



For Immediate Release
March 16, 2007

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**Alliance Details Concerns about MedPAC Recommendations to Congress
*Submits Testimony for the Record to House Committee***

WASHINGTON, DC – The Alliance for Quality Nursing Home Care submitted testimony for the record to the House Ways and Means Committee regarding the recommendations the Medicare Payment Advisory Commission (MedPAC) presented to Congress concerning Medicare payments for skilled nursing care.

The testimony (attached) outlines the Alliance’s concern that MedPAC’s recommended cuts will have a disastrous effect on the quality of nursing home care. “The quality of care Medicare beneficiaries receive today – and the quality of care many of us will require in the decades ahead – relates directly to the federal government’s payment policies, particularly Medicare and Medicaid,” the testimony reads.

“The Alliance is deeply concerned that, all too frequently, the federal government’s approach to funding for Medicare and Medicaid conflicts directly with its goals of sustaining and improving the quality of patient care. When Medicare funding for skilled nursing services is stable, quality of care and services improves. When Medicare funding is inconsistent and unstable, our nation’s long term care infrastructure deteriorates, to the detriment of every senior today and every retiree tomorrow.”

The testimony explains the inextricable relationship between Medicare payments and Medicaid payments, and how “robust and positive Medicare operating margins effectively subsidize negative Medicaid operating margins.” The testimony also offers insight into the recent dramatic quality improvements in skilled nursing facilities, which these cuts will imperil. “Sustained quality improvement depends on maintaining the stable Medicare funding which the sector has begun to enjoy in the past few years.”

The testimony urges Congress to take into account the relationship between these two programs in nursing home care. While MedPAC “rejects any consideration of overall operating margins in formulating its recommendation...Congress certainly is not so limited.” The testimony addresses in detail MedPAC’s assertion that Medicare payments to skilled nursing facilities are adequate, even in the face of losses from Medicaid.

The testimony concludes: “The Alliance respectfully urges Congress to reject MedPAC’s recommendation that SNFs receive no market basket increase in FY 2008.”

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The Alliance for Quality Nursing Home Care (www.aqnhc.org) is a coalition of 17 of the nation’s largest skilled nursing providers who deliver care to hundreds of thousands of patients on a daily basis.

U.S. House of Representatives
Committee on Ways and Means
Subcommittee on Health

Hearing on MedPAC's March Report on Medicare Payment Policies
March 1, 2007

**Written Statement of
The Alliance for Quality Nursing Home Care
Submitted for the Record, March 15, 2007**

The Alliance for Quality Nursing Home Care (the "Alliance") represents seventeen of the nation's largest providers of long term and post-acute care and services. The roughly 2,000 skilled nursing facilities ("SNFs") owned and operated by Alliance companies care for more than 300,000 older Americans and employ more than 300,000 people in forty-nine states. As compared to Medicare-certified SNFs as a whole, Alliance members disproportionately provide skilled nursing care to Medicare beneficiaries.

The quality of care Medicare beneficiaries receive today – and the quality of care many of us will require in the decades ahead – relates directly to the federal government's payment policies, particularly Medicare and Medicaid. The Alliance is deeply concerned that, all too frequently, the federal government's approach to funding for Medicare and Medicaid conflicts directly with its goals of sustaining and improving the quality of patient care. When Medicare funding for skilled nursing services is stable, quality of care and services improves. When Medicare funding is inconsistent and unstable, our nation's long term care infrastructure deteriorates, to the detriment of every senior today and every retiree tomorrow.

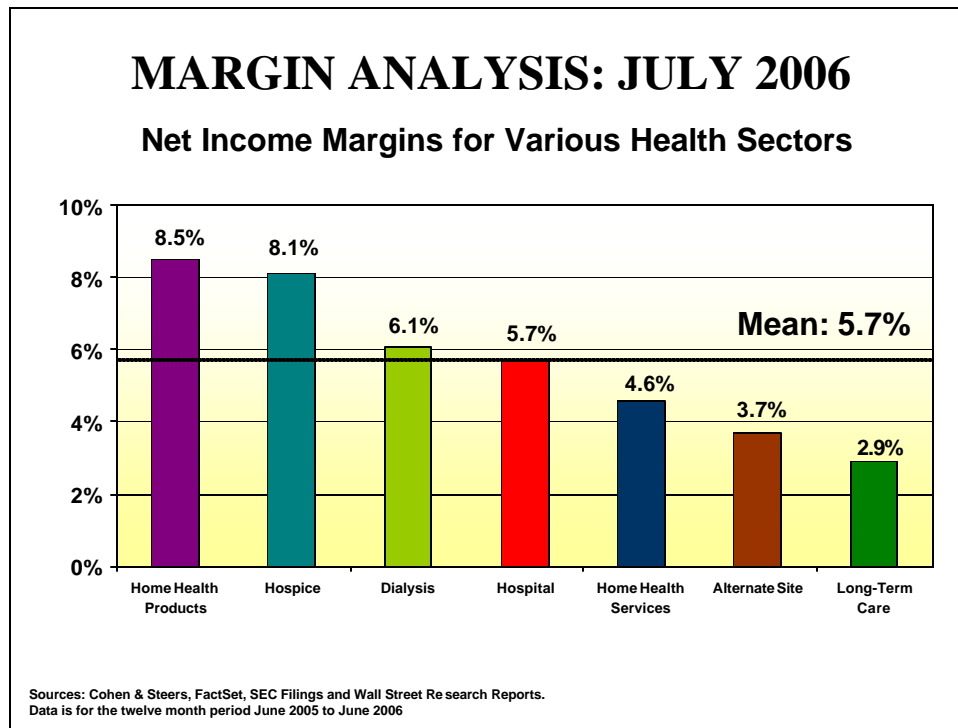
At a time when Congress and the Centers for Medicare and Medicaid Services ("CMS") increasingly look to develop a more rationale post-acute Medicare benefit, an objective that the Medicare Payment Advisory Commission ("MedPAC") has long championed, we remain concerned that MedPAC's restrictive view of Medicare payments to SNFs undermines not only care and services for Medicare beneficiaries, but for all nursing home patients as well. In addition, we are concerned that MedPAC's short-term recommendations undermine its long-term goal of a more rational and unified post-acute benefit.

MedPAC's sole recommendation is that SNFs receive no market basket adjustment in FY 2008. Its March 1, 2007 report notes that, if Congress were to adopt this recommendation, payments to SNFs would be \$250 million to \$750 million less next year than the Medicare baseline otherwise would allow. Given that the President's proposed FY 2008 budget also eliminates the market basket increase for SNFs and scores the impact at \$1 billion, it seems likely that the impact will be at least \$750 million. We respectfully submit that this recommendation is short-sighted and urge that Congress reject it in favor of a more expansive view to assure that all SNF patients continue receiving high quality care and services.

The Relationship between the SNF Marketplace and Medicare Payments

A fair evaluation of MedPAC's recommendations requires an appreciation for the economic realities for SNF operations. In SNFs today, Medicare pays for 12% of patients but represents 26% of revenues, Medicaid pays for 66% of patients but represents only 50% of revenues and private sources (commercial insurance, long term care insurance and out-of-pocket expenditures) pay for 22% of patients but represent 24% of revenues. While MedPAC estimates that SNFs **Medicare** operating margins in 2007 will be 11%, MedPAC does not acknowledge that **Medicaid** operating margins are *negative* 7% and private payment operating margins are less than 2%.¹

As a result, according to independent analysis, overall after-tax operating margins for SNFs were only 2.9% in July 2006, the lowest overall operating margins of any Medicare Part A provider group.



Given these economic realities, robust and positive Medicare operating margins effectively subsidize negative Medicaid operating margins. The Medicare and Medicaid programs, moreover, pay for three of every four SNF patients. While Medicare cross-subsidization of Medicaid may not be optimal policy in the long run, it is necessary at least until the inadequacy of Medicaid payments is addressed effectively.

Over the past decade, moreover, Medicare funding for SNFs has been volatile. The Balanced Budget Act of 1997 ("BBA") slashed Medicare payments to SNFs and forced 20% of SNFs into bankruptcy. In 1999 and 2000, Congress enacted temporary additional payments to help SNFs overcome the most severe consequences of BBA. Thereafter, CMS made certain administrative changes designed to maintain some stability in Medicare payments. Ultimately, in 2006, all Congressional add-ons expired and CMS refined the payment system to better recognize the growing intensity of rehabilitation services Medicare beneficiaries now receive in SNFs.

¹ Source: The Lewin Group analysis of Lewin survey data from multifacility organizations.

The net effect of these changes is that, only in 2006 did average Medicare payments to SNFs return pre-BBA levels. In 1998, average per diem payments were \$367. In 2006, average per diem payments were \$366.²

Nursing Home Quality Has Improved Significantly

It is noteworthy that America's SNFs have led the quality movement despite comparatively low overall operating margins and volatile Medicare payments. The sector's leadership – which includes the Nursing Home Quality Initiative (a partnership between CMS and providers), the Quality First initiative (a voluntary provider effort) and most recently the Advancing Excellence in America's Nursing Homes campaign (a partnership among providers, consumers, unions, private foundations and CMS) - has helped to improve the overall quality of care in our nation's nursing homes.

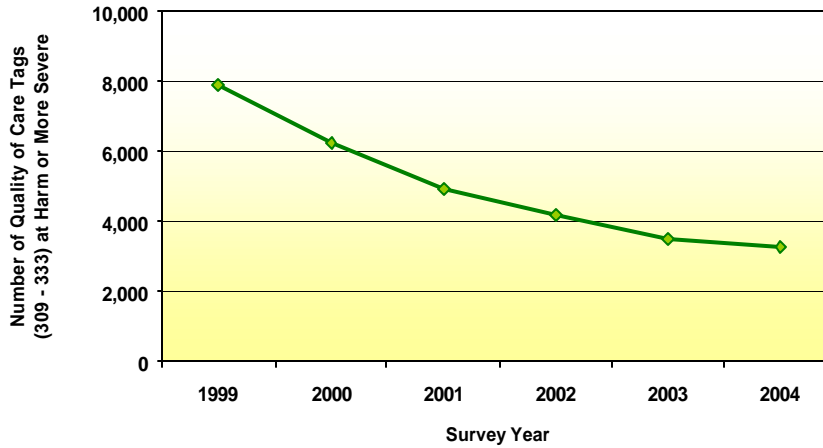
As part of CMS' Nursing Home Quality Initiative, the agency now reports comparative clinical data for use by consumers in choosing SNFs and by SNFs to benchmark and improve performance. Quality First was the first nationwide, publicly articulated pledge by providers in any health care sector to voluntarily establish and meet quality improvement targets. The Advancing Excellence campaign, which was launched in September 2006 and is modeled on the recently completed "100,000 Lives" campaign in the acute care sector, seeks to improve quality in eight clinical and operational domains over a two-year period. Taken together, these efforts underscore that SNFs are committed to accountability for the quality of care and services they provide, as well as prudent use of government resources.

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

² United BioSource analysis of Alliance database.

RESULTS: CITATIONS DROP NEARLY 60%

Number of Severe Quality of Care Citations Drop
(1999 – 2004)

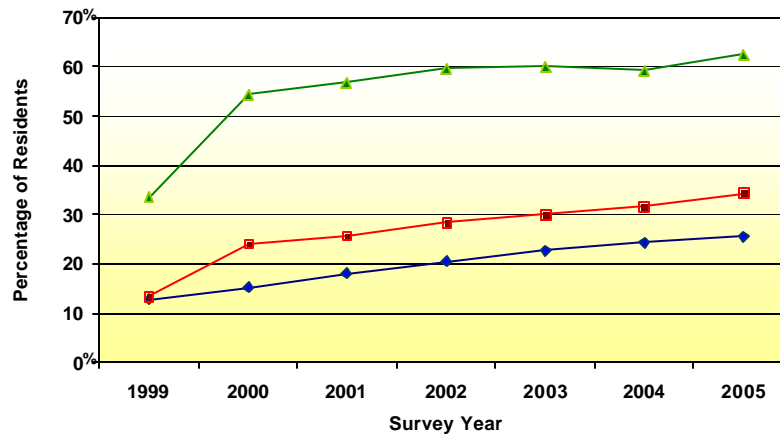


Source: LTCQ, 2006

Similarly, over the same period, clinical processes like pain management and vaccination rates showed marked and sustained improvement as well.

SUBSTANTIAL IMPROVEMENT IN CARE OUTCOMES

Clinical Processes Show Marked and Sustained Improvement



Source: LTCQ, 2006

Consumer satisfaction with nursing home care also reflects noteworthy quality improvement. In 2005, 80% of nursing home patients and their families found the care SNFs provided to be excellent or good. By contrast, 80% of Americans rate their overall health care as excellent or good.

The Alliance remains committed to sustaining these quality improvements for the future. However, sustained quality improvement depends on maintaining the stable Medicare funding which the sector has begun to enjoy in the past few years.

Congress Should Reject MedPAC's Recommendation for FY 2008

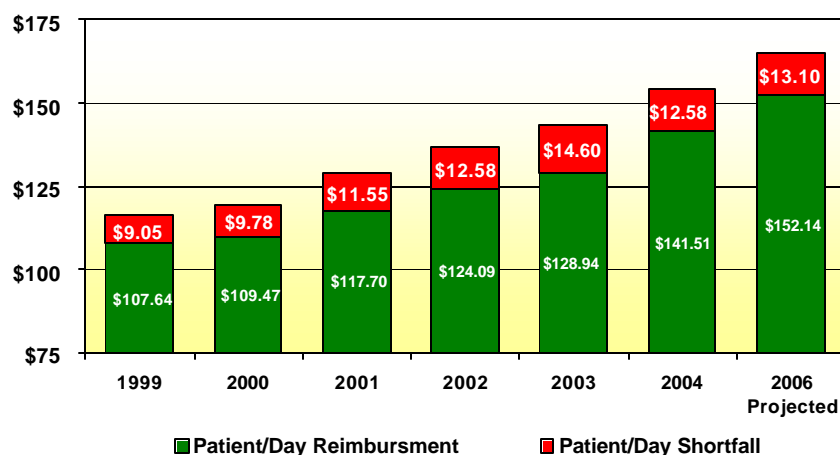
MedPAC specifically acknowledges that its recommendation that SNFs receive no market basket increase in FY 2008 is based solely on its evaluation of Medicare payments to SNFs. Consequently, MedPAC directly rejects any consideration of overall operating margins in formulating its recommendation.

While this may be consistent with MedPAC's legislative charter, Congress certainly is not so limited. Congress should base its decision not only on budgetary concerns with respect to the Medicare program, it also should assess the impact on the provision of care and services overall. Given the recent history of volatility in Medicare payments to SNFs, the importance of robust Medicare margins to overall SNF operating margins and therefore to assuring that SNFs have the resources necessary to continue quality improvement efforts, Congress should reject MedPAC's recommendation that Congress forego the market basket increase that current Medicare law otherwise would afford to SNFs.

MedPAC's March 1 report does attempt to address the effect of Medicaid payments on overall margins. Its arguments, however, are unpersuasive. First, MedPAC asserts that Medicaid payment rates are adequate because, since the elimination of the Boren Amendment in 1998, Medicaid payments to SNFs have risen and state revenues in 2006 and 2007 have grown. In fact, Medicaid payment rates prior to repeal of the Boren Amendment were inadequate, such that growth since 1998 does not reflect adequacy of Medicaid payments. Indeed, the gap between the reasonable cost of care and Medicaid payments to nursing facilities has grown consistently since 1999.

MEDICAID SHORTFALLS (1999 – 2006)

Shortfall per Medicaid Patient Day All States in Each Year



Source: BDO Seidman LLP., 2006: *A Report on Shortfalls in Medicaid Funding for Nursing Home Care*

The fact that state revenues increased in 2006 and 2007, moreover, ignores the fact that, earlier in the decade, state revenues were severely threatened and, as a result, Medicaid payments were undermined, particularly given that, in more challenging economic periods, Medicaid enrollment swells. While overall Medicaid expenditures may increase in such circumstances, this does not reflect more robust payments for services. Rather, it reflects more enrollees, which places even greater strain on state Medicaid budgets and prompts even more aggressive cost containment initiatives.

It is noteworthy that historic reports from the Kaiser Commission on Medicaid and the Uninsured, the very group whose work the MedPAC report cites in support of its argument, has a long history of reports to the contrary.³ Congress itself recognized the financial straits states faced earlier in the decade, and the adverse impact on Medicaid programs, by temporarily increasing the federal Medicaid matching rate in the Federal Fiscal Relief Act.⁴

MedPAC also argues that paying nursing facilities higher Medicare rates misdirects resources because facilities with higher Medicare census benefit from additional payments but such payments

³ See, e.g., the following Kaiser Commission reports, [State Fiscal Conditions and Health Coverage: An Update on FY2004 and Beyond](#) (September 2003), [Medicaid Spending: What Factors Contributed to the Growth Between 2000 and 2002?](#) (September 2003); [The Current State Fiscal Crisis and Its Aftermath](#) (September 2003); [States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment](#) (September 2003); [State Responses to Budget Crisis in 2004: An Overview of Ten States](#) (January 2004); [Is the State Fiscal Crisis Over? A 2004 State Budget Update](#) (January 2004), [States Respond to Fiscal Pressure: A 50-State Update of State Medicaid Spending Growth and Cost Containment Actions](#) (January 2004); [The Role of Medicaid in State Economies: A Look at the Research](#) (April 2004), [State Fiscal Conditions & Medicaid, April 2004](#) (April 2004), [Medicaid and the 2003-05 Budget Crisis--State Case Studies](#) (August 2005), available at www.kff.org/statepolicy/budgets.cfm.

⁴ Kaiser Commission on Medicaid and the Uninsured, [Financing the Medicaid Program: The Impact of Federal Fiscal Relief, April 2004 Fact Sheet](#) (April 2004), available at www.kff.org/statepolicy/budgets.cfm.

should be directed to facilities with higher Medicaid census. This claim misapprehends the ownership structure of a majority of America's nursing homes. Most nursing homes are not owned independently as freestanding facilities. Rather, they are part of multi-facility organizations. Within multifacility structures, providers cross-collateralize across all facilities. Operating losses in facilities with higher Medicaid census are offset by operating gains in facilities with higher Medicare census. The facility-by-facility approach MedPAC suggests is not in keeping with the operating realities of the nursing home financial environment.

In addition, MedPAC's recommendation for FY 2008 threatens its longer-term objective to develop a unified and more rational post-acute benefit. As part of this objective, MedPAC has encouraged policy changes that create incentives for Medicare post-acute patients to receive care and services in the least costly setting consistent with appropriate quality outcomes. CMS has acted on these recommendations in various ways, including refinements to the Resource Utilization Groups ("RUGs") payment system for SNFs effective in FY 2006. These refinements have encouraged SNFs to care for higher acuity patients, particularly those patients requiring short-term rehabilitation care.

Eliminating the Medicare market basket increase in FY 2008 would deprive SNFs of resources necessary to continue expansion of care for these beneficiaries, undermining the effort to rationalize the post-acute benefit. Since SNFs frequently are the lowest cost settings in which such services may be provided, the intermediate-and-long-term impact could well be to increase overall Medicare post-acute spending by continuing to provide post-acute care in higher cost settings. For example, based on CMS data for FY 2004, the average cost to Medicare for an episode of care in a SNF was \$7,000, while the average cost to Medicare for a comparable episode of care in an Independent Rehabilitation Facility was \$12,525, or 78% higher than the cost per episode of care in a SNF. Slowing the trend toward SNFs treating a growing percentage of Medicare post-acute patients similarly slows efforts to rationalize the post-acute system and better control Medicare spending growth in the future.

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In conclusion, the Alliance respectfully urges Congress to reject MedPAC's recommendation that SNFs receive no market basket increase in FY 2008.