and I will work with you to see if we can't begin getting that out there and test it, because it is truly the rational way to begin to bring fee-for-service Medicare into the capacity to deliver chronic disease management. We have some demonstrations out there to be sure that the fee-for-service component of Medicare keeps up with the times. We can mandate it on the plans, and they have the technology to do it, and they are more integrated, so it is harder for fee-for-service to do it.

I think your approach not only will help us get to proper reimbursements of family physicians and internists that will practice family care, but also will give us a way for that family care to address what we know to be a significant problem with Medicare, and that is the number of seniors with multiple chronic illnesses. When 20 percent at five or more, and almost every senior has at least one, you really are then responsible for moving the system from a silo incident illness payment model to a more holistic health prevention and management model. I look forward to working with you. Our bill needs some refinement in that regard, and I open that opportunity to you and anyone else who is interested. Since your testimony went right to that, I was particularly interested in mentioning that.

The other thing I want you to think about is that MedPAC's testimony recommends these panels, which I think is a promising idea, but only for overvalued services. Undervalued services are just as important, and it was only a couple years ago that MedPAC was concerned about under coding. One of the reasons people aren't choosing family practice is because we undervalue the services that a family practitioner provides. I think it is equally important that if we re going to get into this panel formation, that we get into it with both feet and look at both over reimbursement and under reimbursements. There is a lot to be learned there. I think the system is really quite considerably off base from where it was when it began. I just want to comment on a couple of other things in your testimony, and then I am going to yield to Mr. Stark, and let you add as you would like.

I do want to comment, Mr. Guillard, that while I appreciate the seriousness of the Medicaid under reimbursement issue, you have to admit that the Medicare payment system is a very blunt instru-

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[14] Hakim RM, Levin N., *Malnutrition in Hemodialysis Patients*. Am J Kidney Dis., 1993 Feb;21(2):125–37.

[15] Owen WF Jr, Lew NL, Liu Y, Lowrie EG, Lazarus JM, *The Urea Reduction Ratio and Serum Albumin Concentration as Predictors of Mortality inPatients Undergoing Hemodialysi* s. N Engl J Med., 1993 Sep 30;329(14):1001–6.

ment, because as Mr. Hackbarth pointed out, a home that gets lots of Medicaid and no Medicare, gets all the benefit of the high reimbursements and little of the problem of the low reimbursements. Those homes that take the—you know 95, 90 percent, 85 percent Medicaid are really left then with a problem. I think MedPAC needs to begin mentioning that. I think this Committee needs to be talking about that. We need to be talking about to the other Committee about that. If we want to accurately pay for the services we provide, we are really going to have to insist that other payers, especially that we participate in, at least are accountable to that same measure.

I do want to mention, Mr. Evans, that in your testimony you point out that if the President's recommendations are implemented, you will lose $30 million next year. That is a lot of money when you add up all the factors that you laid out. You brought up in your testimony something that I tried to discuss with MedPAC, but not very well. You are losing money. You say in your testimony that 70 percent of all hospitals lose money on Medicare patients, and yet, you are opening a new hospital. They are seeing that then as everything is all right. If that doesn't indicate that everything is all right, since you have the money to open another hospital, then you need to explain why you are opening another hospital even though you have negative Medicare margins, and maybe may not indicate that everything is all right. I conclude my comments with that question. I invite you to answer it, and then we will go to Mr. Stark, and then you will each have another shot at——

Mr. EVANS. You won't be surprised, Madam Chairman, to learn that I get asked that question fairly often. We have three downtown hospitals, a large pediatric hospital, Riley Hospital for Children, highest level of acuity in America there; Indiana University Hospital, which is an academic medical center. That is where Lance Armstrong went to get his treatment, just to give you some idea of what goes on there. Then a large community hospital, Methodist Hospital, which has the large emergency department that I referred to earlier. We have about 1,200 beds downtown. They are not economically sustainable, so we require a system to support the 1,200 that we have downtown, so we build or own other hospitals throughout the State so we can be a viable system in totality. That is, we have hospitals that lose money and we have hospitals that make money.

At the end of the day, the overall margin for Clarian Health Partners is 4.8 percent. That includes our investment portfolio, which at times during the last decade has been profitable and at time has not been profitable, but we are trying to build an integrated system, so that we are able to support the critical care that occurs downtown by having the more profitable work that occurs in the suburbs—where we built the new hospitals has been in the suburbs.

Chairman JOHNSON OF CONNECTICUT. I think that is telling. In the suburbs you are likely to get a more higher percentage of payers who pay you the cost.

One last question to you, because it also goes to my concern about MedPAC's methodology. Given the things they look at to de-

termine cost, do you think they adequately consider the cost of running an emergency room?

Mr. EVANS. Absolutely not. I will tell you, the emergency rooms, as every manager in this room knows, go on diversion on a regular basis. Every community has to have one that doesn't. That is ours. It does not. It can be profitable to the extent that it feeds certain kinds of trauma to the main hospital, no doubt about that, but a great deal of what it does is the 24-by-7 service that it provides. I am not sure the level of acuity that a Level 1 trauma center presents to its parent hospital is properly recognized anyplace. Madam Chairwoman, here is the tough decision, I think, does society want it or not? If society wants it then they should value——

Chairman JOHNSON OF CONNECTICUT. Like so many things, it wants it but it doesn't want to pay for it, and it is another one of those undervalued service areas. You talk to any emergency room physician—and they don't stay there long because they can't afford to stay there long. It is just as important to look at undervalued services as overvalued services, and that might be part of straightening out the reimbursement kind of mess that we put hospitals in.

My point was—and if you support it, you have to give more and more examples—my point was you just can't look at the bottom-line margins, either Medicare or total, without looking at a combination and what is behind it, where really are the losses being absorbed and where are the profits to offset them. If a specialized hospital bills in the area and draws paying patients off, or in ambulatory surgery center is established and draws paying patients off, what does the community hospital do? Do they cut out services for the poor that are losing money, or do they build cancer care services that might make money?

We need to know more about how in a sense the beast is responding to the pricks in its skin because the responses now are going to have long-term implications for the availability of care in many, many areas, but you all who are professionals can help me know whether my general view is true or not. I am always open to being wrong. If it is true, we have to fill it with far more detail because it is not driving the analysis that drives reimbursements. I could easily be wrong, but anyway, thank you for your testimony.

Mr. Stark.

Mr. STARK. Thank you, Madam Chair.

I just don't know where to begin. I guess I should tell Mr. Evans that I just got a call from the American Hospital Association, and they are going to raise your dues for not pushing for a higher reimbursement. I am not sure they are going to welcome you back to the convention, but I will vouch for you.

I am concerned that in your testimony, there are two things that puzzle me. You suggest that if the rates are cut, you are just going to get more efficient. Now, you did pretty well. You made 72 million bucks in 2003, but isn't your board going to be upset if we were to tell them we heard that you had a lot of areas where you could increase your efficiency and you haven't done it yet?

Mr. EVANS. My board reminds me almost on a monthly basis.

Mr. STARK. I can't also resist, having watched "Goodnight and Good Luck," trying to mimic my former Senator when I grew up, but are you now, or have you ever been——

[Laughter.]

Mr. STARK. —in any kind of a business relationship with or professional relationship with Pat Rooney?

Mr. EVANS. Me?

Mr. STARK. Yes.

Mr. EVANS. I used to be a practicing lawyer, and my law firm represented Golden Rule.

Mr. STARK. Which is where you get your interest in health savings accounts?

Mr. EVANS. No.

Mr. STARK. Okay. Mr. Guillard, and Dr. Hedberg, are either of you guys worried about what is going to happen if we continue to overpay HMOs, what is going to happen to your reimbursements? That trouble you, ever thought about it, Mr. Guillard?

Mr. GUILLARD. In terms of our sector, at the present time we have a growing level of referrals from managed care organizations, and we continue to try to ensure that we get adequate rates from those managed care organizations.

Mr. STARK. you are happy, if we pay it more, you come out well?

Mr. GUILLARD. We still struggle to get rates that are appropriate, given the acuity level of the patients.

Mr. STARK. Dr. Hedberg?

Dr. HEDBERG. What was your question again, sir?

Mr. STARK. We have talked about it, but we are overpaying managed care plans, with the result that we don't have as much money to pay the people you represent. Does that concern you?

Dr. HEDBERG. Many of the people we represent work in HMOs, including Kaiser Permanente and others all over the country, that is part of our Membership, and I haven't thought of this as a major concern.

Mr. STARK. I was thinking for those who operate in fee-for-service. The Kaiser guys are on salary, so that doesn't trouble them.

Dr. HEDBERG. I think most of us recognize that there is a broad spectrum of internal medicine being practiced, and that some are going to be salaried and some are not salaried, and I don't think we pay too much attention to the differences.

Mr. STARK. Mr. Thiry, can you tell me a little bit about DaVita pulled in 228 million bucks and change in profit in 2005. How much of that came, or how do you relate drug rebates that dialysis providers traditionally get from pharmaceutical manufacturers? How big a item is that in your profit?

Dr. THIRY. I don't know the answer offhand. I would have to go back to my group.

Mr. STARK. Would you guess? I don't know the answer. A little bit or a lot?

Dr. THIRY. What I think, we do about 4½ billion dollars in annual revenue, and——

Mr. STARK. How much of that is drugs?

Dr. THIRY. That is at about 35 percent of our cost structure, so we are talking about well over a billion dollars in drug expense, and so——

Mr. STARK. If you have a 5 or 10 percent rebate, it would be a big chunk of change.

Dr. THIRY. Correct.

Mr. STARK. Okay. I guess I would just ask you, are you all sanguine with the budget for this year? Mr. Evans is.

Mr. EVANS. No. In my written statement I did not——

Mr. STARK. I know what I want to ask you. Tell me this—let me give you my test, and I am not really being facetious. Let me ask you how much does a base mammography exam cost at your hospital?

Mr. EVANS. I don't know.

Mr. STARK. How much does a proctoscopic examination cost at your hospital?

Mr. EVANS. I just had one. I will let you know when I get the bill.

Mr. STARK. You don't know it, do you?

Mr. EVANS. No.

Mr. STARK. Who would know more, the chief executive officer of the hospital? I tried this on doctors. We talk about shopping for stuff. Nobody knows what it costs.

Mr. EVANS. Yes. We are——

Mr. STARK. Seriously now.

Mr. EVANS. You are absolutely right.

Mr. STARK. You could give this test, I will bet you Dr. Hedberg isn't sure what a proctoscopic examination costs in his neighborhood, unless you had one just recently.

Dr. HEDBERG. Well, it is very rarely done. It is now a colonoscopy.

Mr. STARK. I am sorry, okay.

[Laughter.]

Dr. HEDBERG. I think that Medicare pays about $250, something like that, $200 to 250 dollars, but some of the private patients are charged much more, maybe in the 600-700 dollar range. These figures are just a guess.

Mr. STARK. I just raise that——

Dr. HEDBERG. I haven't had one for 2 years. It may have changed.

Mr. STARK. What is it, 5 years now or 10? Five, 10 for you.

Dr. HEDBERG. Generally, I think it is 10 now for people who are really clean.

Mr. STARK. I raise that only to say that this idea of the free market is difficult. We met with a thoracic surgeon yesterday, and as he pointed out, 70 or 80 percent of the procedures that he performs are done in a hurry because the ambulance just brought him in, and you are not apt to shop with the ambulance driver giving a Chinese menu of where you could go to get it at what price, and that is what troubles me a little bit about this idea that just by transparency we are going to have people picking things which Dr. Hedberg to help me select, but I am never sure that I know until I talk to him. Then he says, "Stark, you need to do this or that," and I say, "Yes, sir."

Dr. HEDBERG. The instance you brought up though is probably a gunshot wound and nobody argues with anybody in those situations.

Mr. STARK. No. I mean the heart guy goes into some kind of, what do you call it, cabbage or whatever? I mean it is bang, and they need to go quickly. This surgeon said that he thinks about 70 percent of the people he sees in that procedure aren't there—you know it isn't an elective procedure.

Madam Chair, again, thank you. I think it has been a fascinating hearing, and I appreciate your indulgence.

Chairman JOHNSON OF CONNECTICUT. Thank you.

Mr. Evans, is your hospital in Indianapolis involved in one of the demonstrations on price transparency? We are going to have a hearing on this.

Mr. STARK. Can I ask one more?

Chairman JOHNSON OF CONNECTICUT. Yes.

Mr. STARK. You mention in your testimony, the veterans. Do you use that system?

Mr. EVANS. We work with Dr. Bagidn and the Veterans Administration, and we have a——

Mr. STARK. Do you like it?

Mr. EVANS. Yes. We have a robust relationship, and we have a robust——

Mr. STARK. Do you have a chief nerd who knows all about computers and IT on your staff?

Mr. EVANS. We have a nerd department.

Mr. STARK. A whole nerd department.

Mr. EVANS. Yes.

[Laughter.]

Mr. STARK. Mrs. Johnson and I are in the business of chatting with nerds about this stuff, and I am wondering about the veterans program, which people say, "Oh, gee, it is old-fashioned and stuff," but that is why——

Mr. EVANS. The Veterans Hospital is on our campus, so is our Children's Hospital, University Hospital and community hospital are within walking distance of each other, and the public hospital is as well. We have a very robust——

Mr. STARK. We should go look. Will you invite us out to observe?

Mr. EVANS. Consider the invitation extended, and we would be happy to show you how it works, and how the patient can see through the silos if——

Mr. STARK. Dr. Hedberg, if he had Vista could get—and if I was a patient at your hospital and I went to see him, he could get the information quickly——

Mr. EVANS. We went fully online last week, as a matter of fact, and before I came here I asked our chief nerd how many data transmissions we had had so far, and it was well over 100,000. The amount of data is huge. I personally went through it a couple weeks ago with my mom, who presented herself at one of our suburban hospitals, and we were able to get the data transmitted immediately. I consider it a moral imperative, by the way, and this is what I—I didn't say it, but collaboration rather than competition is the way to deal with disease, rather than making the patient jump around from place to place.

Chairman JOHNSON OF CONNECTICUT. Mr. Evans, do you think that the gain-sharing model might be able to encourage collaboration?

Mr. EVANS. Yes, ma'am, for sure.

Chairman JOHNSON OF CONNECTICUT. On the collaboration issue, how many of your physicians out in the community can communicate with your system?

Mr. EVANS. Well, we have all the large groups signed up, so I would guess it is 30 to 40 percent of the physicians. The primary care doctors are organized in large groups, so they will be signed up. We either are affiliated with or own the larger group, so they will be required. Now, signing them up and getting them to use it are two separate things.

Chairman JOHNSON OF CONNECTICUT. Who pays for the technology?

Mr. EVANS. We are paying for it. We have a demonstration grant with CMS. We are the home of Regenstreif Institute, which is the largest clinical——

Chairman JOHNSON OF CONNECTICUT. I think it would be very useful to do that. People do not realize how much CMS is doing to enable the system to try out, to get to the point of interoperability. These grants are very important. I didn't realize you had one.

Then, to answer my first question, aren't you involved in transparency demo too?

Mr. EVANS. I am not sure.

Chairman JOHNSON OF CONNECTICUT. Price transparency.

Mr. EVANS. We have a price transparency demo going on, but I don't know if it is the one to which you are referring.

Chairman JOHNSON OF CONNECTICUT. There aren't very many. I think it is with Aetna in your area.

Mr. EVANS. No. That is the one in Cincinnati.

Chairman JOHNSON OF CONNECTICUT. That is the one in Cincinnati, okay. Well, we will check on that, but we will try to get out and see all the things you have going. Thank you very much.

Mr. STARK. Dr. Hedberg.

Dr. HEDBERG. I just wanted to mention, Thank you very much, Madam Chairman, for your interest in the Advance Medical Home. We think that this proposes a way that we can get proper preventive chronic care for everybody, and we hope that eventually the uninsured would be benefited tremendously by this. This is a comprehensive plan.

Chairman JOHNSON OF CONNECTICUT. In terms of the grants that the government is making available, they are making available some of these grants to urban areas, and they are connecting people up from the emergency room with Medicaid with a chip, and then making sure that the other people do get an electronic health record and are placed with a physician who provides them essentially this medical model, medical home model. However, we need to follow that with a different payment system if you are a medical home. For the uninsured in the small cities—this is not a population that changes a lot, the homeless population doesn't change a lot—we could actually do a far better job of providing not only good care, but preventive care, early intervention

care for the poor, uninsured and homeless by following this model. There are things we need to see out there in the real world, and we will try to make it out.

Dr. HEDBERG. We will be glad to work with you on that, and we believe very strongly that health information technology, the electronic health record and its interoperability is the basis of all of this.

Mr. STARK. Can I follow up?

Chairman JOHNSON OF CONNECTICUT. You certainly can.

Mr. STARK. Doctor, do you see any hope that this medical home or disease management or call it what you will, and its proper reimbursement to the providers might be a special task that the primary care docs, the family docs, and the internists would be best suited to provide?

Dr. HEDBERG. Absolutely.

Mr. STARK. I don't see a surgeon, he would see you once or twice or she would see you once or twice after they spent a couple hours with you, but it is who calls you to say, "Did you walk your half mile today?" It is you guys, and you don't usually get paid much. If we paid them, maybe we would get more——

Dr. HEDBERG. Correct.

Mr. STARK. —or would they worry about signing up at med school, and saying, "Gee, I am just being another clerk."

Dr. HEDBERG. We want to make primary care exciting, and what would make it exciting is to be able to provide what we think they need and what we think they want.

Mr. STARK. A little money might help too.

Dr. HEDBERG. Money helps.

[Laughter.]

Dr. HEDBERG. I like the statement that we want a proactive medical system in the home. That is the spirit, and we want an active patient who knows about their disease.

Chairman JOHNSON OF CONNECTICUT. Dr. Hedberg, one reason I find it distressing to have the kind of conversation we have had earlier in this hearing is that ultimately the combination of the advanced medical home and distance technology will allow rural physicians to manage almost any care protocol because they will have the specialist at their fingertips through the imaging technology, through the consulting technology. It is implanting that technology that was the reason for the Rural Caucus wanting higher reimbursement rates so the plans would be able to afford to hook rural medicine into urban medicine and into medical centers.

Although I know the money sounds bad and we need to look into this, we have to keep in mind that if we don't connect up rural care more effectively so a rural physician, who has had all these years of training and internship and residency, will want to stay there because some of his interesting patients he gets to follow, he gets to manage.

Dr. HEDBERG. Sure. Let's say this: we are desperate to get all of medicine wired into modern health information technology.

Chairman JOHNSON OF CONNECTICUT. We are desperate and that is why I don't like the recommendation, not taking that into account, and I am glad you addressed the pressure you are under from your board every day on productivity.

I do also think that there was a—see, our instruments are too blunt. The Rural Caucus wanted something to happen that we wouldn't have objected to, so your concept gives us a way to begin to re-approach that in a way that is more carefully associated with care. The blunt instrument of raising the rural floor was not something I supported to begin with, but it is there, and that was the reason for it, to keep physicians in the rural area, and to give plans enough reimbursement to use the technology to be able to hook people together. I was there when those discussions were held. That is what the slush fund is for that the Administration doesn't want to give up, and so on and so forth.

We need to look holistically at the system like we need to look holistically at individual people and their health needs, and I hope we will be able to get to that in a rational way, although this environment is far from a rational environment in which to try to do that. Thank you very much. I appreciate Mr. Stark for staying, and his real intense interest in the topic that we have come to here at the end, which is ultimately the challenge we face.

Dr. HEDBERG. We feel that we can link this concept with the traditional physicians' feelings for their patients and wanting to help, and wanting to have the time to help. We can really rejuvenate the profession.

Chairman JOHNSON OF CONNECTICUT. Thank you. The hearing is adjourned.

[Whereupon, at 5:24 p.m., the hearing was adjourned.]

[Question submitted from the Honorable Sam Johnson to Glenn M. Hackbarth and his response follows:]

Question: MedPAC has articulated its support for giving the HHS Secretary authority to regulate gainsharing arrangements. However, one of my concerns with gainsharing is its impact on small, innovative medical device companies (some of which are in my district), who must already overcome restrictive/anticompetitive practices in the current marketplace.

My understanding is that the practical implication of gainsharing—whatever its hypothetical implications may be—is that hospitals are contracting with only the market leaders. Therefore, gainsharing could have the unintended negative consequence of limiting diffusion of new technology into the marketplace and ultimately harming patient care and stifling innovation. Can you please address this issue?

Answer: Gainsharing should improve competition based on cost and quality for medical devices and supplies. Under gainsharing, hospitals and physicians agree to share savings from reengineering clinical care in the hospital setting. Such efforts could include the use of lower-cost, but equally effective, supplies and devices and improving compliance with clinical protocols.

There arrangements have the potential to improve care and reduce costs, provided there are safeguards in place. In MedP AC's report on the issue, we recommended that these arrangements include specific measures to ensure that lower quality does not result. Gainsharing arrangements would also need measures to ensure that physicians are not rewarded for changing their referrals. For example, arrangements approved by the Office of the Inspector General do not limit physicians' ability to choose the most clinically appropriate device or supply.

Currently, physicians often do not benefit from choosing lower-cost, equally effective products because the hospital in which the physician works keeps all of the savings (and is prohibited under law from sharing these savings with physicians). Under gainsharing, the hospital could share these savings with physicians. Device companies would be rewarded for developing lower-cost, clinically equivalent products. Because physicians would still be able to choose the most appropriate device for a patient, companies that develop higher-cost products that are clinically superior would not be penalized.

[Submissions for the record follow:]

Statement of American Association of Homes and Services for the Aging

The American Association of Homes and Services for the Aging (AAHSA) appreciates this opportunity to submit a statement for the record of the Ways and Means Health Subcommittee's hearing on the March report by the Medicare Payment Advisory Commission (MedPAC).

AAHSA members serve two million people every day through mission-driven, not-for-profit organizations dedicated to providing the services people need, when they need them, in the place they call home. Seventy percent of our members are faith-based. Our members offer the continuum of aging services: home and community based programs, adult day programs, continuing care retirement communities, nursing homes, assisted living, and senior housing. AAHSA's commitment is to create the future of aging services through quality people can trust.

We are extremely concerned about MedPAC's recommendation that nursing facilities should receive no payment updates for inflation in 2007. We believe that MedPAC's own findings do not support this position for non-profits. MedPAC itself found that (1) Medicare margins for non-profit skilled nursing facilities are approaching zero, and (2) that the Medicare Resource Utilization Group (RUG) system adopted by CMS last year does not accurately account for the cost of caring for residents with complex conditions. The combination of these factors has a devastating impact on non-profit nursing homes.

1. Not-for-profits' Medicare payment margins are approaching zero

On Dec. 8, 2005, the MedPAC staff publicly reported the difference between for-profit and non-profit skilled nursing facilities' Medicare reimbursement margins for the first time. While for-profit margins were well over 10 percent, margins at non-profits approached zero. MedPAC could not provide conclusive evidence to explain this difference, but they did find that non-profits had higher costs per day than for-profits, possibly due to higher nursing and other care-related costs.

The report stated that:

"Although the estimated overall SNF sector margins adequate to cover the costs of providing care to Medicare patients . . . as the margins are projected to decline in 2006 [to 9.7 percent for all SNFs] certain categories of providers—government facilities and voluntary facilities—margins are approaching zero." (page 176)

On not-for-profits' access to capital:

"Analysts continue to have a negative outlook for the non-profit SNF sector. Annual public debt issurance for non-profits dropped again in 2004 . . . and it's expected that there won't be any investment grade [non-profit] nursing homes." (page 174)

MedPAC reported that, for FY 2004, for-profits had margins of 16% and non-profits had margins of 4%. In December, MedPAC estimated the 2006 Medicare margin for all (for-profit and not-for profit) freestanding skilled nursing facilities to be 9.7% based on policy in current law. Changes to bad debt reimbursement policy and the Deficit Reduction Act would reduce the overall margin to 9.4%, with non profit margins approaching zero. The significant reduction in margin percentage between 2004 and 2006 results from the revised RUG system and the accompanying elimination of temporary payment add-ons.

MedPAC estimated that in 2006 the combined effect of all these payment changes will be a 0.1% increase for all facilities, and a negative 0.4% for freestanding skilled nursing facilities. Hospital-based facilities are estimated to receive payment increases. Urban hospital-based facilities are expected to see increases of 4.6% and rural ones 4.1%. Despite these modest gains, hospital-based SNFs are still projected to have extremely negative margins—losing money on every Medicare patient they treat.

2. Revised RUG system will cut skilled nursing facilities' reimbursement

The Medicare skilled nursing facility reimbursement system, which is prospective based on Resource Utilization Groups (RUGs), is supposed to determine acuity of need and responsibly calculate the cost and pay for it. CMS issued a revised RUG system in 2005 that was supposed to accomplish this goal, but as MedPAC has acknowledged, the payment system still contains significant flaws.. Medicare payment add-ons that had been in effect before the latest revision in the RUG system ended at the beginning of this year. The new system inadequately reflects the true costs of care for medically complex patients, who generally require not only extensive nursing care but also significant amounts of medications, supplies, tests, respiratory care, and other so-called "non-therapy ancillaries". Nursing facilities therefore face significant losses in Medicare reimbursement this year and every year hereafter.

CMS began revising the RUG III system shortly after it went into effect in 1998 because research clearly showed that the system did not pay accurately, especially for medications and other "non therapy ancillaries." Medicare reimburses skilled nursing facilities for many very expensive patients at considerably lower rates than Medicare pays for patients whose care costs much less. The Inspector General, MedPAC, and the GAO have all reported that these inaccuracies. As MedPAC noted in its comments to CMS on the proposed refinements, CMS did not adequately address these problems when it removed the add-ons, leaving care of complex patients still not properly accounted for.

The new RUG system poses the following problems for nursing homes and their residents:

(a) Quality of patient care implications

- The new system creates strong financial incentives for nursing facilities to find patients who qualify for the nine new RUG groups.
- To qualify for the nine new (higher) payment groups, patients must be assigned to intensive physical therapy and to "Extensive Services." The "Extensive Services" designation requires that the patient have an activities of daily living score greater than 7 and have had intravenous medications, ventilator or respirator care, a tracheotomy or suctioning within the last fourteen days, or intravenous feeding within the last seven days, even if these treatments were given during hospital stays.
- There will be intense financial pressure on facilities to "find" such patients, because otherwise facilities will have substantial financial losses under the new rule, about 7—8 percent below current reimbursement.
- The availability of patients qualifying for the new RUG categories will depend heavily on local hospital practices, particularly as to how frequently intravenous medication (rather than oral) is ordered. Hospitals seeking to find a SNF for patients who are being discharged will soon learn that Medicare payment rules favor SNF patients who had an IV in the hospital. Practice patterns are likely to shift in ways that have more to do with perverse payments than with good clinical care.

(b) There is no evidence that payment accuracy will be improved by the new payment system; in fact, accuracy could actually be reduced.

- CMS cites only one piece of scientific evidence in the final rule in an attempt to justify the nine new RUGs groups and the contention that the new system is more accurate, as Congress required. But this bit of "evidence" is not relevant to the changes CMS actually made in the payment system and is the result of researchers studying a completely different issue.
- CMS has refused to release the scientific study on which the new system is supposed to have been based; nor has the agency sent Congress the legally mandated report on the topic, due January 1, 2005.
- Increased payments are not targeted to medically complex patients who do not receive rehabilitation, even though their care can be very costly, with heavy use of non-therapy ancillaries. The previous payment add-on for these patients has expired, reducing the reimbursement for their care relative to payments for care of non-medically complex patients receiving rehabilitation.
- Also, non-therapy ancillary costs would continue to be paid as if they correlated with nursing costs, which research has repeatedly shown is not the case. CMS itself noted that the new payment system would not account accurately for non-therapy ancillary costs, and that the addition of nine new RUG categories didn't solve this discrepancy. CMS attempted to solve the problem by applying the same small increase in the nursing index across all RUG groups, about three percent of total revenues. But because the payment system doesn't accurately cover non-therapy ancillaries or correlate to the nursing index, the payment system still does not accurately correlate costs of care with payment rates.
- CMS used tiny samples of patients who classify into the new RUG groups in doing its data analysis. For three of the new RUG groups, payments for millions of Medicare days are being set based on what happened to fewer than ten patients in a small number of facilities nine to twelve years ago. Among other problems, this use of small samples risks destroying the accuracy of the current payment system's correlation of payment rates to nursing and therapy staff times.
- In doing its data analysis, CMS mixed apples and oranges, using some numbers from Abt Associates and other numbers from the Urban Institute. Each of these

studies used different databases, different analytical techniques, and likely different trim points.

- The new RUG system incorporated an inaccurate therapy index for computing reimbursement, a mistake that CMS did not adequately correct before the new system became final.

(c) Revisions to the wage index will cause severe financial losses to many facilities and will result in geographic inequities in payment rates.

- Although CMS has predicted a $20 million increase in payments to nursing facilities for *fiscal year* 2006 (October 1, 2005—Sept 30, 2006), in *calendar year* 2006 and in *every year thereafter*, facilities will have real losses in revenue because the previous payment add-ons have ended and the inaccuracies in the system have not been fixed.
- The new RUG system continues to use inpatient hospital wage data to define local market differences for skilled nursing facilities. This hospital wage index does not as appropriately adjust for variations in nursing home labor costs as an index specific to nursing homes would.
- The new rule applies new labor market designations issued by the Office of Management and Budget to nursing facility payments. According to calculations by over 800 AAHSA nursing facility members, the redrawn geographic areas will cause substantial losses to many facilities.
- Because of the lack of a nursing facility-specific wage index, these facilities cannot apply for reclassification, as hospitals located in the same geographic areas might.
- The short, one-year phase-in period that CMS set in the final rule will make it especially difficult for skilled nursing facilities to adjust to the new geographic designations and wage index based on hospital data.
- CMS could have, but failed to mitigate the losses through a more equitable transition, involving a temporary redistribution of resources from facilities that experience extremely large increases in wage index to those that experience large decreases.

3. Medicaid under-reimburses for nursing home care

In the long-term care field, Medicaid serves as a stable but inadequate source of reimbursement for the care of those who have exhausted their own financial resources. The costs of care do not disappear, however, if they are not fully covered by Medicaid.

Federal law mandates that nursing homes in particular provide the level of services that residents need to achieve and maintain their highest practicable level of functioning. Nursing homes have to spend whatever it costs to provide this level of care. If states reimburse nursing homes at less than the cost of care provided, as they generally do, the shortfall must be made up from other sources.

Approximately 66% of nursing home residents have their care covered by the program, as do 35% of those receiving home and community-based services. Medicaid's failure to adequately reimburse health care providers for the care it covers makes it all the more important that nursing facilities receive appropriate reimbursement levels from Medicare. Every year, the Medicare Payment Advisory Commission (MedPAC) reports to Congress that nursing homes are being well paid by Medicare for the costs of care covered by that program. These reports never discuss the fact that Medicare reimbursements must cross-subsidize inadequate Medicaid reimbursement.

Similarly, nursing homes frequently are forced to raise rates for privately-paying residents above the level they otherwise would have to pay in order to counteract the inadequate reimbursement facilities receive for the care of residents covered by Medicaid. Thus, inadequate funding by public programs has become an unfair tax on privately paying frail seniors, those whose modest savings and incomes are already stretched.

4. Cost of providing nursing home and home health care is rising

CMS itself projected that the cost of the things that skilled nursing facilities must buy will increase by 3.1% over the next year.

A key component of long-term care, both in nursing homes and in the community, is staffing. Long-term care is a labor intensive service—40% of the cost of nursing home care is for nursing staff—the key to quality. Adequate funding therefore is a necessary (if insufficient) condition of quality care. The literature confirms the obvious: homes that spend more on nursing have better quality of care.

President Bush's budget for fiscal year 2007 proposed a 2.2% pay raise for both federal civilian employees and military personnel. This budget request reflects the Administration's recognition that higher wages will be necessary to attract and re-

tain qualified workers in the coming year. In view of the continuing severe shortage of nurses nationwide, health care providers may well have to offer even greater pay increases in order to attract and retain the caliber of direct care workers needed to give high-quality care.

Conclusion

The denial of a payment update to skilled nursing facilities in 2007 would impose a severe hardship, especially in the not-for-profit sector, making it extremely difficult for facilities to meet the costs of staffing and other elements of high-quality care. Data from CMS and MedPAC themselves indicate the need for a payment update in the next fiscal year, and Congress must allow the update for which current law provides.

Striving to provide the highest quality of care, not-for-profit nursing facilities are spending every dollar of reimbursement they receive from Medicare. The denial of a payment update would be a heavy financial blow to these facilities.

Statement of American College of Cardiology, Bethesda, Maryland

The American College of Cardiology (ACC) appreciates the opportunity to provide a statement for the record of the subcommittee's hearing on the March 2006 Medicare Payment Advisory Commission's (MedPAC) report to Congress.

The ACC is a 33,000 member non-profit professional medical society and teaching institution whose purpose is to foster optimal cardiovascular care and disease prevention through professional education, promotion of research, and leadership in the development of standards and formulation of health care policy.

The ACC commends the subcommittee for its work to address the problems with the current system of Medicare physician reimbursement. We are committed to working with Congress and the Administration to strengthen the Medicare program and to ensure that Medicare patients can benefit from the life-saving and life-enhancing care that cardiovascular specialists provide. As such, the ACC outlines its position below on many of the issues MedPAC addresses in its current or past reports, including the Medicare physician reimbursement formula, office-based medical imaging, valuing of physician services and pay-for-performance.

Medicare Physician Reimbursement Formula

The ACC thanks Congress for its action to stop the 4.4 percent cut in Medicare physician reimbursement scheduled for 2006 by enacting a one-year freeze in reimbursement levels through the Deficit Reduction Act of 2005 (DRA). However, we are concerned that physicians continue to face cuts in reimbursement totaling 25 percent over the next six years, including a 4.6 percent cut scheduled for January 1, 2007. The ACC is also concerned that Congress singled out office-based medical imaging for significant cuts in the DRA arbitrarily and without a public vetting process. The cumulative effect of these cuts, in addition to administrative changes being considered by the Centers for Medicare and Medicaid Services (CMS), will devastate some physician practices like never before, resulting in challenges for Medicare beneficiaries in accessing needed medical services.

We appreciate that MedPAC recommends an update of 2.8 percent in 2007 Medicare physician reimbursement in its report to Congress. The ACC urges Congress to act in 2006 to avert further scheduled physician reimbursement cuts and to correct underlying flaws in the Sustainable Growth Rate (SGR) reimbursement formula. This formula should be eliminated and replaced with a formula that more accurately reflects the cost of providing health care services to Medicare beneficiaries. Medicare physician payment rates that keep pace with the rising cost of practicing medicine are essential to physicians' efforts to improve the quality of care provided to Medicare beneficiaries, and in some cases, to provide care at all.

The ACC also commends the efforts of Congress to address quality improvement through pay-for-performance type programs. The ACC's position on pay-for-performance is described in detail below; however, it is important to note that physicians will be unable to develop the infrastructure required to support effective pay-for-performance systems if steep cuts in reimbursement are allowed to continue. The ACC is grateful for Chairman Johnson's attention to this concern, and we support her legislation, the "Medicare Value-Based Purchasing for Physicians' Services Act of 2005" (H.R. 3617), which would replace the SGR formula and establish a value-based system for Medicare physician reimbursement. In addition, we are pleased that several of the health information technology (HIT) proposals before Congress would provide incentives, such as tax credits, to physician offices for implementing

HIT systems. Such incentives will be critical in helping physician offices build the infrastructure necessary to participate in pay-for-performance systems, particularly for small physician practices.

Office-Based Medical Imaging

The ACC believes the increase in office-based medical imaging utilization needs to be studied to determine the extent to which the growth is appropriate and medically necessary. MedPAC, in its 2005 examination of imaging growth, could not determine if the growth in imaging utilization is inappropriate. The ACC recognizes the intense pressure to control Medicare spending; however, Congress should be cautious in singling out specific physician services (such as medical imaging) on the basis of growth alone to achieve cost savings through arbitrary cuts.

The ACC is disappointed that Congress enacted significant cuts to office-based medical imaging in the DRA, and we urge Congress to mitigate the cuts before they take effect on Jan. 1, 2007. Under the DRA, the technical component of office-based imaging services will be paid at the lesser of the Medicare Physician Fee Schedule (MPFS) or the Hospital Outpatient Prospective Payment System (HOPPS) rate. These cuts were included in the dead of night without open dialogue. In many cases, the HOPPS payment rate would not reflect the true costs of owning and operating imaging equipment in the physician office. Many physicians may no longer be able to afford to provide imaging in their office due to the cuts, which will drive Medicare beneficiaries to the hospital setting where they could have longer wait times, will loose the benefit of having imaging services performed by their treating physician, and in some cases, will be responsible for co-pays up to 40 percent of the hospital payment. Co-pays in the physician office setting are limited to 20 percent.

Quality initiatives for medical imaging developed by specialty societies, such as the development of appropriateness criteria, quality measures and certification standards, are growing and should continue. For instance, the ACC is working to foster collaboration among health plans, payers and cardiologists to improve the efficiency and equity of cardiovascular imaging. Last fall, the ACC and the American Society of Nuclear Cardiology (ASNC) released Appropriateness Criteria for Single-Photon Emission Computed Tomography Myocardial Perfusion Imaging (SPECT MPI) as a means of defining "when to do" a specific procedure in the context of scientific evidence, the health care environment, the patient's profile and a physician's judgment. The ACC currently is developing appropriateness criteria for CT, MR and echocardiography, all of which will be completed in 2006. It is important to note that the ACC is employing a collaborative and multi-disciplinary approach to the development of appropriateness criteria.

The ACC believes that such efforts help to ensure that Medicare and private payers spend its resources on the most effective, most appropriate care for beneficiaries. Neither arbitrary payment cuts, nor one-size-fits-all regulatory requirements can achieve this goal. Public policy initiatives should support efforts by individual medical societies to ensure appropriate utilization by qualified specialists, but should not encumber these efforts by overly burdensome regulations or duplicate them through the implementation of generic, non-specialty specific requirements.

Valuing Physician Services

Ensuring the accuracy of the work relative value units in the physician fee schedule and the fairness of the process for reviewing those values is a high priority. During the past year, MedPAC has devoted substantial attention to discussions about the role of the American Medical Association Specialty Society Relative Value Scale Update Committee (RUC) in helping the Centers for Medicare and Medicaid Services (CMS) review, maintain, and update Medicare's Resource Based Relative Value Scale (RBRVS). The ACC was a founding member of the RUC and has been an active participant in the RUC process since its inception. The ACC believes that the cooperation between the RUC and CMS is an outstanding example of a successful public-private partnership and we take MedPAC's recommendations for improving this process very seriously. We are, therefore, concerned with several aspects of MedPAC's report on valuing physician services.

The Commission's recommendations for improving the review process for the work relative values center on establishment of an expert panel to assist CMS and "augment" the RUC process. There is no question that lack of resources limits CMS's ability to identify services that warrant review and to provide the RUC with supporting data for that review. MedPAC has not, however, provided evidence that investing resources in an expert panel is the best way to improve the accuracy of physician reimbursement. The ACC urges that CMS be consulted regarding the need for and potential benefit of an expert panel before one is established. We also note that the RUC and the specialty societies are acutely aware of MedPAC's concerns

about the RUC's ability and willingness to identify and review overvalued services. The RUC is now considering ways in which to strengthen its performance in this area.

The Commission has been concerned about the ability of the RUC to overcome what the report describes as specialty societies' financial stake in the outcome of the RUC's deliberations. Although it is certainly true that members of one specialty society may have a financial stake in having the RUC recommend high values for their codes, physician reimbursement still operates within a zero sum game. Therefore, the RUC process assures that one specialty society's representatives must also persuade other physicians who have a financial stake in keeping other specialty's values low. Competing interests result in the RUC providing a very rigorous review of all specialties' recommendations.

MedPAC has also been concerned that the RUC's composition does not provide adequate representation for primary care physicians. The RUC's primary function is to recommend relative values for new procedures, most of which are performed by non-primary care specialties. It is essential that the RUC encompass the broad spectrum of medical practice to ensure that adequate expertise is available to review new procedures. The combination of viewpoints and broad range of experience RUC members bring to the process has been a key to the committee's ability to closely examine and evaluate the work of new technology.

Pay-for-Performance

Discussions regarding physician payment reform increasingly revolve around proposals that would transition the Medicare program to a performance-based reimbursement system. The ACC supports the concept of aligning financial incentives with the performance of evidence-based medicine to inspire greater focus on improving care delivery systems. In fact, the ACC has a long history in working with CMS on cardiovascular care performance measurement and quality improvement. Below are a few examples of our collaborations:

- The ACC and American Heart Association (AHA) issued their first clinical practice guideline on Implantation of Pacemakers in 1984, in part to respond to a CMS (then HFCA) request for expert opinion on patient indications for the device.
- In 1993, the ACC lent support to development by CMS of objective performance measures based on the ACC/AHA Guideline for the Early Management of Patients with Acute Myocardial Infarction. These measures tracked inpatient care first at the state level and then at the national level.
- The ACC, AHA and Physician Consortium collaborated in 2003 on coronary artery disease (CAD), Heart Failure and Hypertension measurement sets. CMS agreed to use many of the measures from these sets in the Doctors Office Quality demonstration project.
- The ACC, AHA, CMS and JCAHO collaborated on updating the ACE measure for acute myocardial infarction (AMI) and Heart Failure patients in 2004.
- Last spring, the ACC, AHA, CMS, JCAHO and AHRQ issued a practice advisory on the impact of the COMMIT trial on current beta blocker measures for AMI patients.
- In the fall, CMS announced mandatory use of NCDR ICD Registry for data collection for the devices.
- Finally, in 2006, the ACC, AHA, CMS, JCAHO and AHRQ issued an editorial on collaboration related to evolution of STEMI/NSTEMI measures.

The ACC's experience with performance measurement in cardiovascular care reinforces our belief that physician pay-for-performance systems should be designed to support and facilitate the quality improvement process and strengthen the patient-physician relationship, not just to report performance and outcomes or to control Medicare spending. The ACC, therefore, developed the following principles to guide the development of pay-for-performance programs. Physician pay-for-performance programs should:

1. Be built on evidence-based, well established and proven performance measures.
2. Provide adequate incentives for investments in structure, best practices and tools that can lead to improvement and high quality care.
3. Reward process, outcome, improvement and sustainability.
4. Assign attribution of credit for performance to physicians in ways that are credible and encourage collaboration.
5. Favor the use of clinical data over claims based data.

6. Set targets for performance through national consensus processes that address factors such as local resource constraints and socio-demographic differences.
7. Address appropriateness (i.e. what behaviors should be encouraged as well as discouraged).
8. Emphasize success and reward achievement, rather than be punitive.
9. Use an objective third party to audit performance measure data.
10. Establish transparent provider rating methods.
11. Not create perverse incentives, such as excluding sicker patients from a physician's panel.
12. Invest in outcomes and health services research.

Conclusion

As the subcommittee works this year to strengthen the Medicare program and improve the Medicare physician reimbursement system, the ACC is committed to working with you. Thank you for the opportunity to provide a statement for the record. Should you have any questions, please contact Camille Bonta or Jennifer Brunelle.

American Dietetic Association
Chicago, Illinois 60606
March 14, 2006

Nancy L. Johnson
Chairman
Subcommittee on Health of the Committee on Ways and Means

The American Dietetic Association (ADA) represents the largest professional association of Registered Dietitians (RDs) with a membership of approximately 65,000. RDs apply evidence-based practice and intensive counseling to promote and achieve good health through behavior, nutrition and physical activity interventions. ADA presents the following comments regarding the Medicare Payment Advisory Commission's (MedPAC) March Report on Medicare Payment Policies.

Registered dietitians became Medicare Part B providers in 2002, when the Centers for Medicare & Medicaid Services developed regulations for the Medicare medical nutrition therapy (MNT) benefit that was signed into law by President Clinton. RDs are paid from the physician fee schedule, therefore MedPAC's comments are of interest to ADA.

Update the Physician Fee Schedule in 2007

ADA supports MedPAC's recommendation "Congress should update payments for physician services in 2007 . . ." ADA agrees the impending physician fee schedule cuts that CMS projects through 2011 will adversely affect Medicare providers' participation in Medicare Part B. Although MedPAC's report reviewed access to beneficiary care provided by physicians, ADA is concerned that continued fee schedule reductions will negatively impact participation in the program by other Medicare non-physician providers. In certain geographical settings, beneficiaries may have limited access to nutrition services provided by RDs due to fee schedule rates that limit RD participation in Medicare. Continued decreases in the fee schedule may impact current Medicare RD providers' level of participation, and limit future Medicare RD provider enrollment.

Seek alternatives to the flawed SGR

ADA feels the sustainable growth rate (SGR) is flawed and contributes to the ongoing problems associated with downward spiraling of the Medicare physician fee schedule rates. Similar to many other medical societies' recommendations for fixing' the SGR, ADA believes the SGR should reflect professional services. The inclusion of drugs in the SGR is unwarranted and should be removed.

Quality indicators for Medicare services

ADA agrees with MedPAC's recommendations to improve the value of services provided to beneficiaries through quality improvement initiatives. RDs provide patient-focused, evidence-based practice using nationally recognized protocols to deliver quality services to Medicare Part B beneficiaries with diabetes and renal disease. We agree that adoption of quality measures extends beyond Medicare; support and adoption of common measures are needed among all third party payers.

Considerable effort will be needed to coordinate the development of standard quality measures, develop an infra-structure for data collection, data analysis and re-

porting of quality measure results, including the training and inter-rater reliability measurement of those collecting the data.

ADA and its members are involved in a variety quality improvement initiatives spearheaded by the ADA Quality Management Committee. A few of these activities are listed in Appendix 1.

Closing comments

ADA recognizes MedPAC's effort to complete the recent Medicare Payment Policies report. We concur with the need to adjust the physician fee schedule and SGR. While MedPAC indicated that primary care physicians were the group most impacted by the current fee schedule methodology, ADA believes access to quality Medicare Part B services provided to beneficiaries by a variety of Medicare providers, physician and non-physician professionals, will be restricted if corrections to the fee schedule are not undertaken next year.

ADA will continue to actively participant in dialog with CMS and Congressional leaders to impact physician fee schedule methodologies. Please do not hesitate to call either Pam Michael, MBA, RD, Director of Nutrition Services Coverage team at 312–899–4747 or Mary Hager, PhD, RD, Senior Manager, Regulatory Affairs at 202–775–8277 with any questions or requests for additional information.

Best regards,

Pam Michael, MBA, RD
Director of Nutrition Services Coverage
Mary H. Hager, PhD, RD
Senior Manager, Regulatory Affairs

Appendix 1

American Dietetic Association Quality Improvement Activities

As MedPAC and CMS moves forward with efforts to measure healthcare quality in skilled nursing facilities, please take into consideration some of ADA's ongoing quality improvement initiations:

- The American Dietetic Association is preparing a Nursing Home Weight Loss Quality Measure toolkit for Registered Dietitians, April 2006
- The American Dietetic Association has established a process for evidence based-analysis that will be essential to the development of any nutrition and food service-related quality measures:

http://www.adaevidencelibrary.org/default.cfm?auth=1
http://nutritioncaremanual.org/

- The American Dietetic Association is preparing the following evidence-based guidelines from which national quality measures can be developed:

1. Disorders of Lipid Metabolism Toolkit, June 2006
2. Adult Weight Management Evidence-Based Guideline, May 2006
3. Adult Weight Management Evidence-Based Toolkit, October 2006
4. Critical Illness Evidence-Based Guideline, July/Aug 2006
5. Pediatric Weight Management Evidence-Based Guideline, May 2007
6. Hypertension Evidence-Based Guideline, Dec 2006/Jan 2007
7. Heart Failure Evidence-Based Guideline, Dec 2006/Jan 2007

- The American Dietetic Association requests the opportunity to contribute to if not lead the work related to the development, collection and analyses of nutrition and food service quality measures.
- The American Dietetic Association requests the opportunity to provide comments regarding improvement opportunities surrounding the current Nursing Home Weight Loss Quality Measure.
- The American Dietetic Association requests the opportunity to provide comment regarding all nutrition and food service-related Nursing Home Quality Measures, currently in place.
- ADA Publication: Niedert KC, Dorner B. Nutrition Care of the Older Adult: A Handbook for Dietetics Professionals Working Throughout the Continuum of Care 2nd Edition; Part V. Regulatory Compliance; Ch. 27. Quality Management; Ch. 28. Federal Regulations. American Dietetic Association, 2004.

Statement of the American Medical Association

The American Medical Association (AMA) appreciates the opportunity to provide our views today regarding MedPAC's March Report on Medicare payment policies, and we commend you, Madam Chairman, and Members of the Subcommittee, for all of your hard work and leadership in recognizing the fundamental need to address the fatally flawed Medicare physician payment update formula, called the sustainable growth rate, or SGR.

CONGRESSIONAL ACTION IS NEEDED THIS YEAR TO HALT PHYSICIAN PAYMENT CUTS SCHEDULED FOR 2007

We are grateful to the Subcommittee and Congress for enacting a freeze in Medicare physician payment rates for this year, reversing the 4.4% cut that had taken effect for 2006. Despite this intervention, however, a crisis still looms. It is projected that on January 1, 2007, payment rates will be cut across-the-board by about 5%. **The 2006 Medicare Trustees report is expected to project cuts in physician payment rates totaling 34% through 2015.**

The AMA shares in federal policymakers' vision of transforming the Medicare physician payment system into a system that delivers the highest quality of care to patiemts using kealth information technology(HIT) and quality improvement initiatives. To fulfill this vision, Medicare payments to physicians must be premised on a stable physician payment system that provides positive payment increases to physicians and accurately reflects increases in physicians' pratice costs. Positive payments are vital for encouraging and economically supporting physicians' ability to make the very significant finanical investment required got HIT and perticipation in quality improvement programs.

There is widespread consensus that the SGR formula needs to be replaced: (i) many members of this Subcommittee, as well as many Members of Congress on a bipartisan basis, have advocated the need to avert the projected physician pay cuts and establish a formula that accurately reflects increases in physician practice costs; (ii) the Medicare Payment Advisory Commission (MedPAC) has recommended that the SGR be replaced with a system that reflects increases in practice costs, as well as a 2.8% payment update for 2007 (as further discussed below); (iii) CMS Administrator McClellan has stated that the current physician payment system is not sustainable; and (iv) the Military Officers Association of America (MOAA) has stated that payment cuts under the SGR would significantly damage military beneficiaries' access to care under TRICARE, which will have long-term retention and readiness consequences.

PROBLEMS WITH THE MEDICARE PHYSICIAN SGR PAYMENT FORMULA

The projected physician pay cuts are due to the SGR formula, which has two fundamental problems:

1. Payment updates under the SGR formula are tied to the growth in the gross domestic product, which does not factor in patient health care needs, technological advances or physician practice costs; and
2. Physicians are penalized with pay cuts when Medicare spending on physicians' services exceeds the SGR spending target, yet, the SGR is not adjusted to take into account many factors beyond physicians' control, including government policies and other factors, that although beneficial for patients, increase Medicare spending on physicians' services.

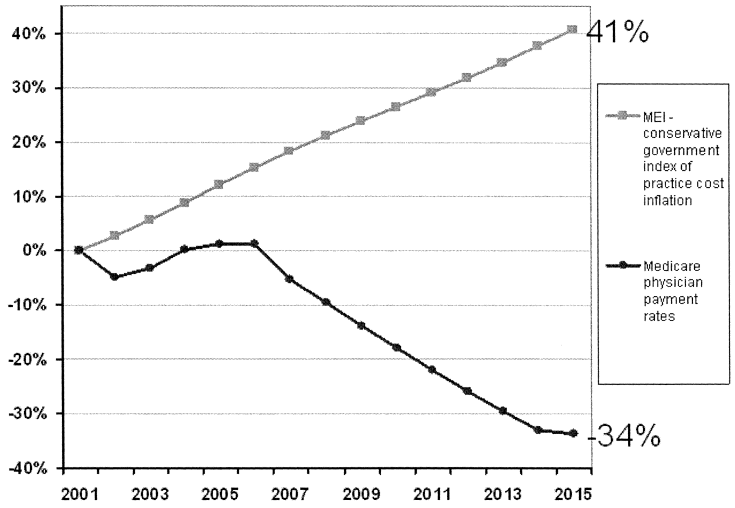
Because of these fundamental defects, the SGR led to a negative 5.4% update in 2002, and additional reductions in 2003 through 2005 were averted only after Congress intervened and replaced projected steep negative updates with positive updates of 1.6% in 2003 and 1.5% in each of 2004 and 2005. We greatly appreciate these short-term reprieves. Even with these increases, however, Medicare physician payment updates during these years were only about half of the rate of inflation of medical practice costs.

Furthermore, as shown by the graph below, these reductions come at a time when, even by Medicare's own conservative estimate, physician practice costs from 2001 through 2015 are expected to increase by 41%. The vast majority of physician practices are small businesses, and the steep losses that are yielded by what is ironically called the "sustainable growth rate," would be *unsustainable* for any business, especially small businesses such as physician office practices.

The **UN**-Sustainable Growth Rate

2001 through 2015:

Physicians' costs **up** 41%; Medicare payments **down** 34%



Sources: Conversion factor update and MEI data from Centers for Medicare and Medicaid Services, Office of the Actuary. Analysis of updates relative to inflation by American Medical Association, Division of Economic and Statistical Research, February 2006.

Sustainable? No way!

Only physicians and health professionals face updates of 7% below the annual increase in their practice costs. Other providers are receiving updates that fully keep pace with their market basket increases. In 2006, for example, updates for other providers were as follows: 3.7% for hospitals, 3.1% for nursing homes, and 4.8% for Medicare Advantage plans (which are already paid at 107% of fee-for-service costs). In addition, CMS recently estimated a national per capita Medicare Advantage growth percentage of 6.9% for 2007.

Similar to these other Medicare providers, it is critical that physicians receive positive payment updates. This is necessary to achieve the new, improved Medicare program envisioned by policymakers that seeks to assure access and the highest quality of care to fee-for-service patients through the use of HIT and quality improvement programs.

Increases in Growth of Volume of Services

Some government officials have argued that the SGR formula is needed to restrain the growth of Medicare physicians' services. This argument ignores the fact that volume growth has accelerated despite the SGR, and blindly assumes that some of this growth must be inappropriate. Spending on physician services, however, is growing for a number of very legitimate reasons. The number of elderly Americans is increasing and more of them suffer from obesity, diabetes, kidney failure, heart disease, and other serious chronic conditions.

Further, last year, Medicare officials announced that spending on Part A services was decreasing. This suggests that, as technological innovations advance, services are shifting from Part A to Part B, leading to appropriate volume growth on the Part B side. In fact, new technology and drugs have made it possible to treat more people for more diseases and to provide this treatment in physicians' offices rather than in more expensive hospital settings. Quality improvement initiatives also have increased the number of beneficiaries receiving physician care. This has led to fewer hospital admissions, shorter lengths of stay, longer life spans, and fewer restrictions in activities of daily living among the elderly and disabled. One of the more interesting findings in MedPAC's 2006 Report is a finding that, based on its 38 quality tracking measures, more Medicare beneficiaries received necessary services in 2004 than in 2002 and potentially avoidable hospitalizations declined as well.

While the foregoing studies suggest appropriate volume growth, in contrast, there are no studies documenting systematic inappropriate care. Without valid studies, it

is impossible to determine what volume growth is appropriate or inappropriate. If there is a problem with volume growth regarding a particular type of medical service, the AMA looks forward to working with Congress and the Administration to address it. This would effectively address the problem.

Beneficiary Premium Increases

CMS has also noted that an increase in Medicare payments for physician and other health professionals would, in turn, increase the Medicare Part B premium for beneficiaries. Part B premium increases are due as much or more to increased spending on other health benefits, including Medicare Advantage plans and hospital outpatient services. In addition, low-income Medicare beneficiaries are protected from such increases through programs that cover the cost of their premiums. In fact, according to CMS, many beneficiaries are protected from premium increases because one in four is eligible for Medicare premium subsidies. Many others have access to low or no cost Medicare Advantage plans.

Physician pay cuts will ultimately cost beneficiaries more because these cuts will force physicians to discontinue providing certain services in the physician's office. Patients then will have two choices. Either they will have to go without care until their illness has become more severe and costly to treat, or they will have to seek care in higher-cost hospital settings where they will experience more inconvenience, and higher deductibles and co-payments than if they had been treated in their physician's office.

ACCESS PROBLEMS FOR MEDICARE BENEFICIARIES UNDER THE CURRENT MEDICARE SGR PHYSICIAN PAYMENT FORMULA

Physicians simply cannot absorb the pending draconian payment cuts. A 2005 AMA survey shows that if steep cuts are enacted:

- More than a third of physicians (38%) would decrease the number of new Medicare patients they accept;
- More than half of physicians (54%) plan to defer information technology purchases;
- A majority of physicians (53%) would be less likely to participate in a Medicare Advantage plan; and
- One-third (34%) of physicians whose practice serves rural patients would discontinue their rural outreach services.

Physicians are the foundation of our nation's health care system. Continual cuts put patients' access to care at risk, and there are signs of a problem already. A MedPAC survey found that, in 2005, 25 percent of Medicare patients looking for a new primary care physician had some problem finding one and that a growing number had a "big problem." It concluded that some beneficiaries "may be experiencing more difficulty accessing primary care physicians in recent years and to a greater degree than privately insured individuals." In the long-run, all patients—especially baby boomers—may find it more difficult to find a physician. The Congressionally-created Council on Graduate Medical Education is already predicting a shortage of 85,000 physicians by 2020, and multi-year cuts in Medicare are nearly certain to exacerbate this shortage by making medicine a less attractive career and encouraging retirements among the 35 percent of physicians who are 55 or older.

Further, Medicare physician cuts have a ripple effect across the whole health care system and leverage down payment rates from other sources. For example, TRICARE, which provides health insurance for military families and retirees, ties its physician payment rates to Medicare, as do some state Medicaid programs. Thus, Medicare cuts trigger TRICARE and Medicaid cuts as well. In fact, MOAA has sent letters to Congress urging Congressional action to avert the physician payment rate cuts, which would "significantly damage" military beneficiaries' access to health care services. MOAA stated that "[w]ith our nation at war, Congress should make a particular effort not to reduce health care access for those who bear and have borne such disproportionate sacrifices in protecting our country."

MEDICARE PAYMENT ADVISORY COMMISSION MARCH REPORT RECOMMENDATIONS ON PHYSICIAN PAYMENT POLICIES

MedPAC Recommends a Positive Medicare Physician Payment Update in 2007

The Medicare Payment Advisory Commission (MedPAC) is expected to recommend that Congress increase Medicare physician payment rates by 2.8% for 2007. The AMA agrees, and we urge the Subcommittee to approve legislation adopting this recommendation. This positive update would avert the pending cut expected to take effect on January 1, 2007, and would more accurately reflect increases in physician practice costs.

We caution, however, that MedPAC's cost estimates associated with this recommendation appear to assume that this positive update would be self-funded through additional Medicare physician pay cuts in later years. In other words, the 2007 update would be another temporary increase that would penalize physicians with greater cuts in later years. This is simply untenable when physicians already face nine years pf Medicare pay cuts. In fact, every temporary fix merely digs the physician payment system deeper into a hole that, each year, becomes more costly for Congress to fix and increases the risk of a meltdown in Medicare patients' access to care.

Productivity Adjustment

MedPAC's recommended 2.8% update in Medicare physician payment rates for 2007 is based on a projected 3.7% increase in physicians' costs minus a.9% productivity adjustment. At the same time, however, MedPAC is recommending a hospital productivity adjustment of only half the amount (.45%) it is recommending for physicians. We see no rationale to support this disparity. Physicians are already at full capacity seeing patients and complying with layer upon layer of administrative paperwork burden due to such laws as HIPAA and new quality improvement reporting programs recommended by MedPAC and proposed by CMS that will further reduce productivity. There is simply no reason to suggest greater productivity increases by physicians than hospitals. **Thus, we urge that physicians be subject to the same productivity adjustment as is applied to hospitals.**

Quality Standards

MedPAC evaluated the impact on quality of care with regard to 38 quality measures for ambulatory care. Initial results show that the number of patients receiving appropriate care increased for 20 of the 38 measures and remained the same for most others. Significantly, the study also found that for several measures, increases in the use of physician services was associated with declines in potentially avoidable hospitalizations.

This conclusion is consistent with the Leapfrog Group, which recently announced the results of a long-term national study, including seven experimental projects designed to test a variety of pay-for-performance models. The study showed significantly increased physician visits for many services (as well as physician investment in information technology and electronic medical records.) More physician services, however, means increased Medicare spending on physician services, which is extremely problematic under the SGR spending target system.

Pay-for-performance and the SGR are not compatible. Pay-for-performance may save dollars for the program as a whole. Many performance measures, however, ask physicians to deliver more care, as indicated by the Leapfrog and MedPAC studies. If the SGR is linked to pay-for-performance, because the SGR imposes an arbitrary target on Medicare physician spending, more physician services will result in more physician payment cuts. Further, pay-for-performance programs depend on greater physician adoption of information technology, as indicated by the Leapfrog study. Unless physicians receive positive payment updates, however, these investments will not be possible. As discussed above, an AMA survey indicates that steep pay cuts beginning in 2006 would cause more than half of physicians to defer IT purchases.

As discussed above, positive payment updates for physicians are necessary to realize the vision of a Medicare physician payment system that emphasizes health information technology and quality improvement. **We urge the Subcommittee, therefore, to ensure that pay-for-performance initiatives are premised on a stable Medicare payment system that reflects increases in physicians' practice costs.**

Alternatives to the Medicare Physician SGR Formula

MedPAC has been asked by Congress to review alternatives to the current Medicare physician SGR payment formula. Alternatives under consideration include using multiple targets that could be based on: (i) geographic regions; (ii) types of services; (iii) physician group practice affiliation; (iv) hospital medical staffs; and (v) outliers—physicians with extremely high volume of services.

The AMA believes a multiple target payment system would create just as many problems as physicians experience under the SGR system. Spending targets have not and never will achieve policymakers' goal of reducing volume growth by discouraging inappropriate utilization. This type of system does not create the incentives needed at an individual physician level to achieve its cost containment goal, and produces an inaccurate and arbitrary payment system. Furthermore, spending target systems are based on the fallacious premise that physicians alone can control the utilization of health care services, while ignoring patient demand, government

policies, technological advances, epidemics, disaster and the many other contributors to volume growth.

Additionally, if a multiple target system intended to influence the behavior of smaller groups of physicians were used, that would be an administrative nightmare and virtually impossible to administer. The current problems with estimating and administering the current SGR target would multiply exponentially. As discussed above, the AMA has continued to advocate that volume growth issues be tackled through targeted actions that deal with the source of the increase. This would give Congress more control over the process than exists under the current system.

The AMA appreciates the opportunity to provide our views to the Subcommittee on MedPAC's March Report to Congress, and we look forward to working with the Subcommittee and CMS to develop a payment system for physicians that ensures the highest quality care and accurately reflects increases in the costs of practicing medicine.

Statement of HealthSouth, Birmingham, Alabama

Introduction

HealthSouth Corporation (HealthSouth) is pleased to submit this statement for the record in connection with the Subcommittee on Health of the House Committee on Ways and Means' "Hearing on MedPAC's March Report on Medicare Payment Policies" (March 1, 2006), and for the Subcommittee's consideration regarding the 2007 Medicare Payment Advisory Commission ("MedPAC") recommendations on Medicare payment policies, specifically as those recommendations pertain to inpatient rehabilitation and long term care hospital services.

HealthSouth is one of the Nation's largest healthcare services providers, providing comprehensive medical, diagnostic, therapy and other post-acute services in both inpatient and outpatient settings. We provide diverse services to a broad patient mix via our inpatient division (comprised of 95 inpatient rehabilitation hospitals and 10 long-term acute care hospitals); our surgery division (comprised of 158 ambulatory surgery centers and three surgical hospitals); our outpatient division (comprised of 620 outpatient rehabilitation sites); and our diagnostic division (comprised of 87 diagnostic imaging centers).

Executive Summary

In this statement, we discuss our reactions to and concerns with recent MedPAC recommendations affecting inpatient rehabilitation facilities ("IRFs"), and in connection with recent Congressional policymaking in this area; and long—term acute care ("LTCH") hospitals, and in connection with recent regulatory proposals published by the Centers for Medicare and Medicaid Services ("CMS") applicable to LTCHs. In short, we believe the MedPAC recommendations calling for zero updates for IRFs and LTCHs in 2007, if implemented, could jeopardize access to high quality services for some of the Medicare program's sickest and most vulnerable beneficiaries. Our statement also shares with the Subcommittee the rationale behind our ongoing commitments to research and study in the area of post-acute care services, and reviews current and anticipated activities in this area. We also discuss our support for implementation of quality measurements that can be used for a pay-for-performance framework applicable to inpatient rehabilitation providers. Finally, we express our support for the post-acute care payment reform demonstration program in section 5008 of the Deficit Reduction Act of 2005.

Inpatient Rehabilitation Facilities

HealthSouth respectfully disagrees with MedPAC's contention that IRFs can accommodate the cost of caring for Medicare beneficiaries in 2007 without an increase in the base rate (currently forecast by CMS to equal 3.4 percent).[1] We believe IRFs require an update in order to continue to preserve patients' access to high quality, intensive rehabilitative care that includes the services of highly-skilled physicians, rehabilitation nurses, and therapists, and the most cutting edge, cost-efficient technology.

As the Nation's single-largest provider of inpatient rehabilitative care and services, we are in a unique position to testify to the special role that IRFs play within our healthcare system. IRFs are an essential provider of post-acute hospital care,

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[1] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2006 at 238.

providing comprehensive, intensive rehabilitative care and therapy in combination with management of a patient's primary diagnosis and comorbidities. Care is coordinated through a multi-disciplinary team that includes specialty-trained rehabilitation physicians, nurses and therapists—a service model that is unique and unmatched by any other provider within the post-acute continuum.

We are concerned that a zero update in 2007 will affect our ability to attract and retain skilled clinical in the face of competition form hospitals and providers that will be receiving increases in 2007. Keeping pace with increases with basic labor and supply costs also allows facilities to acquire and implement new technologies to meet the increasingly complex needs of our patients. Without an update in 2007, our ability to accomplish these goals will be compromised.

Our disagreement with the zero update recommendation for IRFs is particularly heightened by the implementation of the so-called "75% Rule." Under the Rule, which Congress stayed for one additional year effective in July, 2006,[2] 75% of an IRF's patients must fall into one or more of 13 qualifying conditions.[3]

Even before the Congressional stay at 60% was implemented, IRFs experienced a significant drop in patient caseload that was attributable to the 75% Rule's effects. In all, patient caseload in IRFs declined by approximately 52,000 cases in the roughly one year period between Q3 2004 and Q3 2005[4]—far in excess of CMS' own projections of 1,750 cases.[5] In the first three quarters of 2005, the downtrend in patient caseload due to the 75% Rule is equivalent to a 16% annual decline in discharges.

We recognize that a key policy objective of this Rule is to ensure that IRFs are treating the right types of patients who require our services. We wish to emphasize with the Subcommittee that we agree with this objective—IRFs should treat patients whose medical conditions and needs require intensive inpatient rehabilitative care. However, because too little is known about the 75% Rule's effects on inpatient rehabilitation providers and patients who need post-acute rehabilitative care and services, a zero update for 2007 is not warranted.

MedPAC underscored the concerns about the unknown effects of the Rule in its March 2006 Report by acknowledging its inability to fully evaluate whether the 75% Rule is creating access to care problems for patients requiring intensive rehabilitative care. "If patients who need intensive rehabilitation are still getting it, the drop in volume [due to the 75% Rule] may not be an access issue. Moreover, patients no longer treated in an IRF can receive care in other settings, such as outpatient, home health, or skilled nursing facilities. *However, we are unable to judge whether patients are treated in the appropriate setting.*" [6] (Emphasis added). MedPAC also predicts that the 75% Rule will require IRFs to lower patient caseload volume by as much as 25% during 2007 in order to comply with the 75% Rule, and that such reductions will result in overall increased costs due to the fewer numbers of cases over which overhead costs can be spread.[7]

We firmly believe that until the impact and effects of the 75% Rule on inpatient rehabilitation providers and our patients are more fully known and understood through dedicated study and research—a process HealthSouth is committed to and will discuss in more detail below—it would be shortsighted to withhold the annual update for IRFs in FY 2007. We believe that IRFs should receive the full update available to them under current law in 2007.

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[2] Deficit Reduction Omnibus Reconciliation Act of 2005, Pub L. No. 109–171, § 5005. The Conference Agreement established the compliance threshold for IRFs at 60 percent during the 12-month period beginning on July 1, 2006; at 65% during the 12-month period beginning July 1, 2007; and at 75% beginning on July 1, 2008 and subsequently.

[3] *See* Medicare Payment Advisory Commission, *supra*, n.1 at 230. The 13 CMS conditions are: (1) stroke; (2) brain injury; (3) amputation; (4) spinal cord; (5) fracture of the femur; (6) neurological disorders: (7) multiple trauma; (8) congenital deformity; (9) burns; (10) osteoarthritis, after less intensive setting; (11) rheumatoid arthritis, after less intensive setting; (12) joint replacement, bilateral, for patients 85 and older, with body mass index of 50 or greater; and (13) systemic vasculidities, after less intensive setting. Categories (10)-(12) replace polyarthritis on the old condition list created by the then-Health Care Financing Administration.

[4] The Moran Company, *Utilization Trends in Inpatient Rehabilitation: Update through QIII 2005* (December 2005). The Moran data set comprises 77 percent of total Medicare volume estimated by CMS; the Moran Report accounts for the remaining 23 percent of IRF data to arrive at an overall caseload decline of approximately 52,000 cases.

[5] *See* 69 *Fed. Reg*. 25,772 (May 7, 2004). The CMS estimate is based on projected $10M in FY 2005, divided by $5,710, the "net savings" per case reduction due to movement to skilled nursing facility, home health, etc.

[6] See, Medicare Payment Advisory Commission, supra,n.1at 226.

[7] *Id.* at 239.

Long Term Care Hospitals

Like the IRF recommendation, we respectfully disagree with the Commission's recommendation to freeze the LTCH update in 2007. We dispute the notion that LTCHs should be able to accommodate cost changes in rate year 2007 without an increase in our base rate (currently forecast by CMS to equal 3.5 percent).[8] As the Subcommittee is aware, CMS recently issued a proposed rule for the LTCH PPS that includes a zero update for 2007, a proposal with which we disagree.

LTCHs specialize in providing intense care to patients with complex conditions and multiple comorbidities, such as ventilator-dependent patients or patients with severe burns or skin ulcers. The costs of providing highly intensive, life-sustaining services like these increase every year, and even though MedPAC has noted an increase in case volume and in new LTCHs since 2001—facts it uses to support the zero update recommendation—the ability of LTCHs to remain competitive and provide high quality care to this complex patient population would be jeopardized by withholding the annual update.

We believe a zero update recommendation, especially when read together with CMS' proposed regulation of January 27, 2006 that sharply reduces Medicare spending for LTCH services,[9] overreacts to concerns with the rate of growth in LTCH services. Spending on LTCH care remains less than one percent of overall Medicare spending. The total effects of the various adjustments contained in CMS' proposed rule, such as the proposed revision to payments for short stay outlier cases, stand to result in LTCH payment reductions in excess of 15%. This would be one of the single-largest payment reductions imposed upon any Medicare payment system, whether through administrative or legislative processes.

HealthSouth agrees with MedPAC and CMS that a more uniform policy defining the types of patients treated by LTCHs is warranted, but we remain concerned that the payment and regulatory changes proposed by CMS, try to achieve this objective without a sufficient clinical or evidence-based foundation. In 2004, CMS awarded a contract to Research Triangle International, Inc. ("RTI") to evaluate LTCH policies and to review prior MedPAC recommendations regarding LTCHs. The RTI's final report is expected to be delivered in a few months and we believe its findings should be evaluated before the changes in proposed rule are permitted to take effect. In the face of this nearly completed research, we believe any substantial change to current LTCH payment policy would be premature.

HealthSouth believes the more reasonable course is to wait for the results of the RTI report to be made public and evaluated by policymakers and providers. We fully agree that appropriate uniform patient criteria should be developed and used to distinguish the types of patients who are appropriate for LTCHs. HealthSouth welcomes the opportunity to work with CMS, Congress, and MedPAC in the development of these criteria. We therefore respectfully request that the Subcommittee reject MedPAC's zero update recommendation for LTCHs in 2007 and that it urge CMS to forgo implementation of its proposed LTCH rule, including the zero update, until appropriate uniform patient criteria for LTCHs are developed.

Research and Study: Our Commitment to Fair, Rational, and Sound Policymaking

HealthSouth recognizes that the current and future financial environment of the Medicare program requires that it be a prudent purchaser of healthcare services. We believe scientific research and evidence-based decision-making is essential for the development of effective, cost-efficient, and sound policies within the Medicare program's various levels of post-acute care. It is in this spirit that we recommend that proposed LTCH changes be postponed until further evidence-based assessments can be evaluated in order to develop appropriate uniform patient criteria to distinguish patients who are appropriate for LTCHs. It is also in this spirit that we have undertaken a landmark scientific study on treatment protocols and patient outcomes for lower extremity joint replacement patients treated in post-acute settings.

In order to provide enhanced awareness and understanding of the 75% Rule's impact on patient care, HealthSouth and its professional partners in the rehabilitation and hospital communities have undertaken a national research initiative, designed to evaluate the efficacy of care and outcomes for post-surgical rehabilitative care provided to joint replacement patients in the skilled nursing facility ("SNF") and IRF settings. This is a prospective study of 2,800 patients, equally divided between IRF and SNF admissions. The aim of the study is to more accurately identify and define the types of joint replacement patients who are most suitable to the environment of care available in IRF and SNF settings and what elements of care have the

[8] *Id.* at 218.
[9] *See* 71 *Fed. Reg.* 4648 (January 27, 2006).

greatest effect on patient outcomes. The initiative responds to CMS' own request for research in this area.[10]

The research initiative is being directed by the widely-respected National Rehabilitation Hospital ("NRH") in Washington, D.C., and the Institute for Clinical Outcomes Research ("ICOR") of Salt Lake City, and includes a policy advisory panel comprised of participants from National Institutes of Health, the Association for Health Care Research and Quality, the American Medical Rehabilitation Providers Association, the American Hospital Association, the Federation of American Hospitals, the American Association of Homes and Services for the Aging, the American Physical Therapy Association and various other organizations. Although the study is underwritten by the American Hospital Association, the Federation of American Hospitals, and HealthSouth, the principal investigators are NRH and ICOR.

The study includes the participation of 1,400 IRF patients and 1,400 SNF patients drawn from 20 geographically diverse facilities—11 IRFs and 9 SNFs. The study questions are as follows:

- What are the characteristics of joint replacement patients (DRGs 209 and 210) served in IRFs and SNFs? How are they similar or different?
- How are the interventions and processes of care for joint replacement patients different in IRFs than SNFs?
- What specific interventions or combinations of interventions in IRFs and SNFs make the biggest difference in outcomes for joint replacement patients taking into account patient differences?
- Which joint replacement patients do better in an IRF and which do better in a SNF?
- What is the relative cost-effectiveness of IRF and SNF care for joint replacement patients?
- Are comorbidities among joint replacement patients an adequate indicator of additional medical need during the rehabilitation process? Can a severity-of-illness measure serve as a better indicator of medical need? Are patients with greater medical needs served better in an IRF or a SNF?
- Can we design a more efficient course of rehabilitation interventions for joint replacement patients in IRFs and SNFs to reduce the length of stay and costs?

We believe the study's findings will shed new light on the types of joint replacement cases requiring post-surgical rehabilitative care who are appropriately treated in IRFs and SNFs. The findings should also serve as a guide for policymakers in setting rehabilitation payment and regulatory policies in the years to come. We recognize the need for additional research within the post-acute space, and we are committed to doing our part to pursue it. Indeed we are actively pursuing other research opportunities as of this writing, and we will apprise the Subcommittee on their status and progress later this year. We also wish to commend CMS for its active interest in the joints study; their observatory participation throughout the various stages of the study's development and implementation will be critically important to its overall utility. Complete information about this study is available on the internet at www.jointsstudy.org.

Post-Acute Care Payment Reform Demonstration

As one of the Nation's leaders in the provision of post-acute hospital services, we applaud Congress' and the Subcommittee's commitment to study and test new payment and regulatory pathways in post-acute care. HealthSouth stands ready and eager to participate in this important exercise of cutting-edge policy development.

For too long, Medicare's post-acute payment systems have offered financial incentives to classify patients by service type, with more focus placed on where patients receive medical care and services and less focus placed on what their medical needs are and the appropriateness of the settings of care in which those needs are served. We agree with Congress, CMS and MedPAC that post-acute care treatment decisions should be made based upon patient needs. These decisions should be based upon the best evidence-based and clinical grounds possible, and appropriately tailored to meet individual patient needs.

We believe the demonstration program in section 5008 of the Deficit Reduction Act is a tremendous opportunity to "level the playing field" with respect to financial incentives in post-acute care payment policy and to promote fair and clinically-appropriate treatment decisions. We stand ready to work with CMS and Congress in the development and implementation of this important post-acute care policy.

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[10] *See, e.g.,* 69 Fed. Reg. 25752 at 25762–63 (May 7, 2004).

IRF Pay For Performance

HealthSouth believes that IRFs are a provider type that is ripe for the development and implementation of a pay-for-performance framework. We embrace the principle that the Medicare program must be a prudent purchaser of efficient, cost-effective healthcare services. Basing a portion of IRFs' payments from the Medicare program upon the quality of care we provide to our patients is the right thing to do and makes sense for everyone—providers, patients, and taxpayers. Indeed we believe in the power of competition and the positive outcomes it can produce.

The IRF industry is particularly well-suited for a pay-for-performance model because the necessary data systems to implement such a model have been in existence for more than 15 years and are widely accepted and used by the inpatient rehabilitation industry. These include, for example, the inpatient rehabilitation facility patient assessment instrument ("IRF PAI") and the functional independence measure ("FIM™"). Furthermore, the existing IRF PPS contains features, such as its case mix groups, that could be easily adjusted and integrated into a quality measurement and pay-for-performance model. We believe the existence of these kinds of instruments, through which data collection and reporting activities are already occurring, can readily permit quality measurement and payment incentive structures *without* the creation of new or additional measurement tools and *without* the creation of additional data collection or reporting burdens on providers.

We encourage the Subcommittee to consider the existing assets that are inherent within the widely used data collection and reporting tools and the IRF payment system, for use in quality improvement and payment reforms for inpatient rehabilitation providers. We are willing to test these assets within our own hospital network in an attempt to evaluate their effectiveness and scalability on a program-wide basis.

We hope the Subcommittee finds this information useful. HealthSouth appreciates this opportunity to share its views on the 2007 MedPAC recommendations and on related policy matters pertinent to the provision of post-acute care services associated with those recommendations. If you have any questions, please do not hesitate to contact Justin Hunter, HealthSouth's Vice President for Government and Regulatory Affairs.

Statement of Anthony Messana, National Renal Administrators Association, Prescott, Arizona

We greatly appreciate the opportunity to submit the following statement for inclusion in the record of the March 1, 2006 hearing of the Subcommittee on Health on the Medicare Payment Advisory Commission's (MedPAC) recommendations in its recent report to Congress. We will focus our comments on the portion of the report concerning the adequacy of payment for providers that care for patients with end stage renal disease.

The National Renal Administrators Association (NRAA) is a voluntary organization representing professional managers of dialysis facilities and centers throughout the United States. Our membership includes free-standing and hospital-based facilities, which are for-profit and non-profit providers located in urban, rural and suburban areas and serving dialysis patients in all settings. Many of our members are small providers that provide dialysis services to patients in underserved areas in rural and inner city locations. NRAA members are located in virtually every Congressional district.

Before addressing MedPAC's specific recommendations, I want to call to the Subcommittee's attention the fact that, unlike most providers participating in the Medicare program, those of us who care for dialysis patients do not have a statutory mechanism to update our reimbursement on an annual basis. We must seek Congressional action in order to gain any increase in the composite rate, which serves as the basis for our reimbursement under Medicare.

While we greatly appreciate the 1.6 percent increase that Congress provided in the Deficit Reduction Act of 2005 over the last five years the composite rate has only been adjusted twice for a total of 3.2 percent. Quite simply, Medicare payments do not cover the patient's dialysis treatment costs. For most of our members, since Medicare and Medicaid account for 70 percent to 95 percent of their revenue, it is impossible to compensate for these losses by seeking higher reimbursement from private insurers.

This problem is particularly difficult for the smaller provider that has to absorb increases in pharmaceutical costs and medical products, employee compensation and

benefits, utilities, and other requirements simply to continue to serve their patients. Unfortunately, some are being forced to close their doors, forcing patients to seek care in other facilities, which in rural areas, can require hours of driving time.

Given the fact that most patients must receive treatment for the better part of a day-three times a week—the additional driving time is a tremendous hardship. Unfortunately, in some instances, patients have decided to stop treatment rather than place the burden of travel on their loved ones.

NRAA members are committed to providing their patients with the best possible care. But the current reimbursement system under Medicare makes it difficult to fulfill this commitment. To ensure the quality of care that Medicare beneficiaries deserve and to guarantee reasonable access to dialysis services, it is essential that Congress provide an annual update mechanism.

We urge the Subcommittee to give serious consideration this year to the Kidney Care Quality and Improvement Act (H.R. 1298) and begin the process of moving this legislation through the Congress to enactment into law. Among the many important provisions in this legislation is one which would establish an annual update process for providers of dialysis services.

With regard to the MedPAC report, we fully support the recommendation proposing that Congress update the composite rate "by the projected increase in the ESRD market basket, less half the productivity adjustment, for services provided in calendar year 2007." We greatly appreciate the detailed analysis in the report and MedPAC's consistent commitment to improving patient care while seeking improvements in the outdated dialysis payment system.

The proposed update in the composite rate for 2007 is not only justified, it is essential to enabling our members to continue to provide quality care to dialysis patients and to assisting them in meeting the costs of providing such services. But this should be the first step, and not the last, in modernizing the current payment system. For the past five years, MedPAC has recommended updates in the composite rate. But Congress has acted only twice to increase the composite rate, and at a much lower level than was recommended by MedPAC.

Needless to say, while these increases have been helpful, they have not eliminated the ongoing Medicare deficit. Simply stated, the current system is not sustainable. We are ready to work with MedPAC and Congress to fashion an update mechanism that would bring the necessary consistency and fairness in Medicare payments that are available to other providers. We believe that an annual update formula modeled after the hospital prospective payment system would be appropriate. We also believe that Congress should recognize and take into account the higher costs and difficulty of providing quality services faced by smaller providers in medically underserved areas.

Given the financial strains inherent in the current system, it is a tribute to our membership and their concern for their patient well being that, over the last ten years, dialysis providers have dramatically improved the quality of care for patients with end stage renal disease. Dialysis providers are only one of three Medicare provider sectors that currently report quality of care indicators to the Centers for Medicare and Medicaid Services (CMS) and that information is publicly available on the Dialysis Facility Compare website and in Medicare's Clinical Performance Measurement annual publication.

Some indicators of the improvements in quality of care are: the percentage of patients receiving adequate hemodialysis was 94 percent according to a 2004 CMS Clinical Performance Measurement report compared to 85 percent in 1998; anemia management has dramatically improved, with hemoglobin levels greater than 11gm/dl increasing from 43 percent in 1997 to 80 percent in 2003; hospital days for dialysis patients have decreased 15 percent from 1993 to 2001, despite an increase in dialysis patient age and co-morbidities; and the use of fistulas has increased by more than 7 percent from 1998 to 2002.

Each of these is a quantifiable and demonstrable improvement in patient care, enabling Medicare beneficiaries with end stage renal disease to have a better quality of life. We are also working with others in the kidney care community to design a system for rewarding providers who produce improvements in patient clinical outcomes that would be tied to an annual update mechanism. We would be pleased to work with the Subcommittee and the Administration as this process moves forward.

In conclusion, we greatly appreciate the opportunity to state our views for the record. We look forward to continuing to work with the Congress and MedPAC on improving the dialysis program and to ensure that Medicare beneficiaries receive the best possible care. We are hopeful that Congress will act this year to implement the MedPAC recommendation for increasing the composite rate and that an annual update mechanism will become a reality.

Statement of Val J. Halamandaris, President, National Association For Home Care and Hospice

The National Association for Home Care & Hospice (NAHC) respectfully submits this statement to the Subcommittee on Health of the Committee on Ways and Means of the U.S. House of Representatives. The statement relates to the Subcommittee hearing regarding the report of the Medicare Payment Advisory Commission (MedPAC) scheduled for March 1, 2006.

NAHC is the largest trade association representing the interests of home care and hospice providers in the United States. In that capacity, NAHC represents, among others, the vast majority of home health agencies (HHAs) participating in the Medicare program. The NAHC membership includes Medicare-participating home health agencies for all of the states and U.S. territories, small and large agencies, rural and urban providers, nonprofit and proprietary organizations, and freestanding and facility-based entities. As such, NAHC is uniquely capable of addressing the recommendation of MedPAC with respect to Medicare home health payments rates and the underlying rationale for that recommendation.

On January 10, 2006, MedPAC commissioners voted to recommend that Congress freeze Medicare rates of payment to home health agencies in 2007. This recommendation was made with the expectation that Congress would enact and the President would sign into law the Deficit Reduction Act of 2005, which contained a Medicare payment rate freeze for 2006.

NAHC believes that the Subcommittee should reject the recommendation of MedPAC with respect to the 2007 Medicare home health services payment rates. Instead, NAHC recommends that the Subcommittee engage in active support of the current home health services payment rate reforms under way at the Centers for Medicare & Medicaid Services (CMS) that are designed to better align payment rates with the level of resources required by Medicare home health services patients. A second consecutive year of payment rate freezes in the face of rising transportation, technology, and personnel costs places continued access to care, the quality of home health services, and the delivery system of home care at significant risk. In addition, a payment rate freeze in 2007 would interfere with the proper development, implementation, and evaluation of the systemic payment method changes that should be unveiled by CMS later this year.

The Medicare Home Health Services Payment System

After nearly 20 years of effort by Medicare and the home health services community, the Medicare home health services benefit was transformed on October 1, 2000, into a modernized benefit that replaced an antiquated and inflationary cost reimbursement system with an episodic prospective payment methodology that allows flexibility in meeting the patient's home care needs while encouraging positive patient outcomes and discouraging unnecessary utilization of care. Instead of a system where rates were annually adjusted to reflect costs that were controlled by the providers, home health agencies are required to deliver care within a set episodic payment rate that reflects the expected care needs of Medicare patients with one of 80 different case mix categories over a 60-day period of time. The changes have generally been positive, with the home health agencies incentivized to rehabilitate patients rather than drive them toward dependency. As the MedPAC report notes, patient outcomes have improved under the prospective payment system (HHPPS) in spite of a financial design that may encourage shorting or "stinting" on care and premature discharges.

However, the system is not without its weaknesses. In October 2000, HHPPS was fully implemented without any testing of the payment methodology and its payment distribution mechanism, the 80-category case mix adjuster. An earlier demonstration program employed virtually nothing of the system that was ultimately implemented. Now, over five years after implementation, the strengths and weaknesses of HHPPS are apparent, with the most disturbing aspect being the unreliability of the case mix adjuster that determines the actual episodic payment rate for each of the 80 patient categories. As a MedPAC analysis revealed, the accuracy of the case mix adjuster is so limited that in 60 of the 80 case mix categories the payment rates are significantly unrelated to the range of resource needs of the patients. In layman's terms used by MedPAC, the range of services provided for the same rate of payment in these 60 categories is "2300 minutes, give or take 2300 minutes." Recent analyses by CMS indicate comparable findings with the estimated "explanatory

power" of the case mix adjuster being 21 percent, meaning that in 79 percent of the nearly 3 million episodes of care, the payment rate is either too low or too high.

CMS is not sitting on its heels, leaving this inaccurate system to continue to operate. An intense effort has been under way for months to refine and reform the case mix adjuster. In a highly responsible manner, CMS has included in-house and outside technical experts to design system improvements. Further, CMS has openly included home care industry representatives in the process. MedPAC has actively participated in this reform process as well, both independently and in consultation with CMS. It is expected that the research and redesign will be completed later this year.

Adopting the MedPAC recommendation to freeze payment rates in 2007 is not a solution. It only enhances the problems of repairing a payment system by creating a "moving target" where efforts at reform are hampered by across-the-board payment cuts that are directed against all home health agencies arbitrarily, without any relationship to the merit of imposing those cuts on providers who are serving underpaid patient categories. The only result of such across-the-board cuts for home health services in the past has been an increase in the number of HHAs operating with financial margins in the red.

MedPAC's Analysis is Incomlete and Unreliable

MedPAC's underlying rationale for its recommendation to freeze Medicare home health services payment rates for a second consecutive year is that HHAs had a 16 percent average profit margin in 2004, access to care is "good," and the quality of services has improved. It is notable that the MedPAC standard of good access is that nearly 20 percent of patients seeking home health services report that they have difficulty in accessing care.

MedPAC's analysis of the financial condition of home health agencies is of equal concern. It explains that the average Medicare margin in 2004 among home health agencies is 16 percent, and estimated to fall to 14.8 percent in 2006 as a result of the payment freeze contained in the Deficit Reduction Act of 2005. However, in reaching these calculations, MedPAC fails to report or acknowledge that:

1. It excluded nearly 30 percent of all HHAs from its analysis because these HHAs are part of a hospital system. In some parts of the country, the only access to home health services is through a hospital-based HHA.
2. It used a concept of "average" that fails to recognize the local nature of home care, favoring large metropolitan HHAs over small rural HHAs in the method employed.
3. It did not adequately reveal the extraordinarily wide range in financial margins among HHAs that indicates a failure of the payment system to fairly and properly distribute payments.
4. It did not reveal that over 33 percent of all HHAs had Medicare margins less than 0 percent in 2004 and that number will rise to over 42 percent with payment freezes in 2006 and 2007.
5. It did not explain that the overall financial margins of HHAs when considering all revenue sources, including Medicare, Medicaid, and managed care, are significantly lower, with average margins for freestanding HHAs at 1.56 percent.

MedPAC Ignores All Hospital-Based HHAs

In a manner inconsistent with its analysis of the financial status of hospitals, the MedPAC evaluation of Medicare profit margins of HHAs excludes consideration of all hospital-based providers of home health services. Instead, MedPAC evaluates only freestanding HHAs.

Today there are approximately 8,000 Medicare-participating HHAs. In 1997, there were over 10,400. Between 1997 and today, the provision of home health services through hospital-based HHAs has become essential, with the closure of HHAs in many parts of the country leaving the hospital-based program as the only surviving provider. Approximately 2,000 Medicare HHAs are part of a hospital system. In parts of the country, it is the only provider of home health services.

MedPAC excludes the hospital-based HHA from its analysis ostensibly because Medicare cost reporting standards require a cost allocation methodology that assigns a share of the system's administrative costs to the HHA. However, while MedPAC excludes hospital-based HHAs from its home health rate analysis, it includes all hospitals with home health agencies in its hospital rate analysis. MedPAC has never explained its discriminatory approach.

HHAs across the country report that their hospital system continues to measure the financial viability of continuing to operate their HHA through the Medicare cost reporting analysis of the individual HHA financial margins. Whether MedPAC considers the data to be skewed is irrelevant: the marketplace views a hospital-based HHA with negative financial margins as a candidate for closure. When that occurs,

many communities are left with no home health services or an inadequate supply to meet residents' needs.

When including hospital-based HHAs in the calculation of the financial status of Medicare home health services, the profit margin in 2004 is 2.91 percent (facility weighted).

MedPAC Uses a Confusing "Average"

Only statisticians with doctoral degrees can appreciate the concept of "average" that MedPAC employs in evaluating the Medicare margins of home health agencies. Rather than recognize that every HHA contributes to access to care in its specific community, MedPAC lumps them all together nationally and favors large metropolitan HHAs in calculating an average national margin. The approach used is known as a "revenue weighted averaging", whereby the financial condition of a few very large HHAs can significantly affect the calculation of the "average." This approach ignores the reality that a large metropolitan HHA in the Northeast cannot relocate its operation or duplicate its economies of scale in a small Midwestern town.

MedPAC's failure to correlate Medicare margin calculations with localities results in a wholly misleading picture of the financial condition of home health agencies. When focusing the analysis on a smaller geographic area, such as congressional districts, the financial picture of HHAs sharpens and reveals that the Medicare margins in these areas range dramatically, thereby indicating an instability that a freeze in rates can only exacerbate.

An alternative to the revenue-weighted average used by MedPAC is a "facility-weighted average." This method, while far from perfect, offers a cleaner picture as to the financial condition of home health agencies by recognizing that each entity has value in its community. The facility-weighted average Medicare margin in 2004 is 2.91 percent for all HHAs and 8.56 percent for freestanding HHAs only.

The Wide Range in Medicare Margins Indicates Severe Flaws in the Payment System

Even with the MedPAC analysis, it is apparent that the Medicare HHPPS is failing to distribute payments in a fair and appropriate manner. The only reliable explanation that has surfaced is that the case mix adjustment methodology is the culprit. CMS recognizes its severe weaknesses and is diligently moving ahead with corrective action.

The range in financial results driven by a flawed case mix adjuster and other HHPPS weakness is startling. For example:

State	Lowest Margin	Highest Margin
Alaska	(243.19)%	32.51%
Connecticut	(111.50)	53.17
Florida	(339.28)	76.43
Illinois	(198.37)	79.05
Louisiana	(258.23)	69.92
Montana	(217.70)	53.82
New Mexico	(280.81)	79.40
Texas	(326.60)	78.77
Washington	(157.60)	45.58

(Parentheses denote negative margins)

The lowest margin is not exclusively held by hospital-based HHAs. In fact, the lowest margins listed above for Louisiana, New Mexico, and Texas belong to freestanding HHAs. Accordingly, the extreme range in Medicare margins indicates a poorly-operating system in need of repair rather than an across-the-board payment rate cut.

The Number of HHAs Operating With Negative Medicare Margins Is Growing

A bell weather of impending crisis is the proportion of home health agencies that are at risk of closure due to inadequate payment rates from Medicare. Over the last five years, HHAs received a full inflation rate increase only once. In 2002, rates were reduced by nearly 5 percent after the application of the so-called 15 percent cut (the real effect was a reduction of approximately 7 percent) and the 2.1 percent inflation update (3.2 percent minus 1.1 percent as mandated). The year 2003 saw another reduction of the inflation update of 1.1 percent. In 2005, the update was

delayed from October 2004 to January 2005 and was reduced by 0.8 percent. Originally, the inflation rate for 2006 was to be reduced by 0.8 percent. Instead the DRA 2005 froze 2006 rates at 2005 levels, representing a combined cut of 3.6 percent for 2006.

These cuts have had an effect on the financial stability of HHAs. In 2002, 31 percent of HHAs had Medicare margins less than 0 percent. That has risen in 2004 to 33.4 percent. Of those in 2004 with positive margins, 8.7 percent of HHAs had Medicare margins between 6.2 and 0 percent. With the effect of a rate freeze in 2006 and the MedPAC proposed freeze in 2007 estimated as reducing payment rates by 6.2 percent in comparison to pre-DRA 2005 projections, **the estimated number of HHAs that will be operating with negative Medicare margins in 2007 rises to 42.1 percent.**

The Overall Financial Margins of Home Health Agencies Indicates Serious Problems

Unlike its analysis of hospitals, MedPAC did not evaluate the overall financial condition of home health agencies when opining that access to care would be unaffected by a second consecutive rate freeze in Medicare payments. This is a serious shortcoming of the MedPAC review. The absence of such information makes it impossible for the Subcommittee to determine the likely impact of accepting the MedPAC recommendation.

NAHC has conducted an analysis of the overall financial margins of home health agencies participating in Medicare. It is limited to freestanding HHAs (the focus of MedPAC's reviews) because data from hospital-based HHAs does not make it possible to separate non-Medicare home care revenues from other hospital revenues. Freestanding HHAs submit a slightly different cost report to Medicare that includes a total revenue and total cost report.

The NAHC analysis shows that the 2004 overall financial margins for freestanding HHAs was 1.56 percent. In 2002 and 2003, the margins were 2.53 percent and 1.34 percent, respectively.

The Medicare cost report does not allow the differentiation of one type of non-Medicare revenue source from another. However, HHAs anecdotally report that the primary revenue sources outside of Medicare fee-for-service is Medicaid and Medicare Advantage. These HHAs further report that Medicaid payments rates fall far short of actual costs. Similar reports have been received regarding Medicare Advantage plan contracts. With respect to Medicare Advantage, HHAs also report that home health services provided to patients in those plans have higher administrative costs because of extensive authorization processes. Therefore, it appears that any "profits" that HHAs receive through Medicare are transferred to the support of Medicaid and Medicare Advantage patients.

In the event that Congress enacts the 2007 recommendation from MedPAC, the reduction in available payments will affect the overall financial status of providers and jeopardize the delivery infrastructure. While Medicare should not be expected to subsidize Medicaid and Medicare Advantage plans, the reality of 2006 is that without the Medicare margins, home health agencies cannot continue to provide the access to care currently available in their communities.

RecommendationsK

NAHC respectfully recommends that the Subcommittee reject the MedPAC recommendation on home health services payments. In addition, NAHC recommends that the Subcommittee direct MedPAC to provide the following information:

1. Comprehensive data on the overall financial status of Medicare-participating home health agencies, including data on revenues and costs from Medicare Advantage plans and non-Medicare payers for services provided to non-Medicare patients.
2. Medicare financial margin data from all Medicare-participating home health agencies, including hospital-based HHAs.
3. Medicare financial margin data as above, segmented by state and Congressional district.
4. An analysis of the strengths and weakness of the current Medicare HHPPS, including its case mix adjustment methodology and the area wage index.
5. A zip-code based analysis of patients served by HHA by year since 1997.

NAHC further recommendations that the Subcommittee make available all resources necessary for CMS to expedite the development and implementation of a refined HHPPS that calculates payment rates in a manner reasonably consistent with a patient's need for health care resources. NAHC is available at any time to assist in the development of such reforms.

Conclusion

The National Association for Home Care & Hospice, on behalf of the home care community, wishes to thank the Subcommittee for its longstanding dedication to improving the Medicare home health benefit.