



COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

U.S. HOUSE OF REPRESENTATIVES

**“HEARING ON CERTAIN PAYMENTS TO CERTAIN MEDICARE FEE-
FOR-SERVICE PROVIDERS”**

TESTIMONY OF

THE FEDERATION OF AMERICAN HOSPITALS

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Presented by:

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President**

On behalf of the Federation of American Hospitals (FAH), I am pleased to offer our views on Medicare fee-for-service payments to hospitals. FAH is the national representative of investor-owned or managed community hospitals and health systems throughout the United States. Our members include general community hospitals and teaching hospitals in urban and rural America as well as rehabilitation, long term acute care, psychiatric and cancer hospitals.

Challenges Facing Hospitals

This hearing comes at a crucial time for America's hospitals. Full-service community hospitals are facing growing cost pressures and challenges, none more so than the national crisis of the nearly 46 million uninsured Americans – one in six among us.

No one better understands the crisis of the uninsured than the hospitals they turn to for care, which is why the Federation is proud to have introduced a comprehensive, fair and reasonable plan, entitled "Health Coverage Passport" to cover all Americans. Insuring them is the single most important action Congress can take to increase the health security of all Americans, transform our health care system, make it more patient-centered, increase its efficiency and unlock its value.

The inability of Federal payments to keep pace with rising hospital costs, however, can undermine this dynamic. These are costs over which hospitals have limited control – new and costly pharmaceuticals and medical devices, labor shortages, modernizing facilities, meeting new labor-intensive mandates for quality reporting, investing in the information systems technology that will drive efficiency and quality gains, maintaining emergency room capacity and securing physician specialists to provide on-call services, and preparing for a possible pandemic or terrorist act, when hospitals will be on the front line to assist the communities they serve.

All of these factors are contributing causes for MedPAC's estimate that the hospital overall Medicare margin will drop to negative 5.4 percent in 2007, the lowest Medicare margin MedPAC has ever reported, and the fifth consecutive year of negative and declining margins, notwithstanding four years of full market basket updates.

That margin decline was a key reason why MedPAC recommended to Congress that hospitals receive a full market basket update in FY08, a recommendation we

fully support. We understand the need for Congress to maintain fiscal discipline as demonstrated by the imposition of “pay-go” this year, and recognize that difficult decisions will need to be made in order to fund national priorities. However, we encourage Congress to strongly consider MedPAC’s payment recommendations as it confronts these difficult funding challenges, especially maintaining physician payments and strengthening SCHIP.

As the Congress moves forward this year on these priorities, it is important that policymakers recognize health care coverage and expansion as a societal problem that demands a societal solution, and that they should have available to them every possible funding source to address this dilemma. The Federation believes that one possible source of funding could be the tobacco tax provision that passed the Senate earlier this year.

IPPS Rule

Meanwhile, CMS recently issued its proposed rule governing Medicare inpatient hospital payments for FY08, within which is a proposal, under the guise of DRG payment reforms, to cut hospital payments some \$25 billion over the next 5 years. This loss of funding results from an across-the-board 2.4 percent cut in FY08 and another 2.4 percent cut in FY09, as well as cuts to capital payments that would total some \$1 billion.

The \$24 billion cut is tied to CMS’s proposal to restructure the diagnostic related groups (DRGs) in an effort to reflect the relative severity of the patient’s medical condition. The Federation is not opposed to thoughtful refinements of the classification system that are used to assign patients into payment categories. However, we are extremely concerned that CMS is acting too hastily in moving forward with this system and has not completed its analysis or provided sufficient justification to impose, in advance of this system, \$24 billion in hospital cuts. These cuts, euphemistically referred to as “behavioral offsets,” are imposed with scant data to support CMS’s assumptions regarding anticipated coding practices. This raises the question as to whether this serious payment cut has more to do with the federal deficit reality than it does with anticipated hospital coding practices under this new, untested system.

For example, CMS cites, as support for the cuts, examples of increases in the case mix index attributable to changes in documentation and coding practice that do not reflect changes in “real” case-mix in three prior instances – when a prospective payment system was introduced for inpatient rehabilitation hospitals and units in

2002; when the state of Maryland converted to a severity-adjustment system that is substantially different from the one CMS proposes and calls MS-DRGs; and when the original DRG system was implemented for short-stay inpatient hospitals back in 1983.

Each of these experiences presents a flawed precedent for cutting hospitals 4.8 percent and ignores the fact that hospitals have accumulated some 25 years of coding experience and expertise under a classification system that forms the foundation for the new system. The introduction of prospective payment systems as a substitute for cost-based payments, where coding has little payment consequence, presents a fundamentally different situation than what CMS is proposing – in effect, a refinement of an existing PPS. In addition, CMS’s proposed refinements, while sharing some similarities to the patient severity adjustment system Maryland has adopted, follow a different coding path, which raises many questions. A proposal to cut \$25 billion demands a more rigorous analysis than CMS has shared. Under the system CMS has proposed, there is little opportunity for hospitals to change coding practices, and it is a fallacy to assume that hospitals stand to reap a financial windfall from the movement to MS-DRGs that warrants a prospective 4.8 percent payment cut.

Lacking clear and convincing evidence that MS-DRGs will lead to the case mix changes CMS suggests “might” occur, the more prudent course would be to wait until the system is in place and an empirical analysis can be conducted using actual claims. Appropriate payment adjustments then can be made on the basis of experience rather than conjecture.

The cuts to capital payments are particularly puzzling. For one thing, they are based on an analysis by CMS that purports to show that hospitals are experiencing substantial positive margins under the capital payment framework. The analysis, which averages hospital inpatient Medicare capital margins for the period 1996-2004, is deficient in several respects. The most obvious, of course, is that what hospitals experienced in 1996 is irrelevant to the operating environment today, eleven years later. And as noted earlier, MedPAC estimates an overall hospital Medicare margin in 2007 of negative 5.4 percent. Whether or not hospitals experience a narrow positive margin for their capital payments is of small consequence to the hospital losing money, on average, every time it treats a Medicare beneficiary. Moreover, this should not be discussed in isolation from the overall payment effect in an effort to put the best face on what is a significant capital cut.

Indeed, CMS's analysis concludes in 2004, the year when the margin dropped to its lowest point, 5.1 percent, in the time period CMS selected -- 34 percent below the capital margin in 2003 and 41 percent below the capital margin in 2002. Extending that trend line implies that capital margins today are negative, which should not surprise because it is the very same overall Medicare margin trajectory that MedPAC has documented -- a sharp and steady decline since 2002 -- from positive 2.4 percent to an estimated negative 5.4 percent in 2007.

These capital cuts also are troubling and counterintuitive because they will seriously impair the ability of hospitals to make the very investments the Administration repeatedly has called for in health information technology, including electronic health records, and to carry out the President's Executive Order. With the many advances in technology, hospitals are constantly looking at ways to evolve toward that ideal hospital of tomorrow, yet these capital cuts send a conflicting message about the degree to which the Medicare program is willing to help bring about these important advancements for its beneficiaries.

Common sense dictates that a hospital must maintain a healthy positive margin, both operating and capital, in order to sustain the level of investment necessary to run a high quality, efficient facility. Instead, the Administration seems to view a modest positive capital margin -- 5.1 percent in 2004 (and likely lower today) -- as excessive.

I would also like to applaud Representatives John Lewis and Jerry Weller (and Senators Salazar and Roberts) for their concern about this Rule and their leadership on a letter they are crafting to CMS. The Federation encourages all Members of Congress to sign onto this letter and express opposition to this rule.

Self-Referral to Physician-Owned Specialty Hospitals

The irony of the Administration's proposed cuts is that they flow from payment reforms that were recommended as an answer to the problems posed by physician-owned limited service facilities, otherwise known as "specialty hospitals." MedPAC and others repeatedly have found that limited service facilities engage in patient selection, in effect taking healthy and wealthy patients. These and other findings led MedPAC to recommend that CMS reform the DRG payment system and minimize what it maintained were inaccuracies and distortions in DRG payments that incentivized physician owners to select certain patients. CMS

agreed and began the process of implementing MedPAC's recommendations last year by phasing in cost-based DRGs.

The evidence is inconclusive as to whether these DRG payment refinements lead to more accurate payments or are otherwise an improvement over the DRG system that has functioned reasonably well for over 20 years.

What we can conclude, however, is that these refinements accomplish absolutely nothing with respect to the underlying conflict of interest that drives physician-owners of specialty hospitals. Consequently, the CMS payment changes will have virtually no effect on the proliferation of specialty hospitals, the development of which will always be influenced primarily by self-referral policies and not payment policies.

Payment changes do not eliminate the incentive to increase utilization, especially in outpatient services, to avoid Medicaid and uninsured patients, to divert to their own facilities' well-insured and healthy private pay patients, to avoid emergency room and on-call obligations, or even to continue to engage in careful selection of Medicare patients. For as MedPAC noted, "[o]pportunities for selection never fully disappear," in part because "physicians always know more than CMS about individual patients' expected costs."

And payment changes will have no deterrent effect on the conduct of specialty hospitals that resulted in the multiple tragic and regrettable patient safety problems resulting in patient deaths which have occurred in recent years. We appreciate the steps that CMS is taking to address concerns arising from these situations. While the lack of specialists available to community hospitals for on-call services continues to be a serious problem needing to be remedied, we find it very telling that the limited service facilities, which have exacerbated the on-call availability problem for our members, are apparently themselves often not in position to provide patients with physician care during off peak times to address potential patient emergencies. The limitations associated with this limited service model show that in many instances, these facilities operate as a hospital in name only and do not provide the level of the care in the traditional sense of the term and as Medicare beneficiaries would expect.

Because the Administration has failed to exercise its clear administrative authority to interpret the Stark law the way in which Congress originally intended, we strongly urge the Congress this year to permanently ban self-referral to these facilities.

Medicare Rural DSH

Hospitals in rural America continue to experience unique fiscal challenges that must be addressed, especially when they result from payment inequities embedded in law or regulation. One example of this concerns Medicare disproportionate share hospital (DSH) payments. Currently, hospitals receive Medicare add-on payments to help cover the costs of serving a high proportion of uninsured patients. While large urban facilities (greater than 100 beds) receive DSH payments that more closely correlate with their indigent caseload, rural and small urban facility (less than 100 beds) DSH payments are subject to an arbitrary cap of twelve percent. The Federation supports legislation – most recently included in H.R. 6030 in the 109th Congress – that would remove this cap, bringing rural DSH payments in line with other hospitals.

Quality Measurement, Reporting and Value-based Purchasing

The Federation has been a proponent of quality and performance measurement and reporting for many years, and is a charter member in the Hospital Quality Alliance (HQA) –a multi-stakeholder organization including both the private and public sector which reviews and recommends quality and performance metrics for use by CMS and others. The HQA has proven to be a workable model of the public and private sector collaboration that can contribute significantly to improving the quality of patient care in the hospital and better value for the health care dollar.

The HQA is only one piece of an emerging national quality and performance measurement and reporting infrastructure which has been built over the last decade since the landmark Institute of Medicine reports that called for initiatives to improve both the quality and safety of health care in the United States. This testimony will first examine the role of the HQA and recommend needed policy in the area affecting hospitals, and then will discuss the larger policy critical to making the quality and performance infrastructure achieve its important missions.

Federation hospitals helped initiate and committed to participate in the voluntary quality reporting program that HQA spearheaded and that predated the Medicare Modernization Act (MMA) which eventually required hospitals to report 10 measures in order to receive a full hospital update. Following MMA, the Deficit Reduction Act in 2005 made permanent the requirement to report in order to receive the full market basket update and increased the market basket penalty for non-reporting hospitals from 0.4 percent to 2 percent. Hospitals now must report

on 21 HQA recommended quality measures across three disease conditions (heart failure, myocardial infarction and pneumonia). Thirty-day mortality measures and measures of patient satisfaction (the HCAHPS) currently are being collected and will be publicly reported by June 21 of this year.

Further, CMS's FY08 hospital inpatient proposed rule would add new reporting measures which the Federation supports. In addition, the proposed rule seeks comment on additional measures for 2009 and beyond. The Federation will provide detailed comments and intends to recommend that CMS move forward with collection of data on hospital infection measures. Additionally, Congressional action on physician payment taken at the end of the last Congress also calls for new measures and reporting for outpatient hospital care, so the agenda for hospital reporting is anticipated to expand significantly.

Beyond reporting, CMS now is moving forward on developing its DRA-mandated implementation plan for hospital pay-for-performance program, which HHS is calling "Value-Based Purchasing." Congress will receive CMS's report this summer, and we look forward to working with the Health Subcommittee and others with appropriate jurisdiction as this potentially profound payment change is considered by the Congress.

It is important to note that the data from the current pay-for-reporting program demonstrates, quite clearly, that reporting alone can have a significant effect on hospital performance. Across-the-board improvement can be seen for the quality measures for which reporting are required since the program's inception. There is every reason to conclude that quality improvement will continue to improve under the current pay-for-reporting program and that as that program expands its performance measurement, it will touch even more areas of patient care.

But while there is an empirical basis for selecting the performance measures and linking reporting and payment, linking payment to quality performance is a relatively nascent concept with little real world experience. The CMS Premier pay-for-performance demonstration has shown positive results as have certain private payer quality performance for payment programs. However, the jury is clearly still out as to whether or not these experiences can be generalized or whether or not their applications have the potential for short term gains but would result in longer distortions in payment policy.

At this early stage, the Federation urges Congress, should it choose to move forward with a pay-for-performance or value-based purchasing plan, to exercise

extreme caution and to move only incrementally. For example, we suggest keeping incentive bonuses very limited relative to payment and including carefully selected performance measures that can span all hospitals.

While considerably more research and analysis needs to be done, the Federation is encouraged that CMS's draft VBP plan appears to be moving in the right direction on several key issues; most notably; structuring incentive payments to reward both the hospitals achieving predetermined goals as well as those hospitals that demonstrate improvement.

For either the current pay-for-reporting system or a new VBP system to succeed, the current hospital national quality infrastructure that CMS uses must be strengthened significantly. Pressure continues to build from consumers, the business community, third party payers both governmental and private as well as hospitals to add more performance metrics to reporting. Unfortunately, the current system lacks the capability and capacity for handling the size and scope of the measures that HQA can recommend. Additional resources are needed both for the measurement reporting process and display of the results of data submission.

The quality reporting system includes hospitals reporting specific data on measures endorsed by the National Quality Forum (NQF) and recommended by the HQA. The data, for the most part, is reported through vendors approved by The Joint Commission to a data storehouse managed by CMS. CMS has delegated the storehouse and its processing function to the Quality Improvement Organization (QIO) in Iowa. At the warehouse, the data is validated, and prepared for uploading on HHS's Hospital Compare Web site.

In the VBP Options paper, CMS recognized that both the storehouse and Hospital Compare need additional resources. The Federation strongly endorses the further development of a fully funded data storehouse that is chosen by CMS through a bidding process.

Further, it is critically important that the data repository accept performance measures across all hospital patients regardless of whether or not they are covered by Medicare. The current scheme includes data from all adult patients, but has yet to incorporate measures relating to the care of children. We believe that CMS has the authority already to fund broad-based reporting, but Congressional direction may be needed to instruct CMS to use its resources for the inclusion of data for pediatric as well as adult patients.

The data storehouse should be capable of accepting and processing the full agenda of quality and performance measures that the HQA may recommend and to implement the processing in a timely manner. This data infrastructure and its validation methodology should be transparent, and the data should be generally accessible through the Hospital Compare Web site for seamless use by consumers, private as well as public third party payers, employers, researchers, and physicians and hospitals.

The Federation suggests that in order to further develop the storehouse, CMS should use a competitive bidding process to ensure that the organization is most qualified and that it has no conflicted business interests. It is essential that the enhanced data storehouse be operational in the near future so that the HQA program can meet the mandates of existing legislation for reporting as well as anticipated needs for improving the reporting programs both for governmental and private payers and employers. It appears likely the current storehouse, at existing funding levels, will be incapable of managing even the modest expansion in measures anticipated in the next several years.

In addition, the Federation believes the Hospital Compare Website should be enhanced. Hospital Compare, the publicly-accessible web site that displays hospital-by-hospital performance on the reporting measures is an immensely powerful tool that is driving improvement in hospital performance. It can be a useful portal for helping consumers gain access to meaningful, transparent quality and performance information about the hospitals where they or their family members may seek care.

However, the current web site is frankly not easy to navigate. A new enhanced web site would need to be made more consumer friendly, and it should provide for easy comparison of hospitals across all types of patients. The site must be robust and highly useable for consumers, physicians, providers, employers, third-party payers, and researchers. We commend CMS for recognizing this need and seeking comments on it in its VBP options paper. But the web site needs a major upgrade now, regardless of the fate of the VBP program.

We believe that the current reporting program that HQA has developed and promotes is improving quality in patient care. It has been developed through the contributions of many parties both in the public and private sectors. The HQA's effort results from a blending of public and private commitment, expertise and funding, but it only covers the hospital side of care. The Federation recognizes that patient care proceeds over a continuum that includes various settings, activities

and practitioners and facilities. Optimal performance and quality measurement must take this into account. So, the further development of the entire quality and performance measurement endeavor needs to be addressed by the Congress.

From the Federation's view, a next step would be Congressional attention to the overall establishment of an overarching quality and performance measurement process. What is needed is a national policy on the priority setting for the development and reporting of quality, safety and performance measurement. Next all the stakeholders have to agree on one endorser of measures, which should be simple, given that the NQF already serves this function, and then there has to be the establishment of responsibility for ongoing monitoring of measures and assurance that measures are harmonious. And, finally, as electronic medical records come on line, the standard setting bodies for health information technology need to be advised on how best to incorporate the requirements of the measure reporting process.

The NQF could serve all these functions with sufficient Congressional direction and funding. The NQF is a multi-stakeholder organization in which 350 organizations representing consumers, purchasers, health care professionals, provider organizations, health systems, health insurers, suppliers, state governments, and federal agencies all participate. The key is for Congress to designate NQF as the National Coordinating and Standard-Setting Center for Performance Measures. With this designation and proper support the NQF could serve as the entity that sets the priorities and agenda for measurement. The NQF could focus physician and provider attention, systematically raise the bar of performance expectations, and assure the efficient and effective deployment of scarce measure development resources.

The NQF could give direction to HQA and its sister organization, the AQA, which serves the same functions for the physician community, as well as others developing and implementing reporting programs.

This designation would also reinforce the current role of NQF of measurement evaluation and endorsement. These functions are critical to the quality improvement activities of providers, informed decision-making by consumers, and accountability and pay-for-performance programs. To meet these broad needs, NQF has to have the resources to consider priority measures without concern for having to find the funds for each evaluation.

Once measures are approved, the measures need to be managed over time. The measure owners who develop the measure themselves have responsibility for keeping the measures relevant both in terms of the science and their applicability to care. But, there should be an overarching manager that assures measure upkeep, and NQF can assume that role for its endorsed measures.

At the same time, NQF is well positioned to facilitate greater communication between the health information technology standard setting bodies, performance measurement community and Electronic Medical Records vendors to encourage the three to move in a direction that will make reporting more automated in an environment with greater availability of electronic medical records. This will help promote measure developers following common conventions and carefully specified measure data elements. Subsequently, NQF could bring closer alignment between performance measures and clinical decision-support.

Finally, with proper agenda setting for measurement development, more funds are needed to finance the development of measures. These funds are not going to be available from any sources other than the federal government, and the HHS Agency for Health Care Research and Quality (AHRQ) is well situated to administer this funding. It should be noted though that AHRQ already provides some support for measure development and funding is needed beyond current levels to meet the needs of clinical practice.

The Federation urges the Committee to consider legislation that would:

- provide competitive bidding for the establishment of and the necessary funding for a national hospital data storehouse for quality measure submission and processing and that the storehouse be funded to collect data across all types of patients for those measures designated by HQA recommendations;
- provide the necessary funding and direction for upgrading the Hospital Compare Web site
- recognize the role of NQF as the national priority and goal-setting organization for quality and performance measurement
- recognize the role of the NQF as the sole evaluator and endorser of measures for the purpose of public reporting programs
- recognize HQA's role as the sole stakeholder group that advises CMS on measure reporting for hospitals
- recognize the role of NQF as the sole organization to oversee the harmonization and maintenance of endorsed measures

- recognize NQF's role in providing guidance to standard setters, measure developers, and electronic medical record vendors regarding measurement and reporting
- provide sufficient funding both for NQF to carry out these functions as well as to the fund additional measure development through the AHRQ

Post-Acute

Other hospital sectors in the post-acute care continuum also are confronting increasingly difficult payment policies as a result of excessive and in some cases reckless regulation that fails to fully recognize the unique clinical benefits of inpatient rehabilitation hospitals and units, as well as long-term acute care hospitals.

Ultimately, seniors' quality of care suffers when CMS, through arbitrary payment policies, handicaps providers' ability to operate efficiently or restricts patient referral sources. These policies too often ignore both the medical needs of patients and the judgment of the treating physician.

Inpatient Rehabilitation Hospitals and Units

In the case of rehabilitation hospitals and units, there is no disputing the fact that the 75 Percent Rule has materially altered this sector and also has substantially reduced patients' access to the care and services that they provide. Studies commissioned by the Federation and others examining current claims data document a stunning patient caseload reduction in excess of 20 percent following the implementation of the revised 75 Percent Rule in 2004. CMS's estimate called for a caseload decline of approximately two percent, a ten-fold difference.

Although this rule is not fully implemented, it is clear that its policy and program spending effects far exceed what CMS expected at its fully implemented levels. Enforcing the current rule – an outcome that would be achieved by the bill introduced by Congressmen Tanner and Hulshof of this Committee – is a responsible, balanced solution that would permit CMS to continue achieving its policy objectives in this area, while at the same time ensuring that patients who need the unique, high-quality, inpatient rehabilitation care, for which there is no substitute, can receive it. The Federation strongly supports the enactment of H.R.1459. It is an important step on the path to a more rational post-acute care system.

We also are concerned about the high rate of denied claims by fiscal intermediaries asserting lack of medical necessity, which inpatient rehabilitation hospitals and units have experienced over the past 12 to 18 months, and continue to experience. Most of these denials ultimately are reversed by administrative law judges, but only after lengthy and costly litigation proceedings, depleting resources that could otherwise be devoted to patient care. We believe many of these denials are inconsistent with applicable medical necessity criteria for the Medicare program's inpatient rehabilitation benefit. H.R.1459 would help alleviate this problem by codifying long-standing criteria used to determine medical necessity of inpatient rehabilitation.

Long Term Acute Care Hospitals (LTACHs)

LTACHs may be the most misunderstood and unfairly maligned hospital sector. CMS recently finalized a LTACH payment rule that implements far-reaching policy changes for LTACHs that affects both the acute and post-acute sectors. These latest changes to the LTACH payment system come on the heels of three years of payment cuts for LTACHs, the cumulative effect of which is to reduce payments well below the cost of caring for Medicare's most medically complex patients.

Specifically, even before the Final Rule, MedPAC estimated that LTACH Medicare margins are between zero and 1.9%. CMS projects that in the first year alone the Final Rule will reduce LTACH payments by an additional 3.5%, well below costs, and that in future years payments will drop even further. In addition, CMS payment policy has brought LTACH growth to a virtual standstill.

What is particularly troubling is that the Final rule not only arbitrarily reduces LTACH payments below the cost of care, it imposes an arbitrary cap (25 percent) on the percentage of patients that freestanding LTACHs can admit from any primary referral source without suffering a payment penalty. FAH is very concerned about the dangerous precedent of setting limits on where physicians can send patients for treatment, especially when these limits are not based on any clinical considerations but instead are based on arbitrary caps with no relationship whatsoever to patient needs.

In addition, CMS imposes a severe payment penalty for cases that CMS characterizes as "very short stay." These payment penalties apply to a large number of so-called "short stay" patients whose length of stay in LTACHs is actually close to or in excess of 25 days, the current criteria needed to qualify as a

LTACH. Again, this payment policy ignores the clinical characteristics and costs of caring for these patients and is predicated, in large part, on a misguided and unsupported notion that short-stay acute care hospitals are discharging patients “early” to LTCHs in order to maximize DRG payments or otherwise avoid losses under the “high cost outlier” payment policy. The data clearly refute this assertion.

The time is long past due for CMS to advance the June 2004 recommendations from MedPAC to modernize and strengthen the certification criteria for LTACHs to ensure that LTACH payments are being made only to those providers that are administering medically complex care to severely ill patients. As MedPAC recently reiterated in its comments about the LTACH proposed rule, CMS should pursue facility and patient criteria rather than “approaches other than criteria... such as the 25 percent rule...[that] are more arbitrary and increase the risk for unintended consequences.”

This clearly is the preferred policy route to define the appropriate role of LTACHs in the post-acute continuum, and one which FAH strongly supports. Along these lines many members of both the Senate and House of Representatives, led in the House by Representatives English and Pomeroy, have expressed their opposition to CMS’s LTACH rule and have indicated their strong preference that CMS implement revised certification criteria for LTACHs.

Conclusion

America’s hospitals are at a crossroads. We need the support of Congress to continue our vital mission of serving the health care needs of every American in every community across the country, 24 hours a day, seven days a week, under every and any circumstance, and with the highest quality care possible. Federal payment policies are one of the most important factors in determining our ability to meet that mission. And yet, as outlined above, we are concerned that some of those key policies will hinder rather than help us achieve this shared goal.

Overall Medicare hospital margins are negative and falling. However, CMS proposes a payment rule that only will exacerbate this deteriorating Medicare hospital fiscal condition at the same time that physician-owned limited service facilities, built on a foundation of self-referral, continue to flourish. Our hospitals will embrace change, including a restructured DRG system, but we have to be convinced that the change that is being proposed is thoughtful, based on empirical evidence, and in the best interests of the beneficiaries we exist to serve. Our

analytic work continues, but at this point we are not yet convinced that this proposal meets that test. Certainly, there is no basis for a 4.8 percent payment cut.

The same is true of the movement towards pay-for-performance. CMS has put forward a draft plan that has many thoughtful elements. However, there still are too many unanswered questions, first and foremost being whether such a system truly is necessary, what are the potential unintended consequences, and will it improve quality much more than the improvements in quality we already have witnessed through the quality reporting program that still is in its infancy.

Finally, I believe everyone here recognizes the need to create a more rational post-acute care payment and delivery system that more clearly defines the appropriate role of the various providers in the post-acute continuum. But this need does not justify abrupt and unreasonable regulations that substitute blunt payment policies for thoughtful, data-driven analysis, and which may have adverse consequences for seniors. For example, nursing homes have an important place in this continuum, but they are not structured to provide the high-quality, intensive rehabilitative and medical, rather than custodial care, that inpatient rehabilitation hospitals routinely provide. In the same vein, long term acute care hospitals may cost more, but the intensity of the hospital care they provide for the most medically complex seniors is unmatched. In short, they deliver value, and are a critical asset as we strive to deliver the quality of care that seniors deserve.

Mr. Chairman, on behalf of the Federation's hospitals, I want to thank you for holding this important hearing, and for giving us the opportunity to testify. I would be pleased to answer any questions you or the other members of the Committee may have.