

# Payments to Selected Medicare Fee-for-Service Providers

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Statement of  
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Chairman Stark, Ranking Member Camp, distinguished Subcommittee members. I am Mark Miller, executive director of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this afternoon to discuss Medicare fee-for-service payments to certain Medicare fee-for-service health care providers. As you know, MedPAC has particular expertise and an extensive track record in this area. In its work on Medicare payment policy, the Commission has consistently conducted its analytic work guided by three key principles to ensure a conceptual consistency in Medicare fee-for-service payments: Medicare payment systems should ensure beneficiary access to high-quality care in an appropriate setting, they should give providers an incentive to supply care efficiently, and they should appropriately control program spending.

The Commission has become increasingly concerned with the trend of higher Medicare spending—at a growth rate much higher than for the economy overall—without a commensurate increase in value to the program, such as higher quality of care or improved health status. Despite this rapid growth in spending, large gaps in the quality of care that is delivered persist, as the Institute of Medicine and others have documented in recent years. The growth in spending, combined with retirement of the baby boomers and Medicare’s new prescription drug benefit, will, if unchecked, result in the Medicare program absorbing unprecedented shares of the gross domestic product and of federal spending. Slowing the increase in Medicare outlays is important; indeed, it is becoming urgent. Medicare’s rising costs, particularly when coupled with the projected growth in the number of beneficiaries, threaten to place a significant burden on taxpayers. Rapid growth in expenditures also directly affects beneficiary out-of-pocket costs through higher Part B and supplemental insurance premiums as well as higher copayments. Policymakers need to take steps now to slow growth in Medicare spending and encourage greater efficiency from health care providers, while ensuring access and maintaining or improving quality.

In our March report to the Congress, we reviewed Medicare fee-for-service payment systems for eight sectors: hospital inpatient, hospital outpatient, physician, outpatient dialysis, skilled nursing, home health, inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCH). Today, my remarks touch on all these providers except for physicians, because of the focus of this hearing. The Commission recommended changes to payment and other policies

designed to make payments more accurate and to improve the value received by beneficiaries and taxpayers for their expenditures on health care. A common theme in the Commission's recommendations for these systems is that Medicare should exert continued financial pressure on providers to control their costs, much as would happen in a truly competitive marketplace. We have found, for example, that hospitals under financial pressure from private payers tend to control cost growth better than those with non-Medicare revenues that greatly exceed their costs.

In all sectors, Medicare should also adjust payments for quality, paying more for high quality and less for poor quality. Further, Medicare must adjust its payment systems to furnish incentives for providers to increase their efficiency in providing health care; in essence, the program's payment systems must better reward providers who take positive steps to control their costs, rather than simply allowing payments to increase in lockstep with growth in health care costs. Because there are numerous payers in the U.S. health care system, achieving gains in efficiency is difficult for any one payer. To engender broader changes among U.S. providers, Medicare will likely need to collaborate with other payers but can take a leading role in driving change.

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

In its March 2007 report to the Congress, the Commission recommended payment updates for 2008 and other policy changes for fee-for-service Medicare. An update is the amount (usually expressed as a percentage change) by which the base payment for all providers in a prospective payment system (PPS) is changed. To help determine the appropriate level of aggregate funding for a given payment system, the Commission considers whether current Medicare payments are adequate by examining information about beneficiaries' access to care; changes in provider supply and capacity; volume and quality of care; providers' access to capital; and, where available, the relationship of Medicare payments to providers' costs. Ideally, Medicare's payments should be linked to the costs of efficient providers, who use fewer inputs to produce quality services. We then account for expected cost changes in the next payment year, such as those resulting from changes in input prices.

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

### **Hospital inpatient and outpatient services**

Most indicators of payment adequacy for hospitals are positive. More Medicare-participating hospitals have opened than closed in recent years. Inpatient and outpatient service volume continues to increase but at reduced rates of growth in 2005 and into 2006, partly due to the increase in beneficiary enrollment in Medicare Advantage plans. The quality of care hospitals provide to Medicare beneficiaries is generally improving. Spending on hospital construction increased substantially in recent years (up 30 percent in 2006 alone), while the median values of several financial indicators (such as measures of debt service coverage) reached their best value ever recorded in 2005.

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

margins were less competitive with nearby hospitals and those with high Medicare margins more competitive.

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

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

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

Source: MedPAC analysis of data from CMS.

Hospitals exhibit a wide range of costs per discharge, even after controlling for factors that are largely outside the control of hospital management. In 2004, for example, the 90<sup>th</sup> percentile value of standardized Medicare costs per discharge was 46 percent higher than the 10<sup>th</sup> percentile value. Excluding hospitals with consistently high standardized costs (about 17 percent of hospitals) would raise the industry-wide Medicare margin by 3 percentage points.

Lack of pressure to control costs because of high non-Medicare revenues also may have contributed to continued high growth in costs per unit of service in 2006 and 2007, which in turn contributes to the negative Medicare margin (–5.4 percent) we project in 2007, a continued decline from the –3.3 percent margin we observed in 2005.

Balancing positive indicators and negative margins, the Commission recommended that the Congress update both inpatient and outpatient payments by the increase in the hospital market basket for fiscal year 2008, with this increase implemented concurrently with a quality incentive payment program. A pay-for-quality-performance program would pay

those hospitals with higher quality more than the basic payment rate. Although such a quality program would operate separately from the update, it is essential that the pay-for-quality program be implemented at the same time as the payment update for the next fiscal year. This means the net increase in payments would be less than the market basket; to receive more, hospitals would have to achieve better performance on their quality scores.

Part of the funding for a quality incentive payment policy for all hospitals should come from reducing payments for indirect medical education (IME). Our analysis finds that more than half of the IME add-on payment is unrelated to the additional cost of care that results from the intensity of a hospital's teaching program (measured by the resident-to-bed ratio). The Commission recommends that the Congress reduce the IME adjustment by 1 percentage point to 4.5 percent per 10 percent increment in the resident-to-bed ratio, concurrent with implementation of a system for adjusting payments for severity of illness. Teaching hospitals as a group already have better financial performance than nonteaching hospitals under Medicare. They will also benefit from the severity adjustments to hospital payments that CMS is proposing for fiscal year 2008, which are necessary to help improve the accuracy of the payment system.

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

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

## **Outpatient dialysis services**

Most of our indicators of payment adequacy for outpatient dialysis services are positive. Beneficiaries' access to dialysis care is generally good; the number of facilities increased, capacity increased, and there do not appear to be access problems. The growth in the number of dialysis treatments kept pace with growth in the number of patients. Recent evidence about trends in opening new dialysis facilities suggests that providers have sufficient access to capital. Between 2003 and 2005, the cost per treatment for composite rate services and dialysis drugs fell, largely driven by decreases in drug prices. We project that Medicare payments will cover the costs of providing outpatient dialysis services to beneficiaries in 2007 with a margin of 4.1 percent, compared with an 8.4 percent Medicare margin for freestanding facilities in 2005. Quality of care is improving for some measures; more patients are receiving adequate dialysis and more have their anemia under control. Yet, one quality measure—patients' nutritional status—has not improved during the past five years.

Considering expected input costs and our payment adequacy analysis, the Commission recommends that the Congress update the composite rate for outpatient dialysis services in 2008 by the projected change in input prices less the Commission's expectation for productivity growth.

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

## **Post-acute care providers**

The recuperation and rehabilitation services that post-acute care (PAC) providers furnish are important to Medicare beneficiaries. In our March 2007 report, the Commission analyzed payment adequacy for several types of PAC providers, including skilled nursing facilities (SNFs), home health agencies (HHAs), IRFs, and LTCHs.

PPSs for each setting were developed and implemented separately. As a result, Medicare's payments for similar (if not identical) PAC services can vary considerably, depending on the setting where they are provided. For example, the Commission reported in its June 2005 report to the Congress that patients recovering from hip or knee replacement on average cost \$3,400 more to treat in IRFs than in SNFs, even after controlling for patient characteristics. This raises questions about whether the more expensive setting provides better value to Medicare or its beneficiaries. It is also possible that the financial incentives implicit in such payment differentials unduly influence where a beneficiary receives a given PAC service, especially if there are multiple settings that can provide the service in a given market. Additionally, payment inaccuracies *within* each of the PAC payment systems create incentives for providers to seek or avoid certain kinds of patients.

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

- Case-mix measures often do not accurately track differences in the costs of care.
- There is no common instrument for patient assessment across PAC settings, nor are there clear and comprehensive criteria for which setting is best for patients with particular characteristics or needs. This makes it difficult to compare costs, quality of care, and patient outcomes.
- There is a lack of evidence-based standards of care.

Similar barriers limit our ability to compare differences in financial performance among the providers within each post-acute setting. We do not know if better financial performance results from higher efficiency or from differences in the mix of patients chosen for treatment. We did find that facilities with lower costs and higher Medicare margins had consistently low unit costs, used fewer resources, and had higher occupancy.

CMS has begun, most recently in the form of a demonstration project mandated by the Deficit Reduction Act of 2005, to develop a uniform PAC patient assessment instrument. Such an instrument will be essential to the agency's larger goal of reforming Medicare's disparate PAC systems, so that Medicare payments are based on the clinical characteristics and care needs of the individual patient, irrespective of the setting where the patient receives care. A setting-neutral system of paying PAC providers based on patients' clinical characteristics would give providers incentives to provide high-quality care appropriate to patients' needs.

### **Skilled nursing facility services**

Our indicators of payment adequacy are generally positive for SNFs, but quality shows a decline. Beneficiaries have good access to SNF care, although those who need certain expensive services may experience delays in finding SNF care and end up staying longer in the hospital. The number of facilities providing SNF care to Medicare beneficiaries has remained almost constant. SNFs appear to have good access to capital. Spending and volume of days and stays increased in 2005, with cases continuing to shift to rehabilitation case-mix groups, which receive higher payments. We project that Medicare payments will more than cover the costs of providing SNF care to Medicare beneficiaries in 2007, with margins for freestanding SNFs of around 11 percent, a small decline from the 12.9 percent margins reported in 2005. The data suggest that SNFs should be able to accommodate the cost increases anticipated in 2008 within existing payment levels. Therefore, the Commission recommends that the Congress should eliminate the update to payment rates for SNF services for fiscal year 2008.

Some have argued that, although Medicare payments may be more than adequate, Medicaid payments to nursing facilities are inadequate and, therefore, Medicare should increase its payments to SNFs. The Commission rejects this argument for three reasons. First, Medicare

payments should be set to cover the costs of an efficient provider, not to cover the additional costs of caring for non-Medicare patients. Second, increasing Medicare payments would target the wrong facilities; SNFs with more Medicare patients and fewer Medicaid patients would receive larger increases, and those with fewer Medicare patients and more Medicaid patients would receive smaller increases. Third, if Medicare took this perspective, states might scale back their spending in response.

Two outcome measures for Medicare SNF patients show declining quality in recent years: average facility rates of avoidable rehospitalizations increased and discharges to the community declined. SNFs that appeared to provide good quality using these two measures appeared to be poor-quality facilities using CMS's publicly reported PAC quality measures. This inverse relationship, combined with our previous concerns about the publicly reported measures, leads us to urge CMS to report community discharge rates and rehospitalization rates for Medicare patients and to reconsider our recommendation to change the timing of the patient assessments so that changes in health status are gathered for all patients.

The Commission and others have discussed the need for revising the SNF PPS to correct two key problems. First, under the current system patients who need expensive nontherapy ancillary services (such as drugs, intravenous medications, and respiratory therapy) may have difficulty accessing care. Second, the current payment system encourages providers to furnish therapy even when the services are of little or no value. Based on CMS's extensive research, we conclude that options can be designed to better target payments for nontherapy ancillary services and to discourage the provision of unnecessary therapy services. The options vary in the resources required for CMS to implement them, the changes providers would have to undertake, and the incentives to furnish inappropriate care.

### **Home health agencies**

Our indicators for home health services are positive. Access to care continues to be satisfactory, with more than 99 percent of beneficiaries living in an area served by a HHA in 2006. The number of beneficiaries using HHAs increased from 2.7 million in 2004 to 2.9 million in 2005. The number of HHAs participating in Medicare increased by 6.5 percent in 2006. Our projection of the 2007 margin for freestanding agencies is 16.8 percent, up slightly

from the 2005 margin of 16.7 percent. Most quality indicators continue to show improvement, with more beneficiaries reporting improvements in walking, bathing, and other physical activities. The rate of rehospitalizations and emergency room use remains unchanged. The data suggest that HHAs will be able to absorb any cost increases in 2008 within current payment levels, and the Commission recommended that the Congress eliminate the payment update for home health care in 2008.

We have noted several issues with the PPS, which suggest that the current system may not reflect the costs of different types of patients or changes in the benefit since the PPS. The current typical home health episode includes fewer visits and a higher proportion of therapy than it did when the system was created. Medicare's system for classifying patient resource needs, the Home Health Resource Groups, may inappropriately group together patients with different resource needs. Also, MedPAC found that an agency's average case mix had a small but statistically significant relationship with profit margin. These factors suggest that the accuracy of the PPS could be improved. CMS recently released a rule that would refine the PPS for home health, and MedPAC is assessing how the proposed changes will affect payment accuracy.

### **Inpatient rehabilitation facility services**

Medicare is the principal payer for IRF services, accounting for about 70 percent of discharges. Judging payment adequacy for IRFs since implementation of the IRF PPS in 2002 is now more difficult because of a major change in Medicare policy. The change was CMS's modification of the so-called "75 percent rule," which requires IRFs to have 75 percent of admissions with one or more of a specified list of conditions; 2005 was the first full year the rule took effect.

The intent of the 75 percent rule is to ensure that IRFs provide intensive rehabilitation services to unique types of patients; that is, those who really need and will benefit from the intensive level of care these facilities provide. For 20 years, from 1984 to 2004, the same diagnoses were included in the 75 percent rule. In 2002, CMS discovered that fiscal intermediaries were using inconsistent methods to enforce the 75 percent rule. As a result, CMS suspended enforcement of the rule until the agency could examine it and determine whether the regulation should be

modified. The goal of the modification was to identify a class of patients who could uniquely benefit from the intensive—and expensive—treatment IRFs provided. In 2004, CMS redefined arthritis conditions allowed to be treated in IRFs, which removed the largest single category of IRF admissions (major joint replacements) from the 75 percent rule and substituted three more precise conditions. CMS created a four-year transition period for compliance with the revised 75 percent rule. The Deficit Reduction Act of 2005 added a year to the transition. For IRFs with cost-reporting periods beginning July 2007, 65 percent of each IRF's cases must meet the new definition; for those cost-reporting periods beginning on or after July 2008, the threshold returns to the original 75 percent.

The number of IRF cases increased rapidly after introduction of the PPS in 2002 but decreased in 2005 as CMS began to phase in the revised 75 percent rule. We do not have direct evidence to indicate whether this drop in IRF cases reflects a problem with access to IRF care. However, we note that the policy was developed on the premise that IRFs were admitting patients whose severity of illness did not warrant the intensive (and costly) treatment that IRFs provide. For example, in 2005 the Government Accountability Office found that 87 percent of joint replacement patients treated in IRFs in 2003 did not meet the criteria for needing the level of care IRFs provide. We also note that patients who were no longer eligible for care in IRFs as a result of the new criteria could receive care in other settings such as SNFs, but again the lack of a uniform patient assessment instrument precludes us from knowing whether such shifts in setting are clinically appropriate in all cases.

Medicare spending for IRFs followed the same trends, increasing rapidly from 2002 to 2004 but decreasing from 2004 to 2005. Our other indicators show that the supply of IRFs was stable in 2005, the patients IRFs treated in 2005 were more complex than those IRFs treated in previous years. Most IRFs are hospital-based units that access capital through their parent institutions, which have good access.

As expected, in response to the modified 75 percent rule, growth in costs per case accelerated between 2004 and 2005. This is because, although the volume of cases declined, IRFs' patient mix became more complex as patients with lesser needs were treated in other settings.

Aggregate Medicare margins for 2005 were high, around 13 percent. These estimates are averages, however, and historically IRF margins have varied considerably. In 2005, for example, IRFs at the 25<sup>th</sup> percentile had margins of -4 percent, while IRFs at the 75<sup>th</sup> percentile had margins of 22 percent. We estimate that margins in 2007 will be lower, largely because of the effect of the 75 percent rule. We estimate that the margin will range between 0.5 and 5.5 percent, depending on the ability of the IRFs to control their costs to compensate for the drop in volume; IRFs better able to control their costs could expect Medicare margins at the higher end of this range. This possibility is borne out by MedPAC's analysis of the relationship between IRFs' costs and their Medicare margins presented in our March 2007 report to the Congress; IRFs that had consistently high Medicare margins had cost growth between 2003 and 2004 that was one-third the growth in costs of IRFs with consistently low Medicare margins. The Commission recommended that the Congress update payment rates for IRFs for 2008 by 1 percent.

### **Long-term care hospitals**

Our indicators of payment adequacy for LTCHs are largely positive. LTCHs have entered the Medicare program at a rapid rate and publicly announced plans to open more LTCHs, suggesting that payment rates are attractive. (However, CMS data for 2006 suggest that the rate of growth in the number of LTCHs may be slowing.) The expanding supply of LTCHs has resulted in increases in the volume of discharges and in the number of beneficiaries using LTCHs. Medicare spending for LTCH services has grown sharply, climbing 29 percent per year between 2003 and 2005. Aggregate Medicare margins for 2005 are almost 12 percent. However, due to payment policy changes and expected increases in costs, we estimate that 2007 margins will range from 0.1 percent to 1.9 percent.

The evidence on quality in LTCHs is mixed. On the positive side, risk-adjusted rates of death and death within 30 days of discharge showed improvement between 2004 and 2005, as did the rate of postoperative sepsis. However, more patients were readmitted to acute care hospitals in 2005 than in 2004, and patients experienced more decubitus ulcers, infections, and pulmonary embolisms or deep vein thromboses. These negative quality indicators are worrisome, especially since the number of patients treated in LTCHs is growing.

LTCHs can be either freestanding or located within hospitals (hospitals within hospitals or HWHs). CMS has established several policies directed at trying to keep HWHs and satellite facilities operating independently from their host hospitals. One policy, called the “25 percent rule,” limits the proportion of patients who can be admitted from a HWH’s host hospital during a cost-reporting period. When the policy is fully implemented in fiscal year 2008, a HWH will be paid LTCH PPS rates for patients admitted from its host acute care hospital as long as those patients do not exceed a threshold of 25 percent of the LTCH’s cases. If more than 25 percent of the LTCH’s cases are admitted from its host hospital, the excess cases will be paid the lesser of the LTCH PPS rate or an amount equivalent to the acute hospital PPS rate. (For rural HWHs and certain other HWHs, the threshold is 50 percent of cases. Patients who are transferred to a LTCH after being high-cost outliers in the host hospital are excluded from the threshold calculation and are paid at the LTCH PPS rate.) Recently, CMS extended this rule to freestanding LTCHs so that all LTCHs would be limited in the number of patients they could admit from any one acute care hospital.

The Commission believes that, while LTCHs seem to have value for very sick patients, they are too expensive for patients who could be treated in less intensive settings. We see facility and patient criteria as the best way to target LTCH care to patients who need it. We recommended the development and implementation of such criteria in 2004. Patient-level criteria would identify specific clinical characteristics—such as the presence of specific conditions—and specific treatments required by patients cared for in LTCHs. Facility-level criteria would delineate features of the care provided in LTCHs, such as a patient evaluation and review process, a patient assessment tool, and physician availability requirements. Research Triangle Institute, who contracted with CMS to study the feasibility of implementing criteria for LTCHs, has echoed several of MedPAC’s recommendations. An approach such as the 25 percent rule may be administratively less complex than the application of patient and facility criteria, but it is more arbitrary and increases the risk for unintended consequences. At the same time, however, the 25 percent rule and other administrative policies may have created pressure on the industry to develop criteria for ensuring that LTCH services are furnished only to patients who need them. Recently, two industry associations have developed and proposed criteria for LTCHs and their patients. We have urged CMS to work with the industry to develop criteria as we have recommended.

The Commission is concerned about growth in LTCHs because we are not certain that these high-cost services are being used only for patients who need them. LTCHs are not distributed evenly across the nation but instead are clustered in certain states. Since implementation of prospective payment in October 2005, LTCHs entering the Medicare program frequently have located in markets where LTCHs already exist. This is somewhat surprising, since these facilities are presumed to be serving unusually sick patients and one expects such patients to be rare. The clustering of LTCHs and the location of new facilities thus raises questions about the role these facilities play. The availability of LTCHs helps acute care hospitals shorten patients' lengths of stay and reduce their costs under the inpatient PPS by discharging patients sooner than they otherwise would. This may be appropriate for very sick patients who can benefit from specialized LTCH services. Indeed, MedPAC analyses have found that, when LTCH care is targeted to patients of the highest severity, the total cost is comparable to similar patients using other settings. But for other patients, early discharge from acute care hospitals to LTCHs means that Medicare pays more for the total episode of care. Further, this practice distorts calculations of the inpatient PPS relative weights by reducing the acute care costs and charges for the diagnosis related group.

LTCH policies, therefore, cannot be considered in isolation. Indeed, shortcomings in other payment systems have contributed to the industry's growth. For example, Medicare's payments to acute hospitals may be inadequate for the sickest patients. This may strengthen incentives for acute care hospitals to discharge severely ill patients as soon as possible. CMS recently proposed the adoption of a Medicare severity diagnosis related group classification system for acute care hospitals to better recognize severity of illness among patients. Such a system may dampen the incentive for acute care hospitals to discharge patients to LTCHs. Similarly, flaws in Medicare's SNF payment system may make SNFs less willing to admit medically complex patients, which also increases the demand for LTCH services. This demand might be reduced by making refinements to the SNF PPS, such as those recommended by MedPAC.

LTCHs have shown themselves to be very responsive to changes in payments and should be able to accommodate cost changes in 2008. These findings, as well as the other factors the Commission considers, which are almost all positive, led us to recommend in our March

2007 report to the Congress that the Secretary eliminate the update to payment rates for LTCH services for 2008. The Commission recommends limiting growth in payments per case until the industry and CMS agree on patient and facility criteria to better define these facilities and the patients appropriate for them.

I hope these analyses and recommendations are helpful to the Committee's deliberations, and I look forward to your questions.