MEDPAC REPORT ON MEDICARE PAYMENT POLICIES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

MARCH 6, 2003

Serial No. 108–14

Printed for the use of the Committee on Ways and Means

(

U.S. GOVERNMENT PRINTING OFFICE
89–629 WASHINGTON : 2004

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2250 Mail: Stop SSOP, Washington, DC 20402–0001

COMMITTEE ON WAYS AND MEANS

BILL THOMAS, California, *Chairman*

PHILIP M. CRANE, Illinois
E. CLAY SHAW, JR., Florida
NANCY L. JOHNSON, Connecticut
AMO HOUGHTON, New York
WALLY HERGER, California
JIM MCCRERY, Louisiana
DAVE CAMP, Michigan
JIM RAMSTAD, Minnesota
JIM NUSSLE, Iowa
SAM JOHNSON, Texas
JENNIFER DUNN, Washington
MAC COLLINS, Georgia
ROB PORTMAN, Ohio
PHIL ENGLISH, Pennsylvania
J.D. HAYWORTH, Arizona
JERRY WELLER, Illinois
KENNY C. HULSHOF, Missouri
SCOTT MCINNIS, Colorado
RON LEWIS, Kentucky
MARK FOLEY, Florida
KEVIN BRADY, Texas
PAUL RYAN, Wisconsin
ERIC CANTOR, Virginia

CHARLES B. RANGEL, New York
FORTNEY PETE STARK, California
ROBERT T. MATSUI, California
SANDER M. LEVIN, Michigan
BENJAMIN L. CARDIN, Maryland
JIM MCDERMOTT, Washington
GERALD D. KLECZKA, Wisconsin
JOHN LEWIS, Georgia
RICHARD E. NEAL, Massachusetts
MICHAEL R. MCNULTY, New York
WILLIAM J. JEFFERSON, Louisiana
JOHN S. TANNER, Tennessee
XAVIER BECERRA, California
LLOYD DOGGETT, Texas
EARL POMEROY, North Dakota
MAX SANDLIN, Texas
STEPHANIE TUBBS JONES, Ohio

Allison H. Giles, *Chief of Staff*
Janice Mays, *Minority Chief Counsel*

SUBCOMMITTEE ON HEALTH

NANCY L. JOHNSON, Connecticut, *Chairman*

JIM MCCRERY, Louisiana
PHILIP M. CRANE, Illinois
SAM JOHNSON, Texas
DAVE CAMP, Michigan
JIM RAMSTAD, Minnesota
PHIL ENGLISH, Pennsylvania
JENNIFER DUNN, Washington

FORTNEY PETE STARK, California
GERALD D. KLECZKA, Wisconsin
JOHN LEWIS, Georgia
JIM MCDERMOTT, Washington
LLOYD DOGGETT, Texas

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Ways and Means are also published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

CONTENTS

MEDPAC REPORT ON MEDICARE PAYMENT POLICIES

THURSDAY, MARCH 6, 2003

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

The Subcommittee met, pursuant to notice, at 2:00 p.m., in room 1100, Longworth House Office Building, Hon. Nancy L. Johnson (Chairman of the Subcommittee) presiding.

[The advisory, the revised advisory, and the revised advisory #2 announcing the hearing follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
February 25, 2003
HL–3

CONTACT: (202) 225–3943

Houghton Announces Hearing on IRS Efforts to Modernize its Computer Systems

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) recommendations on Medicare payment policies. **The hearing will take place on Tuesday, March 4, 2003, 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 the 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 policy. The Commission is required by law to submit its advice and recommendations on Medicare payment

policy annually by March 1. In its report to the Congress, the Commission is required to review and make recommendations on payment policies for specific provider groups, including hospitals, skilled nursing facilities, physicians, and other sectors.

In announcing the hearing, Chairman Johnson stated, "The MedPAC provides valuable technical advice to Congress on Medicare payments and providers, and this information is important as we continue to explore ways to strengthen the Medicare program for our Nation's seniors. This hearing will offer the Subcommittee an important opportunity to explore in-depth, with Medicare's providers, MedPAC's recent recommendations, as well as the providers' responses to these recommendations."

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Due to the change in House mail policy, any person or organization wishing to submit a written statement for the printed record of the hearing should send it electronically to hearingclerks.waysandmeans@mail.house.gov, along with a fax copy to (202) 225–2610, by the close of business, Tuesday, March 18, 2003. Those filing written statements that wish to have their statements distributed to the press and interested public at the hearing should deliver their 200 copies to the Subcommittee on Health in room 1136 Longworth House Office Building, in an open and searchable package 48 hours before the hearing. The U.S. Capitol Police will refuse sealed-packaged deliveries to all House Office Buildings.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit 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. Due to the change in House mail policy, all statements and any accompanying exhibits for printing must be submitted electronically to *hearingclerks.waysandmeans@mail.house.gov*, along with a fax copy to (202) 225–2610, in WordPerfect or MS Word format and MUST NOT exceed a total of 10 pages including attachments. Witnesses are advised that the Committee will rely 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. Any statements must include a list of all clients, persons, or organizations on whose behalf the witness appears. A supplemental sheet must accompany each statement 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.

f

*** * * NOTICE—HEARING POSTPONEMENT * * ***

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
February 25, 2003
HL–3–Revised

CONTACT: (202) 225–3943

Postponement of Hearing on the MedPAC Report on Medicare Payment Policies Tuesday, March 4, 2003

Congresswoman Nancy L. Johnson (R–CT), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced the Subcommittee's hearing on the Medicare Payment Advisory Commission's (MedPAC) recommendations on Medicare payment policies, previously scheduled for Tuesday, March 4, 2003, at 3:00 p.m., in the main Committee hearing room, 1100 Longworth House Office Building, has been postponed and will be rescheduled at a later date.

f

*** * * NOTICE—HEARING RESCHEDULED * * ***

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
February 26, 2003
HL–3–Revised #2

CONTACT: (202) 225–3943

Johnson Announces Rescheduled Hearing on the MedPAC 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 hearing on the MedPAC Report on Medicare Payment Policies previously scheduled for March 4, 2003, **will now take place on Thursday, March 6, 2003, at 2:00 p.m., in the main Committee hearing room, 1100 Longworth House Office Building.**

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Due to the change in House mail policy, any person or organization wishing to submit a written statement for the printed record of the hearing should send it electronically to *hearingclerks.waysandmeans@mail.house.gov*, along with a fax copy to (202) 225–2610, by the close of business, Thursday, March 20, 2003.

Those filing written statements who wish to have their statements distributed to the press and interested public at the hearing should deliver their 200 copies to the Subcommittee on Health in room 1136 Longworth House Office Building, in an open and searchable package 48 hours before the hearing. The U.S. Capitol Police will refuse sealed-packaged deliveries to all House Office Buildings.

All other details for the hearing remain the same. (See Subcommittee Advisory Nos. HL–3 and HL–3-Revised, dated February 25, 2003.)

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit 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. Due to the change in House mail policy, all statements and any accompanying exhibits for printing must be submitted electronically to *hearingclerks.waysandmeans@mail.house.gov*, along with a fax copy to (202) 225–2610, in WordPerfect or MS Word format and MUST NOT exceed a total of 10 pages including attachments. Witnesses are advised that the Committee will rely 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. Any statements must include a list of all clients, persons, or organizations on whose behalf the witness appears. A supplemental sheet must accompany each statement 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.gov*.

f

Chairman JOHNSON. The hearing will come to order. Mr. Stark will be here momentarily, so I will proceed. The Floor has been canceled, so Members have earlier planes than usual, and we want to get started.

This Committee has the weighty responsibility of making decisions regarding Medicare payments that affect over a million providers and almost 40 million seniors and disabled persons. The Medicare Program is extremely complex and making these decisions accurately becomes increasingly difficult. While we must avoid overpaying providers, underpaying those who care for seniors could create real quality-of-care problems and compromise access to care for our elderly. Recently we saw that all too vividly with our inability to adjust physician payments.

To help us through these tough issues, we rely on the Medicare Payment Advisory Commission (MedPAC). Every year, MedPAC, a Committee of health care experts, including representatives of physicians, hospitals and beneficiaries, makes recommendations to Congress. We look to them as a source of independent, unbiased information. I don't agree with all the recommendations, but appreciate the ideas they put on the table.

This year, MedPAC made a number of recommendations that would both increase and decrease spending. At the same time, in his budget the President set aside $400 billion for Medicare modernization and prescription drug benefits. We have to ensure that any changes in reimbursement rates to providers are fair and necessary, because we have a finite amount of money available for the

Medicare drug benefit and providers. Additionally we have Medicare modernization challenges to meet, such as providing better support for seniors and managing chronic illness.

The MedPAC examines a number of factors before it makes its recommendations for payment updates. It analyzes the financial profitability of Medicare providers, their access to capital, their costs, changes in the number of available providers, beneficiary access to care and other factors. While this analysis is enormously helpful, I am frustrated by the lack of agreement between their analyses and those of individual providers and provider groups.

Assuring a community of stable providers, who are able to improve care as our knowledge and technology advance, is a challenging but crucial responsibility.

Today, we have with us Glenn Hackbarth, the Chairman of the Commission, who will talk about MedPAC's recommendations. We also have representatives from the affected groups—seniors, hospitals, physicians, dialysis facilities, nursing homes, home health agencies. I hope that we can have a straightforward dialog that will help us develop this year's legislation. I can tell you, from reading the testimony, that this dialog will have to go on beyond today for us to get where I think we will all feel comfortable.

Mr. Stark.

[The opening statement of Chairman Johnson follows:]

Opening Statement of the Honorable Nancy L. Johnson, Chairman, and a Representative in Congress from the State of Connecticut

This committee has the weighty responsibility of making decisions regarding Medicare payments that affect over 1 million providers and almost 40 million seniors and disabled persons. The Medicare program is extremely complex and making these decisions accurately becomes increasingly difficult. While we must avoid overpaying providers, underpaying those who care for seniors could create real quality of care problems and could compromise access to care for the elderly.

To help us with these tough issues, we rely upon the Medicare Payment Advisory Commission. Every year, the MedPAC, a committee of health care experts including representatives of physicians, hospitals and beneficiaries, makes recommendations to Congress. We look to them as a source of independent, unbiased information. I don't agree with all the recommendations, but appreciate the ideas they put on the table.

This year, MedPAC made a number of recommendations that would both increase and decrease spending. At the same time, in his budget, the President set aside $400 billion for Medicare modernization and a prescription drug benefit. We have to ensure that any changes in reimbursement rates for providers are fair and necessary, because we have a finite amount of money available for the Medicare drug benefit, providers, as well as Medicare modernization to meet challenges like providing better support for seniors and managing illness.

MedPAC examines a number of factors before making its recommendations for payment updates. It analyzes the financial profitability of Medicare providers, their access to capital, their costs, changes in the number of available providers, beneficiary access to care and other factors. While this analysis is enormously helpful, I am frustrated by the lack of agreement between their analyses and those of individual providers and some provider groups. Assuring a community of stable providers who are able to improve care as our knowledge and technology advances is a challenging but crucial responsibility.

Today, we have with us Glenn Hackbarth, the Chairman of the Commission, to talk about MedPAC's recommendations. We also have representatives from the affected groups—seniors, hospitals, physicians, dialysis facilities, nursing homes and home health agencies. I hope that we can have a straightforward dialogue that will help us as develop this years' legislation.

f

Mr. STARK. Thank you, Chairman, for calling this hearing, probably one of our primary responsibilities on this Committee and this topic. I suspect, and I am afraid, that this may be one of the last times we will have Mr. Hackbarth before our Committee; and I want to take this chance to thank him on behalf of 40 million Medicare beneficiaries and their attendant providers for your service as a Member and, recently, as Co-Chairman of MedPAC.

I think you have done a great job, I think, dealing with an explosive environment and delicate negotiations. I really want to thank you for great service to our country. Thanks very much.

One thing I think is clear from MedPAC's data is that we have nothing to be ashamed of. Medicare pays well. In some cases, I think too well. In others, not as well as it should be, and we seem to be meeting the challenge set before us when we set policy.

There are probably some providers who are in trouble financially; there is no doubt about that. In most of those cases, it is not Medicare's fault. Most of the problems might very well, if they are related to the government, be Medicaid related or else they are related to dumb hospital executives taking low-price contracts from managed care companies on the theory that volume would make up for reasonable pricing.

I can't—we can't solve that problem on this Committee. The groups on the second panel, I think, should be lobbying Congress for more money for Medicaid and opposing Bush's block grant, which will end Medicaid's entitlement nature for the most costly population. When that is gone, those hospitals with negative margins or those physicians with low payments are going to see their payments drop precipitously.

These are difficult issues, but it is important that we let the financial facts drive the policy. I strongly oppose efforts by the majority to use savings from fee-for-service providers, as MedPAC recommends, to pursue a privacy agenda and increase payments to their friends in the insurance industry. I would hope that the providers would be smart enough to figure out that it is easier to lobby Congress, for better or for worse.

You can always get an appointment to see your Congressman; try to get in to see Leonard Schaeffer. Try to get in to see the President of Aetna, and all I am going to tell you is good luck. At least here you get a hearing, you get excellent, well-advised legislators, people like Mr. Hackbarth, and you get a fair shot.

So, when you are going to pick your poison, I would advise you to think carefully before you decide to give up on the government payment systems which may very well serve you much better than the alternative.

To the extent that savings are gleaned by reducing updates for fees-for-service, I think they should be spent improving preventive benefits and coverage for beneficiaries in traditional Medicare.

Having said that again, thank you, Glenn, for your service; I look forward to your comments. Thank you, Chairman.

Chairman JOHNSON. Thank you and welcome, Mr. Hackbarth. It is a pleasure to have you before us again.

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

Mr. HACKBARTH. Thank you Chairman Johnson, Congressman Stark and other Members of the Subcommittee. I have a lot of material to cover, so I will try to proceed very quickly. I know time is short for the Subcommittee.

Let me begin by reminding you about what MedPAC is, specifically who the commissioners are. I know you well know the statutory charge, but I want to just characterize who they are as people.

We have six commissioners with clinical training as either physicians or nurses. Nine of us have executive level or board experience with leading health care providers. Six have executive level or board experience with large private purchasers of health care. Five have high-level experience in the Congress or in Centers for Medicare and Medicaid Services (CMS). Most of us have more than one of those credentials.

I dare say that all 17 commissioners have either a friend or a loved one who is a Medicare beneficiary. So, all of us have not just expertise and experience, but also a stake in the welfare of the health care system in general and a stake in the welfare of the Medicare Program.

You have both alluded to the fact that the issues we deal with are very complex and they are indeed and sometimes controversial. Given that, I think it is remarkable that we have had such a high level of agreement on the recommendations before you today. We had 17 commissioners voting on 19 recommendations included in the report. So, that is more than 300 individual votes. Out of those 300 votes, there were 2 "no" votes.

Let me now turn to the content of the report. Medicare's principal objective, of course, is to assure access to quality health care for older and disabled Americans. Chapter 3 of our report is devoted to the access issue. Let me just very quickly summarize a couple of key findings.

One is that Medicare beneficiaries actually report fewer problems with access than other adults. Now there are some issues for particular sub-populations, low-income groups and the like, but in general, access for Medicare beneficiaries as reported by the beneficiaries themselves is good.

We find, moreover, scant evidence at this point that Medicare's payment systems are hurting access to quality care. We are pushing the health care system to become more efficient, and we believe that requires vigilance in terms of its impact on quality and access. With that in mind, MedPAC is, in fact, expanding its efforts to monitor access to care.

Now, before very quickly reviewing the recommendations, I want to make a few broader observations about our findings and our approach. First of all, the financial performance of providers under Medicare is, on average, good. There are some types of providers that do less well, and we have made specific recommendations to address some of those needs. Examples would include rural hospitals and hospital-based skilled nursing facilities (SNFs). In other cases, we have found that Medicare payments appear to be more than adequate, and examples of that would include home health agencies and freestanding SNFs. It is noteworthy that the pay-

ments for home health agencies and SNFs appear to be more than adequate even after the payment reductions that went into effect October 1.

A second point is that when MedPAC identifies examples of possible underpayment, we prefer targeted solutions, as opposed to across-the-board increases for all providers in a given sector. Moreover, when we identify problems, fixing those payment problems may involve a redistribution of payments within that sector. This occurred, for example, in our recommendations in both the hospital and SNF sectors.

We take this approach because we believe that it makes Medicare payments more accurate and because we are mindful that there are many demands for Federal resources including, as was pointed out, competing demands within the Medicare Program.

Third, we focus on financial performance under Medicare, as opposed to provider total margins. Using Medicare funds, for example, to try to cross-subsidize Medicaid will often be a very inefficient way of getting money to providers in need. Later on we can go into that in a bit more detail.

Fourth, the most recently implemented prospective payment systems (PPSs) for SNFs and home health agencies and hospital outpatient departments are, as intended, changing patterns of care and we believe improving efficiency. That change, of course, is rarely painless. As with the inpatient hospital PPS, these newer systems will no doubt require refinement over time.

Now let me quickly review our recommendations for each of the major sectors beginning with hospital inpatient. Our update recommendation is for a 3.2-percent increase in rates. Because of our proposals for redistributing some dollars within the inpatient sector, many hospitals with lower than average margins would get more than that. Rural hospitals, for example, on average would get a 4.2-percent increase. Urban hospitals in small urban areas would get a 3.6-percent increase. Large urban hospitals, that is, hospitals in large urban areas, would get a 2.7-percent increase. As for physicians, our recommendation is for a 2.5-percent increase.

We do have in this year's report some data directly related to the access issue based on a new survey that we did of physicians and their willingness to accept Medicare patients. We also have some new data comparing Medicare rates to private-sector rates. As far as SNFs are concerned, we recommend a zero update for freestanding SNFs.

As you know, a critical issue there is whether Medicare payments should be cross-subsidizing Medicaid shortfalls. For hospital-based SNFs, we recommend an increase in payments through reallocating some money already in the system. For home health care, again, we recommend no update, but that we retain a 5-percent add on for rural agencies. Our data, post-implementation of the PPS, indicates that payments for home health agencies are more than adequate.

For dialysis providers, we recommend an update of 1.6 percent; and for freestanding ambulatory surgery centers, a zero percent update.

We also urge that CMS proceed as quickly as possible with collecting up-to-date cost data in developing a new payment system.

Pending that new data, we believe that Medicare should not pay more to a freestanding ambulatory surgery center than it does for a hospital outpatient department providing the same service.

So, that is a very quick review. I welcome any questions you have.

[The prepared statement of Mr. Hackbarth follows:]

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

Chairman Johnson, Congressman Stark, distinguished Subcommittee members. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I am pleased to be here this morning to discuss MedPAC's March report including our recommendations on Medicare payment policy.

The Congress has charged MedPAC with reviewing and making recommendations concerning Medicare payment policies. The Commission's recommendations aim to ensure that Medicare's payment systems set rates that cover the costs efficient providers would incur in furnishing care to beneficiaries. If payments are set too low, providers may not want to participate in the program and Medicare beneficiaries may not have access to quality care. If payments are set too high, taxpayers and beneficiaries bear too large a burden.

In our March report to the Congress, we recommend updates and policy improvements for seven Medicare prospective payment systems (PPSs). After examining indicators such as providers' financial performance under Medicare, changes in the volume of services, the quality of and access to care, providers' access to capital, and market entry or exit, we find that in general, Medicare payments are adequate to cover the costs of efficient providers. Therefore we recommend the following updates for 2004:

- hospital inpatient prospective payment system: a marketbasket index (representing input price changes), less 0.4 representing the net of an increase for technological change and a decrease for expected productivity gains;
- hospital outpatient, physician, and outpatient dialysis payment systems: marketbasket less an allowance of 0.9 percent for expected productivity gains; and
- skilled nursing, home health, and ambulatory surgical center payment systems: zero. For many skilled nursing and home health providers, current payments exceed costs by a large enough margin to offset expected cost growth in 2004. For ambulatory surgical centers the growth in service volume and number of providers suggests payment is more than adequate.

These update recommendations are coupled with others that improve the distribution of payments in a sector to better follow the costs of patient care, or that improve consistency in Medicare purchasing. The update and other recommendations for each sector should be considered as a package, because they are interrelated, and in some cases protect potentially vulnerable providers and thus access to care for beneficiaries.

We also discuss several broader issues related to Medicare payments:

- considering the context for Medicare payment recommendations (e.g. how the growth of Medicare expenditures compares to that of the economy, the federal budget, and the amount paid by other payers; how to characterize the spending impact of our recommendations);
- assessing Medicare beneficiaries' access to care;
- deciding how Medicare should pay for new technologies; and
- examining the health insurance choices available to Medicare beneficiaries and the characteristics of insurance markets that help determine those choices.

Context

We include in our report spending trends not just for Medicare but also for private sector payers and other federal health care programs. Over the long term, the rate of increase in per capita spending for Medicare beneficiaries has been similar to that for members of private sector health insurance plans and several government-sponsored plans (e.g., the federal employees health benefits program). Year to year, there are different patterns and fluctuations, but the factors driving health care costs appear to operate similarly for all payers. We also report trends in Medicare's share of health care spending in the United States and of the federal budget, and the share overall health care spending represents of gross domestic product. Over the

next few decades Medicare will constitute a greater proportion of economic output. Similarly, it will create greater pressure within the federal budget and on beneficiary resources through increased cost sharing.

Therefore, we include in our report estimates of spending changes resulting from each of our recommendations—presented as ranges over one—and five-year periods—and the implications for beneficiaries and providers. Please note that these spending estimates cannot simply be added together to compute an overall estimate. Unlike official budget estimates, they do not take into account the complete package of policy recommendations, the interactions among them, or assumptions about changes in provider behavior.

Assessing payment adequacy and updating payments

We recommend payment adjustments for seven different Medicare prospective payment systems. For each system, we assess whether payments are adequate to cover the cost of efficient providers by using indicators such as providers' financial performance under Medicare, changes in the volume of services, quality of and access to care, providers' access to capital, and market entry or exit. We then address the likely change in efficient providers' costs in 2004. We estimate input price inflation (as measured by a marketbasket index for each sector); allow, when needed, for technological changes that both improve quality and significantly increase costs; and determine a reasonable expectation for productivity gains. For expected productivity gains, we use the 10-year average change in multifactor productivity in the general economy. Our update recommendations reflect our assessment of all of these factors for each payment system. When appropriate, we also make recommendations to improve the distribution of payments among providers within each payment system.

Hospital inpatient and outpatient services—In the hospital sector we make both update and distributional recommendations. These should be considered as a package both because they are so closely interrelated, and because some distributional recommendations would help certain hospitals that are particularly vulnerable, such as some rural hospitals.

Overall we find that Medicare payments for hospital services are adequate as of fiscal year 2003. Using a margin calculation encompassing nearly all Medicare payments to hospitals, and thus not influenced by cost allocation problems, we estimate a margin for hospital services in 2003 of 3.9 percent. (This includes changes legislated for fiscal year 2004 that will reduce payments.) Other broad indicators, such as trends in volume and access to capital, are also generally consistent with a conclusion of adequate payments. This conclusion, together with consideration of factors likely to affect costs in the coming year—including input price inflation, technological advances, and productivity—support an update for 2004 of marketbasket minus 0.4 percent for inpatient services. Because significant technological advances affecting outpatient services are accounted for through new technology provisions in that payment system, we recommend an outpatient update of market basket minus 0.9 percent for productivity improvement.

The distribution as well as the level of inpatient payments is an issue. For example, the overall Medicare margin varies by hospital group, with hospitals in large urban areas having a margin of 6.9 percent and rural hospitals having a negative margin of 1.9 percent. We recommend five policy changes to improve the distribution of inpatient payments:

- expand the current transfer policy for patients in certain diagnosis related groups (DRGs) who are discharged to post-acute settings after very short hospital stays;
- implement an adjustment for hospitals with very few patients;
- reevaluate the labor share used for geographic adjustment of rates;
- increase the cap on disproportionate share payments that applies to most rural hospitals and urban hospitals with less than 100 beds; and,
- eliminate the differential in base rates for hospitals in rural and small urban areas.

This last recommendation was recently put in law for the period from April 1, 2003 to the end of fiscal year 2003.

We recommend expanding the post-acute care transfer policy to additional DRGs to better allow payments to follow patient care and to prevent hospitals that cannot discharge patients to post-acute care from being disadvantaged. We have recommended the other four policy changes in previous reports and reiterate them now as part of the comprehensive package that, taken together with the inpatient update recommendation, will help maintain the financial viability of the hospital sector. The result of the total package of our hospital recommendations is a 3.2 percent in-

patient payment increase for all hospitals taken together. All hospital groups we evaluated show an increase, although the magnitude differs. For example, rural hospitals and hospitals in smaller urban areas would receive increases greater than the market basket (4.2% and 3.6%, respectively). Hospitals in large urban areas, on the other hand, would receive an increase less than the market basket (2.7%). In short, the groups with lower margins before our recommendations would receive higher increases.

A final important issue is the current indirect medical education adjustment to inpatient payments. That adjustment of an additional 5.5 percent for each 10 percent increase in the resident-to-bed ratio, provides payments about twice the level justified by the empirical evidence of the relation between teaching activity and hospitals' Medicare costs. The Commission is not satisfied with the current policy because there is no accountability for the use of the payments above the empirical level. We will explore ways to better target those payments to advance specific Medicare policy objectives through increased accountability.

Physician services—Medicare payment rates for physician services are based on a fee schedule and are updated annually based on the sustainable growth rate system that ties updates to growth in the national economy and other factors. Under this system, the update for 2003 would have been negative 4.4 percent. CMS implementation of recent Congressional action, however, is now expected to produce a positive update of 1.6 percent for 2003.

When assessing payment adequacy we find a mixed picture. The number of physicians billing Medicare has increased and national indicators of access are still good. There are, however, anecdotal reports of access problems in some geographic markets and specialities. A national survey of physicians suggests they are becoming more selective about accepting new Medicare patients—but that is true for private HMO and Medicaid patients as well. Finally, Medicare payment rates have fallen somewhat relative to payment rates in the private sector, although they are still above levels seen in the mid-1990s.

Although there was a negative update in 2002, the volume of physician services increased; as a result, so did program spending. Program spending for physician services is projected to continue to increase even in the face of future negative updates. For example, the March 2002 Congressional Budget Office baseline projected average annual growth in program spending for physician services of 4 percent from 2001 to 2006 even with negative updates for five years.

From this assessment, and given recent Congressional action on the 2003 update, the Commission concludes that payments are adequate. Therefore, we recommend an update for 2004 that equals the estimated change in input prices for physician services, less an adjustment for productivity growth.

Skilled nursing facility services—Aggregate Medicare payments for skilled nursing facilities (SNFs) are at least adequate for fiscal year 2003. For freestanding SNFs—about 90 percent of providers in this sector—we estimate aggregate Medicare margins to be 11 percent in 2003. Including the 10 percent of SNFs that are hospital-based, the aggregate SNF margin is about 5 percent. The high margin for freestanding SNFs reflects a decline in costs in recent years. This decline is a response to incentives in the SNF prospective payment system (PPS) following high cost growth prior to its introduction. Preliminary evidence indicates that the decline in costs has not resulted in a lower quality of care. Because the PPS for SNFs is still relatively new, we expect this cost trend to continue into 2004, offsetting increases in input prices and other factors. Therefore, we recommend that the Congress not update payment rates for SNFs for fiscal year 2004.

Weaknesses in the current classification system for care in SNFs result in payments that are not distributed appropriately to account for the expected resource needs of different types of Medicare beneficiaries. Resources should be reallocated until the classification system is improved or replaced. As a start, we recommend that the Congress give the Secretary authority to reallocate money currently used as a payment add-on for rehabilitation classification groups to other classification groups so that payment more closely follows patient costs. This reallocation will benefit hospital-based SNFs to the extent that they serve patients with conditions more complex than those of patients in freestanding SNFs; therefore, no separate update for hospital-based SNFs is recommended. If this reallocation does not occur in a timely manner, however, the Congress should provide a marketbasket update less productivity adjustment of 0.9 percent for hospital-based SNFs only.

Home health services—Current aggregate Medicare payments for home health services are more than adequate relative to costs. For the first time, we now have cost data showing how home health agencies are performing under the PPS. We estimate that the Medicare margin for home health services in fiscal year 2003 will be over 23 percent, even after accounting for the so-called 15 percent payment re-

duction and the expiration of the current 10 percent rural add-on. Another measure of financial performance, the ratio of payments to charges, also indicates more than adequate payments. Payments are well above charges—12 percent overall—and assuming agencies charge more than costs, payments exceed costs by at least 12 percent. Providers have responded to the new PPS by changing the services they provide during home health episodes: providing fewer visits but more therapy. The cost of providing an episode of home health services is lower as a result. Other broad indicators also suggest that payments are adequate: access to care is generally good, the rate of decline in the number of users has decreased, and the entry and exit of agencies has remained stable for the third year in a row.

In the past, we have recommended updates that emphasized stability for this sector because we lacked data on agencies' financial performance, and also wanted to give providers time to adapt to the new payment system. Home health agencies have adapted, and we expect them to continue to adapt during the coming year, further reducing the costs of providing an episode of care. Therefore, we recommend that the Congress not update payment rates for home health services for fiscal year 2004. Because of potential challenges that providers may face in rural areas, we also recommend that the Congress extend for one year, at a rate of 5 percent, add-on payments for home health services provided to Medicare beneficiaries who live in rural areas.

Outpatient dialysis services—Current aggregate Medicare payments for outpatient dialysis services for beneficiaries with end-stage renal disease are adequate. Together, payments for composite rate services and injectable drugs—the two main components of payment to providers of outpatient dialysis services—exceeded providers' costs by about 4 percent in 2001. We conservatively estimate that the aggregate payment-to-cost ratio will be no lower than 1.01 in 2003. If payment for injectable drugs and their profitability relative to composite rate services continue to increase from 2001 to 2003, as is likely, the ratio will be higher. Other indicators—such as continued entry of for-profit freestanding providers, increases in the volume of services provided, lack of evidence of beneficiaries facing systematic problems in accessing care, continued improvements in the quality of dialysis care, and providers enjoying adequate access to capital—together support the conclusion that Medicare's outpatient dialysis payments are adequate relative to efficient providers' costs. To account for changes in providers' costs in the coming year, the Congress should update the composite rate for outpatient dialysis services for 2004 by the change in input prices, less a 0.9 percent adjustment for productivity gains.

Ambulatory surgical center services—An ambulatory surgical center (ASC) is a distinct entity that exclusively furnishes outpatient surgical services. The current payment rates for ASC services are based on a cost survey conducted in 1986. Because of the age of the data, our first recommendation in this sector is that the Secretary expedite the collection of recent ASC charge and cost data for the purpose of analyzing and revising the ASC payment system. Because there are no recent data on the cost of providing ASC services to Medicare beneficiaries, we looked at market factors and concluded that current payments for ASC services are more than adequate. The growth in the number of ASCs has been rapid: between 1997 and 2001, the number of Medicare-certified ASCs more than doubled. The volume of procedures provided by ASCs to beneficiaries increased by over 60 percent between 1997 and 2001. Over the last 10 years, the increase in payments is even more pronounced—in nominal dollars, payments have increased fourfold. In addition, as indicated by their rapid growth, ASCs have sufficient access to capital. Current Medicare payments for ASC services are at least adequate to cover next year's expected increase in ASCs' costs. Therefore, we recommend that the Congress not update the payment rates for ASC services for fiscal year 2004.

In addition, although costs in ASCs should be lower than in hospital outpatient departments because ASCs have less regulatory burden and serve less medically complex patients, the ASC rate is currently higher than the outpatient hospital rate for several high-volume procedures. Therefore, we recommend the Congress ensure payment rates for ASC procedures do not exceed hospital outpatient PPS rates for those same procedures after accounting for differences in the bundle of services covered.

Access to care

A basic goal of Medicare is to ensure that elderly and disabled Americans have access to appropriate, quality health care. Therefore, we plan to monitor three dimensions of beneficiaries' access to Medicare-covered services each year: (1) the health system's capacity, (2) beneficiaries' ability to obtain care, and (3) access to appropriate care. We do not find widespread problems in beneficiaries' access to care. Although more selective about accepting patients from a number of payers

than in the past, the vast majority of physicians are accepting at least some new Medicare beneficiaries. Post-acute services are generally available, although it has become more difficult to place the most complex patients in SNFs. Nonetheless, some issues will require careful monitoring. As in other populations, certain beneficiaries—those in poor health, with low incomes, and without supplemental insurance—report more difficulty than others in accessing appropriate services. In addition, while the trend is improving, many beneficiaries are not receiving the most appropriate clinically recommended services. Finally, shortages of nurses could affect the availability or timeliness of certain services, and demographic trends raise concerns about the capacity of the health system over time.

Payment for new technologies

Medicare has the dual responsibility to pay enough for beneficial new technologies to ensure beneficiaries' access to care, while also being a prudent purchaser of new technologies. Prospective payment systems tend to promote the use of new technologies that reduce costs, but may slow adoption of technologies that increase costs. The inpatient and outpatient PPSs therefore, incorporate the costs of new technologies through special payment mechanisms as well as through an annual review of payment rates. To ensure fair treatment across technologies and payment systems, MedPAC recommends that the clinical criteria currently applied to all new technology applicants under the inpatient PPS, and to new medical device applicants under the outpatient PPS, be extended to new drugs and biologicals applicants under the outpatient PPS.

Health insurance choices for Medicare beneficiaries

Depending on where they live, Medicare beneficiaries may have a wide array of insurance options beyond traditional fee-for-service Medicare available to them. Those options may include Medicare+Choice comprehensive care plans and private fee-for-service plans, cost contract plans, preferred provider plans, and varying forms of supplemental coverage. Availability of options, and how and when beneficiaries choose among them, depends on specific market conditions and the circumstances of individual beneficiaries. The determinants of market conditions are both local and national. Although Medicare is a national program, it is only at the local level that medical care is delivered, beneficiaries choose insurance options and delivery systems, and insurers make decisions to enter the insurance market. In our report we review the entire spectrum of insurance choices, as a first step in MedPAC's effort to better understand beneficiaries' choices and market conditions.

f

Chairman JOHNSON. Thank you very much for that initial overview. I was curious as to why you used the same productivity figure across the board for everyone.

Mr. HACKBARTH. The productivity figure that we use, 0.9 percent, is based on the long-term, 10-year average in productivity improvement for the economy as a whole. So, as opposed to data on actual sector-by-sector change in productivity, it is probably best characterized as an expectation for improvement in productivity.

Chairman JOHNSON. I am concerned about that approach. To take the productivity figure, which I understand you are saying is from across the whole economy, and apply it to all the different disciplines, given the pressure that providers have been under since 1997 from the government and from managed care and from underpayments in Medicaid, seems to me a leap of faith.

Furthermore, now, productivity increases are going to require more sophisticated technology, not just better billing systems. I don't know how providers, many of whom are quite strapped from having been through transitions, can invest in the technology that might help them increase productivity.

Mr. HACKBARTH. Well, technology is certainly one way to improve productivity, but there are other ways that don't involve that sort of investment. That would be point number one.

Point number two is that we see many of these providers finding adequate capital to make lots of investments in expansion and acquisitions and the like. If they have capital for those purposes, they ought to also have capital for improvements and clinical technology and the like.

Chairman JOHNSON. I do respect that comment, but there are lots of health care providers whose capital access you can't see; they are too small. This is another way in which the system works, on average, where according to national assumptions capital doesn't get down to the little home health agency or the smaller provider that doesn't show up on the indicators. Many of these organizations tend to be investor-owned facilities.

Mr. HACKBARTH. On the subject on improving productivity, let us use the example of home health where there are many relatively small participants in that field.

Now, even if we look at the smallest home health agencies, we find that after the implementation of PPS, that they had 7.5-percent positive margins. This is post-implementation of PPS; this is after the payment reductions of October 1. This is taking those factors into account. So, these are the smallest of players in the field. The average margin in the industry is much, much higher than that.

Now, how did they accomplish that? In a sense, at least broadly defined, they have improved their productivity. They have changed the pattern of care to reduce costs. So, there are lots of ways for this to be accomplished. It is not all about investing in high-cost clinical information systems. In every sector that we look at, we see that when given appropriate incentives, providers can change patterns, lower costs, without hurting access and quality.

Chairman JOHNSON. The point you make is a perfectly valid one.

I think there is a difference between the pressure that has been put on physicians and the number of patients that are now confined to 15 minutes. The decisions I see out there are where physicians are forgoing the responsibility to provide 6-hour operations because they need to be back in their office and do something that the system recognizes as "real work."

This is a longer subject, and I hope you will come back and talk to the Subcommittee at length. If you look at the testimony of the home health people, they do point to some very real concerns about the fact that big repayments that are going to be recouped because of the system problems in Medicare were seen as profit under your analysis. However, they are going to repay all that.

Many of the small organizations were particularly hit by bad debt from the old payment system in the transition. I am not as comfortable as you are that what you are looking at is real money and real profit margin. It is too complicated.

I do want to sit down with you and your staff, and I will invite any Committee Member who wants to come, because I think we are having trouble understanding this issue. I would like to recognize Mr. Stark.

Mr. STARK. Thank you, Chairman. I guess just for the record, does the Commission have a benchmark for an adequate Medicare margin?

Mr. HACKBARTH. We have avoided trying to pinpoint a particular number. The circumstances for different sectors vary so, we haven't tagged a particular number.

Mr. STARK. In general, do you think it is appropriate—I presume you would like to see providers have a positive margin?

Mr. HACKBARTH. Yes.

Mr. STARK. Do you think it is appropriate to look at their entire—make of their entire margins all their business, as opposed to just segregating Medicare and trying to account for that separately and say they have a Medicare margin that is different?

Mr. HACKBARTH. Our general approach is to look specifically at their Medicare financial performance. It may be—a good way to illustrate why we do that is to talk about freestanding SNFs, where this has been a big issue.

According to the data that the industry has presented to the Commission, they more or less agree with our estimate of Medicare margins. Our finding was that the average Medicare margin was about 11 percent, which we think is quite a healthy margin. They argue, however, that that is substantially, if not totally, offset by losses that they incur on Medicaid.

We are unpersuaded by that argument for several reasons. First of all, Medicare patients represent about 10 percent of the business. We think loading the responsibility for the financial welfare of the whole industry on 10 percent of the patients is balancing a whole lot on a narrow base.

Second is that were we to decide to increase Medicare payments for each SNF patient, it wouldn't get the money to the right place. The SNFs that have the most Medicare patients would, by definition, have fewer Medicaid patients, and so we would be adding money to each of the Medicare cases to offset a relatively small number of Medicaid patients.

Mr. STARK. Would the same argument hold with an acute care hospital?

Mr. HACKBARTH. Obviously, the numbers are different in terms of Medicare share of total revenues.

Mr. STARK. In general, you look at the Medicare——

Mr. HACKBARTH. We look at the Medicare margins.

Mr. STARK. You have some historical comparisons of per capita growth for Medicare, private health insurance, the Federal Employee Health Benefit Plan (FEHBP) and California Public Employees Retirement System, and you discuss the relative comparability of the growth rates and you adjust it for the difference in the prescription drug coverage. You show that Medicare's rate comes out at 3.1 percent, while private insurance is at 4 percent.

Now that may not sound like anything but chump change, but isn't that really a 25 percent difference in the growth rate and a rather significant difference?

Mr. HACKBARTH. The Medicare rate of growth is, indeed, somewhat lower for the period that we looked at. We think that that comparison, though, needs to be made with caution.

There are differences in terms of, for example, the benefit package. We didn't attempt to adjust for the fact that there are not prescription drugs in Medicare and that has, in fact, been one of the fastest growing areas in the private sector. So, the numbers are not

quite apples and oranges—or not quite apples and apples, excuse me; they are apples and oranges.

Mr. STARK. You also focus on fee-for-service payments, and you have calculated that we are currently paying Medicare+Choice plans 104 percent of the fee-for-service rates without even accounting for risk selection and the fact that they should have no fraud and abuse because they wouldn't steal from themselves, you hope. They don't pay for graduate medical education because they don't refer as much as they should. So, the actual payments relative to fee-for-service are actually much higher.

Is it therefore correct to say that MedPAC has determined that we are overpaying Medicare+Choice plans?

Mr. HACKBARTH. Two comments: The reason that we are currently paying more is as a result of some of the features of the 1997 law, including the floor payments and minimum rates of increase and the like. So, it doesn't reflect any ill doing on the part of the plans. It is an artifact of the statute.

Mr. STARK. That is good lobbying.

Mr. HACKBARTH. I will let you judge that.

The second point I would like to make is, it is our belief that Medicare ought to offer a neutral choice between private options in the traditional program. So, what we would like to see is that Medicare pay 100 percent of what it would pay to have the patient remain in traditional Medicare after adjusting for risk differences.

Mr. STARK. Thank you, Chairman.

Chairman JOHNSON. Mr. Johnson.

Mr. JOHNSON OF TEXAS. Thank you, Chairman. I believe that Ms. Johnson hit on it when she was talking about your productivity idea. I don't think you told us how you came up with that 0.9 percent.

Mr. HACKBARTH. The 0.9 percent reflects the long-term rate of growth over 10 years in the economy as a whole. So, it is an expectation——

Mr. JOHNSON OF TEXAS. You can predict that growth? We can't.

Mr. HACKBARTH. This is looking back the past 10 years.

What we are trying to do in managing this system of administered prices is mimic, as best we can, what happens in competitive markets to create incentives for efficiency and the like. In fact, as businesses of all types and all sectors across America have experienced over the last decade and more, pressures for improvement in productivity and efficiency in the competitive market are relentless.

By including a productivity factor in Medicare, what we are trying to do is simulate the same thing in this administered price system, for people who pay the taxes to finance the program experience these pressures all the time. We think it is only fair that the providers who get paid by the Federal Government experience the same sort of pressure.

Mr. JOHNSON OF TEXAS. It is different all over the country; I think you would agree with that. There is not one number you can use for every State, every county even.

Let me ask you a question. You recommended raising the base payment for hospitals in rural areas and small cities. In contrast,

the Commission never recommended a floor on the wage index. Can you explain why one proposal was accepted and the other not?

Mr. HACKBARTH. Well, we do need to make some changes in the wage index. We don't think the floor is the right way to go. The changes that we advocate are reexamining the so-called "labor share" within the rate. We believe that the labor share may well be too high for rural areas. The effect of that is to basically redistribute money in the system and increase payments for rural hospitals and reduce payments in high-wage areas. So, that is one recommendation we have made.

A second, which is——

Mr. JOHNSON OF TEXAS. How do you assess the difference between rural and urban? I represent two counties, one Dallas and one Collin. Dallas is urban, Collin is rural. So, how do you assess that?

Answer me another question, if you would. Are your facts current, because in the past we have been told that you are operating with statistics that are 2 or 3 years old.

Mr. HACKBARTH. The definition of urban and rural that we use is the one that you put in statute. For purposes of the wage index, I think most analysts agree that we need better definitions that reflect employment markets, which leads to a second of our recommendations.

Mr. JOHNSON OF TEXAS. You made that recommendation?

Mr. HACKBARTH. Yes. We have recommended that the data be collected that would allow us to explore better labor market areas and make some other adjustments in the wage index that worked to the disadvantage of rural areas.

Mr. JOHNSON OF TEXAS. Okay. Are you using current statistics? You didn't answer that question.

Mr. HACKBARTH. The wage index, in particular, the data are several years old, but our analysis is that the relative relationships as you go across the country don't really change much over time. Everybody may go up, but the relationship between location A and location B tends to be more consistent over time.

So, the age of the data throughout the program is a problem; I would freely concede that. In this particular area of the wage index, we don't think it is the most important problem.

Mr. JOHNSON OF TEXAS. Under current law, targets are set for physician expenditures and physician updates are based in part on comparison between actual and targeted expenditures.

Are there other factors that should be taken into account, such as changes in technology or aging or relative health status of the Medicare population?

Mr. HACKBARTH. Well, our recommendation on the physician payment system has, in fact, been to drop the so-called "sustained growth rate" system that you are referring to. So, we have not taken a stance on particular refinements in the mechanism.

So, the questions that you are asking are simply not questions that the Commission has addressed.

Mr. JOHNSON OF TEXAS. Thank you very much. Thank you, Chairman.

Chairman JOHNSON. Thank you. Mr. Kleczka.

Mr. KLECZKA. Mr. Hackbarth, a couple of questions.

You discussed the skilled nursing problem with Mr. Stark. However, I met with some of these folks from the State of Wisconsin yesterday, and they indicated that because of the loss of the add-on payments, the industry nationwide will lose $1.8 billion; and in the State of Wisconsin, the nursing homes will lose some $40.6 million.

Are you still indicating that their margin is such that they don't need an annual increase?

Mr. HACKBARTH. I believe the numbers that you are referring to, certainly with regard to the Nation as a whole, are total margins and again reflect the fact that they are losing money on Medicaid. That really is the crux of the issue here. For reasons that I have already given, we don't believe——

Mr. KLECZKA. Let me just back up. What they cited to me was that this is a loss in Medicare funding. They didn't discuss the margin and the fact that it is cross-subsidies.

Mr. HACKBARTH. After the withdrawal of the add-ons, the ones that expired in October, we believe the average margin for free-standing SNFs is 11 percent.

Mr. KLECZKA. Even with the loss. So, you are saying——

Mr. HACKBARTH. Even with the withdrawal of all of those add-on payments.

Mr. KLECZKA. Let us say there was no loss of the payments. Was that margin going to increase 15, 16 percent or what?

Mr. HACKBARTH. I don't know what the additional increment would be, but it would be higher than 11 percent certainly, if those payments were restored, yes.

Mr. KLECZKA. Are you saying they are calling "wolf" without the necessity to do so?

Mr. HACKBARTH. What I am saying is that there is a very important analytic and philosophical disagreement. When they say they are losing money, on a national basis at least—I have not looked at the numbers in particular for Wisconsin, but the national basis at least, when they say they are losing money, it is counting the Medicaid patients. In the documents they have given to us, they acknowledge they are making money on Medicare, but they think they need to do that to offset Medicaid losses.

We don't think that is good policy for the Medicare Program.

Mr. KLECZKA. Later this afternoon we are going to hear from the Renal Council and there was a recommendation for an annual adjustment for the renal folks. However, they are also looking for an annual update mechanism.

That is not your bailiwick or your responsibility, but do you have a view on providing for a mechanism?

Mr. HACKBARTH. Current law does not provide for an annual update for dialysis providers. In fact, each year we do look at the rates and analyze whether a change is appropriate. So, in that sense within the MedPAC framework, we do an annual update analysis.

As is true of all providers, I would be a little bit cautious about writing in the statute an automatic increase for dialysis providers. The circumstances in all of these businesses can change a lot year to year, and I think they need to be reanalyzed each year. These should not be formulaic automatic increases, guaranteed.

Mr. KLECZKA. The last concern is the whole question of Medicare Choice. I believe you indicated because of the risk selection for the Choice plans that they should actually receive a lower reimbursement than the fee-for-service Medicare?

Mr. HACKBARTH. That isn't quite what I said.

Mr. KLECZKA. That is what I was hoping you said.

Mr. HACKBARTH. It wasn't quite what I did say, though.

I actually have a lot of personal experience in this field having worked for Harvard Community Health Plan, that had a substantial Medicare risk program. I know from my personal experience that some health maintenance organizations (HMOs) probably get a better-than-average selection of risks while other HMOs may, in fact, enroll more sick people than average. I think the temptation to say HMOs are all the same ought to be avoided.

What we need in Medicare is a payment system for private plans that pays fairly after adjusting for risk. The CMS with help from the industry has been working toward a new risk adjustment mechanism which we are optimistic about. We think it will be an improvement over current law, so we favor that move. For some HMOs, it would be more payment; for some it would be less payment depending on their risk profile.

Mr. KLECZKA. Thank you.

Chairman JOHNSON. Mr. Ramstad.

Mr. RAMSTAD. Thank you, Chairman.

Thank you, Mr. Hackbarth, for the job you are doing in Chairing the MedPAC. This is a tough policy area, very difficult policy area, probably as difficult as any that we deal with at the Federal level, and we appreciate your leadership helping us sort out these Medicare payment policy issues.

I know, Mr. Hackbarth, that MedPAC's recommendations for skilled nursing home care are limited to Medicare for skilled nursing care. I also know that too many SNFs in Minnesota have closed. They have gone broke and they are closing literally every week.

My question is a more broad question than was previously asked. Since Medicare serves as a subsidy, really, for Medicaid, it seems to me these two programs are obviously interrelated, and it would follow that Medicare reimbursement policies have an impact on Medicaid patients' access, certainly to nursing home care. Would you agree with those premises?

Mr. HACKBARTH. That Medicare payments affect Medicaid——

Mr. RAMSTAD. Yes.

Mr. HACKBARTH. Access? I am honestly not sure whether I would agree or not. A lot would depend on the specific circumstances.

Mr. RAMSTAD. Doesn't Medicare essentially subsidize Medicaid?

Mr. HACKBARTH. In general, the Medicare rates are significantly higher than the Medicaid rates.

Mr. RAMSTAD. Therefore, it seems the two are directly related?

Mr. HACKBARTH. Yes.

Mr. RAMSTAD. Then it seems to me that it would follow that Medicare reimbursement policies have an impact on Medicaid patients' access to nursing home care.

Mr. HACKBARTH. Well——

Mr. RAMSTAD. Let me ask you the question I am getting at. I am trying to lay the foundation for this question.

Why doesn't MedPAC expand its scope so that the elderly can be considered in totality, so that we are looking at the total picture instead of just a piece?

Mr. HACKBARTH. We are the MedPAC, of course. Medicaid payment levels are not only beyond the scope of MedPAC's charge, but under the Medicaid framework, are determined at the State level as opposed to the Federal level.

Mr. RAMSTAD. I understand that. I also understand the interrelationship, which you recognize and cited in your colloquy with my friend from Wisconsin, the previous Member who asked questions. It just seems to me that we are kidding ourselves.

I understand your jurisdiction, but it just seems, not to look at the whole access question, in its totality, not to consider the elderly in terms of the total picture is not doing them a service and not doing us a service. We need to reexamine the jurisdictional limitations.

Mr. HACKBARTH. This is really way beyond, though, a point about statutory jurisdiction.

The critical point here is the best way to fix Medicaid's underfunding problem is through Medicaid because, that way, the dollars will flow according to the volume of Medicaid patients served by the nursing facility.

If we try to fix the problem on the Medicare side, the institutions with the smallest Medicaid populations will get the most Medicare dollars. By the same token, the institutions with a lot of Medicaid patients would get fewer Medicare dollars.

Medicare add-ons simply cannot get the resources to the institutions in need. So, it is not a quibble about jurisdiction; it is about getting bang for the taxpayers' buck when we have a lot of other pressing priorities within the Medicare Program.

Mr. RAMSTAD. I see my time is about up, and I appreciate the situation and the predicament, but I also, as the son of a parent who is in the last stage of Alzheimer's disease and somebody who has been looking for an appropriate SNF and talking to—and hearing from these people at that level, there is a real problem out there in the real world—in the State of Minnesota, in the State of Wisconsin, in the State of Connecticut—and we have got to fix it.

So, I hope you will continue to work with us, and I hope—this is one problem we truly need to address in a bipartisan, pragmatic, common-sense, cost-effective, humane way. Thank you Mr. Hackbarth.

Chairman JOHNSON. If I may, I can't help but comment.

I think the problem is when MedPAC looks only at Medicare reimbursements—and I appreciate what you are saying that if you increase reimbursements you aren't necessarily going to get to the Medicaid-heavy facilities.

Nonetheless, it seems to me there is clearly a public interest in the survival of nursing homes and in the problem of underpayment in Medicaid. For us to simply, in our narrow view, deal with our payment problem, knowing that it could put homes out of business because we have no plan to require the States, who are our partners, to reimburse fairly is morally wrong.

It is also wrong from the point of view of public policy because you just can't deal with one public policy in isolation from another failing public policy. So, I think this is why this such a difficult issue.

Mr. STARK. Would the gentlelady yield on that topic?

Chairman JOHNSON. Very briefly.

Mr. STARK. Should we—Medicaid, I suspect, is the highest payer. Private insurance plans are the second highest payer. If we are going to coordinate what Medicare and Medicaid pay, we should also then control what private insurers pay. In a sense, they pay more than Medicare, I think.

Chairman JOHNSON. The great majority of nursing home patients are paid for by Medicaid. The second—it is a relatively small amount, and we have direct responsibility under current law for Medicaid and Medicare.

Mr. CARDIN. We could reinstitute the Boren amendment, and then we wouldn't have to worry about this.

Chairman JOHNSON. Mr. English.

Mr. ENGLISH. Thank you, Chairman.

Mr. Hackbarth, I wonder, following up on Mr. Johnson's question, if I could get you to elaborate further. In regard to the labor share of the wage index, what would you suggest the percentage be adjusted to?

Mr. HACKBARTH. We don't have, Mr. English, a specific percentage in our recommendation. We think that CMS is in the best position to do the recalculation. We have done some analytic work that would suggest that the current labor share of 71 percent is probably a few percentage points too high, something like that, something in that neighborhood.

Mr. ENGLISH. Another question, CMS issued an analysis on June 28, 2002 on the financial status of the home health care industry under the Medicare Prospective Payer System, which concluded that the median profit margin for home health providers was 2 percent prior to the 15 percent cut and elimination of the 10 percent rural add-on and, further, prior to payment of interest, taxes, depreciation and amortization.

Further, an agency of the Pennsylvania General Assembly in November 2002 released a survey of rural home health providers in Pennsylvania, which discovered that 40 percent of the Medicare-certified home health agencies are considered to be financially vulnerable, and 24 percent expressed concern that they might not be able to survive under PPS. Again, these conclusions were reached without taking into account the 15 percent cut, the elimination of the 10 percent rural add-on.

With this in mind, would you please elaborate on how MedPAC concluded in its March 2003 report that, and I quote, "Aggregate Medicare margins and the ratio of payments to charges suggest that current payments are more than adequate in relation to cost"?

Mr. HACKBARTH. I would be happy to.

Here was our approach: First of all, we looked at actual cost report data for the first year under the new PPS for home health agencies. We had cost report data available for about 10 percent of all agencies. This was not a random sample, I want to be clear about that, but it was a reasonably representative sample in terms

of urban and rural composition, for-profit and voluntary ownership and the like.

Using that data, we found that the average margin after the implementation of PPS and adjusting for the so-called 15 percent cut was in excess of 20 percent. There was a slight urban/rural difference, but even the rural margins were up in the neighborhood of 20 percent.

The biggest disparity—the variable that made the biggest difference was size, as I alluded to earlier. The smallest agencies had a positive margin in this sample of about 7.5 percent. So, that is actual cost report data.

Since it was only 10 percent of the agencies and not a random sample, we tried to look at the issue from another vantage point where we could get even more recent data. What we did was look at actual claims data and compare the Medicare payments to the charges, the actual charges, made by the home health agencies. There were two important findings. One was that payments exceeded charges, the amount that was charged, by about 11 or 12 percent and that positive margin of payment overcharges was actually growing over time during the first year-and-a-half of the PPS for home health agencies.

So, with the completely different database—and this one was a random sample—we had results confirming what we got from the cost reports.

Still a third piece of information comes from the U.S. General Accounting Office study estimating payments and costs for home health agencies, which also found very high, positive margins. So, we have looked at it three different ways and we have come to the same basic conclusion.

Mr. ENGLISH. Well, let me simply say, the experience I have, which is limited to a lot of anecdotal feedback in places like northwestern Pennsylvania, suggests a very different story.

I appreciate your testimony, and my time has expired.

Mr. HACKBARTH. Chairman Johnson, if I could make one quick point there.

In every sector that we are talking about, there will be some organizations that do better than others. You know there may be particular organizations that are losing money. That happens all across the economy all the time. Not everybody wins all the time.

Mr. ENGLISH. Chairman, Mr. Hackbarth makes that point, but the feedback that I get in my region is not limited to isolated or scattered organizations. This is a uniform picture that is coming from the providers throughout the region in different communities, and it is pretty much the same story.

So, I would like to revisit your methodology at some point, but I thank you for your testimony.

Chairman JOHNSON. Congresswoman Tubbs Jones.

Ms. TUBBS JONES. Thank you, Chairman.

Good afternoon, sir. How are you? This is my first service on the Committee on Ways and Means and an opportunity the second time to sit on the Subcommittee on Health. So, I am rushing through this report having not had a real opportunity to review it, but I do have a few questions for you.

I am interested in the section that speaks about access to health care and specifically access to health care as it is related to race and ethnicity and socio-economic levels. I just wondered—and I will read just one quickly. It says that "Race and ethnicity were highly significant in influencing whether a beneficiary reported having a usual doctor, and not having a usual doctor seemed to deal with the lack of access."

Ms. TUBBS JONES. Do you make recommendations for how we can address that particular problem?

Mr. HACKBARTH. No, ma'am, not in this particular report.

Ms. TUBBS JONES. Would that be part of your responsibility?

Mr. HACKBARTH. We could take that up in the future, yes, but we have not made any specific recommendations to this.

Ms. TUBBS JONES. I would encourage you to take that up in the future, because it becomes such a significant issue, particularly when you start talking about race, ethnicity and socio-economic income as it impacts, because I am sure that you would agree that over time that problem will create greater problems on the other end, particularly when you look at the report that says that the sickest use more money out of the system than anyone else, and if we could give them health care on the front end maybe we wouldn't spend so much money on the back end.

I also was interested in a chart on page 4 where—specifically going back to the Medicare, spending is concentrated in a small percentage of beneficiaries. Are you making any recommendations on how we adjust that in any way that we don't spend so much money, or is it too late that they are in such bad health care, bad shape that it is too late to try and work on that issue?

Mr. HACKBARTH. It is roughly true. These are ballpark figures, that about 20 percent of the Medicare beneficiaries account for something like 80 percent of the spending. So, the patients who have the most serious health problems, maybe multiple chronic diseases, consume a lot more resources obviously than patients who don't have any medical problems. That is not unique to Medicare. If you look at any insurance program, you see a very similar phenomenon.

Ms. TUBBS JONES. Let me skip to one other thing real quickly since my time is very short. Will you be asked to assess how the delivery of a prescription drug benefit will impact Medicare in the future?

Mr. HACKBARTH. We have not specifically looked at that, nor have we been asked to look at that by the Congress.

Ms. TUBBS JONES. Let me ask, but part of the delivery of health care as we know it in years 2000 and going forward is probably greater—there is a greater use of pharmaceuticals to deal with health care problems than there has ever been before. Is that a fair statement?

Mr. HACKBARTH. That is true. We did do a report June of last year looking at the Medicare benefit package, and one of the points that we made there was not a new one by any stretch, but the role pharmaceuticals play in modern medical practice is much greater than was true 10 or 20 years ago, and so looking at it from the standpoint of a clinician it is really hard to practice quality medicine if your patient can't afford drugs.

Ms. TUBBS JONES. Can you tell me the name of that report? Chairman, that will be my last question.

Mr. HACKBARTH. We would be happy to get you a copy of the report. It is our June 2002 report.

Ms. TUBBS JONES. I am in 1009 Longworth. I would appreciate it. Thank you. Thank you, Chairman.

[This report will be retained in the Committee files.]

Chairman JOHNSON. Mr. Ryan, who is not a Member of this Subcommittee but is interested and has joined us, would you like to question?

Mr. RYAN. I would appreciate that. Thank you, Chairman. Thanks for allowing us.

I have been very interested in the discussion that is going on about the cross-subsidization of Medicare and Medicaid in our nursing homes. I met with the skilled nursing providers in Wisconsin, as Mr. Kleczka did, just about an hour ago, so I don't want to go over that again. I understand, and I think you can appreciate that from a nursing home standpoint they have a large pool of Medicaid recipients that must be cross-subsidized. So, they aren't getting those kinds of margins, only if you look at it in the narrow view of just the Medicare patients. So, I think you can appreciate that.

It sounds like at MedPAC you had a vigorous debate about the appropriateness of cross-subsidization between Medicare and Medicaid patients. I am too new to know how in the world we decided 1 day years ago why a low income senior was a poor person first and then a senior citizen second and coming through Medicaid, but I would like to see if you have actually gone into that in this vigorous debate you had as to the appropriateness of this cross-subsidization or not. Do you look at it from that perspective at all?

Mr. HACKBARTH. I am not sure, Mr. Ryan, that I am—I understand the question. We look at what the proper financial analysis is for Medicare. We don't—we have not looked, at least in my tenure on the Commission, at the specific issues raised by the so-called dual eligibles.

Mr. RYAN. Right. That is what I am talking about.

Mr. HACKBARTH. That is something we have talk about putting on our agenda in the future.

Mr. RYAN. I would be interested in seeing if you would look at that.

The second thing is, with your experience with risk adjustment, I would like to ask you one question about that. That is a very murky science right now, and it has improved lately, but we haven't learned how to build the right kind of risk adjustment mousetrap for the marketplace. What is your opinion about changing the way Medicare+Choice providers are reimbursed from the current kind of program, even if we build a better risk adjustment mousetrap to, say, a mid-based pricing system such as what is employed now at the FEHBP plan.

Mr. HACKBARTH. The current system, as you know, is basically based on demographic factors. We adjust for age, sex and very basic characteristics like that. Those are clearly inadequate to the task. Within each of those categories some patients are sick and some aren't, and so there is way too much variation.

The CMS, as we speak, is in the process of collecting data for a new system that we think would be a significant improvement by incorporating data about the services the patients have been using. Is that going to be a perfect risk adjustment system? No. In fact, the perfect risk adjustment system doesn't exist.

Mr. RYAN. Right. So, isn't a better risk adjustment system a system that continually evolves over time and where the person who bears the risk or who bears the loss if the risk is adjusting properly is the provider, not necessarily the government, and therefore we have plans pulling in and pulling out? Wouldn't it be better for a big-based pricing system that incorporates all of those factors, incorporates all of the risk adjustments, and has an incentive for new risk adjusting technologies to be built into the price? Wouldn't that be a better way of actually reflecting the costs of providing health care in the reimbursement rates and going to that kind of a payment system for Medicare+Choice plans?

Mr. HACKBARTH. I think that there are two distinct and separable issues. One is there may well be substantial merit in going to a competitively set system of pricing for plans for the Medicare Program in general. Competitive markets have many advantages, one of which is the flexibility and fluidity that you referred to.

Even if you go down that path and accept all of that, in order to make the markets work fairly you are going to need a risk adjustment system, because the costs, the future costs incurred vary enormously for different patients. So, I don't think going to a competitive system necessarily obviates the need for a better risk adjustment.

Mr. RYAN. I agree with that. My question is will it make us risk adjust more quickly and more accurately rather than going through the CMS regime that we are doing right now?

Mr. HACKBARTH. Well, I am not sure that I am smart enough to know the answer to that. Risk adjustment is a very difficult field for private plans, as well as for the Medicare Program. One of our commissioners, Alice Rosenblatt, is the Chief Actuary for WellPoint, and she can bend your ear for hours about how difficult this issue is.

Mr. RYAN. I see my time has expired. Thank you, Chairman.

Chairman JOHNSON. Thank you. Mr. Cardin, also not a Member of the Subcommittee but an active participant in our discussions.

Mr. CARDIN. Thank you, Chairman. Mr. Hackbarth, I thought that your response to Mr. Ramstad's point about Medicare and Medicaid was well taken, but I think it does point out the fact that when we repealed the Boren amendment, which required the States to provide reasonable reimbursements under Medicaid, it had an impact on Medicare. Because the pressure is now on the Medicare reimbursement structure to compensate for inadequate State reimbursement rates under Medicaid, that has an effect on the affordability of Medicare and what we can do in Medicare. So, I think there is a relationship here, and I would just encourage us to at least be mindful that the State reimbursement rates are having an effect on access, including seniors' access, to care.

I want to ask you about the rehabilitation therapy caps of $1,500, the caps we implemented in 1997 as part of our cost sav-

ings effort in Medicare, that I must tell you were not well thought out back in 1997. There were no hearings on that. They took effect for 1 year in 1999, and proved to be very difficult for the one out of every six seniors who reached that cap. Congress twice enacted moratoria, which ended on January 1, 2003. Unless we act, access to outpatient therapy services for our seniors will be affected, and I didn't see anything in your written statement on that. I am just wondering whether you have done any work on this issue.

Mr. HACKBARTH. We have not. That is not an issue that we have examined, at least in my tenure, on MedPAC the last 3 years.

Mr. CARDIN. Did you not examine it because you figured we were going to take care of it?

Mr. HACKBARTH. No. Simply because there is just a whole lot of opportunities for doing analysis and making recommendations, and that simply isn't one that we have taken up.

Mr. CARDIN. Well, I would urge you to. Mr. English and I have introduced legislation to try to correct that. The Chairman has been very helpful to us in trying to deal with the $1,500 cap, as has the Chair of the full Committee, and I hope you will take action. I understand from CMS that they can't implement them until July, but then they will affect access to needed therapy services, particularly for those who are in the most dire need. It doesn't make much sense the way the caps are organized. I hope we take care of it here, but I do think you should have it on your radar screen, because I suspect it will have an impact on the work that you are doing, if in fact the therapy caps are permitted to actually affect services for our seniors. I would just encourage you to keep that on your radar screen. Thank you, Chairman.

Chairman JOHNSON. Thank you. Mr. Hackbarth, did you exclude from your home health analysis home health agencies connected with hospitals?

Mr. HACKBARTH. We didn't exclude them for processing reasons. They were not in fact included in that initial 10 percent sample of cost reports. I would ask you to keep in mind, though, we take a little different approach to analyzing the, if anything, performance of the different lines of business of a hospital within the Medicare Program. As you know, there are major questions about how you allocate costs that a hospital incurs across different lines of business, inpatient care versus the hospital-based SNF, versus the hospital-based home health agency, and we think the best approach to dealing with that is to look at the hospital's overall Medicare margin encompassing all of its lines of Medicare business.

So, when we report hospital margins—for example, we estimated the margin for 2003 being on average 3.9 percent. That includes not just their inpatient care but also their SNFs and their home health agencies line of business. Generally speaking, if you break it out line by line, the inpatient margins are overstated and the particular margins on SNF care and home health are understated strictly for cost allocation reasons. It is an accounting issue, not an economic issue.

Chairman JOHNSON. It does suggest that we should look less at hospital inpatient margins and more at hospital total margins?

Mr. HACKBARTH. That has been approached in recent years.

Chairman JOHNSON. Well, that has certainly been my interest.

Last, let me just say you have heard from many Members that their experience out there in the real world is not confirming them what you are telling them. This does raise one other issue that we haven't talked about. We talked about cross-subsidizing and a number of other philosophical issues. The last I would like to raise is this business of dealing on average. You like to stray from that only in targeted ways. So, you target rural providers and give them a bump-up, but you don't target those who serve our inner cities, which often have much higher costs. So, I would like to ask you to do in every provider sector what you are in the process of trying to do for us, look at the ones below the average. Are there common characteristics? Are there certain kinds of home health agencies that tend to have negative margins? Are they just rural? Are they rural and inner city with certain concentrations? Are they only the inner city ones that have security people? This is same with hospitals. We have looked at this some. Unfortunately, we are not looking at some aspects of it, but volume is clearly an issue. Clearly exceptions need to be made for rural, but there are other factors, too. I think we need to put a lot more research into who is below the average. Does being below the average mean that you are "inefficient," and "could do better," and "morally should do better," or does it mean that we are going to put you out of business because we don't understand the clients you serve or the environment in which you serve or the geographics in your area?

Mr. HACKBARTH. We do as a matter of course in each sector look at variations and see if there are certain patterns. So, that is a typical part of our analysis. As you well know, this is an issue that you and I have talked about in the past, and we have embarked upon a piece of analysis for hospitals, which we refer to as the winners and losers analysis, to try to better identify the characteristics that are associated with good performance under the Medicare system and poor performance, and if I am not mistaken, our June report will include some of that analysis.

Chairman JOHNSON. Yes, and I just would point out for the Members to remember that the total margins are higher in the rural areas where we get bump-ups. The very lowest margins often, around 2 percent I think, are the medical centers, if I am not mistaken. We do have to ask ourselves whether these very big medical institutions on which we rely for treating our most difficult patients, life star and burn centers, and all these things should honestly be operating at a 1 or 2 percent margin, whether that is healthy. I look forward to that analysis coming in your June report and I think it should be part of our discussion. I think we are moving into an era where the average is beginning to fail us, and that is why we are looking at the fringe issues and the wage distribution. This is failing us, but there are many other ways in which the on-average analysis is interesting. However, it can't help us assure the public interest in a network of providers that, like the U.S. Post Office, reaches everyone everywhere with adequate access to adequate health services.

So, I thank you for your testimony and for the good work of the Commission. Mr. Stark.

Mr. STARK. Could I get a second crack at the apple here, as it were? Pardon me, Mr. Hackbarth.

Chairman JOHNSON. Yes.

Mr. STARK. This issue of subsidization, I want to touch on that for a moment. Just historically some years ago we examined the idea, at the risk of the more—at the suggestion of the more conservative Members here, we subsume Medicaid into Medicare, with the exception of long-term care; in other words, that we have one Federal payment system for rich and poor or seniors and poor, making it another part of Medicare, so that we had similar patients and similar benefits and then let the States take on the responsibility of home health care. So, that has been examined, or on long-term care, in the past, I suppose could be something we could examine again.

The question has also come up time and time again, we used to call it cost shifting, I guess, and I suspect that 15 or 20 years ago Medicare benefited from the generous fee-for-service payments that private insurance companies were paying. I think that has now turned, and I would ask you—I might suggest that—and I am going to ask you for your opinion of this number, that in the case of hospital payments, that 90 percent of the copayments to hospitals, that Medicare is probably the highest payer for that copayment, or is it 80 percent or 50 percent or 60 percent? What is the guess?

Mr. HACKBARTH. The highest payer for a hospital?

Mr. STARK. For hip transplant, for hospitalization or for a prostrate removal or whatever you want, that if you compare private insurance, Medicare and Medicaid, that Medicare is generally the highest payer.

Mr. HACKBARTH. I am not sure, Mr. Stark, the answer to that, and maybe I can get some help here in just a second. My recollection of the data is that a couple points are important. It varies a lot by market depending on the local circumstances, the amount of managed care and how much aggressive negotiation there is in the private rates. That would be point number one.

Point number two is, as I recall the data, if you look at the country as a whole, that the payment to cost ratio is higher for private payers on average across the country than for Medicare. If I am—they are telling me I was lucky and got it right. So, in some cases that may be true, but on average I don't think it is true.

Mr. STARK. The question has been raised several times by my colleagues on both sides of the aisle dealing with wage rates and classification by location and rural and urban and inner city and teaching and on and on and on.

What in your opinion—and I have often thought about this as an alternative, but as I understand it, there is about 6,000 hospitals in the country, about a dozen per Congressional district.

Mr. HACKBARTH. Uh-huh.

Mr. STARK. Would it be a major undertaking beyond your comprehension, understanding, information technology as it exists, that to say let us quit fussing with this adjusting rates that are universal and then begin to adjust them by region and by a whole host of proxies, and say let us go hospital specific, require the hospitals to—and keep a second set of books for all I care—to have a cost accounting basis that is standard. Then come to us and say we ought to get more—this was done in the State of Maryland, for ex-

ample, but we ought to get more because we are rural and we can't find people or our costs are very high because of weather and we are inner city and we have a huge security problem, and come to this Committee and suggest that they are going to go broke if they are not adjusted and present to us a business plan that says, all right, we will take these actions. If we are given a subsidy or a higher rate, whatever you want to call it, for a certain number of years, we will eventually work our way out? We would say, okay, let us do this. Would that be a horrendous accounting problem for MedPAC to handle a situation like that?

Mr. HACKBARTH. I think the answer to that is yes. The system that we currently——

Mr. STARK. It would put a lot of lobbyists out of business.

Mr. HACKBARTH. The system that we currently have with all of these proxies, as you put it, is clearly imperfect. It is one of the well-known drawbacks of these so-called administered price systems. You are always struggling with trying to refine and improve. I think on average we have done a pretty good job with the Medicare payment system. Frankly, I was in the U.S. Department of Health and Human Services (HHS) when the system was enacted in the early eighties, and I would have bet a lot of money at that point that it wouldn't have worked as well as it has, and I am happy to concede that. It is difficult, laborious to work with these proxies.

The alternative approach that you suggest of hospital-specific budget review, as it were, has a whole different set of problems, and trying to ascertain what is legitimate cost and what isn't, how different the patients are, you will be confronted with problems at every turn there as well. I think what happened in a lot of the State rate-setting problems was you tend to end up saying de facto, well, if you started high, you get to stay high in perpetuity, and that creates a whole different set of injustices. So, these are tough questions. There is no getting around that.

Chairman JOHNSON. Thank you very much. Coming from a State who had that kind of budget review and dumped it, one of the most liberal Democratic States in the Nation. This wasn't a conservative group that dumped it. It has its own set of problems.

As you take your leave, Mr. Hackbarth, would you just reaffirm in my mind whether or not the Commission stands by its earlier recommendations to reform the physician payment system?

Mr. HACKBARTH. Yes.

Chairman JOHNSON. Thank you very much, and thank you for being with us today. You have been very gracious with your time. We appreciate it.

As Mr. Hackbarth leaves, let me call the final panel, and I am going to yield to Mr. English while you are assembling. Mr. English.

Mr. ENGLISH. Thank you, Chairman. This is a rare privilege for me to welcome a witness on this panel from my hometown of Erie, Pennsylvania. James Jaruzewicz is a true expert on the practical implications of Medicare payment policy. Jim is devoted to providing quality care for some of our community's frailest and most at-risk individuals. For almost 10 years, he has worked at St. Mary's Hospital in Erie—I am sorry, he has worked at the hospital

level in my hometown, overseeing the operations, personnel and purchasing. Continuing his commitment to quality health care, he has served as Executive Director of the Visiting Nurses Association since 1985.

He is also affiliated with the Pennsylvania Association of Home Health Agencies, St. Vincent Health System and the Erie Homes for Children and Adults. I want to thank him for participating in the hearing today and look forward to his testimony.

Chairman JOHNSON. Thank you very much, Mr. English, for that nice introduction, and indeed it is very, very nice for all of us to have a representative from the real world that one of our Members knows well, and so we do thank you for being here. Thanks as well to all the others who have come to testify. We look forward to hearing from you. I won't go through the introductions because of the time. Mr. Jaruzewicz.

STATEMENT OF JAMES JARUZEWICZ, PRESIDENT AND CHIEF EXECUTIVE OFFICER, VISITING NURSES ASSOCIATION OF ERIE COUNTY, ERIE, PENNSYLVANIA, ON BEHALF OF THE VISITING NURSE ASSOCIATIONS OF AMERICA

Mr. JARUZEWICZ. Chairman and Members of the Subcommittee, good afternoon. My name, as you know, is Jim Jaruzewicz.

Chairman JOHNSON. Excuse me. You have to pull the microphone close to you, and turn it on.

Mr. JARUZEWICZ. Chairman and Members of the Subcommittee, good afternoon. My name is Jim Jaruzewicz, and I am President and Chief Executive Officer (CEO) of the Visiting Nurses Association in Erie, Pennsylvania. I want to thank you for giving the Visiting Nurses Association of America (VNAA) and me the opportunity to present our testimony. The nearly 500 nonprofit visiting nurse agencies (VNAs), across the country collectively provide home health care to over 4 million Americans each year.

We were disappointed that the Commission—excuse me. Let me begin by saying that VNAA sharply disagrees with the assumptions that were made by MedPAC staff about excessive profit margins and cost of care in the Medicare home health benefit. We are disappointed that the commissioners accept the staff's analysis of the data as sufficiently accurate on which they base their recommendations. Their discussion on the 15th of January was solely based on an assumption that reimbursement exceeds costs. Therefore, reimbursement needs to be cut, period. No further analysis needed.

Their recommendations to freeze the inflation update for home health care for fiscal year 2004 and to reduce the rural add-on from 10 percent to 5 percent were based on what was perceived to be a fact that agencies are making 23 percent average margins and the non-profits 15 percent margins, and therefore money needs to be taken away from them.

The VNAA believes that this finding is absolutely false. The reason that we believe this is because our data shows that VNA's average net income is 1.3 percent, which accounts for only a 3 percent profit under Medicare. This average Medicare profit is used to increase nurse salaries, repay interim payment system (IPS) debt, acquire technology to comply with the Federal regulations and to sub-

sidize losses under managed care in Medicaid. In addition, VNAA believes that the MedPAC data is inaccurate and misleading at best. Here are only two of the nine statistical omissions that we found in the staff's data analysis.

The cost report data was used from a 10 percent nonrandom sample. The MedPAC staff admits that the sample was not geographically representative, and due to CMS programming problems, there is no cost report data available at all from six of the States in which VNAs are most numerous.

In addition, hospital-based agencies were excluded from the margin analysis, because these agencies represent 30 percent of the total home health agencies in the United States. Leaving them out of the data poll is statistically irresponsible. We now understand after listening to their prior testimony that they will never be included in the home health data analysis.

The VNAA believes that MedPAC has put in motion a potentially tragic situation where findings of excessive margins based on statistically unreliable data are now accepted as the truth, which have led to damaging recommendations that would hurt real people if adopted by Congress.

In addition, we believe that MedPAC has done a great disservice to Congress by adding to the circulating rumors that home health care expenditures are increasing. This is absolutely not true, and CMS in its own data confirms that expenditures are not increasing. The latest numbers from CMS now project a decline in home health spending over the next 10 years from what was originally projected.

The U.S. Congressional Budget Office has also said that it will revise its estimates for home health care spending downward in its March report.

We believe that if the 5 percent cut is not repealed and if the pending 10 percent rural add-on is not extended, VNAs will have no choice but to cut clinical staff, which will further reduce their ability to accept patient referrals. Some of us are already turning patients away for the first time in our 100-year history, because we don't have the clinical staff to provide adequate levels of care.

Two days ago the House passed by a 411 to 0 vote, a resolution establishing National VNA Week in recognition of the caring hearts and the willing hands the VNA nurses bring to the Nation's frailest and most at-risk individuals, regardless of severity of the patient's condition or ability to pay. The VNAA asks you to please not to consider legislation that will once again undermine VNAs' very existence, as was done under the former IPS.

Across the board cuts are inherently unfair to home health providers who are desperately trying to meet the health care needs of their patients. It forces agencies with break-even budgets to cut patient care or go out of business.

Finally, we urge Congress to establish a disproportionate share payment for providers who serve the highest percentage of Medicaid patients and provide disproportionate amounts of charitable care. Our specific technical recommendations are included in my written testimony.

[The prepared statement of Mr. Jaruzewicz follows:]

Statement of James Jaruzewicz, President and Chief Executive Officer, Visiting Nurses Association of Erie County, Erie, Pennsylvania, on behalf of the Visiting Nurse Associations of America

Introduction

Madam Chairwoman and members of the subcommittee, good morning. My name is Jim Jaruzewicz. I am President and CEO of the VNA of Erie County in Erie, Pennsylvania. I want to thank you for giving the Visiting Nurse Associations of America (VNAA) and I the opportunity to present our testimony, which addresses the Medicare Payment and Advisory Commission's (MedPAC's) recent data analysis and recommendations to Congress related to Medicare home health payment policy.

VNAA is the national association for Visiting Nurse Agencies (VNAs), which are non-profit, community-based home health agencies governed by voluntary boards of community leaders. The nearly 500 VNAs across the country collectively provide home—and community-based services to over four million Americans each year. Founded in the 1890s, VNAs have continuously served as charitable providers in their local communities, creating a safety net for the poorest and most chronically-ill and functionally-disabled individuals. VNAs serve the majority of Medicaid home health beneficiaries and represent nearly one-half of all non-profit home health agencies in the United States. On average, Medicare and Medicaid represent approximately 82% of VNAs' revenue.

VNAA's Assessment of MedPAC's Data Analysis and Recommendations

VNAA has a lot of respect for the MedPAC commissioners and staff; however we simply disagree with the assumptions that were made about excessive profit margins and cost of care. The discussion during the January 15 MedPAC meeting focused on what was claimed to be "excessive margins," and on what recommendations the commissioners should make to Congress in terms of an appropriate policy response. Because the commission accepted the staff's analysis of the data as sufficiently accurate on which to base policy recommendations, the debate and discussion were based on an assumption that reimbursement exceeds costs; therefore, reimbursement needs to be cut—period—no further analysis needed.

While other issues were discussed and pondered, such as the unexplainable wide variation in visits per patient among different states, and the overall drop in the number of individuals receiving Medicare-covered home health services between 1991 and 2001, the recommendations were based on what was perceived to be a fact—agencies are making 23% average margins (the voluntaries at 15%), and therefore money needs to be taken away from them. MedPAC Chairman Glenn Hackbarth said repeatedly that he did not understand how more money would bring more beneficiaries into the program. We strongly argue that if Congress does not authorize additional expenditures for Medicare-covered home health services, the number of beneficiaries receiving home health care will continue to decline.

The reason that we believe that beneficiary access will continue to decline is because non-profit home health agencies' average bottom line margins are zero or less, making it impossible to expand services to more beneficiaries. In addition, VNAA believes that the MedPAC data is inaccurate and misleading at best, which is explained in detail prior to the conclusion section of this testimony. MedPAC's findings certainly do not reflect my experience. Therefore we believe that MedPAC has put in motion a potentially tragic situation where findings of excessive margins based on statistically unreliable data are now accepted as "the truth," which have led to damaging recommendations that would hurt real people if adopted by the Congress.

In addition, MedPAC has added to the false hysteria of circulating rumors that home health expenditures are increasing. At the time when MedPAC made its recommendations, CMS was projecting Medicare home health spending for FY 2005 to be over $17 billion. *The latest numbers from CMS now project a decline in Medicare home health spending over the next 10 years.* CMS's estimate for FY 2005 has now been reduced to $11.4 billion. CBO has also said that it will revise its estimates for home health spending downward in its March report. *There is absolutely no reason to base cuts in payment rates on the fear of runaway home health spending.* In fact, there is every reason to believe that Medicare expenditures will continue to decline, along with patient access, as payment levels are reduced.

Because the focus of MedPAC's discussion was on positive margins under PPS, I would like to begin by discussing the margin issue. VNAA analyzed a random sample of 32 VNA financial statements from 2001, which indicated that the average net income as a percentage of net revenue that year was 1.3%, which accounts for an average 8% profit under the Medicare prospective payment. The profit margin under Medicare was used to increase nurse salaries to become competitive in local

marketplaces, repay debt incurred under the former Interim Payment System (IPS) at a high Medicare interest rate, acquire technology to comply with OASIS and PPS, and to subsidize losses under Medicaid and managed care.

That average net income of 1.3% included all charitable contributions received that year and does not reflect the 5% Medicare cut that was implemented on October 1, 2002. As a result of the 5% cut, the average 8% Medicare profit was reduced to an average 3% Medicare profit, not taking into account new HIPAA-compliant technology costs (estimated at an average $750,000) or nurse salary increases, which we believe (from our discussion with several VNA CEOs) have reduced the Medicare profit to zero and pushed average overall bottom line budgets into the red. *The Medicare margins are no longer able to offset the other losses mentioned above.*

In its report, MedPAC has said that cost per Medicare home health visit has gone down. We honestly do not understand how they could arrive at such a conclusion. It is almost as if MedPAC staff unknowingly did not review an entire database of agency costs. VNAA's data shows that VNAs' average cost per Medicare visit went from $72 in FY 1997 to $103 in FY 2001 (the first year of PPS). *If technology costs, interest costs on IPS debt, and nursing recruitment and training costs were adequately accounted for, we are certain that MedPAC would not have arrived at the margins that they did.* For example, VNAA's data shows that VNAs have had to raise nurses' salaries by an average 12% during the past two years; however, reimbursement to compensate for increases in labor costs has only increased by about 12.5% during the past five years. In addition, VNAs have had disproportionately high IPS debts because of their low per-beneficiary limits under IPS (another penalty on their cost-efficiency). This is another significant drain on their budgets. MedPAC staff agreed when reporting to commissioners that "IPS repayments continue to be an important factor in their financial stability." However, because MedPAC accepted CMS's cost accounting conventions, it failed to consider agency expenditures to pay back IPS debt and amortization of certain agency expenditures over many years, although the agencies had to incur many costs immediately (e.g. computer hardware and software for HIPAA, OASIS and PPS).

We believe that if the 5% cut is not repealed, and if the pending 10% rural add-on is not extended on April 1, VNAs will have no choice but to cut clinical staff, which will further reduce their ability to accept all patient referrals. VNAA's data indicates that VNAs' average RN vacancy rate is 15%, and our average home health aide vacancy rate is 25%. It also shows that labor costs represent an average 78% of VNAs' overall budgets, so when agencies are desperate to trim costs, they have no choice but to layoff some of their clinical staff. This is exactly what happened under the former Medicare home health interim payment system (IPS), and we strongly believe that IPS was a contributing factor to the current national nursing shortage. Many of our nurses went into other professions where job security and market stability were more predictable.

Therefore, cutting clinical staff simply means that fewer numbers of patients can be admitted for home health services. Because VNAs are often the providers of last resort in their communities and receive a high number of referrals from other local home health agencies, we believe that many of the individuals whom we cannot admit for services must access care through hospital emergency rooms. People with intensive care needs, such as daily wound care, chemotherapy and other infusions, indigent patients with excessive supply needs, and dually-eligible patients are particularly hard to serve. All of these individuals are eligible for the Medicare home health benefit; however, because they require more frequent visits, admission to home health care is difficult because agencies simply do not have enough clinical staff to make the necessary visits.

In order to remain viable under the current 5% cut and nursing shortage, individual VNAs have reported that they are:

- Exerting more caution when reviewing patient referrals from hospitals, physicians and nursing homes;
- Not able to admit some Medicare patients primarily due to staffing shortages (a direct result of non-competitive nurse salaries);
- Less able to serve Medicaid patients with intensive care needs in states with extremely low Medicaid reimbursement (e.g. Florida's reimbursement is $34.45 per visit);
- Restricting service areas to cut down on travel costs;
- Laying off nursing staff, which perpetuates their inability to accept all referrals;
- Reducing the number of visits provided to patients to the extent feasible; and/or

- Reassessing their ability to purchase and/or update electronic equipment to comply with PPS, OASIS and HIPAA requirements, and potentially resorting to paper documentation.

At the very least, the 5% cut has diminished most VNAs' ability to return any additional dollars back into their communities through support services to the poorest individuals.

If the 10% rural add-on is terminated in April, rural agencies are seriously concerned that they will not be able to survive. Services have already been curtailed or eliminated in many rural areas because agencies cannot afford to send their limited clinical staff to outlying areas. Most VNAs report increased waiting times at hospitals and delays in getting to patients on a regular schedule. Again, this is primarily due to the number of unfilled nursing and home health aide positions.

And, if MedPAC's recommendation to eliminate the inflation update for FY 2004 is adopted by Congress, VNAs report they will lose hundreds of thousands of dollars on average. As a result, individual VNAs are contemplating the following actions:

- Cutting clinical and administrative staff (who support the clinical staff);
- Continuing to be cautious about accepting patients with intensive care needs;
- Scrapping plans for new or updated electronic systems and restore to a paper operation;
- Cutting back evening care;
- Cutting back family caregiver support;
- Cutting back maternal and child health programs;
- Utilizing emergency reserves;
- Freezing staff levels and salaries/benefits;
- Cutting specialty services (e.g. psychiatric);
- Re-examining case-mix of patients;
- Reducing home care coordinator services; and
- Cutting back on charitable care.

Another troubling issue concerning the discussion on margins is that it appears that MedPAC automatically assumes that making margins on Medicare is somehow an abuse of the system and should be dealt with accordingly (i.e. across-the-board cuts among all home health providers). It assumes that all providers are the same, make the same margins, and behave in the same ways, and that all patients are the same and have the same needs. This is a broad-brush assessment that does not account for any variations in what agencies do with their margins, what types of patients they serve, and what the geographic variables are.

For instance, we know that 13% of all home health agencies are public agencies operated under state and local governments. Their obvious incentive is to provide the most cost-efficient and quality care with government dollars. *Yet, these and other agencies that operate under the same value and financial objectives are treated in the same way as all others for no other reason than because they have a Medicare home health certification number.*

We do not believe that positive margins are bad when they allow agencies to maintain and build their capacity to provide services that restore or improve people's health and reduce overall medical and social costs. *That is why we believe that across-the-board cuts, as was done under IPS, are inherently unfair to home health providers who are desperately trying to meet the health care needs of their patients.* It forces these agencies with break-even budgets to cut patient care or go out of business.

Recommendations

VNAA recommends that Congress determine if positive Medicare margins are used appropriately in line with congressional intent or if they are used inappropriately or outside congressional intent for the Medicare home health benefit. Do positive Medicare margins help the indigent population who would otherwise rely on hospital emergency rooms? Do they expand services, such as Meals on Wheels and adult day care, which support persons receiving home health care and help people stay out of nursing homes? Do they help attract more clinical staff so that the current staff does not burn out and quit?

During MedPAC's January 15 meeting, MedPAC Commissioner Dr. Newhouse suggested that MedPAC look at behavioral differences among agencies in terms of margin use. "It could be that we have some agencies that are really trying to make out like bandits and we have some agencies. . . . that are doing as much as you can with what you're given. . . . And that may show up in a distribution at the agency level that I haven't really seen," said Dr. Newhouse.

We believe that the Medicare cost reports should be modified in order to better identify all expenditures related to patient care. For example, how have nurse salaries changed over the past few years? This should be determined by tracking the cost reports. IPS overpayment recoupment should be captured on the cost report. The cost report should be modified to show the costs of technology that has been purchased to comply with federal mandates. Care management should be better documented on the cost report, including the costs of telemedicine and coordination among the patient's interdisciplinary team. These are costs that are not reflected as part of the patient visit. PPS was intended to increase flexibility and creativity in home health, yet the cost report fails to capture the cost of innovation and change.

VNAA believes that it is essential to document uncompensated care to indigent patients on the cost report and the losses incurred through serving Medicaid patients. During MedPAC's meeting on January 15, Senator Durenberger urged the commissioners to look at Medicare and Medicaid together. We could not agree more. The federally-funded health care system needs to be looked at in the aggregate. State Medicaid programs are being cut back across the nation, and state governors are turning to the White House and Congress for relief. Significant cuts to optional Medicaid programs, such as nursing home and home health care, have resulted in significant reimbursement cuts to providers. Because VNAs serve the majority of Medicaid and minority home health beneficiaries, we have certainly felt the pinch. Surveys from a random sample of our members showed that 81% of VNAs are losing money under Medicaid. Needless to say, any margins under Medicare quickly vanish by the fact that we serve a large percentage of Medicaid patients.

It is also critical to understand that a significant percentage of home health patients are "dually-eligible" for Medicare and Medicaid coverage. To the degree that federal policy continues to treat such patients as beneficiaries of totally independent funding sources, the well-documented inefficiencies related to funding their care will continue to be exacerbated.

If Medicare home health care is cut, Medicaid patients will be the first to be dropped—and are being dropped now. We understand that the immediate reaction is to say "that is not Medicare's responsibility." But is the right answer cutting Medicare? In some ideal world in which states' budgets are flush with surplus money, perhaps it is. But that has not been the situation in the history of the Medicaid program and it is certainly not the situation now.

If the conclusion is to continue considering the Medicare and Medicaid programs in isolation , then we urge you to establish a disproportionate share payment for home health agencies that serve the highest percentage of dually-eligible patients and provide uncompensated care to individuals who cannot pay for home health services. By tracking such services and related costs on the cost report, not only will Congress have a better understanding of what happens to Medicare margins, but will also have better assurance that beneficiaries have not lost access to home health services. *VNAA strongly urges you to explore the average margin issue and the tracking of margins before any further cuts are made to the Medicare home health benefit.*

In addition, the incentives under PPS could be changed to address MedPAC's concern about the drop in utilization. MedPAC has documented that it is the decrease in average visits that have changed the nature of the home health "product." High average margins are attributed to this reduction, and the tacit assumption is that visits will continue to be cut to maintain margins in the face of further cuts. Meanwhile, those agencies that are providing a higher level of services than the average, and are not enjoying such margins, are nevertheless having their payments cut. As a result, they feel compelled against their will to reduce services and be more selective in admissions.

At the same time, much concern is being expressed about "stinting" on care. The only logical outcome of cutting payments across-the-board is the reduction in services, which prompts yet further payment cuts. *The resulting outcome is a continuous spiraling down of service in home health care until only patients with the most minimal needs can be provided services.* Dr. Newhouse agreed that a reduction in payments would create incentives "to keep cutting the volume and selecting." Dr. Reischauer wondered if "at some point we'll get down to average number of visits of one over the lower limit and the people who are being sent out are the least skilled people we can find and Carol [Raphael] will come back and say that the numbers of people being served has shrunk by 85% and we don't know who they are, who have left the system."

Many of the commissioners were clearly concerned that the benefit seems to be shifting dramatically from one that accommodated both individuals with chronic and acute conditions to one that only accommodates acute conditions. Dr. Nelson said that the Medicare home health benefit is "different now that it was 10 years ago

and payment policy should not force it to become different in a way that's perverse, that's qualitatively perverse."

We believe that there are ways to change the payment system to preserve service levels in the Medicare home health benefit, discourage stinting on care, and create greater stability in the home health payment system. We suggest that you explore creating an incentive to maintain service levels by rewarding those agencies that, going forward, maintain utilization at or above the average number of visits by exempting such full episodes of care from the recent 5% cut and any future market basket reductions. At the same time, the 5% cut would apply to episodes where service levels have dropped significantly below the average number of prior year visits for that PPS payment category (i.e. HHRG). Thus agencies would be encouraged to stabilize service levels in each payment category rather than reduce services in an effort to stay ahead of further budget cuts. Because of the variation in service levels based on locality, we recommend that the average visit threshold be set on an SMSA/non-SMSA basis. This would have the effect of stabilizing margins over time.

Other Recommendations

Technical Changes to PPS

There are also several technical changes that should be made to the outlier and "significant change in condition" (or "SCIC") policies under PPS, which have had a well-documented effect of discouraging care for the most chronically-ill and disabled individuals. CMS has not taken action on either of these components. The outlier component requires agencies to take too high of a loss before payment resumes, thus discouraging its use.

Similarly, the SCIC adjustment was intended to provide additional resources when patients become sicker in the middle of an episode of care. However, it is subjected to a prorating scheme that often results in lower payments. CMS's only solution has been to allow agencies the same payment as when the patient was less sick, but has not increased payments as was intended. *Congress should rectify this situation by mandating that the outlier fixed dollar loss ratio be reduced to $500 and the SCIC proration methodology be based on full episodes of care vs. the current day of service methodology*.

VNAA also recommends that Congress create a low-volume provider payment adjustment to recognize the special problems faced by home health agencies whose low volume of Medicare patients distorts the PPS payment system. Because the PPS system bases payment levels on averages across all home health agencies, it does not function to create consistently accurate payments when agencies serve a relatively small number of Medicare patients. The higher costs from such agencies were excluded from computing base PPS rates. Moreover, the smaller number of patients seen in such agencies does not allow a large enough base to allow underpaid cases and overpaid cases to create an equilibrium, which is intended by the average-payment methodology under PPS. Thus, low volume agencies, usually small and rural, have a much higher probability to take losses on patients requiring intensive care. We recommend that low volume providers be allowed the alternative to be paid at a fixed base rate of $450, plus a prospective, per visit rate set at the per visit, LUPA rate that is established by CMS for short-stay patients. This will encourage such agencies to remain Medicare providers, and help ensure access for intensive-care patients

We recommend the creation of a rural critical access home health concept to maintain access to Medicare home health in underserved, rural areas. With the sunsetting of the rural "add-on" to the home health PPS system, many small, rural home health agencies are being forced to constrict their service areas and be more selective in their admission policies to remain solvent. Others, sadly, are being forced to consider closing their agencies. This is inevitably creating access problems in the most rural areas of the country. These access problems are masked by the inability of CMS to measure access in small subdivisions of the country and by the willingness of rural beneficiaries to endure "going without" rather than get needed services that could improve their health and extend their lives. Clearly, the current model of Medicare home health regulation and PPS payment do not accommodate the kind of small, non-profit agencies that have historically reached out to our most rural citizens. The regulatory burdens placed on home health agencies can only be borne with the help of expensive technology and specialized staffing, whether it is for OASIS assessments, quality measurement activities, HIPAA compliance, or complex PPS billing systems.

VNAA proposes that a separate classification of rural area critical access home health providers be created. This provider type would only be offered to agencies that demonstrate a commitment to serve rural areas in which there is no other

agency willing to accept all home health patients. Such agencies would be paid by Medicare on a reasonable cost basis and be exempted from regulatory burdens that the Secretary shall determine may reasonably be waived in such limited situations.

We also recommend that CMS study the beneficiary access issue specific to geographic areas by identifying by zipcodes those areas where services are disproportionately less or non-existent than other areas. This could be done by analyzing the CMS claims and OASIS databases.

Labor Wage Index

The current manner in which home health payments are affected by the hospital wage index results in a bias against home health recruitment of nurses and other key clinical staff in specific geographic regions, placing stress on the provision of quality home care to eligible beneficiaries. The inconsistent manner in which CMS applies the hospital wage index to hospitals as opposed to home health agencies creates hardship, uncertainty and distortions in the PPS system. Wage indices create disparities in Medicare home health payments that result in competitive disadvantages for the lower paid agencies and prevents them from recruiting and retaining the staff they need.

To resolve these problems, VNAA recommends that Congress amend Section 1895(b)(4)(A)(ii) of the Social Security Act to:

1. Require that home health agency payments be adjusted by the current hospital wage index, rather than the pre-floor, pre-reclassified wage index from the prior year. This should be effective with the calendar quarter following enactment.
2. Provide that for any hospital that is reclassified to a higher wage index area, any home health agency that competes for labor in that same MSA shall automatically be reclassified to an equal wage index.
3. Require a "circuit-breaker" in the wage index applied to home health such that the amount a wage index is reduced in any one year is limited to no more than 2%. If there is a legitimate reduction in wage levels, this will provide for an orderly adjustment by agencies. If the reduction is actually an error or an aberration, this will help maintain services until the index returns to its normal level the following year.

State Surveys

At the same time as one component of CMS is expressing concern about access issues for heavy care patients, another component, Medicare surveyors, are acting to discourage home health agencies from accepting such patients. While motivated by good intentions to allow zero risk to patients in home health, overzealous Medicare surveyors are threatening VNAs with termination of their certification if they accept patients who the surveyors deem as carrying some risk. They have advised VNAs to discharge such patients or not to admit them in the first place, regardless of the patient's and family's wishes in favor of home health care. Let me assure you that no VNA would try to persuade a patient to accept home care where there was a significant risk. At the same time we believe that we should make every effort to accept the choice of patients to avoid institutional care. *Unless Congress takes action to affirm the rights of patients to accept risk to maintain their independence in home care, strict interpretation of zero risk policies by CMS and* its surveyors will force VNAs to eliminate patients from care regardless of their wishes.

Closely related to this problem is the total lack of effective due process protections in the Medicare home health survey process. When VNAs are accused by a Medicare surveyor of a violation of the Medicare rules, the agency has no recourse but to essentially plead guilty. There is no opportunity for third-party review of facts and policy until after the agency must either comply or be terminated, even if they believe the surveyor was totally incorrect. Thus, the surveyor becomes investigator, prosecutor, judge, and jury of alleged home health violations. *We strongly recommend that Congress allow for an independent, third party review of facts and policy, when requested by a home health agency and that this be concluded before the agency is put on track to Medicare termination.* This alternative dispute resolution must be binding rather than advisory to be effective. To allow excessive discretionary power in the hands of only a handful of Medicare survey staff is to encourage further governmental excess that is damaging to home health agencies and their patients, and alien to the American concept of due process.

Finally, we concur with MedPAC's recommendation to expand beneficiary access studies beyond interviewing hospital discharge planners. As MedPAC Commissioner Carol Raphael pointed out, 50% of home health referrals do not come from hospital

discharge planners. Therefore, 50% of referral sources are not interviewed for the feasibility of referring Medicare beneficiaries for home health care.

VNAA's Analysis of the Inaccuracies of MedPAC Staff's Data Assumptions

We believe that MedPAC's data analysis is inaccurate and misleading for the following reasons:

- The cost report data that was used was from a 10% non-random "sample," which could not be truly representative. MedPAC staff admits that it is "a non-random sample" and that "it is not geographically representative." Due to CMS programming problems, there is no cost report data available at all from the six states in which VNAs are most numerous. Moreover, PPS revenues are subject to many forms of post-payment reductions that are not captured accurately on cost reports.
- Hospital-based home health agencies were excluded from the margin analysis. In fact, MedPAC staff said that including hospital-based agencies' data "would decrease the all agencies' 2003 margin [23%] to about 17% and would decrease the rural margin specifically to about 9%." Because hospital-based home health agencies represent 30% of total Medicare-certified home health agencies in the U.S., leaving them out of the data pool for calculating margins is statistically irresponsible.
- In April 2003, CMS is planning to recoup massive amounts of overpaid money from home health agencies. The overpayments were made due to CMS processing errors. These overpayments were included in MedPAC's profit data. The money that will be recouped will significantly lower any profit margins but this will not likely be considered or reported by MedPAC. OIG is also planning to recommend separate recovery actions for billing errors not caught by the CMS claims process.
- The only cost report data on which the MedPAC recommendations are made is from the first year of PPS, an atypical period that fell on the heels of the Interim Payment System (IPS). IPS forced agencies to conserve revenue because of the expected recoupment of "overpayments" in an austere reimbursement environment. Data from the first year of PPS would reflect a "save for survival" mentality that was absolutely essential under IPS.
- MedPAC attributes reduced visits under home health to PPS. Actually 75% of the reduction occurred under IPS and was beginning to move back upward under PPS until the 5% cut. MedPAC fails to report this fact.
- The data is based on averages, which do not account for geographic or clinical differences in patient populations or the inherent distributional problems in the new prospective payment system. Due to its inadequate data, MedPAC does not bore down into its data to highlight those states and agencies that are NOT experiencing high margins. By focusing attention on averages, inequities are masked.
- MedPAC repeatedly makes reference to "estimated" budget increases related to Medicare home health care. Because of the instability created in the home health industry, these CBO budget estimates have continuously decreased as experience proves them wrong. As alluded to above, budget estimates have already dropped dramatically.
- MedPAC denies any access issues in home health yet cannot account for why more than one million fewer beneficiaries are receiving services today than in 1997. This does not make sense in light of the fact that every economic indicator (e.g. increased hospital and nursing home discharges, increased number of individuals over the age of 85) points to what should be an increase in home health admissions, but that is not the case. Why are there less people today receiving Medicare-covered home health services than there were 10 years ago? The oblique suggestion by MedPAC staff that this might be related to their ineligibility for covered care is completely unsupported by any facts. It incredibly suggests that over a million frail elders who had participated in a fraudulent receipt of Medicare services have been driven back by unseen forces.
- MedPAC, knowing the inadequacy of its cost report data, uses charge data in its place. However, the "assumptions" made from using charge data are not based on fact. For example, MedPAC makes no adjustment for the incurred costs of recruiting and retaining nurses due to the well-documented nursing shortage. We believe that the current national nursing shortage and the costs associated with retaining and recruiting nurses must be considered in the overall context of discussing the appropriateness of any margin under the Medicare prospective payment system.

Conclusion

VNAs were beginning to recover from the damaging effects of IPS, but are now once again concerned about their financial stability. We believe that MedPAC's recommendations to freeze the FY 2004 Medicare home health inflation update, reduce the current 10% rural add-on to 5%, and to essentially endorse the recent 5% cut have the potential to seriously damage the Medicare home health benefit. We do not believe that Congress would want to once again look back, as was done under the Interim Payment System, and say "we went too far and we need to correct the unintended damage." I can tell you that this will happen if you let the 5% cut that went into effect on October 1, 2002, remain, and if you do not extend the 10% rural add-on or maintain the FY 2004 home health market basket index.

VNAA believes that the best way to ensure continued access to quality home health care is to break the cycle of uncertain Medicare payments, which feeds the "cut-back mentality" begun by IPS and has been perpetuated by the recent 5% cut.

VNAs are committed to serving their communities and the most at-risk individuals as they have done for over 100 years. We urge Congress to seriously consider the damaging effect that a continued 5% cut, frozen rates, and the elimination of the 10% rural add-on, would continue to have on VNAs' ability to continue to be the safety net providers in their communities. Thank you for allowing me this opportunity to prevent my views and those of VNAA.

f

Chairman JOHNSON. Thank you very much. Mr. Buckelew.

STATEMENT OF LARRY C. BUCKELEW, PRESIDENT AND CHIEF EXECUTIVE OFFICER, GAMBRO HEALTHCARE U.S., LAKEWOOD, COLORADO, AND CHAIRMAN, RENAL LEADERSHIP COUNCIL

Mr. BUCKELEW. Chairman Johnson, Congressman Stark and distinguished Subcommittee Members, thank you for inviting me to discuss MedPAC's recommendations regarding Medicare end-stage renal disease (ESRD) reimbursement. My name is Larry Buckelew, and I am President and CEO of Gambro Healthcare in the United States, and I also serve as the current Chairman of the Renal Leadership Council (RLC), and I will be testifying today on the Council's behalf.

The RLC is particularly pleased to participate in this hearing because of MedPAC's consistent recognition of the need for an annual inflation adjustment to Medicare's dialysis reimbursement. In fact, nearly every year the Commission has recommended positive percentage increases.

Let me begin today by telling you a little bit about the people we serve in the renal care sector. An ESRD is invariably a fatal disease without regular dialysis treatments or organ transplantation. With so few organs available for transplant, most patients have no option but to receive dialysis three times a week in a clinic.

Congress made an important commitment to these ESRD patients in 1972 when it established the Medicare ESRD Program. Today, about 70 percent of the 300,000 dialysis patients in this country are Medicare beneficiaries, and they are older and sicker than those initially enrolled in the ESRD Program.

To add some perspective, let me point out that Congress adopted the composite rate, as it is called, in 1983 as the prospective payment mechanism for outpatient dialysis services. The rate was designed to include all nursing services, supplies, equipment and certain drugs associated with a single dialysis session.

Now, two decades later, the ESRD reimbursement, unlike all other PPSs in the United States, does not include an updating mechanism. The reimbursement methodology of today remains grounded in the medical standards of technology 1983. Over the years the cost to reimbursement ratios have gotten increasingly out of balance. The MedPAC has recognized that dialysis costs are rising faster than Medicare reimbursement rates and have consistently acknowledged the need for an increase in the composite rate.

During 2003, Medicare will cover on average just 94 percent of the costs of delivering dialysis services to Medicare beneficiaries. This represents a loss to ESRD providers of approximately $10 per treatment, for each treatment, and, again, the key to remember, this is 70 percent of our patient population.

The impact of continued underpayment is substantial. It is impeding our ability to recruit and retain the best staff for our facilities. We are at a point where other providers in the other segments of health care who do receive updates in their prospective payment rates are able literally to use that money to hire away our nurses.

The RLC strongly urges Congress to establish a framework that provides for an annual updating formula to the composite rate, as it has already done in each of the Medicare PPSs.

This is a fairness issue. It is also an access to care issue. Congress has taken important steps toward establishing an annual update for the composite rate. The Benefit Protection and Improvements Act of 2000 (P.L. 106–554) requires the Secretary of HHS to develop an ESRD ''market basket'' and report back to Congress.

This ''market basket'' report was due to Congress in July of 2002. It is our understanding this report has cleared CMS and is in the Secretary's office for final approval. The RLC respectively requests that you contact Secretary Thompson's office and ask that he send you this report as soon as possible, because it is, I think, essential that the Committee have sufficient time to study this report before it considers legislation to create an annual updating mechanism for the dialysis composite rate.

In closing, I would like to emphasize that health care quality and access to care are directly related to Medicare payments, and for that reason it is essential that Congress maintain its commitment to ESRD, Medicare beneficiaries, and providers of care by establishing an annual update mechanism for the Medicare dialysis composite rate.

I thank you for the opportunity to share the RLC's views with you today and look forward to answering questions that you will have later.

[The prepared statement of Mr. Buckelew follows:]

Statement of Larry C. Buckelew, President and Chief Executive Officer, Gambro Healthcare U.S., Lakewood, Colorado, and Chairman, Renal Leadership Council

Introduction

Chairwoman Johnson, Congressman Stark, and distinguished Subcommittee Members, thank you for inviting me to discuss the Medicare Payment Advisory Commission's recommendations regarding Medicare End Stage Renal Disease (ESRD) reimbursement.

My name is Larry C. Buckelew, and I am President and CEO of Gambro Healthcare U.S. I also serve as the current Chairman of the Renal Leadership Council (RLC), and I am pleased to testify today on the council's behalf.

The RLC is extremely pleased to participate in this particular hearing, because MedPAC has consistently recognized the need for annual inflation adjustments to Medicare's dialysis reimbursement. In fact, nearly every year, the commission has recommended positive percentage increases. It has also discussed in several reports to Congress the need to add an annual update formula to the Medicare composite rate reimbursement.

I am here today to tell you about the renal care industry and the people we serve. I am also here to underscore the importance of enacting structural reforms to create an *annual update mechanism* for dialysis reimbursement to bring the composite rate in line with other Medicare prospective payment systems. This will level the playing field with other providers, allow us to continue improving quality of care for our patients and help mitigate the closing of dialysis facilities with disproportionately high percentages of Medicare patients.

Overview

Renal care providers are committed to meeting patients' needs—regardless of the circumstances. During Hurricane Andrew, for example, providers mobilized their dialysis facilities to treat individuals whose regular treatment facilities were unavailable. This was also true after 9/11 in New York.

The RLC represents four of the largest renal dialysis providers in America—DaVita, Gambro Healthcare, Renal Care Group, Inc., and National Nephrology Associates. Together, RLC members provide renal replacement therapy services to 40 percent of all dialysis patients in America (approximately 110,000 individuals). We provide services to ESRD patients in more than 1,350 dialysis facilities in 42 states and the District of Columbia.

All of the RLC's members are dedicated to providing the highest quality care to our patients, and we are committed to working with the government to achieve that goal. As part of this commitment, the RLC strives to inform Congress, the Centers for Medicare and Medicaid Services, the Medicare Payment Advisory Commission (MedPAC) and other policy-making organizations about issues related to the provision of renal replacement therapy.

RLC members operate freestanding dialysis clinics and hospital-based centers throughout the country in both urban and rural areas. For example, Gambro has dialysis facilities in the districts of Chairwoman Johnson and Representatives McCrery, English, Lewis and Kleczka. Our clinic in Chairwoman Johnson's district—located in Greater Waterbury, Connecticut—has a staff of 39 providing dialysis care to 222 patients. In the districts of the other Members I mentioned, there are a total of 343 staff members providing care to 1,355 patients. Nationwide, Gambro has 530 dialysis facilities in 33 states and the District of Columbia serving over 41,000 patients.

Background on ESRD—Commitment to Quality of Care

Without regular dialysis treatments or organ transplantation, ESRD is invariably fatal. Because of the severely limited number of organs available for transplant, most patients receive hemodialysis three times per week. Each of the blood cleansing treatments lasts from three to four and a half hours per session.

Congress made an important commitment to these ESRD patients by establishing the Medicare End Stage Renal Disease (ESRD) program in 1972. Today, about 70 percent of the 300,000 dialysis patients in this country are Medicare beneficiaries and they are older and sicker than those initially enrolled in the ESRD program—also their numbers are increasing.

At the same time, I am proud to say the quality of treatment provided to ESRD patients continues to improve. **Our four RLC companies are absolutely dedicated to improving patient care.** Over the past 8 years our companies have been instrumental in essentially **doubling** the adequacy of a dialysis treatment (the key measure of quality), according to CMS' *Clinical Performance Measurement Reports*. In fact, even the Office of the Inspector General (OIG) within the Department of Health and Human Services (HHS) noted that the major dialysis corporations "encourage their facilities to use performance measures to foster improvements in dialysis care . . . [and] look to facilities to conduct quality improvement projects" (January 2002 report entitled "Dialysis: Building on the Experiences of the Dialysis Corporations").

The Medicare Payment Crisis

In 1983, Congress adopted the "composite rate" as the prospective payment mechanism for outpatient dialysis services. The rate was designed to include all nursing services, supplies, equipment, and certain drugs associated with a single dialysis session. Unlike all of the subsequent prospective payment systems, however, the ESRD reimbursement did not include an updating mechanism. Because Congress has not reformed the methodology, it remains grounded in 1983 medical standards and technology. Congress, on occasion, has taken note of new drug treatments to improve patient outcomes (such as intravenous Epogen, iron and vitamin D supplements) through special payment rules. These additions to the composite rate are commonly referred to as separately billable items. Dialysis providers have over the years used the additional reimbursement from separately billable drugs to offset the losses on the composite rate reimbursement but this is no longer a viable option.

MedPAC has recognized dialysis costs are rising faster than the Medicare reimbursement rate and has consistently a rate. In 1999, 2000, and 2002, MedPAC recommended that Congress increase the composite rate 2.4 percent for each subsequent year. For its 2003 report, it appears that MedPAC will recommend an increase of 1.6 percent.

In the face of increasing costs, the composite rate, averaging around $131 per treatment, continues to under-pay dialysis facilities relative to facilities' costs. In January 2003, MedPAC staff indicated that when considering only the composite rate services, the payment-to-cost ratio across freestanding dialysis facilities is 0.97, and in last year's report found the ratio for small facilities to be only 0.86 and 0.94 for rural facilities. The commission projected that input prices would increase 2.5 percent in 2003.

In other words, during 2003 Medicare will only be covering **on average** 94.5% (i.e. 97% minus 2.5%) of the cost of delivering dialysis services to Medicare beneficiaries. This will impede our ability to introduce new technology and recruit the best staff for our facilities. It will also make it virtually impossible to open new facilities in areas where the majority of the patients rely on Medicare coverage for their dialysis care.

Further, contrary to MedPAC's findings, an Abt Associates, Inc. study, conducted in 2002, found that, "the profits made on separately billable items were not large enough to cover the increasing losses on composite rate services." The RLC agrees with the findings of the Abt study: The profits MedPAC attributes to separately billable drugs are essentially creating a break-even situation by cross-subsidizing the losses on the prospective composite rate system.

In short, even with Medicare reimbursement for separately billable intravenous drugs, the composite rate remains woefully inadequate as dialyssi costs continue to increase. The increases are due not only to inflation, but also to several other factors. For example, many patients now require longer treatment times of 4 to 4½ hours, which increase staff, supply and overhead costs. Dialysis facilities also face the same shortage of health care workers that is plaguing providers nationwide. The industry's nursing costs have nearly tripled over the past ten years. The competition to secure qualified, quality health care workers is intense and severe, and dialysis facilities simply cannot compete with the benefits and pay given by providers who receive updates in their prospective payment rates.

When viewed in comparison to the CPI, the ESRD composite rate lags far behind. Since 1996, the CPI has increased 16.9 percent, and the CPI Medical Care Component has risen 26.9 percent. During that same period, the Medicare Hospital Operating Update has increased 11.25 percent. **By contrast, the ESRD composite rate has risen only 3.6 percent—well *below* the rate of inflation (see attachment A).**

The Importance of Enacting an Annual Update

The composite rate adopted by Congress does not provide for an update mechanism, nor does it give the HHS Secretary the authority necessary to develop one. It is essential that Congress act to address the underlying problem caused by the lack of an annual update formula in the composite rate. The ESRD program is essentially the *only* prospective payment in the Medicare program that does not have a methodology in place to adjust payments from year to year to reflect inflation, changes in technology, labor, or other relevant factors.

The RLC strongly urges Congress to establish a framework that provides for an annual updating formula to the composite rate, as it has already done in each of the other Medicare prospective payment systems. Adding an updating formula would finally create a level playing field with hospitals and other

provider prospective payment systems and would constitute real Medicare reform. This is a fairness issue.

This is a fairness issue. Until dialysis providers receive regular inflation updates, the industry will never be able to compete successfully with other providers for the limited supply of nurses and other health care workers. It is also a fairness issue to our patients. Dialysis providers want to deliver the best possible quality of care, and we are proud that patient outcomes have improved significantly over the past several years. However, dialysis providers cannot continue this progress indefinitely without an update formula that takes into account new technologies.

Most importantly, this is an access to care issue. Without regular inflation updates, our companies will be unable to open and operate clinics in areas where there is a disproportionately high percentage of Medicare beneficiaries who require regular dialysis treatments to survive. In the past few years, our companies have actually closed some fifty dialysis facilities in both rural and urban areas where our Medicare economics were unacceptably inadequate. Having only a thirty month ESRD Medicare Secondary Payer requirement further burdens our facilities with a disproportionately high percentage of Medicare beneficiaries. In addition, proposed Medicaid cuts to dialysis payments in a number of states will only exacerbate the looming threat to patient access to care.

The RLC supports an annual update forumla modeled after the one currently used within the hospital prospective payment system. Under this model, the Secretary of 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. 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. 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. The need for reviews and updates is exemplified by the problem created by the nursing shortage

The need for reviews and updates is exemplified by the problem created by the nursing shortage. The industry's nursing costs have nearly tripled over the past ten years and gone up in the range of 18% to 36% in the last three years. Nephrology nurses are very specialized nurses who require more training and education that even ICU nurses. To cope with the nursing shortage and rising costs, dialysis providers have been shifting to the use of more nursing assistants (technicians). The industry cannot continue this trend without harming our patients' health and safety. The Secretary needs the authority to adjust the composite rate to take account of inflationary and market changes, such as this one.

Acting upon the recommendation of the Ways and Means Committee, Congress in 2000 took an important step toward the establishment of an annual update in the composite rate. The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) required the Secretary of Health and Human Services to develop an "ESRD market basket" and report to Congress on it. This "market basket" calculation is to account for the percentage by which the costs for the year of the mix of labor and non-labor goods and services included in the ESRD composite rate exceed the costs for the preceding year and to account for changes in technology, and other relevant factors.

This "market basket" report, along with a report on including additional services in the composite rate, was due to Congress in July 2002. It is our understanding that these two reports have cleared CMS and are now in the Secretary's office for final approval. **The RLC respectfully requests that you contact Secretary Thompson's office and ask that he send you both reports as soon as possible**. It is essential that the Committee have sufficient time to study the reports before it considers legislation to create an annual updating mechanism for the dialysis composite rate.

We would also like to point out that in its March 2001 report, MedPAC conducted a review of the entire prospective payment system for freestanding dialysis facilities and called for an annual update to the composite rate.

The RLC in 2001 and 2002 worked with the CMS Office of Actuary and achieved consensus on all of the elements of a "market basket" formula. We believe the report

will provide a good road map for CMS to follow in establishing an annual updating mechanism. We understand that under this approach CMS would adopt the same annual regulatory process for dialysis reimbursement that the agency currently utilizes for hospitals, and we endorse this process.

In closing, I would like to emphasize that health care quality and access are directly related to Medicare payments. **For that reason, it is essential that Congress maintain its commitment to ESRD patients by establishing an** *annual update formula* for the Medicare dialysis composite rate.

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

Attachment A: Percent Changes in Price/Reimbursement

Year	CPI[1]	CPI Medical Care Component[2]	Medicare Hospital Operating Update	ESRD Composite Rate
1996	3.0	3.0	1.5	0.0
1997	2.3	2.8	2.0	0.0
1998	1.6	3.4	0.0	0.0
1999	2.2	3.7	0.5	0.0
2000	3.4	4.3	1.1	1.2[3]
2001	2.8	4.7	3.4	2.4[4]
2002	1.6	5.0	2.75	0.0
Average:	***2.4 %***	***3.8 %***	***1.6 %***	***0.5 %***
Cumulative Total:	**16.9%**	**26.9%**	**11.25%**	**3.6%**

[1] *Source:* Bureau of Labor Statistics, U.S. Department of Labor.
[2] Id.
[3] *Source:* The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (P.L. 106–113).
[4] *Source:* The Medicare, Medicaid and SCHIP Benefits Improvement Act of 2000 (P.L. 106–554).

f

Chairman JOHNSON. Thank you very much. Dr. Plested.

STATEMENT OF WILLIAM G. PLESTED III, M.D., CHAIR ELECT, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Dr. PLESTED. Thank you, Chairman Johnson. My name is Bill Plested. I am Chair Elect of the Board of trustees of the American Medical Association (AMA) and a practicing cardiovascular surgeon in Santa Monica, California. The AMA would like to express our appreciation to you, Chairman Johnson, to Committee Chairman Thomas, Ranking Member Stark and to every Member of the Subcommittee for your hard work and leadership in fixing the Medicare physician payment mistake.

In the last several years MedPAC has made a number of recommendations concerning Medicare's physician update formula. For instance, last year, MedPAC recommended replacement of an expenditure target system such as the current sustainable growth rate (SGR) with a system that is based on an assessment of increased practice costs, adequacy of payment and beneficiaries' access to care. The AMA agrees.

There are several problems with using an expenditure target. First, it is based on a collective action and does not provide an incentive at an individual level to control utilization. Second, payment updates can fluctuate wildly from year to year, and overall do not keep pace with medical costs. Since 1991, Medicare payments to physicians have averaged only a 1.1 percent annual increase, or 14 percent less than inflation, in medical practice costs as measured by the Medicare Economic Index.

Third, an expenditure target system caps spending on medical services but not the amount of services needed to treat sick patients. When patients' need for and use of medical services exceeds the target, payment rates are inappropriately reduced. This can raise serious access concerns, as occurred after the 5.4 percent pay cut in 2002.

Instead, expenditure target volume growth or other issues could be addressed through specific actions that deal with the actual source of the increase. Accordingly, the AMA recommends that the Subcommittee reconsider the use of an expenditure target system. Short of this, the AMA urges modifications to the SGR.

The SGR links physician updates to changes in GDP. However, GDP is only a measure of growth in the overall economy. The medical needs of the Medicare patients do not wane when the American economy slows. Further, GDP does not take into account health status, the aging of the Medicare population, technological innovations or changes in the practice of medicine. The MedPAC has recommended that Congress revise the SGR to include an allowance for spending increases due to these factors, and the AMA agrees.

Reliance on GDP has also led to a system based on economic forecasts that are unpredictable and thus often inaccurate. This makes it difficult for physicians as small businessowners to make the necessary decisions for the growth and fiscal survival of their practices.

For example, in March 2001 physician payments were projected to fall slightly in 2002. Yet, in actuality, payments were cut by 5.4 percent. A 4.4 percent cut was averted in 2003. However, the formula may still generate payment cuts in future years. The MedPAC has recommended a full inflation update for 2004, as measured by the Medicare Economic Index. The AMA strongly supports a 2004 update that, at a minimum, keeps pace with inflation.

Finally, I would like to address the implementation problems with the SGR. In determining the SGR, calculations of actual physician spending include the costs of prescription drugs. Drugs do not belong on the SGR, because they are paid under a separate fee structure. Furthermore, many HHS policies and goals encourage the development of new drug and cancer therapies. Partially due to these policies, drug spending is rising five times as fast as physician spending.

Inclusion of drugs in the SGR makes it extremely likely that drug spending will give the false impression that spending on physicians' services exceeds the SGR target, thus triggering physician pay cuts and jeopardizing access. We urge the Subcommittee to encourage removal of drugs from the SGR.

Finally, although required by law, the SGR target does not take into account changes in utilization and spending resulting from national coverage decisions. We urge an allowance in the SGR target for these decisions.

Thank you again for the opportunity to provide our views as well as for your strong leadership for the medical community and the seniors that we serve.

[The prepared statement of Dr. Plested follows:]

Statement of William G. Plested III, M.D., Chair Elect, Board of Trustees, American Medical Association

Chairman Johnson and Members of the Subcommittee, the American Medical Association (AMA) appreciates the opportunity to provide our views today regarding the recommendations by the Medicare Payment Advisory Commission (MedPAC) concerning the Medicare payment update formula for physicians and other health care practitioners.

The AMA would like to take this opportunity to commend you, Chairman Johnson, as well as Chairman Thomas and each Member of the Committee, for all of your hard work and commitment to fixing the Medicare physician payment update problem. We greatly appreciate your leadership in working closely with the Administration and the Centers for Medicare and Medicaid Services (CMS) to enact H.R. Res. 2 (*Pub. Law* 108–7), which contains a provision to avert a Medicare payment cut that jeopardized continued access to physicians' services for our nation's elderly and disabled patients.

Without this legislation, a 5.4 percent cut in 2002 would have been compounded by an another 4.4 percent cut on March 1, 2003, and by additional cuts of about 8 percent over the next two years. At the same time, physicians' practice expenses, particularly medical liability insurance costs, have skyrocketed, adding to the already significant pressures on physicians to discontinue or limit the provision of services to Medicare patients. In fact, a recent AMA survey found that had the scheduled 4.4 percent cut gone into effect in 2003, nearly half of all physicians (61 percent of primary care physicians and 44 percent of specialists) planned to reduce the number of Medicare patients in their practice.

As a result of the recent Congressional and Administrative action, physicians and other health care practitioners received a 1.6 percent payment increase instead of the 4.4 percent cut on March 1, and we are hopeful that this will prevent wide scale access problems. The picture for future years is also much improved over the long term. Additional payment cuts, however, are still possible and could be significant. Thus, while we are extremely grateful for the efforts that Congress has made to restore stability to the physician payment system, problems in the design of the formula remain.

Indeed, there have been implementation problems with the physician payment update formula since expenditure targets were first imposed in 1990. As some members of the Subcommittee may recall, problems with the original Medicare Volume Performance Standards (MVPS) targets led to its replacement with the Sustainable Growth Rate (SGR) in 1997, which itself has now required two Congressional interventions. Even with all of these changes, however, the formula may still generate payment cuts that endanger Medicare beneficiaries' access to care. **The Medicare Payment Advisory Commission (MedPAC) has recommended a full inflation update for 2004, as measured by the Medicare Economic Index (MEI), and the AMA strongly supports an update in 2004 that, at a minimum, keeps pace with inflation.**

Further, last year MedPAC recommended that the SGR be replaced with a system where updates are based on an assessment of increased practice costs, adequacy of payment, and beneficiaries' access to care. The medical profession continues to support that recommendation. MedPAC previously called for a number of changes in the SGR, however, and if it ultimately is not possible to replace the SGR target system, the prior MedPAC recommendations would be a good starting point for improving the formula.

The AMA very much appreciates the Subcommittee's continued focus on problems that are inherent in the update formula, and we are pleased to offer the recommendations discussed below concerning the physician payment update system.

USE OF A SPENDING TARGET

The AMA believes that use of an expenditure target in determining annual updates to Medicare payments for physicians' services, does not achieve its goal of reduced volume growth and, further, can lead to serious access concerns for Medicare patients. Indeed, MedPAC in the past has expressed its view that an expenditure target system does not appropriately reflect increases in practice costs and that this could impact access.

MedPAC proposed a different payment system for physicians' services using the same framework that is currently in place for evaluating payment updates for all other Medicare provider groups. Specifically, under that framework, there would be neither automatic bonuses nor automatic cuts in physician payments. However, payments to physicians could still be reduced if MedPAC and Congress believed that cuts were warranted and would not put Medicare's 40 million beneficiaries at risk.

Issues, such as volume growth, could 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.

An expenditure target system does not create the incentives needed to achieve its cost containment goal. As you observed, Chairman Johnson, along with Committee Chairman Thomas in a letter, dated March 21, 2002, to CMS Administrator Scully: "An individual physician who reduces volume in response to . . . the SGR system would not gain a proportionate increase in payments, because payment increases would be shared among *all* physicians who serve Medicare beneficiaries. Contrary to the system-wide goal of restraining volume growth, an individual physician has incentives to increase volume under the SGR system."

There is also a risk in any expenditure target system that payment updates will not keep pace with medical practice costs. Further, this type of system may create instability in rates with payments that keep up with inflation in some years and fall well behind inflation in others. Since 1991, when an expenditure target system was first implemented, Medicare payments to physicians have averaged only a 1.1 percent annual increase, or 14 percent less than inflation in medical practice costs, as measured by the conservative Medicare Economic Index. It is difficult for physicians to make appropriate decisions regarding such matters as staff size and office space, if they cannot rely on a predictable income stream.

Finally, it is important to note that elderly and disabled Americans' need for medical care is not subject to constraints. The United States' population is aging and new technologies are making it possible to perform more complicated procedures on older and frailer patients than in the past. While Medicare's expenditure target system artificially caps spending on medical services, this type of system inherently cannot cap the amount of medical services that are needed to adequately treat sick patients. When patient need for and utilization of medical services is greater than the target, payment rates for individual physicians are reduced. These inappropriate payment reductions lead to serious access problems, such as those chronicled in surveys and news articles as a result of the 5.4 percent Medicare payment cut in 2002.

Accordingly, the AMA recommends, in view of the access implications resulting from an expenditure target system, that the Subcommittee reconsider use of this type of system for determining payment updates for physicians and other health care professionals.

PROBLEMS UNDER THE SUSTAINABLE GROWTH RATE SYSTEM

The current expenditure target system used for determining Medicare payments for services furnished by physicians and other health care professionals is the SGR system. This system manifests all of the shortcomings inherent in any expenditure target, and has led to payment volatility, created substantial patient access concerns and generated significant problems for the Federal Government.

The SGR system also has had a particularly serious impact on physician practices since they generally are organized as small businesses. Indeed, AMA data shows that two-thirds of physician practices have 25 employees or less. Small businesses do not have the economic and other necessary resources to absorb sustained losses or the steep payment fluctuations that have occurred under the SGR system. Further, the unpredictability of the SGR system makes it difficult for physician office practices, as small businesses, to project into the future and make the necessary business and financial decisions needed to operate a sound business over time. For example, when medical practices experienced the 5.4 percent Medicare cut in 2002, as small businesses, physicians and non-physician practitioners and their staff were left with very few alternatives for maintaining a financially sound practice.

As this Subcommittee well knows, it took valiant efforts by full Committee Chairman Thomas, Subcommittee Chairman Johnson, as well as every member of this Subcommittee, in addition to similar efforts by the Senate, the Administration and CMS to avoid another SGR-triggered pay cut in 2003. While we greatly appreciate this effort, we do not believe Congress and the Administration (nor patients, physicians and other health care professionals) should have to struggle with the ill effects of such a system, year after year.

Under the SGR system, CMS establishes allowed expenditures for physicians' services based on certain factors set forth in the law. CMS then compares allowed expenditures to actual expenditures. If actual expenditures exceed allowed expenditures in a particular year, then physician payments are reduced in the subsequent year. Conversely, if allowed expenditures are less than actual expenditures, physician payments increase.

Growth in allowed expenditures under the SGR is determined by changes in (i) inflation, (ii) fee-for-service enrollment, (iii) real per capita gross domestic product

(GDP), and (iv) laws and regulations. There are two fundamental problems with this formula. First, it is highly dependent on projections that in effect require CMS to predict the unpredictable and, second, it uses GDP as a proxy for appropriate growth in the use of physician services. Payment swings under the SGR are unavoidable for several reasons:

GDP Does Not Accurately Measure Health Care Needs

The SGR permits utilization of physicians' services per beneficiary to increase by only as much as GDP. Linking Medicare physician payment updates with GDP is problematic because the GDP is a measure of growth in the overall economy and bears little relation to the health needs of Medicare patients. Specifically, GDP does not take into account health status, the aging of the Medicare population, technological innovations or changes in the practice of medicine. Indeed, MedPAC, prior to recommending an alternative to the SGR system, recommended that Congress revise the physician payment update system to include an allowance for spending increases due to technological advancement as well as demographic changes.

Reliance on GDP has also led to a system that relies on economic forecasts that nearly always turn out to be inaccurate, and thus it is impossible to make accurate projections about payment update levels. For example, in March of 2001, CMS projected that physician payments would fall slightly by about ·0.1 percent in 2002. CMS noted that this projection was based on very early information and could change before a final update was announced in January 2002. In fact, this is exactly what occurred, and Medicare payments to physicians and other health care professionals were cut by 5.4 percent in 2002.

Technological Innovation

Both Congress and the Administration have demonstrated their interest in fostering advances in medical technology and making these advances available to Medicare beneficiaries through FDA modernization, increases in the National Institutes of Health budget, and efforts to improve Medicare's coverage policy decision process. The benefits of these efforts could be seriously undermined if physicians face disincentives to invest in new medical technologies or to provide them to Medicare beneficiaries as a result of inadequate spending targets.

Technological changes in medicine show no sign of abating, and, if the SGR is retained, the AMA agrees with MedPAC that it should include an adjustment for the impact of new technology on physicians' cost and patients' use of services so that Medicare beneficiaries continue to have access to mainstream, state-of-the art quality medical care.

Site-of-Service Shifts

Another concern that is not taken into account in the SGR formula is the effect of the shift in care from hospital inpatient settings to outpatient sites. As MedPAC has pointed out in the past, hospitals have reduced the cost of inpatient care by reducing lengths-of-stay and decreasing staff, as well as by moving more services to outpatient sites, including physician offices. This trend increased the number and intensity of services as patients with increasingly complex conditions are treated in physicians' offices. This increased use and intensity, however, is not directly recognized in the SGR formula. **Thus, the AMA believes the SGR target should also reflect changes in site of service.**

Beneficiary Characteristics

A related factor that also is unrecognized in the SGR formula is changes over time in the characteristics of patients enrolling the fee-for-service program. A 1999 MedPAC analysis concluded that the fee-for-service population is growing older, with proportions in the oldest age groups (aged 75 and over) increasing by 2 percent from 1993 to 1997, while proportions in the younger age group (aged 65–74) decreased by 3.4 percent. Older beneficiaries likely require increased health care services, and, in fact, MedPAC reported that payments per beneficiary rose by about 0.1 percent a year during that same time frame. **As MedPAC has previously recommended, the SGR utilization standard should be adjusted to reflect this sort of demographic change.**

Reliance on Predictions

Use of GDP has led to a payment system that relies on economic forecasts that nearly always turn out to be inaccurate. Medicare actuaries must also predict what actual spending will be, how many beneficiaries will move between Medicare+Choice and fee-for-service, as well as what type of utilization changes will occur as a result

of legislative and regulatory changes, such as the addition of coverage for various preventive services. None of these factors can be accurately predicted before they occur. As a result, payment updates are always based on incomplete and inaccurate data, and can fluctuate wildly from year to year.

In exploring alternatives to the current update formula for physicians' services, the AMA urges the Subcommittee to take into account the uncertainty and volatility resulting from use of the GDP in determining payment updates.

SGR IMPLEMENTATION PROBLEMS

Apart from the inherent structural problems in an expenditure target system, as well as the SGR itself, there are other problems with implementation of the SGR that seriously impact access and inequitably affect payment updates due to factors that are beyond physicians' control.

Inclusion of Drugs in the SGR

As discussed above, in determining the SGR each year, CMS compares actual spending on physicians' services to an amount established under a spending target. Calculations of actual spending include the costs of prescription drugs that are administered in physicians' offices.

The AMA does not believe that drugs should be included in the SGR. Although the physician's administration of the drug is clearly a physician service that by statute must be included in the pool, the drugs themselves are not "physicians' services" and are not paid under the Medicare physician fee schedule. Thus, it is inconsistent to include drugs in the SGR. In fact, in a recent interim final rule (on the application of inherent reasonableness to Medicare Part B services), CMS chose to exclude drugs from the Medicare definition of "physicians' services." To include drugs as a "physicians' service" for certain purposes, but not for others, exacerbates the inconsistency. In the March 2001 letter to Administrator Scully, referenced above, Subcommittee Chairman Johnson and full Committee Chairman Thomas suggested that the Medicare policy of including drugs in the SGR needs modification.

In addition, the SGR does not provide an incentive to individual physicians to control drug utilization. Since the SGR is based on the collective actions of all physicians and other health care professionals who bill the Medicare program, it is difficult for an individual physician to assess, at any given point in time, the impact of needed prescription drugs on the SGR. We also note that Medicare payment for drugs is not based on the SGR. Since neither prices nor utilization of drugs are affected by the SGR, it is inconsistent and inequitable to argue that the SGR controls drug spending.

Further, inclusion of drugs in the SGR is at odds with a number of government policies that encourage the rapid development and use of new drugs and cancer therapies, and, in effect, punishes physicians with lower payments if they provide the very new drugs and therapies that these policies encourage.

Specifically, appropriations for the National Cancer Institute (NCI) increased by more than 35 percent between 1997 and 2000, the Food and Drug Administration (FDA) drug approval process was streamlined, and Congress expanded Medicare to include new screening benefits for breast, cervical, colorectal and prostate cancer. The Department of Health and Human Services has actively promoted these new benefits and the Administration apparently intends to continue these policies, as evidenced by a draft HHS strategic plan that proposes to "accelerate private sector development of new drugs, biologic therapies and medical technology."

While these are laudable policies, and the AMA by no means objects to these policies, nevertheless, they play a large role in causing drug spending to rise at a much greater pace than physician spending. According to AMA analyses, from 1996 through 2001, drug spending growth was 178 percent compared to 35 percent for physicians' services.

The enormous increases in drug spending are also due to innovations in the treatment of cancer and arthritis along with improvements in pain management and modifications in clinical practice. For example, between 1996 and 2001, some 61 new drugs were introduced. Eight of the fifteen most frequently used drugs in 2000 were either brought to market or received FDA approval for expanded uses between 1996 and 2000. In addition, use of some drugs rose dramatically, as is the case with epoetin (previously used primarily to counteract anemia in end stage kidney disease patients). Use of this drug was extended to patients with chronic kidney disease, cancer and other conditions where anemia is common or is a by-product of treatment.

Increased incidence of lung cancer and enhanced efforts to promote screening for breast and prostate cancer also contributed to the expansion of Medicare expenditures for a number of drugs. Between 1996 and 2000, expenditures for chemotherapy drugs increased by 81 percent. Moreover, growing evidence that pain associated with cancer and other conditions is frequently under-treated, along with enhanced abilities to control pain, led to the evolution of pain management as a specialty during this time period.

Additionally, a number of new products, including several additional promising arthritis and cancer drugs, are in the pipe line. This is compounded by the fact most of the more prevalent cancers are found primarily among the aged, and cancer incidence in the U.S. is predicted to double over the next 50 years. (*The Annual Report to the Nation on the Status of Cancer, 1973–1999, Featuring Implications of Age and Aging on the U.S. Cancer Burden*, 94 Cancer 10, at 2766–2792 (May 15, 2002)).

Drug spending as a share of total SGR spending doubled from 3.7 percent in 1996 to 7.4 percent in 2001. CMS actuaries, as well as AMA economists, expect that drug expenditures will continue to outpace growth in spending for physician services. Thus, inclusion of drugs in the SGR makes it extremely likely that spending on physicians' services will exceed the SGR target. Essentially, physicians are being asked to finance drug costs through cuts in their Medicare payments even though they do not have the ability to control the factors that are causing increases in drug utilization, and, therefore, should not be penalized through reduced payments.

We emphasize that Medicare policies have an enormous impact on the SGR. In times slow economic growth, as is currently the case, these policy decisions are critical to determining whether there will be a negative or positive payment update. CMS' decision to include drugs in the SGR could make the difference between a positive update versus a Medicare pay cut in future years. Further, this policy decision will have an even more devastating impact in the event that a Medicare prescription drug bill is enacted and these drugs are also included in the SGR.

We, therefore, respectfully request that the Subcommittee encourage the removal of drugs from the SGR.

Changes In Medicare Spending On Physicians' Services Due To Laws And Regulations

The AMA believes that there must be a full accounting of the impact of regulatory changes on physician spending.

When establishing the SGR spending target for physicians' services, the law requires that impact on spending, due to changes in laws and regulations, be taken into account. The AMA believes that any changes in national Medicare coverage policy that are adopted by CMS pursuant to a formal *or informal* rulemaking, such as a Program Memorandum or a national Medicare coverage policy decision, constitute a regulatory change as contemplated by the SGR law, and must also be taken into account for purposes of the spending target.

CMS' authority to make any regulatory change is derived from law—whether it is a law specifically authorizing Medicare coverage of a new service or a law that provides the Secretary of HHS with general rulemaking authority. Thus, any new coverage initiative is a direct implementation, by regulation, of a law. This is exactly what the SGR requires be taken into account—increases in spending due to "changes in law and regulations."

When the impact of regulatory changes for purposes of the SGR is not properly taken into account, physicians are forced to finance the cost of new benefits and other program changes. Not only is this precluded by the law, it is extremely inequitable and ultimately adversely impacts beneficiary access to important services. Further, in the March 2001 letter to Administrator Scully, referenced above, Subcommittee Chairman Johnson and full Committee Chairman Thomas suggested that national coverage decisions ought to be included in the SGR target.

HHS and CMS actively promote utilization of newly-covered Medicare services through press releases and other public announcements. For example, the Secretary of HHS last year released a report highlighting the importance of medical innovations and new technology, especially new drugs, in helping seniors live longer and healthier lives. Further, another HHS release regarding Medicare coverage of sacral nerve treatment for urinary incontinence stated, "[u]rinary incontinence affects approximately 13 million adults in the United States, with nearly half of nursing home residents having some degree of incontinence. It is twice as prevalent in women as it is in men, and costs more than $15 billion per year, including both direct treatment of the disease and nursing home costs." The Secretary made a similar announcement when Medicare expanded its coverage of lymphadema pumps, stating,

"[i]t's important to make effective technologies available to Medicare beneficiaries when it helps them the most. This coverage decision simplifies Medicare policy to allow older Americans who need these pumps to get them more quickly and easily."

While the AMA supports Medicare beneficiary access to these important services, physicians and other practitioners should not have to finance the costs resulting from the attendant increased utilization.

Accordingly, we urge the Subcommittee to ensure that the impact on utilization and spending resulting from all national coverage decisions is taken into account for purposes of the SGR spending target.

We appreciate the strong efforts of the Subcommittee Chair and Members to avert the Medicare payment cut in 2003 and to further explore the problems presented by the SGR system. We urge the Subcommittee and Congress to consider the recommendations we have discussed today, and we are happy to work with the Subcommittee and Congress as it concerns these important matters.

f

Chairman JOHNSON. Thank you very much, Dr. Plested. Ms. Ousley.

STATEMENT OF MARY K. OUSLEY, CHAIRMAN, AMERICAN HEALTH CARE ASSOCIATION

Ms. OUSLEY. Good afternoon, Chairman and Members of the Subcommittee. Thank you very much for the opportunity to testify this afternoon on the recent MedPAC report. My name is Mary Ousley, and I am representing today the American Health Care Association.

It is essential that as we discuss all of the multitude of the facts associated with the MedPAC findings, that we never, ever lose sight of the fact that we are talking about real human beings and real lives being impacted by these recommendations.

I want to say first and foremost that we strongly, strongly believe that the MedPAC recommendations are, number one, ill-advised and, number two, that they will contribute to the further deterioration of the services being provided to seniors in America in long-term care.

One of the problems that we are attempting to overcome and to deal with and one that is apparent that this Committee also understands well is that MedPAC continues to focus solely on the data regarding the Medicare margins without looking at the associated Medicaid losses and issues with Medicaid.

When it comes to making very important public policy recommendations, it is inconceivable to me that key data used to reach these conclusions about the sufficiency of Medicare payments fails to look collectively at the issues of both Medicare and Medicaid. Again, as this Committee has discussed, some have chosen to dismiss this issue of cross-subsidizing as not relevant to the debate at hand.

What I really want to say to this Committee today, Chairman, is that when you look at the average patient in our SNFs today there is an 85-year-old widowed resident that is in need of care, multiple activities of daily living dependencies, that she does not see herself as Medicare or Medicaid. She sees herself as elderly and sick and in need of care, and these recommendations do not serve this average patient well at all.

When you consider the average Medicaid rate in this Nation of $115 a day, about $5 per hour with multiple States throughout the

Nation paying far less than that, Texas, Oklahoma, Louisiana, the overall picture presented by MedPAC is misleading because of the gross shortfalls in Medicaid, and MedPAC's own research supports that its recommendations would have dire consequences on patient care.

The new payment adequacy framework obviously adopted last year by MedPAC requires that the Commission take into consideration Medicare beneficiaries' access to care and providers' access to capital. These recommendations ignore both, and this is a critical problem.

Today our nursing facilities' capital ratios evaluated by Lewin Group have almost for the entire sector been moved to the status of poor.

The CMS recognized these issues in its own study last year, saying that the 2002 potential cuts then went into effect, that this would have dire consequences on the creditability of nursing facilities throughout this Nation.

Chairman, that issue is absolutely real for us today. MedPAC today, in the conversations at the meeting in December, saying that the overall access to capital is generally good is simply incorrect.

Newspaper headlines across this Nation tell the story: "Centennial into Chapter 11." There are multiple nursing facilities closing all across this Nation. In my company this year I have closed facilities in Massachusetts, California, Washington State. The closings are increasing, and this is a critical problem for seniors.

Significantly, Chairman, I want to say to you, this is not just a problem for one sector. It is not proprietary, non-proprietary, multi-facility, independent owner, small chain. It is a problem for all of us as we continue to try to provide this care.

I agree with the MedPAC recommendations that access to care needs to be carefully monitored as we move forward. It is extremely important, and we certainly see this access to skilled nursing changing.

At the outset of the testimony I said that we should never forget that we are dealing with the most vulnerable individuals in America today. Chairman, I ask that this Committee, our Federal Government, our President, this Administration invest the resources that are needed to provide that care.

Just a few short months ago, one of the proudest days of my career, I stood with Secretary Tommy Thompson, Administrator Scully, American Association of Retired Persons (AARP), Service Employees International Union, and others as we announced the Nursing Home Quality Initiative. Chairman, unless the resources are there to continue this quality initiative, it will fail, and it will fail on the behalf of seniors of America. I ask that you discount the illogical and superficial MedPAC analysis and that you do not accept this data or this view. I believe that we cannot accept, Congress and America cannot tolerate this type of approach to providing care for the most frail, vulnerable individuals in America today, our senior citizens and our disabled.

Thank you very much for the opportunity to express our opinions. Thank you.

[The prepared statement of Ms. Ousley follows:]

Statement of Mary K. Ousley, Chairman, American Health Care Association

Good morning, Madame Chairman and members of this subcommittee. Thank you for inviting me to provide you with **an accurate, balanced perspective on the recent Medicare Payment Advisory Commission (MedPAC) report on Medicare payment policies.**

My name is Mary Ousley, and I am Chairman of the American Health Care Association. I speak today on behalf of all members of the American Health Care Association (AHCA). We are a national organization representing some 12,000 providers of long term care, who serve more than 1.5 million elderly and disabled people annually, employing more than 1.5 million caregivers.

Let me briefly tell you about myself. I have been in the care giving profession for nearly three decades. I am a registered nurse and a licensed administrator. I am intimately familiar with the challenges of being on the front lines of care giving.

I have worked formally and informally with the Centers for Medicare and Medicaid Services (CMS) and its predecessor, the Health Care Financing Administration (HCFA), in various capacities on many issues representing the long term care profession.

I would like to commend you, Madame Chairman, on your vision for long-term care, and for taking the time to understand our profession, its nuances, and the care needs of the beneficiaries we serve.

It's essential, however, that when we discuss the myriad of facts, statistics and analyses associated with the MedPAC findings, we never lose sight of the fact that, really, we're dealing with the lives and well-being of the most vulnerable citizens in our society.

The quality of care our beneficiaries receive today, and the quality of care many of us will receive in the future, is directly related to this important hearing.

Among our primary concerns is the fact that our Federal Government's goals and objectives in regard to quality are directly contradicted by its own actions and policies.

There is a growing disconnect between what government expects and what it is willing to invest—especially in light of the fact that demand for care will increase dramatically in the future. Demographic realities cannot be ignored.

I have been asked to comment on the MedPAC's conclusions. It is my opinion they follow a pattern of government turning a blind eye to an obvious problem that we and others have been pointing out for quite some time: The government is the purchaser of almost all nursing home services; it demands that quality be first rate, as it should; and the reality is that quality care cannot be provided for less than cost.

At a time when we as a nation ought to be strengthening our long term care infrastructure to prepare for the wave of baby-boom retirees who will enter the system, we are, instead, allowing the infrastructure to deteriorate.

We strongly believe the recommendations made by MedPAC are ill-advised, and will contribute to the further deterioration of long term care at a time when every stakeholder can least afford it.

Accurate Analysis Requires Collective Evaluation of Medicare AND Medicaid

One substantial problem we are attempting to overcome—and one we hope this Committee appreciates—is that MedPAC continues to focus solely on data detailing the sector's Medicare-only profits—without also looking at Medicaid losses.

When it comes to making important public policy recommendations that truly impact people's lives, it is inconceivable that key data used to reach conclusions about the sufficiency of Medicare funding fails to look collectively at the real, and growing, interdependence between Medicare *and* Medicaid.

While MedPAC has opted to ignore Medicaid as a determinant in recommending governmental policy, the one million Medicaid patients who rely upon the care we provide do not have that luxury.

Unfortunately, some have chosen to dismiss the issue of "cross subsidization" as not relevant to the debate at hand. Yet, to our average patient—an 85 year-old widowed female in need of care, the cross subsidization issue is real.

As Commissioner and former Senator David Durenberger believes, a far more holistic evaluation is called for at this critical point in time, so that beneficiaries will not fall through the cracks due to an incomplete data picture and a short-sighted policy.

The cross-subsidization of Medicaid by Medicare is a policy that is in place today—empirical evidence and hard data prove it is occurring. We respectfully suggest that you as policymakers consider the ramifications of ignoring this reality, as

MedPAC has done. While no one would advocate that one entitlement subsidizing another is good long term policy, it is a current necessity to ensure the adequacy and quality of patient care.

We must also consider other factors in determining the data that provides an accurate assessment of the bigger picture: Our states are coping with the worst state fiscal crisis since World War II, and the nation's Governors are struggling to ensure their states' most vulnerable citizens do not end up as unfortunate statistics on a balance sheet.

Forty-nine out of fifty states—according to a January 2003 Kaiser Commission on Medicaid and the Uninsured study—will act to reduce their Medicaid spending this year, with 37 planning on reducing or freezing the amount of funding for nursing care. And consider that Medicaid payments average about $115 per day nationally. That's less than $5 per hour—less than many people pay babysitters. Many states pay below the national average. For example, in 2001 Louisiana paid $78 per day; Texas' rate was $97; and Illinois' statewide average rate was $94 per day. And for this funding, nursing facilities provide room, board, 24 hour nursing care, therapies and social activities.

The overall picture provided by MedPAC of the Skilled Nursing Facility (SNF) sector, therefore, is misleading because of the gross shortfalls in Medicaid.

MedPAC's own research corroborates that its own recommendations will have dire consequences for patient care. MedPAC's analysis last year, bolstered by a more recent investigation by the Lewin Group, found that the pre-tax total margins of free-standing skilled nursing facilities are projected to be minus 2 percent.

The deficit resulted from the expiration of $1.8 billion in Medicare payments last October and a $3.5 billion shortfall in Medicaid payments versus allowable costs last year—factors which must be addressed and that will be exacerbated if MedPAC's recommendations are accepted.

The negative 2 percent total margin came from MedPAC's analysis of data existing before the present day worsening of Medicaid—and the current state fiscal crisis.

Imagine, Madame Chairman and Members of the Committee, what present day data would show if these data were available now.

The Capital Crisis and Impact on Patient Care

The new payment adequacy framework adopted last year by MedPAC requires that the Commission take Medicare beneficiaries' access to care and providers' access to capital into account when determining the appropriateness of payments.

The recommendations put forward to you for consideration, Madame Chairman, ignore both factors.

Indeed, access to capital is a critical problem for SNFs, and the problem is not abating. In fact, it is worsening. Bank loans, bonds and other forms of capital fund the day-to-day operations of most nursing facilities, and are an absolute necessity to providing and maintaining quality of care.

According to the most-recent Lewin Group analysis of capital formation, nursing homes' capital ratios and other statistics evaluated by lenders have deteriorated to the point that the credit profile of nearly the entire sector is viewed as poor.

Furthermore, a *Legg-Mason* equity research analysis stated the problem very succinctly by specifying the need for predictability in funding over the long term if SNFs are to regain investor confidence, "and attract the capital needed to meet the future long term care needs of America's seniors."

CMS identified this problem last February in its *Health Care Industry Market Update: Skilled Nursing Facilities*, which reported that the October 2002 expiration of the Medicare SNF payment adjustments would have, and I quote, "a very negative impact on nursing facility company credit profiles and their ability to access capital."

Madame Chairman, CMS' analysis, unfortunately, has proven correct.

According to that report, the "fixed charge coverage"—a statistic used by bond analysts and investors to gauge a company's ability to pay its debt service and other obligations—for six of the seven largest nursing facility providers in the country has dipped below the minimum level considered necessary by analysts to raise capital.

Another statistic closely followed by bankers is the "rent adjusted leverage," which measures a provider's ability to pay rent and interest based on cash flow.

Again, according to the CMS report, the elimination of the Medicare payment adjustments in October 2002 has moved the rent adjusted leverage ratios of several major provider companies into a highly problematic range.

These findings from the Lewin Group and CMS clearly do not correspond with the opinion expressed by MedPAC staff at their December meeting that SNFs' access

to capital is "generally good," and "over investment prior to PPS may mean less need for construction capital in the near term."

A sector that is one-third insolvent does not have "generally good" access to capital.

Although both for-profit and non-profit SNFs can operate with negative margins for a short period of time—as is now the case—the cumulative instability of the sector over the past five years has eroded equity and shortened that grace period.

Even more troublesome is the Lewin Group's finding that one-third of all SNFs, regardless of ownership, will report negative equity in 2006—meaning that their total liabilities will exceed all their assets.

Negative equity is unsustainable for any extended period of time, and makes obtaining access to capital all but impossible.

In the short term, the recently experienced BBA-related Chapter 11 bankruptcies could be followed by a round of Chapter 7 bankruptcies—liquidation versus restructuring.

If Medicare add-ons are not soon reinstated, while the government begins to fix the long ailing Medicaid system, the result may be forced asset sales and facility closures.

The question that emerges from the capital crisis, therefore, is what is the impact on the quality of care ultimately received by Medicaid beneficiaries?

The near term budget reductions are already affecting the capital availability needed to modernize and replenish physical plants and equipment, acquire new technologies, and meet changing community health care needs.

This comes at a time when an aging population will, increasingly, require complex medical services within the nursing facility setting.

The effects of the October 2002 expiration of the Medicare SNF payment adjustments are already being felt. Newspaper headlines across the nation tell the story: Centennial Health Care, which operates 86 nursing homes in 19 states, filed for Chapter 11 bankruptcy protection in December, citing "severe cuts in federal reimbursement."

As a consequence of inadequate reimbursements, nursing facilities in Philadelphia, PA, Oakland, CA, Lynn, MA, and South Austin, TX, have already closed—and additional facilities will soon close their doors in cities such as Minneapolis, MN, Seattle, WA and Burlingame, CA.

These are just a few on the many examples of the consequences of already insufficient reimbursements.

If MedPAC is truly concerned about safeguarding beneficiaries' access to care, outcomes and quality, the Commission should not have recommended eliminating SNFs inflation adjustment for this year based on Medicare-only margins and a selective, superficial assessment of the sector's financial health.

Significantly, Madame Chairman, this is not just a matter of urgency to the for-profit sector; far from it. The largest non-profit nursing facility chain, the 215 facility Good Samaritan Society—whose President and CEO, Judith Ryan, testified before this Committee three weeks ago—had managed to maintain investment-grade bond ratings. Moody's, however, changed the outlook last year from "stable" to "negative."

Decline In Numbers of Skilled Nursing Facilities

On another front, Madame Chairman, we dispute MedPAC's conclusion that there has been in increase in freestanding SNFs. Their analysis is by calendar year, and includes only surveys in the OSCAR data that took place in the twelve months of the year—1998, 2001, and 2002**.**

Since facilities are not necessarily surveyed every 12 months but only required to be surveyed every 15-months, a strictly calendar-year analysis does not include all active facilities—perhaps only 80% of facilities.

Any analysis by calendar year reflects only when survey data were entered into the CMS database—not which facilities existed at any given time.

At AHCA, we take the most recent survey of all facilities at a point in time to do this type of trend analysis. At any point in time, some active facilities may have survey data older than 12 months.

For example, because of the strictly calendar year analysis used by MedPAC, MedPAC shows only 12,862 freestanding facilities exist in 1998.

Taking the most recent survey for all facilities, we show 14,845 in 1998 and, as of December 2002 data, 14,722 freestanding facilities with current survey data.

Measuring Access To Care

One of the MedPAC recommendations was that the U.S. Department of Health and Human Services' (HHS) Office of Inspector General (OIG) should continue to monitor access to skilled nursing care.

We agree that this is important because as the most recent General Accounting Office (GAO) report indicates, access to skilled nursing care is worsening. In 2000, 80% of hospital discharge planners said they could place all Medicare patients in skilled nursing care. One year later, that percentage deteriorated to 73%. Consequently, more than 25% of Medicare patients leaving hospitals could not be placed in skilled nursing facilities by hospital discharge planners.

At the outset of my testimony, I said we should never forget that we are dealing with the most vulnerable in our society—and that we must all make the commitment to quality care the paramount public priority.

Madame Chairman, and Members of this Committee, we continue to ask and hope that the Federal Government—President Bush and the U.S. Congress—will invest the resources that are needed to provide that quality care.

Let us not forget that just several months ago, there was a substantial and certainly successful public relations effort surrounding the announcement of the government's new Nursing Home Quality Initiative (NHQI).

We believe in the goals of the nursing home quality initiative, and we are active participants, and we have supported it since its inception.

Working as partners—cooperatively and collegially—we want to continue working with you to build the best system of long term care our nation is capable of achieving.

There's no doubt: these are challenging times on both the domestic and international fronts. National security is a paramount priority, and this must be so. But, our seniors' retirement security must also be a national priority—and these goals cannot be mutually exclusive.

We want to provide quality care, and the government has the correct expectation that we do so. To achieve this shared objective in partnership, we must consider these issues with a comprehensive understanding by looking at the interaction of patient populations for whom we provide care.

Madame Chairman, we ask for your help, and the help of your colleagues to assure adequate funding to deliver quality care. We are indeed at a crossroads when it comes to deciding whether we succeed, or whether we fail.

We must meet our nation's retirement challenges together because great nations protect those least able to protect themselves.

You must discount the illogical and superficial MedPAC analysis. Acceptance of this myopic view and data while the system disintegrates constitutes a detached perspective on a problem that affects real people—and cannot be accepted or tolerated in an area as important as the frail, elderly and disabled of America.

Thank you Madame Chairman, and Members of the Committee, for providing us the opportunity to share our concerns with you here today.

f

Chairman JOHNSON. Thank you very much. Mr. Barry.

STATEMENT OF DENNIS BARRY, PRESIDENT AND CHIEF EXECUTIVE OFFICER, MOSES CONE HEALTH SYSTEM, GREENSBORO, NORTH CAROLINA, AND CHAIRMAN, BOARD OF TRUSTEES, AMERICAN HOSPITAL ASSOCIATION

Mr. BARRY. Thank you, Chairman. I am Dennis Barry, President of Moses Cone Health System in Greensboro, North Carolina. I also have the pleasure of serving as the Chairman of the American Hospital Association (AHA) Board of trustees.

The AHA is disappointed that MedPAC chose to ignore the needs of both patients and hospitals by recommending reduced hospital payments under Medicare. The Commission's recommendations fail to reflect the enormous economic pressures hospitals are facing today, most of which are beyond our control.

These pressures are many and growing. Health care is experiencing a severe work force shortage, which is driving labor costs

higher than many other parts of the service sector. Liability premiums are skyrocketing. At Moses Cone, our liability premiums have tripled over the past 4 years.

The pace of clinical innovation is increasing rapidly, bringing high-tech improvements to patient care. In our regional cancer center in Greensboro, at a cost of millions, we bring patients the latest and the best drugs that we can. Medicare payment levels for those same drugs, however, don't cover the raw cost of the drugs. Yet, hospitals must absorb these high costs, because Medicare payments for technology are made in a budget-neutral manner.

As America's health care safety net, hospitals provide care regardless of one's ability to pay. With 41 million and growing uninsured Americans, the care demands of this population are increasing. Last year at Moses Cone we took care of thousands of patients who did not have coverage, providing $33 million of free care at our cost.

Given all of these forces and more, the cost of caring is rising. In 2001, it increased by 4.7 percent, more than double than the prior year. Hospitals simply can not sustain additional payment cuts.

MedPAC's update recommendations are appalling. For fiscal year 2004, MedPAC recommends that hospitals receive less than a market-basket update for inpatient and outpatient services. Their recommendation comes even as 36 percent of hospitals had negative Medicare PPS margins in 2000. Medicare reimburses for outpatient services below cost, paying 86 cents on each dollar of care.

In 2001, 57 percent of hospitals lost money treating Medicare patients. Aggregate Medicare margins have dropped every year since 1998. In 2002 at Moses Cone, we received 96.7 cents for every dollar of care we provided to a Medicare patient. A full market-basket update for all hospitals is critical to ensuring that we can continue to care for our communities.

Over the past 4 years, the market basket for hospital care has increased by over 13 percent, but Medicare update payments to hospitals have increased only by 5.6 percent.

I can think of no other field in the private sector where organizations are expected to keep their doors open and serve all when they are paid less than their cost. The MedPAC also recommends expanding the post-acute care transfer provision. We applaud Chairman Johnson's rejection last year of this ill-conceived idea, and we implore you to maintain that stance in the future. Expanding this provision is bad policy.

First, physicians and clinical staff work hard to ensure that patients receive the right care at the right time and in the right setting. Determining when to release patients from the hospital and whether they should receive post-acute care are clinical decisions, not business ones.

Second, expanding the transfer provision undercuts the basic principles of inpatient PPS, a system based on averages and which contains positive incentives to be efficient. The transfer provision unfairly penalizes hospitals for the efficient treatment of patients.

We commend the Commission's rejection of the staff proposal to further reduce the Indirect Medical Education (IME) adjustment. With teaching hospitals still reeling from last October's $800 mil-

lion cut, we doubt that these vital institutions could have sustained reducing the IME adjustment to 2.7 percent. We urge Congress to address the 2002 cuts in IME and restore the adjustment to 6.5 percent.

We appreciate the Commission's recommendation to improve payments to rural hospitals by equalizing the standardized base payment amount, and we urge Congress to permanently adopt the increased standardized base amount for hospitals in rural and small urban settings.

Finally, with regard to the area wage index for rural hospitals, we believe the best way to address this issue is to provide additional resources and lower the labor-related share to 62 percent for hospitals in below-average wage areas while holding harmless all other hospitals.

In conclusion, Chairman, hospitals' total margins are at the lowest point they have been in the last 10 years, and a growing majority of America's hospitals are reimbursed less than what it costs them to treat Medicare patients. The government has a responsibility to be a fair business partner and provide hospitals a payment update that, at a minimum, keeps up with inflation. We urge Congress to reject MedPAC's misguided recommendations to reduce the market-basket payment updates and to expand the transfer provision. We need to repair, not impair, our Nation's hospitals and the communities that they serve. Thank you.

[The prepared statement of Mr. Barry follows:]

Statement of Dennis Barry, President and Chief Executive Officer, Moses Cone Health System, Greensboro, North Carolina, and Chairman, Board of Trustees, American Hospital Association

Mr. Chairman, I am Dennis Barry, president and CEO of Moses Cone Health System in Greensboro, North Carolina. I also serve as the chairman of the American Hospital Association's (AHA) Board of Trustees, and am here today on behalf of the AHA's nearly 5,000 hospital, health system, network and other health care provider members. We are pleased to testify on the Medicare Payment Advisory Commission's (MedPAC) report to Congress. The Commission's recommendations are of great concern to the health care community because they affect more than 37 million Medicare beneficiaries.

Moses Cone Health System is a not-for-profit health system serving the four counties surrounding Greensboro. What was born in 1911 as the result of one woman's vision and generosity—to provide medical care for her fellow townspeople—has grown into a comprehensive health system that includes five hospitals, numerous freestanding outpatient services and two nursing homes. Moses Cone is a recognized leader in cardiology, neuroscience, oncology, rehabilitation and obstetrics. We employ more than 7,000 professionals dedicated to caring for the 725,000 people living in our community, of which approximately 27 percent are seniors. In 2002, our health system cared for half a million patients.

MEDPAC

As the independent advisor to Congress, MedPAC's recommendations have a significant impact on the Medicare program, its beneficiaries and its providers. It's important to note that a single percentage point increase or decrease in MedPAC's update recommendation for one year for inpatient and outpatient care translates into about $1 billion a year either provided to or withheld from America's hospitals in a single year alone—and additional billions in years to come. That's why the Commission's recommendations each year are critical to sustaining the nation's health care system and the continued delivery of Medicare services to America's seniors.

While we are pleased that MedPAC continued its longstanding support of the special role of rural hospitals and also chose not to recommend additional cuts to teaching hospitals at its January meeting, the AHA is disappointed that the Commission chose to ignore the needs of patients and the hospitals that serve them by recommending reduced hospital payments under Medicare. Given the enormous cost pres-

sures hospitals face—from skyrocketing costs of technology, pharmaceuticals and professional liability insurance to spending for disaster readiness—MedPAC's January recommendations are not reflective of today's needs.

TELLING THE HOSPITAL STORY

Hospitals are people taking care of people—doctors, nurses, other health care professionals, support staff, as well as executive and volunteer leaders—working in unique ways to provide essential health care services. In times of need, Americans depend on the hospital promise to be there 24/7 when any health care need arises, when disaster strikes, when an uninsured child needs care, when others have closed for the night, when there is no place else to turn.

But, even as hospitals strive to continue meeting their communities' current needs and rising expectations, their ability to keep the promise of care is being severely challenged. Hospitals are bearing the cumulative impact of a series of forces that are beginning to erode the foundation of the essential public service they provide.

Work force shortages. Health care is about people caring for people, but we face a severe shortage of caregivers and other workers. An estimated 168,000 positions are currently unfilled, and about three-quarters of these are for registered nurses[i] Hospitals are facing billions of dollars in escalating labor costs due to this severe work force shortage. Labor costs comprise more than 60 percent of hospitals' costs. Higher salaries, incentive payments and temporary agency fees designed to help ease the effects of the shortage contribute to even higher labor costs. Hospitals face labor cost increases over 50 percent higher than service industries as a whole.[ii]

Increased demand for services. Since 1997, inpatient admissions have increased 7 percent and outpatient visits have risen 20 percent.[iii] Hospitals face rising demand and constrained capacity—nowhere is this more evident than in our nation's emergency departments (EDs). Our EDs are overcrowded and many frequently must divert ambulances to other facilities because they lack the staff and space to care for additional patients. For example, in 2002 survey of AHA members, 62 percent of all hospitals—and 79 percent of urban hospitals—are operating "at" or "over" ED capacity.

Technology. The rapid infusion of new technologies is steadily improving care, but the investment requirements to keep pace are staggering. While a traditional X-ray machine costs $175,000, a more advanced CAT Scanner—now standard in most hospitals—costs $1 million, and the next round of technology, the PET scanner costs $2.3 million.[iv] As you can see, the pace of clinical innovation is increasing rapidly, yet hospitals must absorb the high costs associated with new technologies. Because the inpatient prospective payment system pays for technology in a budget neutral manner, increased payments for technologies, like drug-eluting stents, result in equally decreased payments for all other services.

Skyrocketing medical liability premiums. According to a recent survey, about one-third of hospitals in 2002 experienced increases of 100 percent or more in their medical liability insurance premiums.[v] At Moses Cone, our liability premiums increased 29.4 percent in 2002, and we received an additional 13 percent price hike for 2003. Skyrocketing premiums threaten access to care and add tremendous cost to hospitals and physicians.

Disaster readiness. As frontline responders in the event of disasters, hospitals are working to upgrade their readiness to respond to nuclear, biological and chemical emergencies. This requires an investment of billions to ensure that every hospital has a minimum capacity to respond to such emergencies. The need to keep our homeland safe has become even more critical as the U.S. is poised for possible war with Iraq.

Regulatory burden. Government regulation of health care is complex and confusing, creating a paperwork burden that takes caregivers away from the bedside. In an era of serious health care worker shortages, caregivers' time must be used as efficiently as possible. But, paperwork requires at least 30 minutes—often as much as an hour—for every hour of patient care provided.[vi] The burden is too heavy—at the expense of patient care. Excessive paperwork not only shortchanges the patient, it also makes the job of the health care professional less rewarding—a key issue in making the health care field attractive to future workers. In addition, new federal regulatory mandates will impose additional administrative and paper-

---

[i] AHA *Trendwatch*, June 2001.
[ii] Bureau of Labor Statistics, data released April 25, 2002.
[iii] AHA Annual Survey, 1997–2001.
[iv] O 2002 University Health System Consortium.
[v] AHA *Trendwatch*, June 2002.
[vi] PricewaterhouseCoopers Survey of Hospitals and Health Systems, 2001.

work burdens. Compliance with the Health Insurance Portability and Accountability Act's privacy regulations alone are expected to cost hospitals between $4 billion and $22 billion.[vii]

Capital costs. Hospitals continually need capital to maintain and update their physical plant, retool facilities to meet changing patient demand, and invest in new technology. For example, the average age of hospital physical plant is at its highest level in over 10 years.[viii] But, hospitals are having difficulty accessing capital to make necessary improvements, experiencing almost six times as many bond downgrades vs. upgrades in 2001.[ix]

Caring for the uninsured. Millions of Americans have no health insurance coverage. Hospitals—by their own mission and under federal law—serve as America's health care safety net, and provided $21.5 billion of uncompensated care in 2001 alone.[x]

Hospitals cannot sustain additional cuts. Hospitals need adequate rates to create a work environment that can attract and retain skilled workers. Hospitals need adequate rates to be able to invest in readiness and patient safety. Hospitals need adequate rates to keep up with the ever-growing demands of our aging population, especially as the capacity to provide this care is strained in many communities.

INPATIENT AND OUTPATIENT HOSPITAL PAYMENT UPDATES

For fiscal year 2004, MedPAC is recommending that for inpatient care, hospitals receive market basket minus 0.4 percentage points; for outpatient services, market basket minus 0.9 percentage points. For the majority of America's hospitals, Medicare already is not paying adequately, and these rates would exacerbate the situation.

- Thirty-four percent of hospitals had *negative* Medicare inpatient prospective payment system (PPS) margins, according to a 1999 MedPAC report (most recent data available).
- For outpatient services, Medicare continues to reimburse hospitals well below the costs of caring—paying 86 cents on the dollar, according to statistics recently released at the January MedPAC meeting.
- In 2001, 57 percent of hospitals had *negative* Medicare margins—that is, the majority of hospitals were paid less than the cost of caring for Medicare patients. Aggregate Medicare margins have dropped every year since 1998, even with the additional congressional funding provided in 1999 and 2000.[xi]
- In total, aggregate Medicare payments to hospitals were *less* than the actual costs hospitals incurred in 2001, with a payment-to-cost ratio of only 98.4 percent.[xii]
- In addition, nearly one-third of hospitals have *negative* total margins, meaning they recover less than the cost of caring for every patient they treat.[xiii]

It is inconceivable to think that a full inflationary increase for both inpatient and outpatient services is not warranted. Medicare has a responsibility to pay its fair share especially as the economy creates financial pressure on states and the ranks of the uninsured swell. Medicare payments to hospital are inadequate. Given current cost pressures, most beyond the control of hospitals, it is essential that Medicare payment updates at least account for inflation. A full market basket update for all hospitals is critical to ensuring that they have the resources needed to continue to provide access to quality health care in their communities. I can think of no other field in the private sector where organizations are expect to operate when they are paid less than their costs.

POST-ACUTE CARE TRANSFER PROVISION

MedPAC is recommending expansion of the post-acute care transfer policy to an additional 13 diagnosis-related groups (DRGs). Some argue that this recommendation will help address "inequities" in the payment system by reducing payments to hospitals for Medicare patients receiving both acute and post-acute care services.

[vii] First Consulting Group Study, 2001

[viii] CHIPS: The 1994 Almanac of Hospital Financial & Operating Indicators; The 1996–97 Almanac of Hospital Financial & Operating Indicators; and The 2001 Almanac of Hospital Financial & Operating Indicators.

[ix] Standard and Poor's.

[x] AHA Annual Survey.

[xi] AHA Annual Survey.

[xii] AHA Annual Survey.

[xiii] AHA Annual Survey.

We, however, contend that expanding the post-acute care transfer provision is bad policy.

First, expansion of the transfer policy undercuts the basic principles and objectives of the Medicare inpatient prospective payment system—a system based on average costs. In general, hospitals are paid below costs for patients with longer-than-average lengths of stay, but they are paid above costs for patients with shorter-than-average stays. The transfer policy makes it nearly impossible for hospitals to break even on patients that require post-acute care after discharge. Hospitals already "lose" if a patient is discharged after the average length of stay and, under the expanded transfer policy, would also "lose" if a patient were discharged prior to the mean length of stay.

The transfer provision prevents hospitals from balancing their losses associated with the many above average length-of-stay cases with these shorter-than-average length-of-stay cases. It unfairly penalizes hospitals for the efficient treatment of patients and for providing patients with the right care, at the right time, in the right place.

Second, concerns about rising Medicare spending for post-acute care have already been addressed through other policy changes. When Congress first called for creation of the transfer policy, both the use and cost of post-acute care by Medicare beneficiaries was growing. Since that time, however, Medicare spending on post-acute care has dramatically slowed as Congress enacted prospective, rather than cost-based, post-acute payment systems. There is no basis for concerns that the growth in post-acute spending may have been due to the early transfer of hospital patients to post-acute care settings. Studies show that Medicare patients who use post-acute care have *longer-than average*—not shorter-than-average—hospital stays. These are patients truly in need of inpatient care and follow-up skilled nursing or home care. Further expanding the transfer policy at this time is unwarranted and bad public policy.

Third, we have yet to see any hard evidence to support how expanding the transfer provision improves patient care. But we do know that expanding the post-acute care transfer provision would be devastating for hospitals. According to CMS' 2003 proposed inpatient rule, the estimated impact of expanding this policy to 13 additional DRGs would have reduced payments to hospitals of $900 million in 2003 alone, adding up to billions of dollars over multiple years.

INDIRECT MEDICAL EDUCATION

We commend the Commission's wise rejection of its staff's proposal to further reduce indirect medication education (IME) payment adjustments. With teaching hospitals still reeling from the $800 million cut that occurred in October 2002, and the largest teaching hospitals facing a total margin of 1.5 percent (as of 2000), we doubt that these vital institutions could have sustained an IME adjustment reduction from the current level of 5.5 percent to 2.7 percent. Such a drastic step would mean more than $2 billion in additional cuts in 2004 alone and $11.5 billion over a five-year period. As MedPAC moves forward, we urge the Commission to remember that IME payments are critical to the viability of teaching hospitals and the patients they serve, and that these special payments must be protected. In addition, we continue to urge Congress to address the October 2002 cuts in IME payments teaching hospitals are currently experiencing.

POST-ACUTE CARE SERVICES

For skilled nursing facilities (SNFs) and home health agencies, the Commission is recommending no update be given. We strongly urge Congress to reject this ill-advised recommendation. SNFs and home health agencies are facing may of the same cost pressures as hospitals—especially work force shortages-related cost. Hospital-based SNFs and home health agencies already dramatically under-funded by Medicare, and they need a full inflationary update in order to keep up with the cost of caring for America's seniors.

We appreciate the Commission's support for addressing the special needs of hospital-based SNFs. MedPAC recognized that medically complex cases require additional resources, and has recommended that CMS develop a new classification system for SNFs to adequately account for these cases. MedPAC also recommends that if this payment inadequacy for medically-complex cases is not addressed quickly, Congress should increase hospital-based SNF payments to market basket minus 0.9 percentage points.

RURAL HOSPITALS

We appreciate the Commission's recommendation to improve payments to providers in rural communities by equalizing the standardized base payment amount. Congress also acknowledged the need to equalize the base payment rate by funding this provision in its fiscal year 2003 omnibus spending bill. We urge Congress to permanently adopt the increased standardized base amount for hospitals in rural and small urban areas. The AHA also supports MedPACs recommendation to increase the Medicare disproportionate share hospital cap from 5.25 percent to 10 percent. These recommendations are a good start for addressing the needs of Medicare patients living in rural areas.

The Commission also recommended that CMS further evaluate the appropriate labor-related share of the inpatient PPS base amount. We're concerned about the competitive problems that result from using the area wage index as health care workers are increasing their willingness to commute longer distances to their jobs. Rural areas are often competing for the same workers as their urban counterparts. Rather than further study, we feel the best way of addressing area wage index problems is to provide additional resources and lower the labor-related share to 62 percent for hospital's in below average wage areas, while holding harmless all other hospitals.

CONCLUSION

Mr. Chairman, Medicare margins are at their lowest level in 10 years and the majority of America's hospitals continue to be reimbursed less than what it costs them to treat Medicare patients. Every day, hospitals walk a tightrope trying to provide more and more patients with the services they need even as resources and federal commitment continue to dwindle. MedPAC's recommendations further upset the balance, and would jeopardize hospitals' ability to care for their communities. Who will lose? Patients and families. That's why we urge Congress to reject the Commission's misguided recommendations to reduce the market basket payment updates and expand the transfer provision. These actions will impair—not repair—our nation's health care system. Thank you.

f

Chairman JOHNSON. Thank you very much, Mr. Barry. Ms. Severyn, pleasure to have you.

STATEMENT OF BETTY J. SEVERYN, MEMBER, BOARD OF DIRECTORS, AARP, CHATTANOOGA, TENNESSEE

Ms. SEVERYN. Chairman and Members of the Committee, I am Betty Severyn a Member of AARP Board of Directors from Chattanooga, Tennessee. On behalf of our more than 35 million Members, I want to thank you for inviting us here today, and I would like to bring a little different perspective to this discussion today.

The AARP Members want Medicare providers to be paid adequately. However, because increases for providers also increase costs to beneficiaries, reimbursement changes should be weighed very carefully.

Congress enacted broad payment increases in 1999 and again in 2000. This year, you acted more narrowly to correct an error in the physician payment formula. These changes have significant impact on beneficiaries' out-of-pocket costs. A good example is the physician payment mix. The AARP supported this fix—it is "fix," not "mix." The AARP supported this fix. It was necessary to correct an error that would have cut physician payments deeply. That would have been unfair and it could have threatened access to care.

The fix had been reported as costing $54 billion over 10 years, but that is only the cost to the Federal Treasury. It will cost beneficiaries $18 billion in higher part B premiums. It will cost yet an-

other $18 billion in higher coinsurance amounts. In total, beneficiaries would be paying $36 billion more over the next 10 years.

This type of net impact needs to be calculated any time provider increases are considered.

While the physician fix was needed to correct an error and protect access, we are not aware of any such errors or access problems with other providers. We therefore urge the Subcommittee to look at MedPAC's careful and objective analysis in considering other changes. Reimbursement changes that are not supported by objective evidence are inherently unfair to beneficiaries who bear a great share of the burden.

Beyond that, unwarranted increases limit the ability of Congress to enact a long overdue Medicare drug benefit. Every dollar spent on provider rate hikes is $1 less that is available for a drug benefit. Our Members want Congress to enact an affordable stable drug benefit this year and one that guarantees all Medicare beneficiaries access to meaningful drug coverage. We know a workable drug benefit requires a sizeable commitment of Federal dollars. Therefore, it would be inappropriate to use limited Federal dollars to increase provider payments without first ensuring that older and disabled Americans get the drug coverage they need.

Medicare beneficiaries, who are your constituents, would not understand why Congress could find the money to make reimbursement changes, but not to help beneficiaries meet increasing drug prescription needs.

Thank you for inviting us to participate in this hearing.

[The prepared statement of Ms. Severyn follows:]

Statement of Betty Severyn, Member, Board of Directors, AARP, Chattanooga, Tennessee

Mr. Chairman and members of the Subcommittee, I am Betty Severyn from Chattanooga, Tennessee. I am a member of AARP's Board of Directors. On behalf of our organization, and its more than 35 million members, I want to thank you for convening this hearing and for inviting us to participate.

More than 41 million older and disabled Americans depend on Medicare for affordable health insurance protection. They also rely on the practitioners who treat them and the facilities and agencies that provide them with quality care. Our members want Medicare to pay health care providers fairly. It is the right thing to do, and critical for ensuring access to care. However, changes to Medicare's reimbursement systems have consequences for beneficiaries and should therefore be weighed very carefully.

Since the enactment of the Balanced Budget Act of 1997, Congress has revisited the issue of provider payments three times—broadly in 1999, again in 2000, and more narrowly this year to correct an error in the physician payment formula. As you deliberate yet another round of reimbursement changes, we ask you to consider seriously the effect that any changes will have on beneficiaries' out-of-pocket costs, as well as the impact on enacting a long-overdue Medicare prescription drug benefit. Each dollar allocated for provider reimbursement increases is one dollar less that will be available for a Medicare drug benefit.

Reimbursement Changes and Increased Beneficiary Out-of-Pocket Costs

Even when errors in payment calculations need correction, it is important to keep in mind that Medicare beneficiaries pay directly for these fixes. For example, AARP supported Congressional action to fix the payment formula error that would have cut physician reimbursement 4.4 percent this year. Nevertheless, this correction came at a significant cost to beneficiaries.

The Congressional Budget Office (CBO) estimates the net cost of the physician fee schedule fix to be $54 billion over the period 2003 through 2013, but that represents only the cost to the federal treasury. Beneficiaries pay approximately 25 percent of Part B costs with their premiums, and the physician fix will increase those pre-

miums by roughly $18 billion dollars over the same timeframe, for a total increase in payments from Medicare to physicians of $72 billion. As a result, beneficiaries will pay about $2.50 more per month in increased Part B premiums next year and will see their premiums continue to increase over the next ten years above the annual Part B premium increases.

The physician payment fix will also add to beneficiary costs by increasing the amount of coinsurance for physician services. That is because the $72 billion from Medicare represents only 80 percent of what physicians are paid for Medicare services. The law requires beneficiaries to pay the remaining 20 percent. This means that—because of the recent fee schedule fix—beneficiaries are estimated to pay an additional $18 billion in coinsurance over the next ten years.

Beneficiaries pay this coinsurance either directly out-of-pocket or indirectly through higher Medigap premiums. Some of the cost is also borne by state Medicaid programs for dually eligible beneficiaries and employers who provide retiree coverage. Additionally, since some physicians "balance bill" patients 15 percent more than Medicare's allowed payment, the total figure may be higher.

The net result is that the physician fix will cost approximately an additional $36 billion in higher premiums and coinsurance over the next ten years—much of it paid directly or indirectly by beneficiaries. Physicians thus will receive around $90 billion in higher total payments, not the $54 billion that has been so widely reported. This type of net impact, especially the impact on beneficiaries, needs to be considered as part of any provider pay increase.

While the physician fix intended to correct a payment formula error, we are not aware of any such errors in other provider payment calculations. We also are not aware of significant access problems in the program. We therefore urge you to look to the careful, objective analyses of the Medicare Payment Advisory Commission (MedPAC) in considering whether any additional reimbursement changes are necessary at this time. Provider pay hikes that are not supported by objective evidence and analyses are inherently unfair to beneficiaries who must bear a great share of the burden.

Priority for a Medicare Prescription Drug Benefit

The need for a Medicare prescription drug benefit for all beneficiaries continues to escalate. Older and disabled Americans continue to face double-digit increases in their prescription costs. Employer-based retiree health coverage continues to erode. Medicare+Choice plans continue to scale back their drug benefits. The cost of private Medigap coverage is increasingly unaffordable. State prescription drug assistance programs provide only a limited safety net, and are themselves at risk because of current state budget crises.

Despite promises of relief, this serious gap in Medicare persists. Beneficiaries continue to struggle to pay for necessary medications. Some even take desperate—and sometimes dangerous—measures. For instance, some beneficiaries do not follow a course of treatment, do not take the prescribed full dosage, or take their prescriptions intermittently. That is why ensuring that beneficiaries have a meaningful, affordable prescription drug coverage is AARP's top legislative priority.

Our members and their families have told us they want Congress to pass legislation ***this year*** that:

- ensures all Medicare beneficiaries have access to affordable, meaningful prescription drug coverage;
- provides stable coverage that beneficiaries can rely on from year to year;
- protects beneficiaries from extraordinary out-of-pocket costs, and ensures reasonable cost-sharing;
- protects those with high drug costs;
- provides lower-income beneficiaries with additional assistance; and
- does not create incentives for employers to drop current retiree coverage.

AARP members are looking to Congress to fulfill the promise to begin to provide long-overdue relief from the devastating costs of prescription drugs. We believe that a prescription drug benefit should be integrated into Medicare in a way that strengthens the program.

We know a workable prescription drug benefit will require a sizable commitment of federal dollars. AARP has urged a level of funding that will enable the Congress to design a Medicare drug benefit that will provide real value to beneficiaries. As we learned from last year's debate, more than $400 billion will ultimately be needed to create a Medicare prescription drug benefit that our members will find valuable.

Therefore, while we want providers to be paid fairly, we also believe it would be inappropriate to use limited federal dollars to increase provider payments without first ensuring that older and disabled Americans get the drug coverage they need.

Our members would not understand why Congress could find the money to help providers, but not to help meet beneficiaries' increasing prescription drug needs.

Conclusion

AARP members want a fair Medicare program—for beneficiaries and for the providers who treat them. As you consider the appropriateness of further payment changes, we urge you to keep in mind the direct impact that these changes will have on beneficiary out-of-pocket costs and on the dollars available for a Medicare prescription drug benefit. We also urge you to consider carefully the recommendations of the Medicare Payment Advisory Commission.

We believe that a Medicare prescription drug benefit must be the top priority this year. We can see no justification for increasing beneficiaries' cost burden through provider pay increases without first meeting the need for assistance with increasing drug costs through an affordable, meaningful benefit available to all beneficiaries. Thank you again for inviting us to participate in this hearing.

f

Chairman JOHNSON. Thank you very much, Ms. Severyn.

We had a little discussion with Mr. Hackbarth about outmoded data. I can't help but think, particularly in view of your comments, Ms. Severyn, how difficult it is for us to reimburse in a way that assures that hospitals can provide you with state-of-the-art equipment on the basis of data that is anywhere from 2—to 4-years-old. So, while proportionately, across the Nation, it may tell us something about payments, it does not help us in meeting a sort of crisis period like we are in.

Just because of 9/11, small providers, small home health agencies in my district are seeing their workmen's comp double and triple when they have never had a claim. So, just the underlying insurance costs—the plummeting of the market is requiring small hospitals to put $2 million they hadn't expected to have to spend into their pension plan to bring it up to government standards. So, this is an extraordinary time for health care providers.

Insurance costs, nursing costs, technology costs are all rising, and we have been through a period of pressure. We have already cut staff; we have done a lot of those things. I know there are Members of the Commission staff still here. We will have a good deal of dialog about this, but it is very hard for Members who are out there all the time and see what is happening in their institutions to put together these national, on-average generic recommendations with the reality that, frankly, you see. You go into an intensive care unit at Columbia University where some of the most cutting-edge care is available—and this is true of any hospital; I just happened to be there—and you see people hooked up to 20 machines, not 2, and all the computer interaction it is overwhelming.

If we are going to be able to provide outstanding quality in the future and see that quality develop, but that frontier of medical science is pressed back, we have to be careful right now what we do about reimbursements. In my estimation—and I could hear it in each of your voices. I have been in Congress for 20 years and have been on this Committee for 17 years, and I've never seen such a disparity between the report of people's experiences and the recommendation of the experts.

I do not mean to disrespect the experts in this regard, nor does it mean that everything the people out there in the real world get

what they want. It does tell you that we have increasing—tension of increasing proportions between what our systems are bringing to us about our health care system and the experience of our health care system.

Now, when you think when the systems were structured and where we are now, it is not surprising. We should have included in our physician payment system the cost of drugs. When we reimburse for those drugs, either separately or not at all, it is a bizarre system that can hardly be dealt with. As drug prices go up, payments go down.

This is the same with the limit, the cap. The cap says: We are just not going to pay any more than that; it doesn't matter how much seniors need.

We do need to make an effort. In this regard, the physicians had the courage—MedPAC had the courage to recommend a major change, which I have introduced. It hasn't gotten very far because it is a major change, but we have to keep at it. If we don't pay our providers fairly, we aren't going to have providers.

We do have some very difficult problems and some totally irresponsible neglect—and I am pointing to my friend, Representative Ben Cardin, over there. Many people mentioned it, and we are ignoring the fact that Medicaid is undermining the payment of the system, whether it is hospitals, nursing homes, or anyone else in the system, including doctors. So, we do have our hands full.

I understand that it does burden our seniors, but it is important for our seniors to remember that they all have access to a health care plan which their grandchildren don't yet. We are struggling to maintain a system that is capable of quality improvements, but on the other hand, it doesn't overpay its providers.

Let me just say that all of you have made very good comments. Your testimony was very detailed, and I particularly appreciate it in the home health areas and the other areas.

Dr. Plested, your specific recommendations, we will look at those carefully. We will look at those with the MedPAC staff and others, because I appreciate the constructive efforts that you have made to help us make some of the systems change. It will enable us to be more accurate in our work.

I also wanted to mention that—I thought it would be interesting, Dr. Plested—CMS is charged by law to take into account all changes in law and regulation. Are there examples you could give us of how physicians' payments have not taken into account even that bottom line of change?

Dr. PLESTED. Thank you, Chairman. We will be happy to provide those to you in writing.

In brief, there are continuous changes in rules that come out that certainly affect what physicians are asked to deliver. There are changes in treatment recommendations for Alzheimer's disease; there are changes in recommendations for treatment of urinary incontinence, to name a couple. A number of these things come through, they aren't prescribed by law as in the directive to HHS, so they don't feel—CMS does not feel they need to make allowance for that.

Chairman JOHNSON. They do have costs associated with them?

Dr. PLESTED. Absolutely.

[The information follows:]

This is to follow up with you concerning the March 6, 2003, Ways and Means Health Subcommittee on the MedPAC Report on Medicare Payment Policies. You requested that the American Medical Association (AMA) provide the Subcommittee with examples of how the Centers for Medicare and Medicaid Centers (CMS) has not taken into account the full impact on physician spending of changes in law and regulations, as is required under the sustainable growth rate (SGR) law.

As the AMA discussed at the March hearing, CMS has not fully accounted for the impact on physician spending due to changes in various regulations. In particular, CMS does not take into account, for purposes of calculating updates in Medicare payments for services furnished by physicians and numerous other health professionals, the impact on physician spending due to national coverage decisions. There have been 62 national coverage decisions since CMS formalized its process for making such decisions in 1999, and this number is growing rapidly, as indicated by the 23 decisions that have already been made in the first 3 months of this year.

An HHS release earlier this year regarding expanded Medicare coverage of sacral nerve treatment for urinary incontinence stated, "[u]rinary incontinence affects approximately 13 million adults in the United States, with nearly half of nursing home residents having some degree of incontinence. It is twice as prevalent in women as it is in men, and costs more than $15 billion per year, including both direct treatment of the disease and nursing home costs." Further, when Medicare expanded its coverage of lymphadema pumps, the Secretary of HHS stated, "[i]t's important to make effective technologies available to Medicare beneficiaries when it helps them the most. This coverage decision simplifies Medicare policy to allow older Americans who need these pumps to get them more quickly and easily."

Other national coverage decisions that expand Medicare coverage of certain services have also impacted spending on physicians' services, including those relating to ocular photodynamic therapy used in conjunction with verteporfin, deep brain stimulation for patients with Parkinson's disease, medical nutrition therapy for patients with diabetes and renal disease, positron emission tomography for patients with breast cancer, image-guided breast biopsies, positron emission tomography for patients with heart disease, and therapy coverage for alzheimer's disease patients. We have attached CMS coverage decisions or press releases concerning these coverage expansions for your review.

While the AMA supports Medicare beneficiary access to these important services, there must be a full accounting of the impact on physician spending due to these national coverage decisions and all other regulatory changes. When the impact of regulatory changes for purposes of the SGR is not properly taken into account, physicians are forced to finance the cost of new benefits and other program changes. Not only is this precluded by the law, it is extremely inequitable and ultimately adversely impacts beneficiary access to important services.

Accordingly, as discussed at the March hearing, we urge the Subcommittee to ensure that the impact on utilization and spending resulting from all national coverage decisions and all other regulatory changes is taken into account for purposes of the SGR spending target.

[Attachments of CMS coverage decisions or press releases covering these coverage expansions are being retained in the Committee files.]

f

Chairman JOHNSON. I wanted to ask you, Mr. Buckelew, about the dialysis issue. One of the things that was a little disconcerting about MedPAC's report was that there has been a rise in freestanding, in-center dialysis—in the number of facilities in that area. I wonder if that is driven by a reimbursement structure, as I want our reimbursement structure to be neutral.

If you look at what is happening in the facility area, 25 percent of the facilities are located in rural areas, but the decline has been in the urban areas. So, is this growth of freestanding, in-center dialysis associated with better service to the suburbs in the rural areas at the expense of the urban areas? Are we prejudicing in-center dialysis over home dialysis?

Mr. BUCKELEW. Yes. Thank you for your question, Chairman.

I think the key issues that come to mind in response to your question are as follows: While there was, in years past, expansion in the number of centers, the current situation we find ourselves in, where the economics are dramatically changing—as you have mentioned and as MedPAC noted, the incredibly increasing cost of care givers, the rates of insurance and so on—what has happened over a very short period of time is that the economics for the dialysis segment have dramatically changed.

What we find today—and there was reference in the report from MedPAC to efficient providers versus less efficient providers—I will tell you that in an analysis that we have done, we find that the larger providers that are there, the chains that represent Members of the RLC, there is a tremendous consistency in the quality of care. What is not consistent is the patient mix.

Again, what is extraordinary is, 70 to 80 percent of all of our patients are Medicare; and so you can see, since the testimony provided today indicates that on each treatment we lose about $10 for each Medicare patient, if a center happens to have a mix that is higher than the average for Medicare patients, then that business model becomes one that is not sustainable. What we are finding is that the areas that are hit the hardest first tend to be center city, where the demographics and such have a higher mix of Medicare and Medicaid patients; and the rural areas, while it is not always the case, they tend to be smaller clinics, which makes them far more sensitive to cost increases because they can't spread their overhead as well.

So, it is a dramatically changing situation and one that we think is not a sustainable business model for us.

Chairman JOHNSON. That is interesting because really what you are saying is—because I think this is not untrue throughout the sector—the reimbursement system is pushing us toward national change. This is because the freestanding "little guy" has less ability to sustain the ups and downs of either patient mix or the relationship between patient mix and reimbursement units or fluctuations in costs. This does concern me. I have seen this in a number of areas, and I don't think that is in our interest.

Incidentally, we are sending a letter to the Secretary to get that report, because it will be very helpful to us. Mr. Stark.

Mr. STARK. Thank you, Chairman. I guess I would be surprised if any of the testimony was any different. I have been listening to this testimony from providers somewhat longer than the Chair, and I have never ever heard a provider come before us and suggest that we were paying them enough. So, it makes sense.

Mr. Barry, based on your cost reports, your inpatient Medicare margin is 18 percent. Your overall margin is almost 6.5 percent. Your occupancy rate is above the national average, 73 percent. Why should we pay you any more?

Mr. BARRY. You must be looking at old data.

Mr. STARK. It is the same data you used in your testimony, 1999 data. You used the same data.

Mr. BARRY. You mean the Moses Cone system?

Mr. STARK. Yes.

Mr. BARRY. I have the data with me, and I will be glad to supply it to you. As I said in my testimony, this past year, fiscal year 2002, we received 96.7 cents on every $1 of Medicare costs.

Mr. STARK. Did you say you have a negative Medicare margin this year?

Mr. BARRY. Yes, sir.

Mr. STARK. What is your average for the past couple of years?

Mr. BARRY. That I can't tell you.

Mr. STARK. That is inpatient? Outpatient?

Mr. BARRY. That is both inpatient and outpatient.

Mr. STARK. What is your inpatient margin?

Chairman JOHNSON. Would the gentleman yield? We just had Mr. Hackbarth say that we should be looking at total margins and not just at inpatient. We would love to look——

Mr. STARK. You didn't like what Mr. Hackbarth had to say——

Chairman JOHNSON. I didn't like a lot of what he had to say, but I thought it was interesting that he admitted that we should look at total——

Mr. STARK. Don't just use them when it is convenient. I am just looking at inpatient margins, and I suspect there aren't many hospitals in North Carolina that have negative inpatient margins, but what do you think a Medicare inpatient margin should be?

Mr. BARRY. I think it ought to be at least at cost.

Mr. STARK. What should the margin be—1 percent, 2 percent, 10 percent?

Mr. BARRY. I think 1 percent or 2 percent would be fine. I would be happy with that personally, if that is what you are asking me.

Mr. STARK. Come on. Higher than that. The margins are far higher than that. If you want to, I will stipulate that we could take 1 or 2 percent and save Medicare a lot of money, but I don't think you want to go back to your hospital association——

Mr. BARRY. As I said earlier, 57 percent of the hospitals in 2001 were paid less than their costs on Medicare patients. Again, that takes all Medicare—inpatient, outpatient—into account.

Mr. STARK. Dr. Plested, if I could digress for a moment, I can't resist because you are a cardiologist practicing in California?

Dr. PLESTED. I am a cardiac surgeon.

Mr. STARK. Do you think you should clean up your own house in California? In other words, I will get right to it. Have you taken any action to get rid of Dr. Moon in Redding?

Dr. PLESTED. The AMA has no power to do anything with Dr. Moon. I can tell you, sir, that nobody, nobody in this country thinks less of a poor physician than physicians. Through our legal system, we are not allowed to do anything other than appear before governmental institutions to testify, and we cannot bring this type of an action ourselves.

Mr. STARK. You are familiar with his case?

Dr. PLESTED. Yes, sir, I am.

Mr. STARK. I trust you think that is not something that the profession should be proud of.

Dr. PLESTED. Absolutely. We are not proud of it at all.

Mr. STARK. It is troublesome, and I hope you will help us in any way we can, because it is only the occasional person that gives it all a bad record, and I would like to get rid—the other issue is that

I want to make clear that the reduction in the physician payment structure which—I happen to believe the formula should be corrected, but I want to make clear that that was a per procedure reduction; is that not right?

Dr. PLESTED. The decrease that came about with the mistake in the SGR? I believe that is the case, sir.

Mr. STARK. That in many cases, it is conceivable that physicians could have earned more money or had a higher gross income if they done more procedures?

Dr. PLESTED. That is a fair assumption.

Mr. STARK. Okay. So, that—and we are having some trouble—and as a matter of fact, there are some of us who think that is fair. As you have higher technology, which Mrs. Johnson would like to—years ago, cataract surgery was maybe $1,800. As they got lasers and got more skilled at it and it took less time to train, I think we cut the price to maybe $1,200, which was still maybe a reasonable payment, but we got some of the advantage of productivity, and I think that is a fair trade.

I just wanted to suggest that it is possible that some physicians made as much money, or more, even though there was this incorrect reduction in the per procedure fee.

Dr. PLESTED. I certainly agree with you. What we are interested in, of course, is fair payment.

Mr. STARK. Now, in getting to that, your colleagues in California were very helpful and very forthcoming, as we Californians always are.

I asked—and I asked this before; this is in, I think—I think this is probably 2001 data, but just a couple of procedures. We were not the bad guys, and I am just going to quickly go through this.

In Sonoma County, for dermatology, new patient routines, the Medicare rate was $101.82. The average private HMO rate was $98. Established patient routine, we were $56.54. The HMO rate was only—was $58, $2 higher.

A hip replacement, for example, in Santa Clara County, our rate was $1,697.67. The average HMO rate was $1,600. They tend to follow us anyway.

If I knew what this was, an arthroscopic knee. I don't know if that is a new knee or replacing it, but we were within $1.

For your primary care brethren in Alameda County, my home county, new patient routine, the Medicare rate is $102; the average HMO rate, $67. Established patient routine, $57 for us, $41 for HMO. Established patient extended visit was $88.94 for Medicare, $52 for HMOs.

So, I wanted to get this in the record only to suggest that we are not always—and I am sure you would agree that Medi-Cal pays less than either of those and causes in your profession, in and for hospitals, real concern.

So, while I am perfectly willing to help SNFs or others, this is all taxpayers' money. Ms. Ousley, I would suspect that your group strenuously opposes the President's suggestion for block granting Medicaid; is that correct?

Ms. OUSLEY. I would say—or I personally have just started to look at that proposal, just reading part of it coming up on the plane. I would say that at this point in time with that very prelimi-

nary review, we certainly have some very, very major concerns about whether or not that would deal with the issues for our residents, and just don't think it would shore up what we have detailed today as the significant problems in Medicaid reimbursement.

Mr. STARK. If could address Ms. Severyn's concern in her excellent testimony, and if the Chair will indulge me for another minute or two.

Dr. Plested, do you think, if we are not there now, that we are approaching the time in overall medical care where prescription drug protocols will be equally as important to a physician as a hospital facility?

Dr. PLESTED. I think we are definitely approaching that time rapidly. There are other factors we have to consider.

Mr. STARK. That may not have been the case 20 years ago, but it is becoming a major part of tools for you to use in your practice of medicine?

Dr. PLESTED. Yes, sir.

Mr. STARK. Ms. Severyn was suggesting to us, if we are going to have a Medicare payment system to provide for our seniors, that we are kind of—we have got a three-legged stool there at least, and we are kind of hobbling along on two legs; and decent medical care requires that we provide as part of the protocol for the quality care that we pride ourselves in in this country that we get to a prescription drug benefit.

I appreciate your taking the time, Ms. Severyn, to come in and present your position, which is also one that AARP presents. I appreciate all of you taking the time. I wish we had enough money—and we don't—to correct the problems that may be covered by—whether it is Medicaid that is causing the problem or whether it is aggressive private insurance companies or managed care plans or anything else, we have to do that as an entire government payment plan.

Then I don't suppose you care where the money comes from. You would just be happy if we raised Medicaid, wouldn't you? So, while we recognize that we may be the next best source for visiting nurses or SNFs, we also have to take care of Dr. Plested's Members and Mr. Barry's Members, and the dream that Ms. Severyn represents for the seniors, who would like to be included. If we are going to cut Medicaid, which is being done and the States are all in financial trouble, I am not sure we can do all of that just through the part A, part B, and what hopefully will be the new drug system, but we will try.

Thank you for coming and thank you, Chairman, for the hearing.

Chairman JOHNSON. I thank you all for coming.

I would like to end on a note that I think reflects my state of mind. There was an article in the New England Journal about a month ago called the Homeostasis of Medicine Today, and it goes through all the changes in law, I mean major changes in law, that have affected our medical delivery system in recent years. It makes, I think, a very compelling case for the fact that we have made it through an awful lot of change. However, the balance within the system is far more delicate, the stability of individual providers is far more fragile.

The message, to me, was very clear. If we make a mistake now of serious proportions, either in a reimbursement rate setting or in the way we change the law, we will have consequences on the system that will be irreversible. I think if we hadn't done something about physician payments, for example, we would have lost many, many physicians who have 10 good years of practice left in them.

Just as serious, our failure to wait until the 11th hour, one might even have said the 12th hour, is discouraging young people from going into medicine. It is preventing our filling certain kinds of residencies.

It is having an impact already on the future quality of our health care system, and unless we straighten up and get some formulas out there that are fair, and get a system that can run without Congress' passing a bill every year, you are not going to have the quality of people going into medicine, the quality of administrators and small businesspeople opening home health agencies, or small nursing homes that have been typical of the care system.

In the end, that is what it is, it is primarily about care of people with needs. We will erode the quality of the human beings we are attracting into health care if we cannot create a health care system that runs more fairly and without congressional intervention every single year.

I think often about that issue of homeostasis. It is true, your body has it. If you are in good shape, you can take exposure to diseases. If you have one illness, you are more likely to get another, and after awhile, you are just vulnerable to anything that comes along small, medium, or large.

I consider this a very serious moment right now, and I think your testimony reflected your concern and frustration with formulas and the reality that you face in which nursing costs are rising rapidly and insurance costs are rising rapidly. Fuel costs are now going to rise rapidly; technology costs are rising rapidly.

We have made the system far more complicated with the Health Insurance Portability and Accountability Act 1996 (P.L. 104–191) and every other law, and so on and so forth. That is the reality. So, we need to work closely together and see if we can't get through this period well. I think the next round will give us an opportunity, on the basis of far more sophisticated technological capability in medicine, to provide better quality care and managed care in such a way that we can also control costs.

So, I think the future out there is enormously positive, and I think the present is extraordinarily dangerous.

Chairman JOHNSON. I thank you for your testimony and look forward to working with you.

[Whereupon, at 4:30 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of David Shapiro, M.D., American Association of Ambulatory Surgery Center, Johnson City, Tennessee

The American Association of Ambulatory Surgery Centers is delighted to provide this statement concerning the Medicare Payment Advisory Commission's (MedPAC) recommendations regarding Medicare payments for services furnished in ambulatory surgery centers (ASCs). Our members either own or perform surgery in Medicare-certified ASCs. As such, our membership is very interested in potential changes to Medicare reimbursement for services furnished in ASCs.

AAASC is a professional medical association of physicians, nurses, and administrators who specialize in providing surgical procedures in cost-effective outpatient environments, primarily in Medicare-certified ASCs. For more than twenty years, ASCs have offered Medicare beneficiaries patient-friendly, cost-efficient, and high-quality alternatives for surgical services, and saved the Medicare program literally billions of dollars in the process.

ASCs save the Medicare program hundreds of millions of dollars each year. Medicare payments to ASCs for outpatient surgical procedures are usually substantially lower than payments to hospitals (both on an inpatient and outpatient basis). Moreover, ASCs have brought the benefits of competition to the entire outpatient surgery market: the opening of an ASC in a particular area has frequently been followed by a significant reduction in the charges of local hospitals for outpatient surgery, as well as increased attention on the part of the hospitals to quality of care and patient satisfaction.

MedPAC's March 1st report to Congress, and subsequent testimony before the House Ways & Means Subcommittee on Health made three recommendations with respect to ASCs. This statement seeks to provide the Subcommittee with supplemental information that it should consider when evaluating MedPAC's recommendations.

Recommendation 1: The Secretary should expedite the collection of recent ASC charge and cost data for the purpose of analyzing and revising the ASC payment system.

AAASC agrees with MedPAC's recommendation. Congress, MedPAC, and the Centers for Medicare and Medicaid Services (CMS) should have better data for the purpose of analyzing ASC payment rates. In many ways, MedPAC's report and recommendations are unreliable and incredible because the Commission lacked contemporary data on which to evaluate Medicare ASC payment rates. However, for two reasons, AAASC cautions Congress from advancing legislation that requires CMS to collect ASC cost data.

First, Congress need not advance legislation to require CMS to collect ASC facility cost data. Medicare statute (Soc. Sec. Act 1833(i)(2)(A)) already requires that CMS survey ASCs for facility costs every five years. As such, further congressional action on this matter would be redundant.

Second, facility surveys are an impractical way of rebasing ASC payment rates. Past history has shown that CMS is incapable of defining a survey instrument able to accurately capture ASC procedure cost experience. Moreover, most ASCs are insufficiently sophisticated and equipped to accurately respond to such a survey. As such, Congress should not expect, nor urge, CMS to undertake a survey process for the sake of rebasing ASC rates. Congress twice intervened, once in the *Balanced Budget Refinement Act of 1999,* and again in the *Benefits Improvement and Protection Act of 2000,* to prevent CMS from implementing rebased rates proposed in 1998 that were based on the flawed survey and rebasing methodology CMS conducted between 1994 and 1998. *Congress should not conclude from MedPAC's recommendation that a survey of facility costs continues to be the best way to rebase payments to ASCs.*

Rather, Congress and CMS should explore new alternatives to rebasing ASC rates. AAASC has been working collaboratively with CMS since 2000 to identify mutually acceptable alternatives to rebasing ASC rates, and we believe that we may be close to making a recommendation to Congress to implement one such alternative. In the interim period while AAASC and CMS work to develop these alternatives, Congress should refrain from directing CMS to undertake obsolete approaches to rate rebasing.

Recommendation 2: The Congress should eliminate the update to payment rates for ASC services for fiscal year 2004.

AAASC strongly disagrees with this recommendation, and particularly with the bases on which MedPAC reached this recommendation. First, Congress has held ASC payment rates steady for more than 10 years. Although the Medicare statute currently requires CMS to update payment rates to ASCs each year by the consumer price index for urban areas (CPI–U), Congress did not always provide for these inflation adjustments. In fact, the *Omnibus Budget Reconciliation Act of 1993* froze Medicare payments to ASCs for 1994 and 1995. Consequently, ASC payments were not adjusted for inflation, or by any other factor, in those years. The *Balanced Budget Act of 1997* similarly limited Medicare ASC payment updates to CPI–U minus 2% for the period 1998 through 2002. During that five-year period, CMS updated payments by less than 1% in most years, since inflation was so low, and did

not update payments at all in 2000, since CPI was only 2.1%. For these reasons, ASC service payment updates averaged only 1.88 percent per year between 1991 and 2002. By comparison, the hospital market basket index, a measure of health care cost inflation, averaged nearly 3 percent in the last 8 years.

Second, MedPAC's assertion that changes in technology and productivity since 1986 have made procedures less expensive to furnish is unsupported and wrong. While true that some procedures may be furnished faster and more efficiently, input costs for many procedures have continued to increase. Procedures that used to be performed by open techniques, but that may now be done with closed techniques, require expensive scopes and video monitoring equipment. Even common instrumentation, like scalpels, is more expensive now in relative terms. Moreover, rent, labor, and liability insurance costs have continued to inflate, and are largely unaffected by technological advancements.

Third, MedPAC relied considerably on ASC growth statistics, and asserted that recent growth in the number of ASCs is attributable to payment rates that exceed costs. No evidence supporting this proposition was presented. Moreover, there are many explanations why the number of ASCs has grown in recent years.

- The Medicare ASC benefit is only 20-years-old, and so the market is still in a growth phase.
- Many states in recent years have loosened or eliminated certificate of need laws, which previously contained ASC growth. As proof, Congress should take note that ASC growth has been largely focused on a few states where CON laws have been relaxed. In states where CON remains a substantial hurdle, there has been virtually no ASC growth, and remains limited alternatives to hospitals for surgical care.
- Technological advancements—e.g., closed surgical techniques and fast-acting anesthetics—have made it possible for a broader range of procedures to be performed in the ASC setting.
- The number of ASCs has increased commensurate with CMS expanding the list of procedures approved for the ASC setting. In the early years of the ASC benefit, only 400 procedures were covered in the ASC setting. As more procedures have been added, it becomes increasingly feasible for ASCs to operate, and more ASCs are developed.
- ASCs are attractive to the physicians who develop them, because they return control over procedure scheduling to the surgeon. Surgeons develop ASCs because they expect to improve their overall productivity by being able to perform more surgical procedures per day and, thus generating more professional fees.
- Private payors, particularly managed care entities, also are driving ASC growth in many areas, because they recognize the efficiencies and savings inherent in ASC settings.
- Most importantly, patients tend to find ASCs to be friendlier environments, and prefer the convenience and efficiency offered by most ASCs.

MedPAC failed to recognize the limited effect that Medicare rates actually have on growth of ASCs. If, as MedPAC itself says, Medicare accounts for only 20 to 30 percent of revenues received by the largest for profit chain, then clearly Medicare payments cannot be a driver of facility expansion.

Congress should recognize that Medicare payments to ASCs have been held relatively flat in recent years, and therefore should allow CMS to inflate Medicare rates by the CPI for 2004 .

Recommendation 3: Until the Secretary implements a revised ASC payment system, the Congress should ensure that payment rates for ASC procedures do not exceed hospital outpatient PPS rates for those procedures after accounting for differences in the bundle of services covered.

AAASC concurs that there should be more of a relationship between the amounts Medicare pays for outpatient surgical services. AAASC further applauds MedPAC for recognizing that creating greater consistency cannot be achieved through arbitrary across-the-board adjustments, but rather must be achieved only after a careful accounting for differences in the bundle of services reimbursed through each payment system. In considering its recommendation, MedPAC recognized that Congress has ordered CMS to develop payment rates for outpatient surgical services for ASCs, hospitals, and physician offices using different methodologies and data sets, and that each system is designed to reimburse providers for different bundles of services. For example, in addition to the base payment rates for hospital outpatient procedures (which is all that MedPAC examined), hospitals are entitled to numerous payment add-ons and adjustments—*e.g.,* outlier adjustments and drug and device pass-throughs—that inflate the base payment amount. ASCs are not entitled to

these same treatments. The base payment amount made to an ASC is all that the ASC will receive for furnishing that service. Congress should not draw conclusions by comparing base payment rates alone. These differences must be identified, quantified, and evaluated before true relationships can be established across systems.

Nonetheless, AAASC believes that MedPAC substantially underestimated and disregarded numerous other important considerations in making its recommendation. First, MedPAC failed to appreciate that hospital outpatient service payments are not a credible measure of the cost of furnishing hospital outpatient services on a procedure-by-procedure basis. In fact hospital outpatient payment rates are not derived from costs, and they are widely recognized to be less than actual costs in many instances. Consequently, it is irresponsible to compare ASC rates to hospital rates, and conclude that ASC rates are inappropriate simply because they are higher in some instances. This conclusion presupposes that hospital rates in each specific instance are an accurate measure of procedure costs and appropriately reimbursing hospitals, neither of which is a correct presupposition.

Additionally, MedPAC failed to report to Congress the implications of its proposal on single-specialty ASCs. While many ASCs perform procedures of various types—*e.g.*, orthopedic, gastrointestinal, and ophthalmologic—the majority are single specialty, furnishing procedures of only one type. In multi-specialty ASCs, as in the hospital setting, if some Medicare procedure reimbursement amounts are less than costs, the efficient facility should still have a positive net margin, because other procedure payment rates will be higher than costs. The same may not be true for single-specialty ASCs, many of which furnish only a narrow range of procedures, and which therefore cannot cross-subsidize in the same manner.

MedPAC also failed to point out to Congress that hospital payment rates are in flux, and have varied wildly in the first years since the payment system was implemented. MedPAC's comparisons presented a moment-in-time snapshot using only 2003 rates. Where an ASC reimbursement amount may well have been more than the corresponding hospital base payment rate in the year studied, it very well may have been lower in the previous year, and may be lower again the next year. MedPAC should have shown comparisons using 2001 and 2002 rates, too, and, at the very least, pointed out to Congress that hospital outpatient rates have fluctuated significantly in the early years, making a comparison based on one year incomplete.

Congress should not take hasty, arbitrary action to ensure that ASC rates do not exceed hospital rates, or vice versa. Rather, efforts to create a credible relationship between hospital and ASC rates should be done as part of a thoughtful effort to rebase ASC rates, and only after fully accounting for differences in the bundle of services covered, and other differences between the two payment systems.

f

Statement of the American Association of Health Plans

Madam Chair and members of the subcommittee, the American Association of Health Plans (AAHP) appreciates the opportunity to provide a written statement in response to the Medicare Payment Advisory Commission's (MedPAC) March 2003 Report to Congress on Medicare payment policies. AAHP represents more than 1,000 health plans, including HMOs, PPOs, and similar network plans providing coverage to more than 170 million Americans. AAHP member plans are dedicated to a philosophy of care that puts patients first by providing coordinated, comprehensive health care.

MedPAC's March 2003 report includes a chapter on the choices that Medicare beneficiaries currently have to receive care within the Medicare+Choice program. These include Coordinated Care Plans, managed fee-for-service plans, and preferred provider organizations (PPO). MedPAC finds that 80 percent of Medicare beneficiaries currently live in areas where these choices are available. In addition, many Medicare beneficiaries throughout the country purchase Medigap plans, have access to employer-sponsored retiree benefits, and if low-income, may be eligible for their state's Medicaid program. While MedPAC notes that beneficiaries in many areas may have significant choices, those living in other areas may have none. The Commission proposes to study the factors that contribute to the variation of the number of choices available to Medicare beneficiaries in different areas.

The report also notes the concerns with Medicare commonly expressed by managed care plans that have caused a significant number of managed care plans to leave the Medicare program. These include inadequate payment rates, regulatory burdens, and limits on plan benefit design to offer flexible benefits. MedPAC does

not provide recommendations to address these concerns. AAHP believes that certain changes to the Medicare+Choice program must be made to provide more program stability and improve the access beneficiaries have to the high quality, more comprehensive care offered by Medicare+Choice plans.

Medicare+Choice enrollees receive high quality health coverage through Medicare+Choice plans.

Medicare+Choice plans offer a different approach to health care than beneficiaries experience under the Medicare fee-for-service program. Instead of focusing almost exclusively on treating beneficiaries when they are sick or injured, Medicare+Choice plans also place a strong emphasis on preventive health care services that help to keep beneficiaries healthy, detect diseases at an early stage, and avoid preventable illnesses. At the same time, Medicare+Choice plans have improved the overall delivery of health care services by coordinating care through medical professionals who are responsible for coordinating medically appropriate health care services on a timely basis.

Medicare+Choice plans today are delivering more and better coverage—including access to prescription drugs—than the Medicare fee-for-service program:

- A January 2003 report by the Kaiser Family Foundation (KFF) shows that Medicare+Choice—despite being drastically underfunded—generally costs beneficiaries less, charges lower premiums, and provides coverage for services that are not available under Medicare fee-for-service.
- According to an AAHP analysis of data published in the *Journal of the American Medical Association* (JAMA) and data compiled by the National Committee for Quality Assurance (NCQA), Medicare+Choice plans outperform Medicare fee-for-service in five of seven key HEDIS quality measures: beta blockers after heart attacks; annual flu vaccines; breast cancer screenings; diabetes testing; and diabetes lipid screening.

Medicare+Choice plans also introduced the concept of disease management programs to Medicare—improving quality of care for beneficiaries with diabetes and other chronic conditions by focusing on the comprehensive care of patients over time, rather than individual episodes of care. A recent AAHP survey, based on responses from 131 health plans, found that 97 percent have implemented disease management or chronic care programs for diabetes, 86 percent have programs for asthma, and 83 percent have programs for congestive heart failure. Health plans also are developing disease management programs for end-stage renal disease, depression, and cancer.

The Medicare+Choice program serves as an important safety net for low-income and minority Medicare beneficiaries.

Medicare+Choice plans play an important role in providing health coverage to many low-income and minority beneficiaries who cannot afford the high out-of-pocket costs they would incur under the Medicare fee-for-service program. For many beneficiaries who do not receive supplemental coverage through Medicaid or a prior employer, the Medicare+Choice program provides comprehensive, affordable coverage that is not available under the Medicare fee-for-service program.

Medicare+Choice payments are not keeping pace with the rapidly increasing costs of providing health care services to Medicare beneficiaries.

Since 1998, a large proportion of Medicare+Choice beneficiaries have been enrolled in health plans to which payments increased by only the minimum annual update—which has been set at two percent since 1998 (but was temporarily increased to three percent in 2001 only). To underscore the inadequacy of government payments to Medicare+Choice plans, it is useful to compare Medicare+Choice to other government health programs and private sector health coverage. In 2003, funding for the health benefits of all Medicare+Choice enrollees increased by only two percent. The following facts highlight the inadequacy of this increase:

- the Office of Personnel Management (OPM) has estimated that, on a per enrollee average, total premiums collected by health plans in FEHBP increased by **10.5 percent** in 2001 and by **13 percent** in 2002;
- PricewaterhouseCoopers has estimated that health insurance premiums increased by an average of **13.7 percent** for large employers between 2001 and 2002; and
- the William M. Mercer consulting firm has released survey findings showing that spending for employer-sponsored health coverage increased by an average of **11.2 percent** in 2001 and **14.7 percent** in 2002.

These examples raise important concerns about the adequacy of Medicare+Choice payments. Any serious effort to stabilize the Medicare+Choice program must directly address these concerns by committing a significant level of additional funds to support the health benefits of Medicare+Choice enrollees.

Conclusion

AAHP appreciates this opportunity to submit a written statement to the Committee on the March 2003 MedPAC report. We believe the report provides substantial insight—MedPAC fairly represents our members' concerns with the Medicare+Choice program and the report's discussion of the impact of local factors, including regulatory environments, is extremely useful.

We look forward to working with MedPAC and Congress to address the problems that MedPAC identifies and improve the choices available to Medicare beneficiaries. Over the past two years, more than 120 Members of Congress—including 79 Democrats and 43 Republicans—have cosponsored bills or signed letters indicating their support for legislation to address the Medicare+Choice funding crisis. The Bush Administration has also proposed additional funding to stabilize the Medicare+Choice program. Building upon this strong base of bipartisan support, it is critically important for Congress to pass legislation to provide additional funding to protect the health care choices and benefits of Medicare+Choice enrollees.

f

Statement of the American College of Surgeons

The American College of Surgeons—an organization representing more than 64,000 surgeons dedicated to accessible, high-quality care for surgical patients—is grateful to Chairman Thomas, Chairwoman Johnson, and the other distinguished Members of the Ways and Means Committee who worked diligently to avert the 4.4 percent physician payment cut that was scheduled to take effect this week. By providing the Centers for Medicare and Medicaid Services (CMS) with the legal protection to correct faulty data from projections made about gross domestic product (GDP) and fee-for-service enrollment growth for 1998 and 1999, your work guaranteed a 1.6 percent increase in physician payments. Surgeons historically have had particularly high Medicare participation rates. Your advocacy takes an important first step in guaranteeing the profession's continued participation in the program.

We are pleased that the subcommittee is hosting this hearing on the Medicare Payment Advisory Commission's (MedPAC) report on Medicare payment policies. Unfortunately, MedPAC fails to adequately address our concerns in two important ways. First, it inappropriately stresses the importance of data regarding physician participation as an indicator of patient access. Second, its treatment of rising liability premiums is at best cursory. It is within this context that we offer the following comments.

The emerging access issue

Over the last 15 years, Medicare reimbursements for surgical services have declined steeply. Indeed, payments for many surgical procedures are now less than half of what they were before the current physician payment system was implemented in 1992 (in actual dollar amounts, without any adjustments made for inflation). Because the price of medical liability insurance and other practice costs continue to escalate, surgeons and other physicians find themselves struggling to keep up with the demands of an aging population.

Physician practices are essentially small businesses. As is true for many small enterprises, there are limited options available to physician practices for reducing overhead costs. Unlike other business, however, when faced with decreasing income and soaring expenses, doctors cannot simply charge higher rates for their services. To keep the operating doors open, practices must make tough choices. Some delay the purchase of new equipment. Others reduce the size of their staff. Many increase the percentage of non-Medicare patients they see.

While we were pleased to avoid another payment cut, it is important to recognize that a 1.6 percent increase does not keep pace with the inflationary costs of operating a practice. And, for surgical specialties in particular, the more recent crisis in the Medicare payment system comes on the heels of a series of steep reductions that were implemented over the past decade. For most surgical practices, there simply aren't too many cost cutting options left.

Those who are skeptical about the need to increase funding for physician payment often cite the high participation level in the Medicare program as evidence that re-

imbursement rates are at least adequate. MedPAC frequently looks to the number of participating physicians as an indicator of payment adequacy. Analysis of payment adequacy, however, is subtler.

MedPAC relies on the fact that physicians are participating or that they continue to accept Medicare, managed care, and other private plan payment rates. This analysis, still, overlooks the important point of the unequal contractual relationship between physicians and payors. For example, a vascular surgeon has no choice but to see Medicare patients if he or she wants to remain in practice. They comprise the majority of a vascular surgeon's practice.

MedPAC also notes that since 1994 Medicare payment rates have remained competitive with private plan rates. This ignores the fact that the fee schedule has been adopted increasingly by private payors since its phased implementation by Medicare began in 1992 causing payments to track more closely. There may be a causal relationship here that their analysis fails to address.

Additionally, MedPAC relies on the fact that more physicians see Medicare patients than Medicaid patients. They note as an examples that finding referrals for Medicare patients is easier than for Medicaid patients. Again, the analysis here could go deeper. It may be possible that Medicaid access problems are becoming more apparent because rates paid by Medicare and others are falling. Since few earn their living caring for Medicaid patients to begin with, this population is easier to drop as the cross-subsidization of their care by other payors such as Medicare continues to erode. We are troubled by this and see it as a precursor of emerging access problems for patients covered by other plans like Medicare.

True, most surgeons will continue see some Medicare patients even as rates continue to fall. It is difficult for physicians to sever long-standing relationships with their patients. More telling, however, is the number of physicians accepting new Medicare patients into their practices. As more and more doctors curtail the time they devote to Medicare patients, seniors and disabled patients will wait even longer to visit a specialist. Moreover, like Medicaid providers, they will struggle to find physicians available for referrals for follow-up chronic care.

One problem associated with decreasing reimbursements is especially acute within the surgical community. The number of physicians who elect to practice surgery is declining. Many variables enter into a medical student's choice of specialty. Among these factors is the viability of maintaining a practice. As reimbursements fail to keep pace with inflation, so too do the number of applicants interested in pursuing surgery. For example, following the most recent residency match, 15 percent of the positions in thoracic surgery went unfilled. Similarly, a significant number of openings in general surgery and neurosurgery remained unsatisfied.

Underserved communities that traditionally struggle to recruit and retain physicians are particularly hard hit. Expanding the number of patients seen is one of the most common means to bolstering a beleaguered practice—an option that often cannot be exercised in sparsely populated communities. Rural areas find it particularly challenging to attract young specialists, again because they cannot supply a sufficient patient base. Never are the consequences more dire than for trauma patients in underserved areas. The inability to sufficiently staff hospitals in emergency situations is one of the ripple effects of cost-cutting in physician reimbursement.

Not only are we seeing a decline in the number of young surgeons, the ranks of older surgeons are beginning to diminish as well. Faced with lagging reimbursement rates and dramatically increasing liability premiums, many of our most experienced surgeons are pursuing early retirement. As the number of Medicare patients continues to increase in our aging population, conversely the number of seasoned surgeons is decreasing, further exacerbating all of the problems associated with access to care.

The College implores Congress to work with CMS to keep physician participation in Medicare at optimal levels. We suggest two areas for Congressional action. First, as part of on ongoing effort to reform the Medicare physician payment update system, Congress should urge CMS to revise the SGR formula to reflect changes in Medicare benefits that are attributable to national coverage decisions. Second, Congress must examine the adequacy of Medicare reimbursement for physician liability insurance costs and urge CMS to make necessary revisions in the malpractice relative value units (RVUs) in time for implementation with the 2004 Medicare fee schedule.

1. Congress should urge CMS to revise the SGR to reflect changes in Medicare benefits that are attributable to national decisions.

The ultimate solution to the update problem is for Congress to fix the flawed formula that is used today to calculate the annual changes made to the conversion fac-

tor. Physicians are the only provider group that has payment update that reflects a sustainable growth rate or SGR, and the formula has other parts that are faulty—such as its use of gross domestic product (GDP) growth as an "affordability" factor. One thing CMS can do, though, is to adjust the SGR formula to reflect changes in Medicare benefits that are attributable to national coverage decisions. (Of course, there are many other problems with the SGR formula that Congress and CMS need to pursue, as well.)

Although one component of the SGR reflects changes in law *and* regulation, CMS currently only includes changes in program benefits that are attributable to legislation. By excluding important benefit expansions that are made through national coverage decisions, CMS compares actual expenditure data that include these services against a spending target that does not include them, making it more likely that the target will be exceeded. We urge Congress to work with CMS to correct the SGR formula.

2. To ensure that reimbursement adequately encompasses liability premium costs, Congress must urge CMS to make necessary revisions in the malpractice expense RVUs in the final rule for the 2004 fee schedule. Additionally, Congress should recommend the immediate public release of the most current professional liability data. Furthermore, Congress should also consider new mechanisms for ensuring that Medicare payments for physician liability costs are adequate.

The growing cost of liability insurance is a primary concern for most surgeons, and for many other specialists, as well. In a growing number of states, surgeons are having difficulty obtaining medical liability insurance, and for those who are able to find coverage the cost is often prohibitively high. The large premium increases and declining number of liability insurance carriers are forcing many surgeons to make difficult decisions about limiting the scope of their practice, moving to other states, or retiring early. Medicare payment cuts only add more financial pressure to make these decisions.

For most surgeons, the increases are quite tangible. In Broward County, Florida, for example, the premium of a general surgeon was $67,647 in 2001. In 2002 that surgeon's premium rose to $108.997—a 61 percent increase. In Ohio, the premium for an obstetrician-gynecologist was $95,310 in 2001. In 2002 that physician paid a $152,496 premium—a 60 percent increase. According to the *Medical Liability Monitor*, an independent trade publication, the median increase in premiums for general surgeons was 29.1 percent last year.

The College appreciates CMS' recognition of the growing liability crisis and is pleased that the agency has responded by implementing an increase in the Medicare Economic Index (MEI) update for professional liability insurance of 11.3 percent in the 2003 Physician Fee Schedule. While we support this increase, there is a heightened concern that specialties being hit the hardest by rising insurance costs are not getting the help they need.

MedPAC fails to take into consideration that those specialties experiencing the greatest liability premium hikes are coincidently the same groups who have been experiencing net pay decreases for a number of years. This results from the transition to a single conversion factor, followed by the phase-in to the generally lower resource-based practice expenses. Certain surgical specialties—such as neurosurgeons, general surgeons, thoracic surgeons, and those in obstetrics-gynecology and orthopaedics—pay the highest premiums as a matter of course and are suffering disproportionately from the current escalation in premium rates. Yet, any MEI adjustment applies broadly and cannot direct funds to those who are actually experiencing these increases—even if the faulty SGR system did not eliminate the benefits of such an adjustment entirely.

This may be the best place to note that MedPAC imprecisely restricts its comments of increasing liability premium costs to its discussion of the MEI. As stated previously, we appreciate the 11.3 percent increase in 2003, but it in no way results in a payment increase commensurate with the added cost that many are experiencing—even if the update were set at the MEI with no SGR performance adjustment. Since the MEI applies equally to all fee schedule services, it does not channel new money to those who are actually providing the higher "resource inputs" by paying higher premiums.

We cannot emphasize enough how important it is to address this problem and ensure that the resource-based payment system reflects the costs involved. Professional liability premiums are a major resource "input," the cost of which falls outside physicians' control. Further, as press reports have shown, the recent escalation

in these costs is starting to have a significant adverse impact on access to many important services. Since the Medicare fee schedule is used as the basis for determining payments for many insurers, it is critical for the entire health care system—not just Medicare—to account for these costs appropriately.

We are concerned that CMS has not devoted the staff and resources necessary to assure that the relative value units for malpractice truly reflect the relative costs associated with liability premiums. To some extent this is understandable, given the resources that must be devoted to the physician work and practice expense portions of the fee schedule. The College strongly supports the HEALTH Act, HR 5, legislation to stabilize volatile jury awards and rising premiums. Until that meaningful liability reform is enacted the liability crisis will persist, and it must be addressed immediately.

Section 1848(c)(2)(B)(i) of the Social Security Act requires that "The Secretary, not less often than every 5 years, shall review the relative values established under this paragraph for all physicians' services." The current resource-based malpractice expense RVUs were implemented on January 1, 2000. Therefore, the resource-based malpractice expense RVUs resulting from a 5-year review must be implemented on January 1, 2005. That may seem like a long way off—but the reality is that the refinement of malpractice RVUs should already be well under way. Therefore, it is essential that the proposed rule for 2004 address the refinement of the malpractice RVUs. We believe the agency should present options and invite public comment on various approaches to refinement.

The College is involved in its own development and analysis of various alternatives. As part of our process, we believe it is essential that we have access to the data used by CMS in the calculation of the 2003 MEI update. In the final rule for the 2003 fee schedule, CMS stated that the professional liability data used to develop the 2003 MEI update was based on premium rates effective as of June 2002. These data included both the premium amount and effective date, which CMS used to create a quarterly time series. Thus, the professional liability insurance component of the 2003 MEI update includes effective premium rates through the second quarter of 2002.

We have requested this data, but to date it has not been provided to us. **We ask Congress to request the immediate public release of this current professional liability data to facilitate the development and review of various options for refining the malpractice expense RVUs.**

Finally, we are so concerned about the impact of rising premiums that we believe CMS must be prepared to make necessary revisions in the malpractice expense RVUs in the final rule for the 2004 fee schedule. While the statute requires that refinement must take place by 2005, the actual wording of the statute is "not less often than every 5 years." CMS has the flexibility to revise the RVUs in 2004. **In light of the crisis created by the dramatic increase in liability premiums for many critical specialties, we ask Congress to call on CMS to include in the proposed rule for 2004, an explicit request for comments on the appropriateness of refining the malpractice expense RVUs in 2004, rather than 2005.**

Conclusion

One of the greatest achievements of the Medicare program is the access to high-quality care it has brought to our nation's senior and disabled patients. This level of access cannot be expected to continue uninterrupted in the face of continued cuts and ballooning liability premiums. We cannot emphasize enough how important it is for this Subcommittee to take steps to ensure that physician payment adequately reflects the cost of doing business.

Thank you for your consideration of Medicare payment policies, including the adequacy of reimbursement for physicians. The College appreciates this opportunity to present its views and looks forward to working with you to ensure continued access to Medicare.

f

Statement of the American Gastroenterological Association, Bethesda, Maryland

The American Gastroenterological Association ("AGA") is pleased to submit testimony concerning the Medicare Payment Advisory Commission's ("MedPAC") recommendations on Medicare payments for services performed by physicians in ambulatory surgery centers ("ASCs"). The AGA is the nation's oldest not-for-profit med-

ical specialty society, representing more than 12,500 physicians and scientists worldwide who are dedicated to the prevention, treatment and cure of digestive diseases.

MedPAC RECOMMENDATIONS

I. Physician Payment Update Recommendation

Congress should update payments for physician services by the projected change in the input prices, less an adjustment for productivity growth of 0.9% for 2004.

In addition to a physician payment update for 2004 that keeps pace with inflation, MedPAC also recommended that the sustainable growth rate be replaced with a system where updates are based on an assessment of increased practice costs, adequacy of payment, and beneficiaries' access to care. AGA and the greater medical professional community supports this recommendation and wishes to work with Members of the Committee to reform the physician payment update formula to achieve equitable physician payment rates.

AGA is thankful to Congress in general and the members of the Ways and Means Health Subcommittee in particular for mitigating the physician payment update crisis by enacting H.R. Res. 2, which contained a provision to avert a Medicare payment cut that would have jeopardized access to physicians' services for Medicare beneficiaries. Without this remedy, physicians could have been forced to limit or discontinue services to our nation's seniors.

II. Ambulatory Surgery Center Recommendations

A. The Secretary should expedite the collection of recent ASC charge and cost data for the purposes of analyzing and revising the ASC payment system.

There is no question that better data is needed to analyze the appropriateness and equity of ASC payment rates. In fact, AGA is concerned that MedPAC's recent report and subsequent recommendations relied on obsolete data when evaluating Medicare ASC payment rates.

However, rather than taking legislative action to require CMS to collect ASC cost data, Congress should direct CMS to attentively adhere to current Medicare statute. Medicare statute already directs CMS to survey ASCs for facility costs every five years. Further congressional action would be duplicative and confusing.

Additionally, Congress should not take action to require CMS to further use facility surveys to rebase ASC rates. Relying on facility surveys as an instrument to accurately determine ASC procedure costs has proved to be an impractical means of rebasing ASC payment rates. Congress twice intervened in 1999 and 2000 to prevent CMS from implementing rebased rates that were developed using flawed survey methodology. One reason such surveys have repeatedly failed to capture accurate cost data is because most ASCs are not properly equipped to respond to such a survey.

Instead, Congress should consider new approaches to rebase ASC rates, and urge CMS to work collaboratively with the ASC community to develop methods to accurately capture ASC procedure cost experience and rebase ASC rates. Until a more accurate data collection method is determined, attempts to rebase rates based on obsolete approaches will continue to be inadequate.

B. Congress should eliminate the update to payment rates for ASC services for fiscal year 2004.

AGA does not agree with this recommendation and challenges the rational MedPAC used to reach it. To reach this recommendation, MedPAC made assumptions based on ASC growth statistics, yet did not support the assumptions with evidence. MedPAC concluded that the growth in the number of ASCs is attributable to payment rates that exceed procedure costs.

There are several reasons why the number of ASCs has grown, including the following:

- Technological advancements, including closed surgical techniques—e.g. colonoscopy and endoscopy—and fast-acting anesthetics have made it possible for a broader range of procedures to be performed safely in the ASC setting.
- The number of ASCs has increased proportionally to CMS expanding the list of procedures approved for the ASC setting. As CMS expands this list, it is rea-

sonable to expect that it becomes increasingly feasible for an ASC to operate, modestly sustain itself, and for more ASCs to develop as a result.
- ASCs are attractive to physicians, because they return control over procedure scheduling to the physician. Because of scheduling efficiencies, surgeons are able to perform more surgical procedures per day in the ASC setting and thus provide services in a more efficient and cost-effective manner.
- Managed care entities, including those that participate in the M+C program, are also driving ASC growth, because they recognize the efficiencies and savings inherent in the ASC setting.

Medicare payments to ASCs have been held relatively constant in recent years. In fact, the Balanced Budget Act of 1997 limited Medicare ASC payment updates to the consumer price index for urban areas minus 2% for the period 1998–2002. Therefore, Congress should inflate, rather than eliminate, the update to ASC payment rates for fiscal year 2004, considering the treatment of ASCs in 1998–2002.

C. Until the Secretary implements a revised ASC payment system, the Congress shold ensure that payment rates for ASC procedures do not exceed hospital outpatient PPS rates for those procedures after accounting for differences in the bundle of services covered.

AGA appreciates that MedPAC recognized that creating greater consistency between what Medicare pays for procedures performed in the HOPD and the ASC setting must not be achieved through arbitrary across-the-board adjustments that fail to account for inherent differences in the current payment schematic used to reimburse hospitals and ASCs. Oftentimes, HOPD base payments paint an inaccurate picture of procedure-by-procedure payments, because hospitals are eligible to bill for services that ASCs cannot. Also, hospitals are entitled to supplemental payments and add-ons that ASCs are not.

Additionally, AGA is disappointed that MedPAC compared only 2003 HOPD and ASC rates. Hospital payment rates have varied from year to year. In 2003, an ASC payment rate may have been higher than the HOPD rate. However, the HOPD rate may have been higher in previous years and could be higher in the future. For example, in 2001 HOPDs were paid $396 for three common gastroenterological procedures (diagnostic colonoscopy, colonoscopy with lesion removal and colonoscopy with bioposy), in 2002 the rate for the same procedures fell 6.5% to $372, then in 2003 those rates increased 11% to $413. A comparison based on only one year's rate differences is deficient.

This recommendation also fails to consider the impact on single-specialty ASCs, such as those furnishing only gastroenterological procedures. It is crucial to note that the majority of ASCs are single-specialty. Therefore, if Medicare procedure reimbursement amounts are less than actual costs, a single-specialty ASC would risk having a negative net margin, because unlike multi-specialty ASCs, there is no opportunity for cross-subsidizing less-than-cost procedure reimbursements with other procedure payment rates.

AGA urges Congress not to take sudden action to standardize payment rates between HOPDs and ASCs. Congress should first examine the two settings and consider the similarities and differences. Once that is achieved, ASC rates can be effectively rebased while maintaining the patient-friendly, cost-efficient, and high-quality nature of ASCs.

f

American Society for Gastrointestinal Endoscopy
Oak Brook, Illinois, 60523
March 19, 2003

The Honorable Nancy Johnson
Chair, Subcommittee on Health
Committee on Ways and Means
1136 Longworth House Office Building
Washington, D.C. 20515

Dear Representative Johnson:

On behalf of the American Society for Gastrointestinal Endoscopy (ASGE), I am pleased to submit this statement for the record of the Subcommittee's March 6 hearing on the recommendations of the Medicare Payment Advisory Commission (MedPAC). I request that this statement be made part of the formal hearing record.

ASGE represents more than 7,500 physicians who specialize in the use of endoscopy to diagnose and treat gastrointestinal diseases and conditions. For example,

they use colonoscopy to screen for colo-rectal cancer. Early identification and removal of precancerous polyps can prevent the development of this fatal cancer in almost all cases.

Many of the procedures performed by ASGE members require the use of moderate, or conscious, sedation. In a few cases, even deeper sedation may be required for certain patients. Gastroenterologists, and other physicians who perform these procedures, have found that the ambulatory surgery center (ASC) is an appropriate setting for these services. The regulatory requirements imposed on ASCs by states and Medicare help assure a safe environment for the patient undergoing one of these procedures. Approximately 40% of Medicare endoscopies are performed in ASCs. The balance of the procedures requiring sedation are conducted in the hospital outpatient department. Most physician offices do not meet the safety standards that exist in the ASC and the outpatient department; therefore, few endoscopic procedures requiring conscious sedation are performed in that setting.

Because of the safety, efficiency and cost effectiveness of the ASC, it has become an important part of modern GI practice. Patients often prefer this setting to the hospital, and the co-payments for Medicare patients are generally much lower in the ASC than in the hospital outpatient department. This cost savings to the Medicare patient is an added reason that patients and physicians have found the ASC to be an excellent site for the delivery of GI endoscopy.

Therefore, we are deeply concerned by the Medicare payment reductions recommended by MedPAC. The Commission has made three recommendations to Congress regarding ASC payments. First, MedPAC recommended that the Department of Health and Human Services collect up to date ASC cost information in order to be able to establish appropriate payment rates for the services provided in this setting. Second, the Commissioners suggested that ASCs receive no update in their payments for fiscal year 2004. Third, they have urged that the payment rate for any ASC procedure not exceed the payment for the same procedure in the hospital outpatient department.

ASGE supports the first recommendation. The Centers for Medicare and Medicaid Services (CMS) has failed to comply with the statutory requirement that the agency survey ASCs every five years to determine the costs of providing services. As MedPAC correctly noted, ASCs are paid on the basis of data collected in 1988, updated occasionally for inflation. The list of covered procedures has not been updated since 1995, even though the agency is required to do so every two years. The 1993–1994 survey which was used as a basis for the proposed rule in 1998 was a failure and could not be relied on. Congress recognized this problem and has twice since then passed legislation intended to assure the collection of accurate and current cost information. However, CMS has yet to resurvey ASCs. ASGE urges the Subcommittee to push the agency to meet its statutory obligations. If the agency cannot meet these basic requirements, then Congress should work with the various ASC stakeholders to develop an alternative system that will be reliable and current.

As the transcripts of the November, December and January Commission meetings reflect, MedPAC has no information on the costs of providing services to Medicare beneficiaries in ASCs. We simply cannot understand how the commissioners could favor a proposal that would reduce Medicare reimbursements by an estimated seven percent in the absence of cost data demonstrating convincingly that Medicare payments across all ASC services were excessive. ASGE urges Congress to make certain that it has the information that can help the Members better understand the nature and cost of the services provided in the ASC before addressing the appropriateness of reimbursement in that setting.

In the absence of any cost data supporting MedPAC's action, the Commission made the argument that Medicare payments are excessive because corporate ASC systems are favored by Wall Street and have access to adequate capital. We would argue that quite the opposite is true. Private payers have recognized the value of ASCs and reimburse appropriately for their services. Medicare payment is, as is most often the case, low, and the costs of elderly patients are subsidized by private insurance. Any favorable consideration by the markets is driven by the rate of private health plan payment, not Medicare's rates. Across the ASC industry, Medicare represents less than 30% of total revenue. We urge the Subcommittee to reject this analysis as a basis for ASC rate setting in the Medicare program.

We also object to the proposal that ASCs receive no update in fiscal year 2004. This update is equal to the CPI–U, except in years when CMS rebases rates based on the cost survey. In the last ten years, ASCs have received the full update only four times. In all other years, the update has either been eliminated or restricted by Congressional action. For example, the Balanced Budget Act of 1997 restrained the annual update in ASC payments to CPI minus two percentage points. Effectively, there was almost no update of rates for five years. In fiscal year 2003 that

provision expired, and ASCs received the full update of three percent. This increase was also lower than the increase granted to hospitals for the 2003 hospital outpatient department prospective payment system (HOPD PPS).

ASCs have experienced significant cost increases in many operational areas. Liability insurance premiums have grown significantly in most states, and labor costs, particularly for nursing, have increased substantially. New medical technology, while often very beneficial to the patient, is not inexpensive and the pace of technological change is very rapid. Medicare payments for ASCs are not keeping pace with changing costs. The full inflation update, currently estimated to be 2.7 percent for fiscal year 2004, is badly needed by our centers to help offset some of these cost increases.

ASGE can accept the principle that ASC rates ought not to exceed HOPD rates for the same procedures. However, the comparison of ASC rates to HOPD rates, as if the HOPD PPS were the gold standard of payment, also lacks credibility. The legal bases for determining the rates in both settings are very different. In fact, the ASC payment system is among the earliest prospective payment systems in Medicare. In virtually every other area of Medicare reimbursement, Congress has copied its success. The HOPD PPS is of much more recent vintage and the data sources (hospital cost reports instead of cost surveys) are very different. Even if the Centers for Medicare and Medicaid Services (CMS) had carried out its legal responsibilities toward the ASC payment system, which it clearly has not since there has been no cost survey since 1994, we would not be surprised if the calculations produced results different from those that arise from the use of hospital cost reports to calculate the HOPD PPS. The mere fact that both systems rely on different data sets and different methods of rate calculations will lead to differences in payments for the same services. This does not make either system, or the resulting rates, right or wrong. They are simply different for the reasons stated.

We also note that the HOPD PPS is a work in progress. There has been substantial movement in the payment values assigned to individual services. This has been true of GI services as well as many others. In fact, in those limited situations where the ASC payment for an endoscopy exceeds the outpatient rate, we have noted that the gap has closed as CMS has gained more experience with the PPS. We believe that Congress should delay any action on equalizing ASC and PPS reimbursement until the PPS rates are more settled. To regard this system at this early stage of implementation as the benchmark for payment would be a serious error. In time, as CMS and hospitals gain more experience with the system and the underlying data, the outpatient PPS might become a basis for judging the adequacy of Medicare reimbursement in other settings. However, to give the PPS such a level of credibility at this time is premature.

A further important point is the fact that Medicare bundles medical and surgical services differently in the HOPD PPS and the ASC facility fee. The published fees do not reflect the differences. For example, hospitals are able to bill radiology services separately from the APC for the surgical service. ASCs cannot bill radiology separately from the facility fee. Unless adjustments are made to equalize the service bundles, any simple comparison of rates will lead to incorrect conclusions.

ASGE notes that more than 2300 procedures are covered by Medicare in the ASC. Only 350 of them are paid more in the ASC than in the hospital. All the other rates are below the hospital payments. ASGE is disappointed that MedPAC did not recommend the corollary to their view that the HOPD PPS rate should be the ceiling. Why has the Commission not suggested that those lower ASC rates be brought closer to the hospital level? After all, if one goal is to assure that payment rates do not drive site of service selection, then the rates must be comparable across all settings. This omission, we believe, further undermines the credibility of the recommendation now pending before Congress.

ASGE does not believe that the current ASC payment system is perfect. Indeed there are many problems with it, not the least the fact that CMS has consistently failed in its statutory obligations to keep the cost data and list of covered procedures up to date. We are fully prepared to engage in a serious discussion with Congress on how the ASC payment system could be improved. In fact, we have participated in such discussions with CMS staff since their ASC "town meeting" in 1996. We believe the wiser course for Congress would be to disregard MedPAC's recommendations and focus attention to the need to have a workable, current payment system for ASCs.

In conclusion, we strongly urge the Subcommittee to reject MedPAC's proposals to reduce Medicare payments to ASCs. If adopted, its contribution to deficit reduction would be miniscule, but its impact on the services available to Medicare beneficiaries in ASCs could be significant. Congress would have been better served if MedPAC had made the effort to work with experts in the ambulatory surgery center

arena and then brought recommendations to Congress on ways to keep the ASC payment rates current.

On behalf of our members, and most importantly the Medicare beneficiaries they serve, we urge your careful consideration of these views. ASGE is fully prepared to work cooperatively with Subcommittee to address these important issues. Please contact me directly or our Washington Representative, Randy Fenninger, at 202–833–0007 if you need additional information on the use of ambulatory surgery centers by gastroenterologists and other endoscopic specialists.

Sincerely,

David L. Carr-Locke, M.D.
President

f

Federated Ambulatory Surgery Association
Alexandria, Virginia 22314
March 20, 2003

The Honorable Nancy Johnson
Chair, Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
Washington, D.C. 20515

Dear Madam Chairman:

The Federated Ambulatory Surgery Association (FASA), the largest national association of single—and multi-specialty ambulatory surgery centers (ASCs) and the health care professionals who deliver services in them, submits these comments on the recommendations of the Medicare Payment Advisory Commission (MedPAC) relating to payments to ASCs. We request that this letter be made part of the official record of the Subcommittee's March 6 hearing on the MedPAC recommendations. Attached is the letter sent to MedPAC commenting on the draft ASC chapter. It further documents the lack of information and knowledge that the staff and commissioners brought to this issue.

Access by Medicare beneficiaries and other patients to ASCs is a prime concern for FASA, and thus we appreciate the opportunity to comment on how MedPAC's recommendations to change the reimbursement of ASCs detract from the industry's efforts to deliver high quality and cost-effective surgical care to all patients. We estimate that the total impact on ASC Medicare revenues would be 10 percent, a significant reduction by any standard. In fact, Congress recently acted to prevent a similar occurrence from taking place in physician payments, substituting a payment increase for a payment cut that if allowed to go forward would have reduced physician payments by 10 percent over two years. Congress properly responded to the concerns about access to physicians that were raised. We urge Congress to give similar consideration to the access problems that would result from a 10 percent reduction in ASC payments in one year.

FASA believes that MedPAC may not have been fully informed about the ASC industry and its history. The overall tone of the recommendations and MedPAC's failure to recognize the significant contributions by ASCs to the well being of many Americans, including many Medicare beneficiaries, cause us to question whether MedPAC adequately considered the issues. ASCs offer Medicare beneficiaries and other patients an alternative surgical site in those communities where they exist. In communities where patients have a choice, competition benefits the patient by improving services and increasing choice. However, throughout the chapter, information negative to ASCs is emphasized, but almost no information favorable to ASCs is included, resulting in a biased discussion that does little to meet Congress' need for impartial and reliable information upon which to build payment policies.

In fact, ASCs are well received by patients, physicians and other medical staff. By any measure they provide an excellent surgical result at highly competitive rates. ASCs provide critical space that relieves pressure on existing hospital facilities and makes it possible for patients to have access to surgery more quickly. If all ASCs closed tomorrow, it would be impossible for existing hospitals to fill the void. Certainly, patients would have to wait much longer for surgery.

MedPAC makes three recommendations relative to ASCs; however, only one, the recommendation to expedite the collection of recent cost and charge data, is based on fact. The other two recommendations, to eliminate the annual update and cap ASC rates at HOPD levels, are based only on speculation. The salient fact is that there is no recent data on ASC costs to allow MedPAC or any other agency to deter-

mine if Medicare payments are appropriate to the services provided in these settings. Absent this data, any recommendation on future payments is pure guesswork. It is not at all clear why MedPAC would risk its reputation for fair, data driven analysis to make these recommendations. While ASC payments are less than one percent of all Medicare spending, the damage that the proposals could do is large. The great majority of the approximately 3,300 ASCs in the United States are not part of large corporate chains, but are small community owned enterprises with limited financial resources. More than 61 percent of ASCs employ 20 or fewer employees.

MedPAC bases its conclusions on the adequacy of Medicare rates on "market factors, such as entry and exit of providers, changes in the volume of services, and providers' access to capital." FASA contests the appropriateness of using market factors as a proxy measure for assessing the adequacy of Medicare rates. For this to be a reliable measure, Medicare rates would have to be a significant portion of ASC payments and a major factor in Wall Street's investment assessments. Investment decisions are more dependent on factors other than Medicare payment rates because Medicare is not a dominant payer for most ASCs. A recent FASA survey found that the median Medicare revenue for ASCs was 28 percent. Data from large corporations suggests that it is an even lower percentage for many of them. The market simply is not going to respond to a minority payer whose rates are well known to be on the low side of commercial payment. A major factor in investment decisions is other alternative investment opportunities. Thus, recent problems in other sectors of the economy are a major factor in ASCs' current access to capital. Moreover, the vast majority are small providers as noted above and are not financed by Wall Street.

MedPAC also cites industry growth as another factor illustrating the adequacy of Medicare payments. However, Medicare payments are not generous in comparison to the commercial payers. ASC growth, therefore, must be fueled by other factors unrelated to Medicare payment rates. These include changes in surgical and anesthetic techniques that have allowed more procedures to move to an outpatient setting. In fact, outpatient surgery in all settings now constitutes 70 percent of all surgery performed in the United States; and data show that surgical volume in hospital outpatient departments and physician offices has grown more quickly. Patient and physician desire for an alternative to the traditional hospital model are other forces behind the growth of ASCs. An aging population would account for both the increased use of the ASC by Medicare beneficiaries and an increase in surgical demand.

To examine the adequacy of Medicare payments, MedPAC should have looked at two other sources of information that are far more accurate indicators of the appropriateness of payment than the "market factors" analysis that was conducted. Both sources of information were provided to the Commission during the time it was considering ASC payment issues. They simply were not used.

One measure of the paucity of Medicare ASC payments is a 2002 study conducted by Ingenix, Inc for the Texas Workers' Compensation System. Ingenix was asked to help establish a new fee schedule for the workers' compensation program based on Medicare rates. Ingenix found that commercial rates for hospital inpatient were between 107 and 121 percent of Medicare; hospital outpatient department rates were 140 and 148 percent of Medicare; and ASC rates were between 225 and 233 percent of Medicare, demonstrating the enormous disconnect between Medicare rates and the rest of the market. Moreover, it shows that ASC payments are low even compared to other Medicare rates.

Another point demonstrating the problems with the Medicare rate structure is the distribution of services provided to beneficiaries compared to non-Medicare patients. Of the 2,300 Medicare approved ASC services, only a few ophthalmology and gastroenterology procedures constitute the vast majority of procedures performed. To some extent, the Medicare distribution is due to the Medicare beneficiaries' needs, but the needs of patients of different ages are not as different as these distributions suggest. This maldistribution of services is further evidence that Medicare rates are not adequate across the board, a strong argument against eliminating the annual inflation update that would affect all services.

Even though these two pieces of information did not convince MedPAC that Medicare payments are inadequate, we suggest that there was simply not enough other information available to MedPAC to allow it to make a recommendation to change the Medicare payment structure. Moreover, there does not appear to be a significant reason to do so. ASC payments in total are a miniscule part of the Medicare budget so even a major reduction for our small industry will have a negligible effect on total Medicare spending. In fact, these cuts could drive Medicare beneficiaries into higher cost settings, not only offsetting any savings accrued from the ASC industry, but

also adding to overall costs to Medicare and to beneficiaries. This point is particularly important. Patients who receive surgery in an ASC pay a copayment of 20 percent, regardless of the procedure. In the hospital outpatient, 20 percent is the minimum amount and copayments can run much higher depending on the procedure.

FASA is willing and eager to engage in a thorough discussion of how to appropriately set Medicare payment rates. In fact, we have been engaged in such discussions with the Centers for Medicare and Medicaid Services (CMS) for almost two years. Should Congress adopt MedPAC's recommendations, no benefit will be achieved for the Medicare beneficiary or the Medicare program, nor will there be any measurable reduction in the current federal budget deficit. However, such an action would further the process of making the Medicare patient a second class citizen and limit their options for care even further.

The recommendation that there be no update for fiscal year 2004 is particularly troubling in light of the increased expenses facing ASCs. Like other health care institutions, the nursing shortage has placed significant pressure on wages. The last two years have seen significant increases in the costs of nursing personnel. Congress has acted on several fronts, as has the Administration, to address the nursing shortage, recognizing that it is a problem that affects patient care and medical costs across the health care system.

All insurance premiums have increased, and liability insurance has been particularly volatile. The same increases that affect physicians affect ASCs. The recent passage by the House of H.R. 5 is dramatic recognition of the problems caused by skyrocketing premium costs and limits on insurance availability. ASC's ability to respond to these cost increases is limited. We are disappointed that MedPAC did not pay greater attention to these two important cost drivers. We urge the Subcommittee to rely on its own experience in both areas and reject the call for no inflation update.

Even if ASCs did not face these twin cost pressures, they have fallen further behind inflation over the last decade. The cumulative change in the CPI–U (the basis for the ASC update) from 1994 to 2002 was 22.4 percent. The cumulative updates for ASCs in that same period totaled 9.1 percent. This difference exists because of Congressional action to reduce Medicare spending in omnibus budget legislation in 1993 and 1997. Had ASCs been given the statutory update each year during that period, the rate structure and the distribution of services performed in ASCs would have been very different. For example, Group 7 would be $1311.46 instead of the current national rate of $995. Loss of another update would only increase the disparities between the real costs of providing surgical services and Medicare payments. In our experience, only Medicare has fallen so far behind the realities of medical costs. Private payers recognize the value of ASCs and reimburse them more appropriately.

MedPAC's final recommendation, that ASC rates not exceed APC rates for the same procedure, is equally flawed and premature. First, the rates are calculated in entirely different ways, using different data and a different mix of services. Unless costs in both settings are measured in an identical manner, it is impossible to determine which numbers are correct. Second, use of the APC rate as a gold standard is premature. These rates have changed significantly in the three years that the HOPD PPS has been in place. Until the rates stabilize, it is premature to use them as any kind of standard to justify legislative action now. Third, the services that are included in an APC in the HOPD and in the ASC facility fee groups are not identical. ASCs, for example, cannot bill for radiology. HOPDs can bill separately for this service. Until the service units are defined equally, any comparison of payment rates is meaningless. To suggest otherwise is to mislead Congress and the public.

On behalf of its members, FASA appreciates the opportunity to provide the Subcommittee with these comments on the MedPAC recommendations. Changes in reimbursement will have a dramatic impact on the ASC industry and the delivery of outpatient care for Medicare beneficiaries. We look forward to the opportunity to work with the Subcommittee as it considers the MedPAC recommendations. Please do not hesitate to contact FASA if we can be of any assistance as you consider these recommendations and any other Medicare policy changes that might impact on the delivery of surgical services in ambulatory surgery centers.

Sincerely,

Kathy Bryant
Executive Director

Attachment

Federated Ambulatory Surgery Association
Alexandria, Virginia 22314
January 27, 2003

Mark E. Miller, PhD
Executive Director
MedPAC
601 New Jersey Ave, NW
Suite 900
Washington, DC 20001

RE: Chapter 2, Section 2F: Assessing payment adequacy and updating payments for ambulatory surgical center services.

Dear Dr. Miller:

The Federated Ambulatory Surgery Association (FASA), the largest national association of single—and multi-specialty ambulatory surgery centers (ASCs) and the health care professionals who deliver services in such ASCs, submits these comments regarding the proposed chapter 2, Section 2F issued by MedPAC. Access by Medicare beneficiaries and other patients to ASCs is a prime concern for FASA and thus we appreciate the opportunity to comment on how MedPAC's proposed recommendations changing the reimbursement of ASCs detracts from the ASC industry's efforts to ensure quality and cost-effective health care to all patients.

At the outset, FASA is concerned with regards to the overall tone of the chapter and its failure to recognize the significant contributions by ASCs to the well-being of many Americans, including many Medicare beneficiaries. ASCs offer Medicare beneficiaries and other patients an alternative in those communities where ASCs exist. In communities where patients have a choice, competition benefits the patient by improving services and increasing choice. Throughout the chapter, information negative to ASCs is emphasized, but almost no information favorable to ASCs is included, resulting in a biased discussion that does little to improve the quality of the debate on these issues. A couple of examples demonstrate this point. None of the almost 2000 procedures for which the ASC gets paid less than the hospital outpatient department (HOPD) are even mentioned. In one case, the ASC is paid 2563 percent less than the HOPD. The excellent Wall Street performance of a few ASC chains is discussed, but only one of the several that have had poor Wall Street performance is mentioned and its troubles are dismissed as being unrelated to ASC issues. Further, information on the inadequacy of payment rates is not included.

MedPAC makes three recommendations relative to ambulatory surgery centers (ASCs); however, only one, the recommendation to expedite the collection of recent cost and charge data, is based on fact. The other two recommendations, eliminating the annual update and capping ASC rates at HOPD rates, are based only on speculation. The salient fact is that there is no recent data on ASC costs to allow MedPAC or any other agency to determine if Medicare payments are appropriate to the services provided in these settings. Absent this data, any recommendation on future payments is pure guesswork. It is not at all clear why MedPAC would risk its reputation for fair, data driven analysis to make these recommendations. While ASC payments are only about one percent of all Medicare spending, the damage that the proposals could do are large. The great majority of ASCs are not part of large corporate chains, but are small community owned enterprises with limited financial resources.

MedPAC bases its conclusions on the adequacy of Medicare rates on "market factors, such as entry and exit of providers, changes in the volume of services, and providers' access to capital." FASA contests the appropriateness of using market factors as a proxy measure for assessing the adequacy of payments rates. For this to be a reliable measure, Medicare rates would have to be a significant factor in Wall Street's investment assessments. Conceding that Medicare reimbursement policy is a factor, we do not believe that it is a significant one. First, Medicare is not a dominant payer for most ASCs. A recent FASA survey found that the median Medicare revenue for ASCs was 28 percent. Data from large corporations suggests that it is an even lower percentage for many of these. The market simply is not going to respond to a minority payer whose rates are well known to be on the low side of commercial payment. A major factor in investment decisions is other alternative investment opportunities. Thus, recent problems in other sectors of the economy are a major factor in ASCs current access to capital.

MedPAC also cites industry growth as another factor illustrating the adequacy of Medicare payments. However, growth clearly cannot be the result of generous Medicare payments, because they are not generous in comparison to the commercial payers. ASC growth, therefore, must be fueled by other factors unrelated to Medicare

payment rates. These include changes in surgical and anesthetic techniques that have allowed more procedures to move to an outpatient setting. In fact, outpatient surgery in all settings now constitutes 70 percent of all surgery performed in the United States. Patient and physician desire for an alternative to the traditional hospital model are other forces behind the growth of ASCs. An aging population would account for both the increased use of the ASC by Medicare beneficiaries and an increasing surgical demand.

Having said that market factors are an inappropriate measure of the adequacy of Medicare ASC payments, we would suggest MedPAC look to two other sources of information as to the adequacy.

One measure of the paucity of Medicare ASC payments is a 2002 study conducted by Ingenix, Inc for the Texas Workers' Compensation System. Ingenix was asked to help establish a new fee schedule for the workers' compensation program based on Medicare rates. Ingenix found that commercial rates for hospital inpatient were between 107 and 121 percent of Medicare; hospital outpatient department rates were 140 and 148 percent of Medicare; and ASC rates were between 225 and 233 percent of Medicare, demonstrating the enormous disconnect between Medicare rates and the rest of the market. Moreover, it shows that ASC rates are low, even compared to other Medicare rates.

Another point demonstrating the problems with the Medicare rate structure is the distribution of services provided to beneficiaries of that program compared to non-Medicare patients. ASC services to the Medicare population are heavily weighted to only a few ophthalmology and gastroenterology procedures (approximately 70 percent of all services), with only 30 percent coming from the other 2000 procedures on the ASC list. This skewed distribution does not exist among private patients. To some extent, the Medicare distribution is due to the Medicare beneficiaries' needs, but the needs of patients of different ages are not as different as these distributions. This maldistribution of services is further evidence that Medicare rates are not adequate across the board, a strong argument against eliminating the annual inflation update that would affect all services.

While we recognize that these two pieces of information may not convince MedPAC that the payments are inadequate, we suggest that there is simply not enough information available to MedPAC to make a recommendation to change the Medicare payment structure. Moreover, there does not appear to be a significant reason to do so. ASC payments in total are a miniscule part of the Medicare budget so even a major reduction for our small industry such as those proposed in this chapter will have a negligible affect on total Medicare spending. The harm that could be done to certain segments of the industry could in fact drive Medicare beneficiaries into higher cost settings. FASA strongly recommends that MedPAC hold off making any recommendations on ASC payments until it has the opportunity to study the issue thoroughly. Ironically, the recommendations that MedPAC is making may actually delay the collection of the cost data that it desires as CMS staff are diverted from executing their duties under the existing statutory framework to address what MedPAC concedes are temporary measures until cost data can be collected.

FASA is willing and eager to engage in a thorough discussion of how to appropriately set Medicare payment rates. In fact, we have been engaged in such discussions with CMS for almost two years. FASA and MedPAC may disagree about what is wrong with ASC rates but without data and a thorough understanding of the issues it is likely that more harm than good will be done by premature recommendations that may well divert attention from the real issues. Should Congress adopt MedPAC's recommendations, no benefit will be achieved for the Medicare program or the Medicare beneficiary, but it would only further the process of making the Medicare patient a second class citizen and limiting their options for care even further.

With this as a framework, the remainder of this document raises specific issues with data, facts commentary and conclusions included in the draft chapter. Although FASA is opposed to recommendations for ASC payment changes at this time, we have made numerous suggestions that will improve the accuracy and fairness of the report. FASA feels that these issues must be addressed if the report is to provide accurate and useful information to Congress and the public.

Background

PAGE 2 & THROUGHOUT: The Medicare requirements for ASCs are called "conditions of coverage." To be technically correct, the term "conditions of participation" should be changed throughout the chapter to "conditions of coverage." Conditions of participation is the term used for the hospital conditions.

PAGE 2: Since the beginning of its consideration of ASC payments, MedPAC staff have been raising the issue that four states have 40 percent of the nation's ASCs. We are unsure how this relates to the issues that MedPAC is addressing. Variances in state ASC licensure laws and certificate of need laws are major factors in the development of ASCs. As a result of these laws there citizens of some states have greater access to ASCs than those of other states. Absent MedPAC making a recommendation regarding the benefits of eliminating laws that impede the development of ASCs the geographic distribution appears to be irrelevant.

To the extent that MedPAC addresses the geographic disparity issue, FASA recommends a more thorough analysis. MedPAC notes that 40 percent of the Medicare-certified ASCs are in four states. These states have only 33 percent of the total ASCs and thus have a higher percentage of Medicare-certified ASCs. As mentioned elsewhere, Medicare-certification may be a requirement for state licensure or a major insurer in the area may require it and thus all ASCs in that state will become certified whether or not they treat Medicare patients.[1]

Given the variances in state population looking only at the absolute number of ASCs per state tells little. For example, the states mentioned above with 33 percent of the ASCs have 27 percent of the US population. If one looks at ASCs as compared to patient population one finds that the states with the most ASCs per 100,000 patient population are Arizona, Idaho, Maryland and Nevada. Maryland is the only one state of the four states highlighted by MedPAC that is in the top 10 by patient population. Texas, another state raised by MedPAC as having a lot of ASCs, ranks 30th in ASCs per patient population.

Looking at ASCs by patient population shows a more even distribution. Half of the states have between one and two ASCs per 100,000 population. More than 75 percent of states have greater than 0.90 ASCs per 100,000 population.

Of course geographic variances exist and will as long as individual states determine what constitutes an ASC, regulate differently the operations of the ASCs and impose varying the barriers to building one. For example, only two states have 0.50 or fewer ASCs per 100,000 population—New York and Massachusetts. Both have imposed incredible barriers to opening ASCs. In fact, a 2002 GAO study found that the barriers to opening an ASC in New York resulted in New York City having almost 30 percent of gastroenterological procedures being in physician offices, while in the rest of the country less than 10 percent were being performed in physician offices.

ASCs/100,000 Population	# of States
≤0.50	2
.51–.90	12
.90–1.00	5
1.01–2.00	25
>2.00	6

PAGE 2: The statement, "ASCs also must be licensed by a state agency or accredited by a private accreditation body" is inaccurate. 42 CFR 416.40 provides that ASCs must comply with state licensure requirements. Of course, if under state law a license is not required than an ASC does not need one for Medicare. For example, the New Jersey does not require a state license if an ASC has only one operating room and is owned by licensed physicians. Medicare does grant the four mentioned accrediting bodies deeming authority meaning that a survey by one of these groups can suffice instead of a state or federal survey to determine compliance with Medicare's conditions of coverage.

Procedures covered in ASCs

PAGE 3: MedPAC's discussion of Medicare coverage is misleading. The chapter implies that Medicare will only cover procedures in an ASC if the procedure is on the ASC list. This is not true; rather Medicare only pays the ASC a facility fee if the procedure is on the ASC list. In fact, Medicare pays the physician performing the service whether or not it is on the list. In those situations, Medicare does not pay the ASC a facility fee and dicta in physician fee schedule regulations says that

[1] Please see page 9 for more information on reasons for Medicare certification.

the patient may not be billed by the ASC. Thus, from the physician and Medicare beneficiary standpoint it is covered.

PAGES 2 & 3: Use of the Berenson-Eggers Type of Services Classification system comparison is confusing to those not familiar with the system, which is likely to include many members of Congress. For example, when MedPAC uses "other eye procedure" it raises the question of "other than what." Those familiar with the system may know it means other than cataract removal and lens insertion, but the uninformed may ask what does this mean. Some have thought, for example, it means an eye procedure on the second eye. Similarly, "other ambulatory procedures" could include almost anything and groups totally unrelated procedures together. As a result significant issues are hidden by grouping of unrelated items. If it is going to be used, we'd suggest changing "other eye procedures" to "eye procedures other than cataract removal and lens insertion." Also, "other ambulatory" needs to be clarified. Each time it is used it needs a footnote of what is included.

PAGE 3: Add to the sentence, that CMS is required to update list every two years, "by law" to clarify why CMS is required to update the list.

PAGE 3: The statement "By allowing procedures that are frequently performed in physician offices to be considered for coverage, this could have led to the shift of some procedures from the less-expensive physician office setting to the more-expensive ASC setting." is problematic for several reasons:

1. CMS never proposed allowing procedures frequently performed in the physician's office to be added to the ASC list. CMS only proposed eliminating the strict numerical criteria to allow CMS to make a judgment about the most appropriate sites for the procedure.
2. The fact that CMS considered something for coverage could not contribute to a shift in the site of service where it was performed. Actual reimbursement of a facility fee in an ASC could have an impact on where the procedure was performed.
3. The assumption that a physician's office is always less expensive to Medicare is not a valid one. The costs to Medicare for some procedures may in fact be more. MedPAC would need to look at costs for specific procedures in each setting before this statement could be made.

PAGE 3: The statement that CMS had been planning to issue a revised version of the proposed criteria may not be accurate. The letter from CMS Administrator Scully to Representative Stark solely indicated only that CMS intended to add procedures to the list in early 2003. It did not indicate that any other portions of the proposed rule from 1998 were being implemented.

ASC payment system (level 2)

PAGE 4: Describing current ASC payment rates as ranging from $333 to $1399, while technically accurate, is misleading since the highest payment that any ASC can receive is $995. The footnote to the preceding sentence is not sufficient to clarify the issue as it only says that one group is not currently used but does not specify that the highest paid group ($1399) is the group that is not active. FASA suggests the sentence be modified to read "For fiscal year 2003, the payment rates for the eight payment rates currently used range from $333 to $995." A footnote could be added to this sentence saying that should any procedures be added to group nine the payment rate would be $1399. This would be make it clear that ASCs do not receive this level of reimbursement at this time.

Trends in Medicare payments for ASC services (level 2)

PAGE 5: The statement comparing the growth in ASCs by comparing to physician services and outpatient surgery departments misrepresents the growth and the reasons for growth. If you want to look at growth in ASCs and whether is disproportionate, the appropriate comparison would be the growth of ambulatory surgery in outpatient departments and physician offices. Industry data demonstrates that total surgical volume is increasing at a rate higher than that in the ASC alone. In fact, when reviewing trends for ambulatory surgery the growth in procedures in physician offices and far outpaced that in the ASC. (See attached chart.) Perhaps a partial explanation of the discrepancy is that MedPAC is looking at total volume not ambulatory surgery volume.

Factors affecting growth of ASC services

PAGE 7: The section entitled "Benefits to Physicians" is distorted in that it focuses almost entirely on benefits that are only available to owner physicians. While owner physicians do receive added benefits in terms of control and potential invest-

ment income, ASCs offer benefits to physicians performing procedures whether or not they are owners. If the primary benefits to physicians were those associated with ownership one would expect most of the physicians performing procedures at ASCs to be physician owners. This is not true. In some small facilities designed primarily to serve the needs of the owners, only owners may perform surgery there. However, the more usual model is for ASCs to have many more physicians performing procedures there than those who have an investment interest. MedPAC has many times mentioned the growth and success of the large ASC chains. These chains rely on large volume from non-owner physicians. In fact, in one chain of ASCs almost half of their facilities have no physician ownership. At a minimum this section should have at least as much about the other benefits to physicians as the ownership benefits. The first sentence could certainly be expanded on as many of the Members of Congress will not know why ASCs offer greater control over scheduling, staffing or surgical environment. Explaining this could increase their understanding. In addition, the reference to "performing more procedures" should be in this section since this is an issue related to scheduling, staffing and surgical environment. ASCs allow physicians to perform more procedures through the opportunity to control their schedule and efficiency due to block scheduling and less down time between procedures. Grouping this sentence in the paragraph on investing opportunities could be misinterpreted to imply that it relates to performing unnecessary procedures, which has not be discussed as part of MedPAC's deliberations.

It is true that ASCs offer physicians the opportunity to increase their invest income through investing in ASCs. Although this is an appealing aspect to some physicians, physician investment in ASCs does not usually produce a major source of income as compared to their practice. Discussing this as part of the chapter is appropriate but the discussion should be balanced mentioning the benefits of physician ownership. It should be noted through physician investment in ASCs individuals throughout the country have a choice in where to have procedures performed and have to wait less time to have a procedure performed. Also, in many communities services improve at both the ASC and the HOPD due to the competition. When this happens patients are the beneficiaries. The positive side of physician investment needs to be discussed.

Moreover, it is particularly important that the facts in this section be accurate and clear. The draft chapter is incomplete and gives short-shrift to several facts and thus confuses rather than illuminates the facts. For example, it says that the Stark law does not apply to ASCs. This is incorrect; the Stark law applies to ASCs as it does other health care facilities. However, it only applies to referrals for designated health services. Ambulatory surgery is not a designated health service under the Stark Law. Physicians referring to ASCs for designated health services have the same restrictions under the Stark law as they do in referring to other health care facilities. This discussion is also misleading as it confuses the Stark law and the anti-kickback law. Either one or both could be implicated in cases of physician referral to health care facilities in which he or she have an ownership interest. However, the laws impose varied requirements and cannot be dealt with by broad general statements. Similarly, the statement on the ASC safe harbor under the anti-kickback law is misleading. The conditions for the safe harbor are extremely stringent and difficult to meet to assure that physician ownership is not a subterfuge to allow payments for referral. An adequate discussion of this issue would include this information and a discussion of why a safe harbor exists.

A main argument for not including ambulatory surgery as a designated health service in the Stark law and for a safe harbor under the anti-kickback law was that the physician referring and performing the procedure would generally make so much more from the professional fee that any investment income to be received was unlikely to influence the physician to perform unnecessary procedures. This is easy to understand when one puts in the context that the maximum fee that an ASC receives from Medicare for a procedure is $995. The physician would only receive a small proportion of this. Their share would be what is left after paying facility expenses, such as drugs, supplies, equipment, rent, and staff salaries, divided by investors. Thus, in almost all cases the surgeon's professional fee would be much larger than their share of investment income from a procedure. To the extent there is an incentive to perform unnecessary surgery for financial reasons it is the payment for the professional fee that would be the greater incentive.

Another argument is that the ASC serves as an extension of the physician's office. The physician him or herself actually performs the procedure. This is very different than referrals for laboratory services, etc.

It is inaccurate to say that "Physicians who own an ASC receive both the facility fee and the physician fee for procedures that they perform there." As noted earlier in the draft chapter, to be eligible for Medicare reimbursement the ASC must be

a distinct entity from any other, including the physician's office. Thus, Medicare pays fees for facility use and professional services to two distinct entities. While it is true that a physician who owns an ASC may receive a distribution of profits (after all the expenses of the ASC and its staff are paid) of which some amount may be related to procedures that he or she performed in the ASC, his or her payment is and must be under Medicare laws related to the amount of his or her investment not the volume of procedures that he or she performs there. Thus, two physicians who each invest $500,000 will each get the same distribution even though one may have performed 100 procedures and the other only five. Thus, any connection between procedures performed and return on investment is diluted significantly. For these reasons, this statement should be deleted.

PAGE 7: In MedPAC's discussion of the benefits to physicians, you state that "at least one medical specialty association has encouraged its members to establish ASCs in order to take advantage of favorable Medicare payment rates for ASC services." This is a misrepresentation of the referenced article. Rather than recommending urologists build or invest in an ASC, Rutherford lays out important factors that must be considered by urologists when considering creating an ASC, including potential joint ventures, legal and regulatory issues, and financing issues. In his discussion with regards to payment rates, Ruthorford simply states, "Recent updates in ASC payment rates from Medicare provide additional incentives for urologists to investigate this potential site of service."

The issue of the physician investment in health care facilities is an extremely complex one that cannot adequately be dealt with in a few paragraphs. Given that the focus of this discussion has been on ASC rates, it seems most appropriate to delete this section of the report. To present an accurate and fair discussion to assist Members of Congress in their deliberations would take significant work and time would appear not to allow this.

Collecting recent ASC cost data (level 1)

PAGE 8: The draft chapter claims that payment disparities between settings may be contributing to the growth in the share of surgical services provided in ASCs. This statement makes no sense from an economic standpoint. ASCs or any other health care provider are influenced to offer a service if the reimbursement for the service exceeds their cost of providing it. Thus, in deciding whether to offer a service the ASC considers whether it is financially viable for it to do so. Similarly, the hospital decides whether or not to offer a service based upon its costs and revenue; not the revenue of some other provider. Thus, the decision to offer a service has nothing to do with whether or not another type of facility gets paid more or less. The fact that the most common procedure performed in an ASC on Medicare beneficiaries is paid less than what it is at the HOPD and was still performed several hundred thousand times in an ASC last year would appear to prove this point.

The discussion also ignores that if the service is offered in a community in both an ASC and HOPD it is the physician and the patient that decide where it is performed not the physician. In most cases the physician is not concerned with what the facility makes or loses on a procedure but rather factors related to his or her performance of the procedure.

Recommendation 2F–2

PAGE 9: We would suggest that this recommendation be modified to reflect the law more closely. The ASC statute requires CMS to conduct a cost survey every five years. FASA sees no reason for CMS to collect charge data. In commenting on the draft 1999 cost survey we explained our arguments saying, "We do not understand how this (charge) data is to be used. The law requires a cost survey and the rate to be based on costs so information on charges would seem to be unnecessary and irrelevant. Moreover, in areas of heavy managed care and contract business, charge data has very little relationship to the actual contractual reimbursement. Often a schedule bears little relationship to what is actually paid. In addition, individual contracts with payors change frequently. Given that this question is so time consuming to answer and has little relevance, if any, to HCFA's task of a cost based system, we suggest that it be deleted."

Assessing Payment Adequacy (level 1)

PAGE 9: Including a statement that the proposed rule in 1998 would have reduced payments for certain high-volume procedures, suggesting that the current payments exceeded costs as measured in the 1994 cost survey is yet another example of the bias shown throughout this chapter. If the 1998 proposed rule is to be used as a measure of assessing ASC costs and MedPAC intends to present a fair

picture why are not all of the rates that would have increased under the 1998 rule mentioned. FASA's analysis of the proposed rule, for example, shows that payments for orthopedic procedures would have increased 24 percent when adjusted for Medicare volume.

However, FASA believes it is inappropriate to use the data from the 1994 cost survey at all. This cost survey was significantly flawed in many ways and the proposed reimbursements for more procedures were based upon extrapolations instead of actual cost data. Congress prohibited CMS from implementing and CMS ultimately withdrew that regulation because the industry was able to demonstrate that major problems existed with the data collection and analysis and that it could not be relied upon to set rates. Had that data been reliable new payment rates would be in effect today.

In citing the growth of Medicare-certified ASCs, it should be noted that simply because an ASC is Medicare-certified, the facility does not necessarily provide Medicare services. An OIG study found 16 percent of Medicare-certified ASCs provided no Medicare services in the previous year. ASCs may choose to become Medicare certified for a variety of reasons including state licensure, qualification for certain insurance contracts and demonstrating quality to the public. For the number of providers to be a true measure, one would need to assess the growth in facilities providing a significant amount of Medicare services. Moreover, one would have to compare the growth in ASCs generally with the growth in those providing significant Medicare services.

It is true that most new and existing ASCs are for profit. However, increasingly ASCs are joint ventures between doctors and not-for-profit hospitals.

PAGE 9: As discussed in the opening, FASA believes that reliance on these market factors for determining if Medicare payment rates are adequate is nonsensical at best. Even assuming that market factors could be relied upon for assessing payment adequacies, there are several problems with its application in this case. A major problem with this analysis is that Medicare payments are a small percentage of the business for most ASCs. The survey FASA conducted at MedPAC's request showed that the median Medicare percent of total revenue is 28 percent. Since Medicare is not a dominant payer for ASC services the impact of its rates on Wall Street is impossible to assess. From the limited information it appears that the firms that are often touted in this report may have less than average Medicare volume. For example, in a letter to MedPAC, HealthSouth indicated about 25 percent of their patients were Medicare beneficiaries.

Even assuming that Wall Street likes ASCs, it should be noted that the vast majority of ASCs are not funded by Wall Street. Most ASCs are owned by local physician investors. Physicians generally do not go to Wall Street to obtain financing but rather go to the local bank where access to capital is determined by the physician's credit worthiness. Moreover, recent market experience would suggest that it is risky to base our health care system on Wall Street's views.

In discussing market factors, the report notes the firms that have done well on Wall Street and primarily dismisses those that have not. A balanced approach would require that both be discussed. The one ASC stock mentioned that did not perform well is dismissed as having nothing to do with its ASC operations. This may be true, but it does not appear that this statement is based upon a careful analysis of the situation but rather a glib response to some headlines. Other ASC firms have had stock devalued; some to the point of almost going out of business. It would appear to us that an intelligent and informed discussion of the market as it affects ASC publicly traded companies is beyond the expertise of MedPAC and should not be included in this report.

MedPAC ignored information provided to it showing that rates might not be adequate. For example, FASA provided information about the aforementioned Ingenix study showing that Medicare rates for ASCs were well below market both absolutely and relative to HOPDs and inpatient Medicare rates. If it is intended to be a fair report this information should be included.

Changes in the volume of service (level 2)

PAGES 9 & 10: FASA would suggest that MedPAC reassess whether simple growth in the volume of services provided indicates that the rates are adequate. Even if they are currently adequate, MedPAC should reassess if they will remain adequate without inflation updates and if some can be cut by seven percent without affecting access. Growth in the volume of Medicare procedures performed could be due to increased number of Medicare beneficiaries, aging population, changes in Medicare coverage (such as screening colonoscopies), overcrowding and long waits in hospitals and growth in ASCs. Whether this has anything to do with Medicare rates cannot be determined just by looking at growth. Again, a more reasonable ap-

proach would be to evaluate growth after isolating for these factors and comparing growth in Medicare with growth in private insurance. It should also be noted that Medicare services are concentrated in a relatively few procedures. MedPAC should evaluate why this is. FASA submits that ASC payments for other procedures may be so poor that Medicare beneficiaries are being forced to have these procedures in hospitals. Again, FASA would point to the orthopedic rates as one example.

Accounting for cost changes in the coming year (level 1) PAGE 12:A statement is included that "it does not appear that the ASC payment system has created barriers to the use of new technology." No evidence or basis for this conclusion is offered. Based upon the anecdotal information that comes to FASA, we expect that there are significant barriers to the use of new technology for Medicare patients. One piece of irrefutable evidence that Medicare beneficiaries are being denied access to new technology is that they still do not have access to the several hundred procedures that Medicare proposed adding in 1998. Thus, at a minimum they are at least five years behind and in reality much more than that.

Update Recommendation 2F–2 PAGE 13: MedPAC alleges that eliminating the inflation update in 2004 (to take effect October 1, 2003) will not reduce beneficiaries' access to care or pose a significant burden on ASCs. Little information is provided to support this contention. Absent data to the contrary, it is reasonable to assume that the costs of providing services have gone up at least at the rate of inflation since the last cost survey and rate update occurred in the late eighties. In addition to the overall factors such as increasing real estate and energy costs, specific ASC costs have increased. Costs of all types of insurance have risen significantly over the last two decades. MedPAC is well aware of the escalating costs of providing health insurance and purchasing liability insurance. Recent nursing shortage increases the costs of staffing, which Medicare estimates is about 35 percent of an ASC's costs. Anesthetic drugs are a significant cost to ASCs, and a rising cost as are prescription drugs generally but also particularly due to shortages and improved drugs. Medical technology improves and increases in costs. The chart below shows the limited inflation updates that ASCs have received over the last decade. To again, deny ASCs an inflation update would further limit their ability to treat Medicare patients. To make the statement that this proposal would not decrease beneficiaries access one has to conduct a more thorough analysis. For example, other payers are probably subsidizing the care provided to Medicare patients. This subsidy is only so great and at some point the reductions in Medicare payments will make it impossible for ASCs to continue to care for Medicare patients at the expense of others. Moreover, this cut has to be evaluated together with the other recommendation. Together the recommendations are almost a 10 percent cut in ASC payments. To suggest payments can be cut 10 percent and beneficiaries will see no impact is ridiculous. If the assumption is that if they aren't seen in an ASC they can go to the HOPD, MedPAC needs to acknowledge the higher co-pays beneficiaries would incur and ascertain if the HOPD has adequate capacity to handle the increased volume. Longer wait times may very well be experienced. This is worth noting.

Even if one assumes that the average ASC can continue to serve Medicare patients if rates are decreased by 10 percent, one cannot make that assumption for many single-specialty facilities whose Medicare patient volume is significantly higher than average. According to our recent survey, one-third of single-specialty ASCs had a median of 80 percent Medicare revenue. These facilities will be particularly hard hit. With higher Medicare volume the cuts will be a larger cut in total revenue. In addition, since they are disproportionately eye and GI centers the second recommendation will hit these facilities much harder. Of the seven percent reduction proposed by limiting payment to the HOPD, five percent of it comes from a few ophthalmology and gastroenterology procedures. In addition, these facilities have less ability to make up cuts by performing more, profitable procedures or attracting more non-Medicare patients than do other ASCs.

PAGE 14: The report notes that there is no data to suggest that ASCs do not incur higher costs than HOPDs. This is a purely speculative and without any data to back it up. If MedPAC is going to include purely speculative comments it should indicate that they are speculative. FASA would argue that the only specific data that we have on these procedures is the data from the last cost survey in 1986 and this data shows that these rates are appropriate. It should also be noted that there can be absolutely no confidence at this point that the HOPD rates are not too low. It may well be that the HOPD costs are higher than the ASC's and it is the HOPD rate that is too low. The new HOPD system has been particularly volatile and no rates have been subject to more criticism than the GI ones. The chart below shows the variability between 2000–2003 in HOPD payments for top volume procedures. To use the HOPD payments as a gold standard at this point in time is unwise. Most experts appear to believe it will take a few more years for this system to stabilize.

At that point comparisons might be worthwhile, but they are certainly premature at this point.

PAGE 14: The report notes that there is no data to suggest that ASCs do not incur higher costs than HOPDs. This is a purely speculative and without any data to back it up. If MedPAC is going to include purely speculative comments it should indicate that they are speculative. FASA would argue that the only specific data that we have on these procedures is the data from the last cost survey in 1986 and this data shows that these rates are appropriate. It should also be noted that there can be absolutely no confidence at this point that the HOPD rates are not too low. It may well be that the HOPD costs are higher than the ASC's and it is the HOPD rate that is too low. The new HOPD system has been particularly volatile and no rates have been subject to more criticism than the GI ones. The chart below shows the variability between 2000–2003 in HOPD payments for top volume procedures. To use the HOPD payments as a gold standard at this point in time is unwise. Most experts appear to believe it will take a few more years for this system to stabilize. At that point comparisons might be worthwhile, but they are certainly premature at this point.

VARIABILITY IN HOPD RATES 2000–2003

CPT Code	DESCRIPTION	% Change HOPD From 02–03	% Change HOPD From 01–02	% Change HOPD From 00–01
66984	Cataract surg w/iol, i stage	9.90%	·19.86%	2.29%
66821	After cataract laser surgery	10.91%	·8.70%	2.29%
45378	Diagnostic colonoscopy	10.95%	·5.98%	2.29%
43239	Upper GI endoscopy, biopsy	4.75%	4.07%	2.29%
62311	Inject spine l/s (cd)	29.39%	6.87%	2.29%
45385	Lesion removal colonoscopy	10.95%	·5.98%	2.29%
45380	Colonoscopy and biopsy	10.95%	·5.98%	2.29%
45384	Lesion remove colonoscopy	10.95%	·5.98%	2.29%
43235	Uppr gi endoscopy, diagnosis	4.75%	4.07%	2.29%
52000	Cystoscopy	25.25%	·2.47%	2.29%
64476	Inj paravertebral l/s add-on	9.38%	66.94%	2.29%
64483	Inj foramen epidural l/s	9.38%	66.94%	2.29%
64475	Inj paravertebral l/s	9.38%	66.94%	2.29%
64721	Carpal tunnel surgery	18.43%	0.58%	2.29%
43248	Uppr gi endoscopy/guide wire	4.75%	4.07%	2.29%
28285	Repair of hammertoe	16.67%	2.97%	2.29%
G0105	Colorectal scrn; hi risk ind	9.81%	·15.24%	188.43%
62310	Inject spine c/t	29.39%	6.87%	2.29%
55700	Biopsy of prostate	·22.18%	0.97%	2.29%
43450	Dilate esophagus	9.93%	22.99%	2.29%
29881	Knee arthroscopy/surgery	12.74%	·0.83%	2.29%
67904	Repair eyelid defect	20.11%	5.99%	2.29%

VARIABILITY IN HOPD RATES 2000–2003—Continued

CPT Code	DESCRIPTION	% Change HOPD From 02–03	% Change HOPD From 01–02	% Change HOPD From 00–01
45383	Lesion removal colonoscopy	10.95%	·5.98%	2.29%
29877	Knee arthroscopy/surgery	12.74%	·0.83%	2.29%
66170	Glaucoma surgery	8.99%	·4.52%	2.29%

Two justifications are given for why hospitals costs may be higher than ASCs. In both cases, the analysis is simplistic and incomplete and will do more to confuse issues than to clarify Congressional understanding.

It is true that hospitals and ASCs have different regulatory burdens. However, one can't conclude that one is more onerous than the other without analyzing the complete set. Two examples of regulatory burdens are provided—EMTALA and privacy requirements. It is true that in general ASCs are not covered by EMTALA. Having said that it does not mean that they do not have any obligation to emergency patients that may show up at the ASC. Moreover, if an emergency Medicare patient is treated at an ASC the ASC receives no Medicare payment whatsoever for those services. From time to time, ASCs have to provide services to family members of patients having surgery and again usually no reimbursement is received. When hospitals provide EMTALA benefits they are allowed to bill the insurance company or Medicare if coverage exists.

The other example—privacy is just incorrect. HIPAA applies to ASCs as it does hospitals, and as small businesses the cost of compliance is much higher for ASCs per patient. Moreover, many states and accrediting bodies have privacy requirements.

Finally, ASCs are subject to regulatory requirements that hospitals are not. Before concluding that regulations are more expensive for ASCs or hospitals a more complete analysis needs to be done. What can be said is that the regulatory burdens are different.

The second assertion is that hospitals treat more high-risk patients and the implicit argument is that this justifies higher payments. FASA challenges both assertions. First, two pieces of information are provided to support the contention that for any given procedure hospital outpatient departments treat higher risk patients. For example, we have found no information to support the contention that cataract patients treated in a HOPD are higher risk than those treated in an ASC. Truly high risk patients are more likely to have surgery performed as an inpatient and thus are treated in the hospital but this is irrelevant to the outpatient reimbursement and comparisons.

We are not familiar with the first measure of patient level of risk. When it was presented at the MedPAC meeting, we immediately requested more information of staff and were told that we would get that with the chapter. The chapter does not include sufficient information for us to analyze it nor did we have time in the three working days before comments were due to research this.

The second analysis is sheer nonsense. Due to the unconventional nature of what was being suggested as a risk analysis when it was presented at MedPAC, it was difficult for commissioners and audience to understand. As we have come to understand it, staff are suggesting that you can measure whether a patient is likely to require more services during a particular surgical procedure by measuring the total payments Medicare makes on their behalf during a year. It is hard for us to understand an informed health policy group even making such a suggestion. More Medicare expenses would appear to mean only that that person is accessing the health system more or in more costly ways. Why they access the health system more would determine whether or not it is a measure of riskiness. A few examples might best demonstrate the flaws in this logic.

- A person with a high risk condition who is being treated regularly may see a health care provider more and incur higher costs while a person with the same condition but undiagnosed may incur few expenses in that year. Most surgical providers would prefer to treat the first person rather than the second.
- A person in a car accident (before or after outpatient surgery) would have very high expenses but would not impose any greater risk for surgery.
- A very high risk person that had surgery in the first month of the year and was murdered three days after surgery would have still been high risk at time of surgery but would be very low risk in MedPAC analysis.

- A person living in the city with easy access to providers might make more visits than a similarly risky individual living 200 miles from the nearest hospital.
- Ability to pay for care might affect access but not risk.
- A provider that orders more tests and procedures may affect how much care a patient receives but not riskiness.
- Lonely elderly patients visit providers more driving up costs but not changing risk factors.
- High use of the emergency room rather than a primary care provider may increase costs but not risk.

These examples demonstrate why a simple comparison of Medicare payments shows little about riskiness. We believe it is fundamentally flawed and should not be used to even make crude comparisons of risk.

PAGES 14 & 15: Even if one accepts that hospitals treat patients with more health conditions, we are not convinced this justifies higher payments. Usually riskier patients cost more to treat because you are looking at the total care provided. For example, a riskier patient in skilled nursing needs more care or the primary doctor must provide treatment for a whole variety of conditions. This makes sense. However, for outpatient surgery reimbursement you are talking only about the facility costs that are incurred on one day. This is episodic care and the presence of risks and complicated conditions may not affect significantly the usual cost of providing care. Of course, the patient may incur some additional pre-testing to determine the appropriateness of surgery in the outpatient setting but this is not part of the payment for surgery and thus is either paid to another provider such as lab or x-ray facility or physician or an additional payment to HOPD.

FASA asked a few of its members to determine additional costs of caring for high risk patients. The general conclusion was that the impact on the bottom line of costs was minimal. Most additional tests required would be conducted before surgery and the costs paid to another provider or in the HOPD case as a separate payment. Some additional costs were incurred but most found these to be limited. For example, for the diabetic patient the additional costs were for a fingerstick blood glucose test immediately before surgery and before they were discharged. Some also thought the diabetic patient might be in recovery slightly longer than a regular patient. Based upon this quick review, we do not think justifying additional payments based upon a slightly higher risk status of patients is legitimate. We would have liked to have done a more comprehensive assessment but time did not permit.

PAGE 17: The draft chapter asserts that revising the ASC payment system based upon recent cost data should reduce disparities between HOPD and ASCs. This may be true, but at this point it is pure conjecture. No information has been considered that suggests the variations are due to anything other than different methods of collecting the data. If in fact, there are legitimate differences in the cost of treating in different settings more recent data might increase not decrease disparities.

PAGE 17: As discussed on page 8, paying different providers different amounts does not in and of itself create an incentive to move the case from one site to another. The issue is profitability for the facility that affects the decision.

Recommendation 2F–3

MedPAC's final recommendation, that ASC rates not exceed APC rates for the same procedure, is equally flawed and premature. First, the rates are calculated in entirely different ways, using different data and a different mix of services. Unless costs in both settings are measured in an identical manner, it is impossible to determine which numbers are correct. Second, use of the APC rate as a gold standard is premature. These rates have changed significantly in the three years that the HOPD PPS has been in place. Until the rates stabilize, it is premature to use them as any kind of standard to justify legislative action now. Third, the services that are included in an APC in the HOPD and in the ASC facility fee groups are not identical. ASCs, for example, cannot bill for radiology. HOPDs can bill separately for this service. Until the service units are defined equally, any comparison of payment rates is meaningless. To suggest otherwise is to mislead Congress and the public.

It is also a fallacy to assume that a hospital or an ASC will make a decision on whether or not to provide a service based on the payment made to the other facility. ASCs do not care if the HOPD can provide the service based on the financial impact of APC rates. They care only if they can provide the service based on the financial realities of their own rate structures.

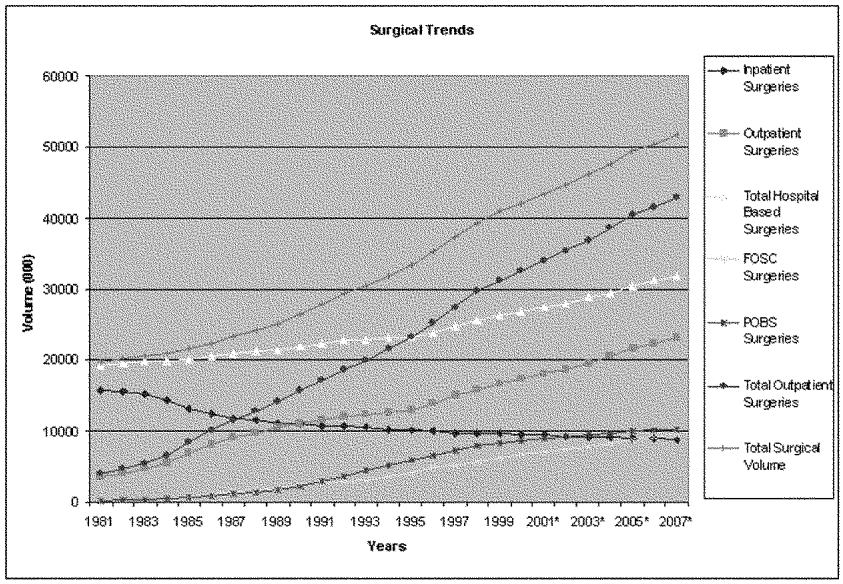
On behalf of its members, FASA expresses appreciation to MedPAC for considering our comments on your report to Congress. Changes in reimbursement will have a dramatic impact on the ASC industry and the delivery of outpatient care for

Medicare beneficiaries. We also appreciate the time that MedPAC Commissioners and staff have devoted to this issue and in particular to conversations with FASA and other ASC industry representatives to facilitate a thorough understanding of the issues. We look forward to speaking with you about the issues we have raised. Please do not hesitate to contact FASA if we can be of any assistance as you finalize the chapter.

Sincerely,

Kathy Bryant
Executive Director

Attachment



f

Statement of the National Association of Home Care and Hospice

The National Association for Home Care and Hospice (NAHC) is the largest national home health trade association representing nearly 6,000 member organizations. Among our members are Medicare-participating home care providers, including nonprofit agencies like the VNA, for-profit chains, public and hospital-based agencies, free-standing agencies. We also represent home care aide and hospice organizations.

NAHC is pleased to be able to submit our statement for the record to the Committee on Ways and Means Subcommittee on Health on the Medicare Payment Advisory Commission's (MedPAC) recommendations and report to Congress on home care payment adequacies. Those recommendations include a freeze in payment rates with no market basket inflation update for fiscal year 2004, a one year increase of 5 percent in PPS rates for rural patients (to replace a 10 percent add-on that expires in April 2003), and the Department of Health and Human Services' continuing analysis of access to home health services. MedPAC did not address the 15 percent cut that took effect October 1, 2002. The MedPAC recommendations are based upon a number of factors including profit margins, entry and exit into the marketplace, access to care and other factors demonstrating payment rate adequacy.

NAHC believes that MedPAC's recommendations fail to address serious and growing access problems under the Medicare home health benefit. Further, NAHC believes that MedPAC recommendations are based upon extremely limited and soft

data and projections on provider costs and revenues. Finally, MedPAC recommendations appear to be based upon the acceptance of a dramatically altered scope of the home health benefit without any authorization from Congress for that benefit change.

In specific response to the recommendations it must be noted:

- In the first full year of PPS, 300,000 fewer Medicare beneficiaries found access to home health services. This represents a 12 percent decline in the number of Medicare home health users in just one year. This decline is on top of the 1 million-user decrease from 1998 to 2000.

CY	TOTAL MEDICARE HOME HEALTH PATIENTS
1997	3.6 MILLION
1998	3.1 MILLION
1999	2.7 MILLION
2000	2.5 MILLION
2001	2.2 MILLION

- Medicare home health users now represent approximately 5 percent of all Medicare enrollees, a level lower than in 1991. The reduction in the number of Medicare users precedes the payment rate cut of October 1, 2002, the pending loss of the 10 percent rural add-on, and the recommended freeze in rates beginning October 2003.
- MedPAC relies upon extremely limited cost report data involving a non-random sample of a small portion of all home health agencies (10 percent) since cost report data is not otherwise available. While MedPAC presents average profit margins from this limited data, it does not discuss the actual ranges in margins which would show home health agencies losing money, breaking even, as well as achieving profits prior to the October 1, 2002 additional cuts. Additionally, MedPAC misleadingly estimated average profit margins by weighing more heavily-high volume Medicare providers. Given the direct relationship between volume and estimated profits (MedPAC Report, page 107), it is clear that this weighing skews the profit averages toward the higher volume/higher profit agencies.
- This provides an inaccurate view of actual profits being experienced by individual agencies and the breadth of the access problems that could result from the October 2002 and April 2003 payment cuts, and from a freeze on rates for fiscal year 2004. A full display of ranges by geographic location is necessary to understand the impact of MedPAC's recommendation. Areas where there are only low margin providers are likely to experience access to care problems.
- Further, the prospective payment system (PPS) data does not include pending retroactive adjustments due to the Centers for Medicare & Medicaid Services' (CMS) implementation problems that have led to higher than appropriate payments in the first year of PPS. These adjustments will significantly reduce profit margins.
- MedPAC suggest that home health agencies can further reduce services to patients as the means of addressing rising costs and lower payment rates. Since 1997, the average visits provided over a 60 day episode has dropped from 36 to 20. With the MedPAC analysis, the average visits would drop an additional 2 to 3 visits. MedPAC has offered no support for its assumption that there would be no adverse consequence to patient's clinical outcomes.
- MedPAC fails to consider foreseeable increased home health costs in estimating profit margins. Costs related to staff shortages, workman's compensation and health insurance increases, purchases of new technologies, HIPAA compliance, bioterrorism and emergency preparedness, and the installation of new information systems to accommodate PPS have not been considered. Further, MedPAC fails to consider increases in per visit costs triggered by the allocation of fixed operational costs to a lower visit volume.
- MedPAC did not evaluate the overall financial status of home health agencies. In its review of hospital services, MedPAC properly analyzed the total financial bottom line because it is necessary to understand the potential impact of Medicare payment changes on the whole delivery system to ensure access to care. Home health agencies are in financial jeopardy as a result of Medicaid cuts, low private payment rates, and Medicare IPS overpayments.

Most telling in the MedPAC Commissioners' discussion of the recommendations is an acknowledgement that the scope of the Medicare home health benefit has been completely changed in the last few years. Commissioners expressed concern that this change may not have been intentional. The Commissioners, however, failed to connect the change in the scope of benefit with the dramatic alterations in Medicare reimbursement systems for home health services. It is very apparent that acceleration in the reduction of users in Medicare home health services was directly triggered by the implementation of PPS.

Madame Chairman and members of the Subcommittee, on behalf of home care providers and the patients they serve, NAHC encourages you to question MedPAC regarding payments to home health agencies and ascertain the answers to the following questions.

Quality of Care Under the Medicare Home Care Benefit

- While MedPAC believes that quality of care was not affected by a reduction in numbers of visits per patient during 2002, what evidence does MedPAC have that further reductions in numbers of visits per patient, as suggested by MedPAC as an acceptable reaction to the elimination of the rural add-on and/or elimination of the FY2004 inflation update, would have no harmful effect upon patient care?

Percentages of Medicare Beneficiaries by Provider

- How does the current percent of total Medicare fee-for-service beneficiaries receiving home health care compare with the same figure from the early 1990s? What are the comparable percentages for fee-for-service hospital and skilled nursing facility use for the same time periods?
- MedPAC's data indicate a further reduction of 300,000 beneficiaries receiving home health services during the first year of PPS. What analysis has MedPAC done on who these beneficiaries are?

Failure to Examine the Ranges of Profit Margins of Home Health Agencies

- What is the range of profit margins for agencies in the sample of 700 agencies used, including the pure range, the unweighted average, geographic ranges, and by type of home health agency?

Overall Financial Status of Home Health Agencies

- What is the overall margin for home health agencies considering the effect of all payors, including Medicaid, as well as repayments to Medicare?

CMS is already working on reforms to the Medicare home health PPS. The reforms can not be appropriately targeted and implemented if there is no stability in these early stages of PPS. Both Congress and CMS recognized that the implementation of an untested PPS posed some risks for patients, providers and Medicare. It was anticipated that CMS would make any necessary adjustments when the impact of PPS could be properly analyzed. As such, it is premature for Congress to accept the MedPAC recommendation and institute across the board cuts and rate freezes before CMS has had the opportunity to finish its plan of action on PPS fine tuning.

NAHC recommends that Congress reject MedPAC's advice in order to stem further losses of access to home health services. While maintaining the status quo through restoration of the 15 percent cut, continuation of the 10 percent rural add-on, and application of a full inflation update will not guarantee the restoration of access to hundreds of thousands of individuals who have lost home health services recently, it should prevent further erosion in access. Congress should also undertake an immediate effort to institute corrective action to provide an opportunity for the full scope of the Medicare home health benefit to be honored and access restored.

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

f

Statement of the Outpatient Ophthalmic Surgery Society

The Outpatient Ophthalmic Surgery Society (OOSS) appreciates the opportunity to present testimony to the Ways and Means Subcommittee on Health regarding

recommendations made by the Medicare Payment Advisory Commission (MedPAC) in its March 2003 *Report to Congress*. OOSS members are particularly interested in MedPAC's recommendations concerning Medicare reimbursement for procedures performed in ambulatory surgery centers (ASCs).

OOSS is an organization comprised of approximately 600 ophthalmologists dedicated to providing high-quality ophthalmic surgical care in various outpatient settings. A substantial number of our members either own or perform surgery in Medicare-certified ASCs. As such, our membership takes a keen interest in proposals to modify Medicare payment to ASCs.

Before providing our comments on MedPAC's recent ASC-related recommendations, we must applaud Congress and this subcommittee in particular for answering the plea of physicians nationwide for relief from the pending physician payment update. Without your responsiveness, physician payment would have been drastically cut for a third consecutive year, which would have forced many physicians to re-evaluate their participation in the Medicare program and caused an access crisis for beneficiaries.

With respect to ASCs, MedPAC issued three recommendations. These recommendations are as follows:

- The Secretary should expedite collection of recent ASC charge and cost data for the purpose of analyzing and revising the ASC payment system;
- Congress should eliminate the update to payment rates for ASC services for fiscal year 2004; and
- Until the Secretary implements a revised ASC payment system, Congress should ensure that payment rates for ASC procedures do not exceed hospital outpatient PPS rates for those procedures, after accounting for the differences in the bundle of services.

OOSS agrees with MedPAC's recommendation that urges CMS to collect recent data on ASC costs. Current cost data is the foundation of equitable payment rates. However, we remind Congress that Medicare statute already requires the regular, every five years, collection of ASC facility costs. We discourage Congress from taking action that is unnecessary and redundant.

Additionally, *we discourage Congress from further urging CMS to rebase ASC rates from a facility cost survey*. CMS's past facility surveys have failed to yield accurate cost data for ASCs. Congress acted in 1999 and again in 2000 to prevent CMS from implementing rebased rates that were based on data collected using imperfect methodologies. Instead, we recommend a completely different approach and departure from the facility survey as the means to rebase ASC rates.

OOSS disagrees with MedPAC's recommendation that payment updates for ASC services should be eliminated for fiscal year 2004. The ASC setting has proven to be an efficient environment in which to perform outpatient surgeries. This efficient quality has helped the ASC community survive consecutive years of minimal updates. However, input costs, such as clinical staff, surgical instruments and equipment, liability insurance, office space rent and utilities, that are largely out of the control of ASCs, continue to increase. *A payment update is needed to offset these input cost increases.*

OOSS encourages Congress to proceed cautiously with respect to MedPAC's third recommendation. Certainly, CMS should take steps to bring a greater degree of consistency between what Medicare pays for outpatient surgery across various settings. However, as MedPAC suggests this should not be done by arbitrary across-the-board cuts or with an assumption that the current rates that Medicare pays HOPDs or ASCs are an accurate calculation of actual procedure-by-procedure costs. Rather, this standardization can be achieved only after a careful accounting for differences in the bundle of services reimbursed through each payment system. These differences must be identified, quantified, and evaluated before true relationships can be established across systems.

Additionally, before taking any action, Congress should remember the following:

- Hospitals are eligible for add-on payments that ASCs are not, such as outlier adjustments and drug and device cost pass-throughs;
- Hospitals are permitted to bill for services that ASCs cannot, such as radiology procedures; and
- The bundles of services that ASC and HOPD rates are based upon differ.

Additionally, when Congress looks to standardize outpatient surgery payment rates it should compare multiple years of rate data for the HOPD and ASC setting to account for year-to-year payment rate fluctuations. MedPAC chose to only compare the 2003 rates, which in our opinion distorted the comparison of rates. For example, for cataract removal with lens insertion, HOPD payment rates in 2001 were

$1,317; in 2002, the HOPD rate was cut by 19.8% to $1,055; then, in 2003, the rate was increased by 10% to $1,160. With variation of this degree, multiple years of rate data must be considered for comparison purposes, especially before reaching a conclusion that payment in one setting is inappropriately greater than the other setting.

It is imperative that Congress not take hasty, impulsive action to standardize ASC rates and HOPD rates. Rather, efforts to create a credible relationship between hospital and ASC rates should be done as part of a thoughtful effort to rebase ASC rates, and only after fully accounting for differences between the two payment systems.

fi