



THE SECRETARY OF HEALTH AND HUMAN SERVICES  
WASHINGTON, D.C. 20201

**MAR 14 2002**

The Honorable Bill Thomas  
Chairman  
Committee on Ways and Means  
U.S. House of Representatives  
Washington, D.C. 20515

The Honorable Nancy L. Johnson  
Chairman  
Subcommittee on Health  
Committee on Ways and Means  
U.S. House of Representatives  
Washington, D.C. 20515

Dear Chairman Thomas and Chairman Johnson:

Thank you for your letter to the two of us regarding the President's budget and the ways Congress could adjust Medicare payments to health care providers in a budget-neutral fashion. We know you share the Administration's dedication to better meeting the health care needs of elderly and disabled Americans, and appreciate your longstanding interest in and untiring dedication to these important issues.

President Bush believes that the Nation has a moral obligation to fulfill Medicare's promise of health care for America's seniors and people with disabilities. Medicare has provided this security to millions of Americans since 1965. However, as Medicare's lack of prescription drug coverage demonstrates, Medicare is not keeping up with rapid changes in the way health care is delivered or with benefits available in the private health insurance market.

To ensure that Medicare continues to provide our nation's elderly and disabled secure access to modern health care, the President's Fiscal Year (FY) 2003 Budget renews his commitment to comprehensive Medicare modernization with integrated prescription drug coverage. His proposal is based on the framework for bipartisan legislation that he proposed in July 2001. Specifically, the President's budget proposes to invest \$190 billion in Medicare to modernize the program by improving health insurance plan options that include prescription drug coverage. We agree with you completely that all of the new funding should be used for the President's top priority of improving the coverage options available to beneficiaries, including prescription drugs, and not for increasing payments to fee-for-service Medicare providers.

The President's top three goals for improving Medicare include quickly phasing in assistance with drug costs for Medicare beneficiaries, sustaining and enhancing the options available to beneficiaries in Medicare+Choice, and strengthening and modernizing the Medicare program. This includes transitioning low-income prescription drug assistance into a drug benefit that serves all Medicare beneficiaries and adding new plan options for beneficiaries and updating the benefit package. Many of these improvements, such as full implementation of a prescription drug benefit, will take several years to set up. The needed improvements identified in the President's budget can begin to take effect sooner by building on existing programs.

We agree with you that the current administrative pricing system creates extremely complex provider payment systems that do not always function smoothly or equitably. In our view, these problems further underscore the need for the President's priority of fundamental modernization of the Medicare program. We believe the primary focus of the Congress should be on strengthening and modernizing Medicare, not on revamping outdated, overly complex payment systems.

While we appreciate the work the Medicare Payment Advisory Commission (MedPAC) has put into developing their proposals, we do not believe these ideas are the appropriate starting point for a discussion of Medicare provider payments.

We have no compelling evidence that there is a problem with the overall adequacy of provider payments, although we recognize that recent short-term adjustments have been substantial in the system Medicare uses to pay physicians. For example, while home health services are vitally important to the Medicare program, home health spending is expected to rise by over 42 percent this year and 12 percent next year, and this includes the adjustment to payments already scheduled in current law. And although certain provider payments may benefit from adjustment, we believe such adjustments can be accomplished without draining new funds that are even more urgently needed for improving Medicare benefits.

In the context of moving forward on our shared goal of modernizing and strengthening Medicare, the Administration is willing to work with Congress to consider limited modifications to provider payment systems in order to address payment issues. Most importantly, as we all consider changes to payment systems, we need to be cautious and recall that any increases in spending will be borne, in part, by beneficiaries in the form of higher premiums and coinsurance payments.

Therefore, while the President's Budget did not contemplate any particular provider payment changes, we are willing to consider limited adjustments to payment systems and to work with you to develop a comprehensive package that is budget neutral across providers. We will not support any package of provider payment changes unless it is

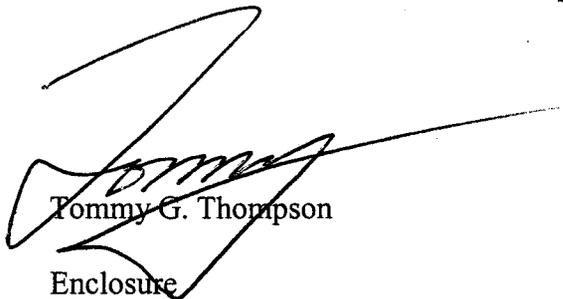
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budget neutral in the short- and long-term. To this end, we recognize that some provisions in law that, in the past, have restrained growth in payments are about to expire, and extension of these provisions is one potential way to ensure a budget-neutral package of reforms.

We believe it is possible to develop a fiscally responsible package of provider payment adjustments that remain budget neutral. We are happy to begin to work with you to provide technical support for such a package if you desire. Enclosed is some additional information on various provider issues that we hope will be useful in our continuing discussions of these issues.

We look forward to working with you to advance the priorities of a prescription drug benefit, a strengthened Medicare+Choice program, and a modernized Medicare program, while also pursuing the issues surrounding modifications to provider payment systems.

Sincerely,



Tommy G. Thompson

Enclosure



Mitchell E. Daniels, Jr.

## Administration's Views on Various Provider Payment Issues

### *Physician Payment Update*

The current system for updating Medicare's payment for physician services was originally established in law in 1989, and has been adjusted a number of times since then, eventually resulting in the Sustainable Growth Rate (SGR) system that is used today. In general, Congress' goal for the payment system was to restrain unsustainable growth in physician payment under Medicare. The system has been working precisely as designed.

Between 1997 and 2001, Medicare physician spending increased from 17.6 percent to 20.5 percent of total Medicare fee-for-service spending. Moreover, physician spending continued to increase, growing 5.3 percent in 1999, 10.7 percent in 2000, and 11.2 percent in 2001, far outpacing inflation in the broader economy.

Last year, a number of factors combined to cause the physician payment formula, as set in law, to produce a negative update. First, there has been a downturn in the economy, which affected the SGR because it is tied to estimates of the nation's Gross Domestic Product growth per capita. Second, actual cumulative Medicare spending for physicians' services in prior years was higher than expected. Third, information on services that were not previously included in the measurement of actual expenditures was now included. Had this information been captured in the measurements originally, spending increases would have been 5.9 percent in 2000, and 9.7 percent in 2001, rather than the respective 10.7 and 11.2 percent increases mentioned above. Counting these previously uncounted actual expenditures, as required by law, contributed to this year's negative update to physician payments. However, despite the negative update, overall Medicare physician spending is not projected to decrease this year. In fact, as the Congressional Budget Office (CBO) noted before Congress two weeks ago, program spending increases by 5.9 percent in 2002.

While a formula that produces these payment fluctuations year-to-year should be reviewed, the underlying system is sound and effective. As CBO Director Dan Crippen concluded in his testimony before Congress:

"In considering whether to change the current system for setting Medicare physician payments, the Congress confronts the prospect of reductions in the fees paid per service for the next several years. MedPAC's recommendation would increase the federal government's spending for physicians' services under Medicare by \$126 billion over the next 10 years. In contrast, other approaches might have the potential to lessen the volatility in the update without dismantling the mechanism for linking physician fees to total spending for physicians services or growth in the economy.

Changes that increase Medicare payments to physicians will increase federal spending. Incorporating higher fees for physicians' services into Medicare spending as currently projected would add to the already substantial long-range costs of the program and to the fiscal challenge to the nation posed by the aging of the baby boomers. Raising fees would also increase the premium that beneficiaries must pay for Part B of Medicare (the Supplementary Medical Insurance program). Inevitably, over the long run, higher spending by Medicare for physicians' services will require reduced spending elsewhere in the budget, higher taxes, or larger deficits."

We believe that considerations of sustainability and of our other urgent priorities in Medicare argue strongly that, if changes in the physician payment system are undertaken this year, they should be undertaken carefully and implemented in a way that does not significantly worsen Medicare's long-term budgetary outlook. The Administration supports reforms in physician payment that lessen volatility, and further believes that any short-term payment problems can be addressed at a much lower cost than the MedPAC recommendation implies.

### *Home Health*

The President's budget also assumes no further delay in the implementation of the "15 percent reduction" in home health interim payment system (IPS) limits. As you may know, this reduction is somewhat of a misnomer. It does not translate into an across-the-board, direct cut in Medicare payment rates for home health services, as many have described it. Rather, the 15 percent reduction is a decrease in the payment caps under the old IPS. The actual percentage reduction in payments that will result from lowering the limits is much less. In fact, the CMS actuary estimates that the 15 percent reduction will only reduce payments to home health agencies by about 7 percent, not 15 percent. Further, after the PPS rates are reduced by 7 percent, we would apply the home health update (currently estimated to be 2.1 percent), leading to a net reduction of approximately 4.9 percent.

Home health spending is expected to rise by 42 percent for FY 2002. Even if the 15 percent adjustment occurs, we estimate that home health spending would increase 12 percent in FY 2003, 8.3 percent in FY 2004, and 7.8 percent in FY 2005. Therefore, we do not support a repeal of the 15 percent adjustment in the caps.

### *Skilled Nursing Facilities*

Prior to the enactment of the Balanced Budget Act of 1997 (BBA), many nursing home companies were expanding rapidly, taking on significant debt, and leveraging themselves heavily for acquisitions of new homes and allowing their debt-to-equity ratios to escalate

steeply. That strategy backfired on many of the industry's biggest companies when the nursing home industry came under financial pressure resulting from the implementation of the Prospective Payment System for skilled nursing facilities (SNFs) and other Balanced Budget Act of 1997 provisions. As a result, Congress passed two laws to provide some relief. The Balanced Budget Refinement Act of 1999 (BBRA) and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) required three Medicare payment "add-ons": a 4 percent increase in per diem rates; a 16.66 percent increase in the nursing component of each Resource Utilization Group; and a 20 percent increase for certain categories of high-cost, medically complex patients. The first two add-ons expire on October 1, 2002. The third will expire when HHS implements a case-mix refinement rule. The Administration is currently moving forward in its development of this refinement rule.

The President's budget proposal reiterates the Administration's commitment to paying SNFs fairly and appropriately for the delivery of services to Medicare beneficiaries. CMS recently explored the fairness and appropriateness of Medicare SNF payments in the February 6, 2002, *Health Care Industry Market Update -- Nursing Facilities*. While we surely want to avoid overpaying any of our providers, we also must be sensitive to their funding needs in order to maintain high quality services. We are willing to continue to review the substantive justification for modifying SNF payments with the Committee.

### *Hospital Updates*

Under the President's budget assumption, inpatient hospital payments for FY 2003 would follow current law and be updated by the market basket, which accounts for inflation in the factors that contribute to the costs to provide hospital services, minus 0.55 percentage points. Under current law, the update beyond FY 2003 would be equal to the full market basket. Since the inception of the inpatient prospective payment system (PPS), hospitals have received a full market basket update only once in FY 2001. Since FY 1984 hospitals have received on average approximately 60 percent of the market basket forecasted increase. Even so, since the early 1990's, the Medicare PPS inpatient margin has risen sharply from 1.3 percent in FY 1993 to an historical high of 16.0 percent in FY 1997. Although there was a decrease in FY 1999 to a 12.4 percent margin, the Medicare inpatient hospital margins have begun to increase again. In addition, since the early 1990's, there has been a significant drop in the number of hospitals with negative inpatient margins. In FY 1991, 61.2 percent of hospitals had negative inpatient margins compared to approximately 25 percent in FY 1999.

The stabilization of overall hospital margins in recent years suggests that, overall, the restrictions on market basket increases of recent years have not resulted in inadequate hospital payments. Reasonable and modest limits on hospital market basket updates would appear to provide adequate reimbursement for hospitals. Modest limits below full

market basket updates could be linked to continued careful review of Medicare hospital margin data to ensure that margin problems do not worsen, and certain hospital types that show clear evidence of negative and declining Medicare margins could be monitored closely for special consideration. The Administration believes that the savings from such measured changes in hospital payment updates could be more than adequate to finance reasonable net increases in total payments to physicians.

There are market updates for other providers that were established in the Balanced Budget Act of 1997. To help restrain spending growth, you could also consider extending market basket update reductions to the calculations for other prospective payment systems.

We are prepared to provide further technical guidance to the Committee whenever it is requested.