United States Senate
SPECIAL COMMITTEE ON AGING
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Medicare Payment Advisory Commission
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Chair
Medicaid and CHIP Payment
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Dear Mr. Hackbarth and Ms. Rowland:

During the last several weeks, I have heard from a number of non-profit skilled nursing facilities in my state expressing concern about a final rule issued July 29, 2011 by the Centers for Medicare and Medicaid Services (CMS), *"Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2012,"* which will decrease program payments to such facilities by 11.1% beginning on October 1, 2011. The agency's final rule will be implemented in order to correct overpayments to facilities apparently resulting from changes in provider behavior.

As Chairman of the Senate Special Committee on Aging, I am well aware that the nation's nearly 16,000 nursing homes depend heavily on both Medicare and Medicaid reimbursement. With Medicaid nursing home rates in most states now substantially lower than Medicare reimbursement rates, and with the possibility that economies in some states may not fully recover for several years, the lack of analysis on how federal and state policy together impact the nursing home sector across both Medicare and Medicaid is troubling.[1]

In view of the key role played by MedPAC and MacPAC in advising Congress on reimbursement and coverage policy, I would like to request that your organizations combine efforts to provide high-level, clear analysis of the impact of both federal and state policy changes on total reimbursement rates on nursing homes on an ongoing, periodic basis.[2] With 70 percent of nursing facility patients reimbursed by

[1] Medicare reimbursement information comes from: Medicare & Medicaid 2010 Statistical Supplement Review (Table 6.2). https://www.cms.gov/MedicareMedicaidStatSupp/09_2010.asp and Medicaid information comes from: The Lewin Group, *Medicaid and Long-Term Care: New Challenges, New Opportunities*, (2010):20. http://www.lewin.com/content/publications/Genworth_Medicaid_and_LTC_Final_Report-6.23.10.pdf#page=25

[2] Medicare SNF rates cover more than typical Medicaid NF services packages, e.g. physical therapy and occupational therapy. Also services included in Medicaid packages vary by state (source: LeadingAge)

Medicaid, it seems contrary to reason that these two funding sources are not considered together when making reimbursement decisions.[3]

Indeed, the Affordable Care Act charges MedPAC and MacPAC with coordinating analysis in a number of key areas, including policy on dually eligible beneficiaries.[4] If such coordinated analysis included nursing home services, this would improve the understanding of policymakers in addressing the quality of care provided to Medicare and Medicaid beneficiaries receiving services in these settings, as well as the cost-effectiveness of those services across both programs.

Currently, non-profit facilities in Wisconsin and across the country are reporting a 9.5 percent margin compared to a 20.3 percent margin for for-profits in 2009.[5] Additionally, many states are looking to further reduce Medicaid spending by reducing reimbursement to Medicaid providers and to increase beneficiary out-of-pocket costs. According to the 2011 "Fiscal Survey of States" by the National Governors Association and the National Association of State Budget Officers, "almost all states are planning to contain Medicaid costs in proposed fiscal 2012 budgets. Proposals for fiscal 2012 include reducing provider rates (33 states) and freezing provider rates (16 states), enhancing program integrity efforts (32 states), limiting spending on prescription drugs (27 states), limiting benefits (25 states), instituting new or higher copayments (21 states), changing the delivery of care (20 states) and expanding managed care (19 states)."[6]

Absent careful planning, continuing reductions in Medicare SNF reimbursement levels, coupled with budget pressures to reduce Medicaid rates, could over time have a negative impact on the ability of facilities, particularly those in the non-profit sector, to continue providing quality care.

CMS' Center for Medicare and Medicaid Innovation is currently administering various demonstrations that are designed to spur states to establish new, high-quality and cost-effective methods for serving dually eligible beneficiaries in coordinated care models. This is a welcome development, but it is not clear that these will produce recommendations and solutions for improving nursing home care.

I would ask that as your respective Commissions continue their excellent work, that you give serious consideration to coordinating recommendations on nursing home reimbursement policy in future reports to Congress.

Sincerely,

Herb Kohl

Herb Kohl
Chairman

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[3] Marwood Group, *Washington Healthcare Report,* Vol.10, No. 2(2011):33.

[4] "CONSULTATION AND COORDINATION WITH MEDPAC.—"(A) IN GENERAL.—MACPAC shall consult with the Medicare Payment Advisory Commission (in this paragraph referred to as 'MedPAC') established under section 1805 in carrying out its duties under this section, as appropriate and particularly with respect to…those Medicaid beneficiaries who are dually eligible for Medicaid and the Medicare program under title XVIII, adult Medicaid beneficiaries (who are not dually eligible for Medicare), and beneficiaries under Medicare. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MedPAC."

[5] Marwood Group, *Washington Healthcare Report,* Vol.10, No. 2(2011):33.

[6] National Governors Association and the National Association of State Budget Officers, *The Fiscal Survey of States,* Spring 2011:51.