S. HRG. 106–109

IMPLEMENTATION AND IMPACT OF CHANGES MADE TO MEDICARE BY THE 1997 BALANCED BUDGET ACT

HEARINGS

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED SIXTH CONGRESS

FIRST SESSION

ON

FEE-FOR-SERVICE AND MEDICARE+CHOICE PROGRAMS

MARCH 17, JUNE 9 AND 10, 1999

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IMPLEMENTATION AND IMPACT OF CHANGES MADE TO MEDICARE BY THE 1997 BALANCED BUDGET ACT

WEDNESDAY, MARCH 17, 1999

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:05 a.m., in room SD–215, Dirksen Senate Office Building, Hon. William V. Roth, Jr. (chairman of the committee) presiding.

Also present: Senators Grassley, Hatch, Mack, Moynihan, Baucus, Rockefeller, Breaux, Graham, Bryan, and Kerrey.

OPENING STATEMENT OF HON. WILLIAM V. ROTH, JR., A U.S. SENATOR FROM DELAWARE, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will please be in order. We are here today to hold our second Medicare hearing before the Senate Finance Committee in the 106th Congress.

As was noted last week, the Balanced Budget Act of 1997 was the largest Medicare spending and policy change package since the inception of the program in 1965. And as a result, many important issues have arisen in the Medicare program. And I plan to explore them in the committee during this session.

Today, I would like to focus our attention on the implementation and impact of these provisions in both the fee-for-service and the Medicare+Choice Program.

There have been significant delays in implementing certain policies that have resulted in consequences for both beneficiaries and providers. Delays in implementing the hospital out-patient department policy has been very costly to beneficiaries. HCFA actuaries estimate that beneficiaries will pay $570 million in higher co-insurance payment as a result of the delay.

In addition, regulatory burdens and payment issues in the Medicare+Choice Program resulted in almost 100 plans withdrawing or reducing these services to beneficiaries last year.

In fact, Senator Moynihan and I are developing a Medicare+Choice bill to address some of these concerns and will be asking members to co-sponsor our bill shortly.

The committee is honored to have Nancy-Ann DeParle, the Administrator of HCFA to testify before us for the first time. Certainly, we appreciate the pressures HCFA has faced in ensuring

Y2K compliance and the implementation of more than 335 provisions from the BBA.

In addition, we very much appreciate the participation of two other witnesses: Dr. Gail Wilensky, the Chair of the Medicare Payment Advisory Commission and Dr. William Scanlon, Director of Health Financing and Public Health of the GAO.

Senator Moynihan was delayed somewhat.

And do you want to make a statement, Senator Baucus?

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thank you very much, Mr. Chairman. This is obviously a very important and very difficult matter to solve Medicare. My man, my good friend sitting to my right, Senator Breaux from Louisiana probably knows as well as anybody, so does our next witness, Ms. Nancy-Ann DeParle. And in fact, all of us do. It is more difficult than Social Security.

And I hope that we do pass Medicare reform this year. It is taking work, a lot of work. My concern frankly is that it is more difficult in part this year because there is not quite the sense of a crisis that is necessary to force people to be less ideological and force people to be more rationale and comprising and meet the bottom line just to get the job done. And it is unfortunate.

In the very remote sense, I think part of it is the cold war is over and the American economy is doing very well. There is a psychology, well, what is the big deal, you know? What is the crisis? What is the emergency? And that is part of the problem that we face.

I think that sometimes in America, matters of great consequence are only accomplished under one of two conditions, first, as a crisis of extreme cases, Sputnik, Pearl Harbor, the depression, and so forth or where there is extraordinary political leadership.

This is not a time of crisis, although Medicare is certainly more of a crisis than Social Security. It is not enough of a crisis to force people to leave their ideological roots a bit to come toward some reasonable solution.

We do have wonderful leadership. I mean, you, Mr. Chairman, Senator Breaux, and others are trying mightily to solve this. But in this democracy, it takes many, many people to solve a problem.

I urge us to just come together a little more, to be a little less proud, to try to find a solution that fits basically for the American people, and remembering that we cannot let perfection be the enemy of the good. Too often, people push too hard for their own view. And if it is not close enough, they say no because it is not perfect enough.

Well, America is a good country. It is not a perfect country, but it is a good country. And we have to work for good solutions, not perfect solutions. And that it is particularly true because we are a democracy and where the people rule. There is no one person's position rules.

And as we approach solutions, Mr. Chairman, I also urge us to think about different parts of the country. I have mentioned this several times, but I very much hope that HCFA and those of us

who have worked to reform Medicare remember that there are teaching hospitals, as Senator Moynihan often reminds us.

There are rural parts of America, I mean, very rural not Indiana rural and not, all due respect to Senator Grassley of Iowa rural. I am talking about western rural. Some have heard me say this, but when Ms. Clinton was in Montana not too long ago, she said, this is not rural, this is mega rural, this is hyper rural. I mean, the distance, it is just totally overwhelmed her. And she is a smart lady. I mean, she has been around, but she was just overwhelmed with the sense of distance.

So Ms. DeParle, when you work through all of this and particularly as you implement the BBA regulations, I urge you to take distance into more account than HCFA has. You have a rule that there has to be—if I can read it here. It is called your TAGC-207 which states that there must be a practitioner at a critical access facility within 30 minutes.

That does not make any sense in the west. Take Jordan, Montana. You remember Jordan. Jordan is where all the freemen were causing a raucous a few years ago. Well, there are not a lot of people around Jordan. and the nearest dock is probably Mile City, you know, 60 or 80 miles away. And it just does not make sense to have the 30-minute requirement, certainly not in eastern Montana and probably not in Alaska and some other States, too.

And so I urge you very strongly to go back and review that because the law actually says the BBA. And I will stop with this, Mr. Chairman. Section 4201, it says a State may designate a facility as a critical access facility if the facility makes available 24-hour emergency service that a State determines is necessary and not HCFA, the State. So please go back and change that. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Baucus.

I was going to try to shut off all other comments, but just let me publicly recognize the strong leadership that Senator Breaux has brought to the commission. And I think all of us here appreciate very, very much what he and the others member of the panel have done.

And I just want to publicly say to you, Senator Breaux, that we intend to move ahead. We are very much interested by the leadership you have shown and the results of that leadership. We will hold hearings on it.

Senator Baucus, as I said yesterday to the press, it is my intent to move ahead and mark up legislation in a bipartisan fashion as we always do in this committee. So I look forward to working with all of you in that spirit.

And with that, I will call upon Senator Breaux.

OPENING STATEMENT OF HON. JOHN BREAUX, A U.S. SENATOR FROM LOUISIANA

Senator BREAUX. Thank you very much, Mr. Chairman. And thank you for your nice comments. I appreciate them very much. This obviously was an effort by many, many people on the commission that we are trying to really bring about serious reform to a system that while it is a wonderful system, it is still a 1965 model

that does not work as well as it should in the 1999s and as we move to the 21st century.

Members of this committee were on that commission. Senator Graham, Senator Kerrey, and myself all served on that commission and look forward to trying to bring the same type of similar recommendation to the commission for their consideration.

I will point out that while the package did not get the super, super majority that was required, it did receive a majority of the commission, in fact more than a majority. In making that recommendation, I have submitted that document to the legislative council. They are in fact now drafting it in legislative form to present to the Congress hopefully in a bipartisan fashion and hopefully for consideration favorably by this committee.

I would just make one comment and thank you for having these hearings. I mean, the fact that we are having these hearings points out the basic problem. I mean, the Balanced Budget Amendment of 1997 cut $115 billion out of the program. And some would say, well, we did not hurt the beneficiaries. Well, yes, we did because we hurt the people who provide the services to the beneficiaries.

You directly have an affect on the services when we continue to use what I have called the same old-same old approach of saving Medicare. Every year, when we have a problem with Medicare, we do the same thing, SOS, same old-same old. We cut reimbursements to doctors and hospitals and providers. And we announce that we have fixed the program.

And then, we come back in about eight to 12 months later and we have hearings to try and undo what we did the time before because we are getting flak from everybody out there who are providers who are saying we cannot do it anymore. And everyone of us have horror stories about beneficiaries who are not getting adequate service or not being accepted into the program. Providers are not wanting to do those services for the reimbursement rates that Congress is mandating.

And the final point is we should not be doing this. I mean, we are micromanaging health care by body parts. I mean, I have given examples so many times. It is so repetitious about we making a decision about whether we should do colon cancer screening by using barrier minimums of colon microscopies. I mean, should we be deciding that in this committee? That is what we have to do. And it goes on and on and on and on. We cannot continue under this process and have a health care system for the 21st century that is going to work. Thank you.

The CHAIRMAN. Thank you, Senator Breaux. And as I said, we look forward to having your legislation referred to this committee. It is my intent to move very rapidly in holding hearings and developing a bipartisan consensus.

With that, I would like to call forward Ms. DeParle for her testimony. It is the first time I think you have been here for the purpose of giving testimony. And we welcome you and look forward to your comments.

STATEMENT OF HON. NANCY-ANN MIN DEPARLE, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, DC

Ms. DEPARLE. Thank you. Mr. Chairman and distinguished committee members, thank you for inviting me here this morning to discuss our progress in implementing the Balanced Budget Act that added another 10 years to the Medicare Trust Fund.

As you say, Mr. Chairman, it was the most significant piece of legislation in Medicare's history and made some of the most significant changes ever to the program. And it has been, to say the least, a very challenging year at the Health Care Financing Administration.

And I want to thank the members of this committee. I have met personally with many of you to discuss concerns that you have had about the Balanced Budget Act and HCFA's implementation over the year. And you have given us advice in how we go about doing the implementation. It has been very helpful to us.

It has been a year since I became administrator. And the first thing I had to do, Mr. Chairman, was to put together a team of people to help me move forward at the Health Care Financing Administration, including many clinicians who had expertise in the private sector in the managed care area. And one of them is with me today, Dr. Bob Berenson.

I had four goals when I came to HCFA and when I came to this committee to ask for your approval for my confirmation. I listed those goals. And I just want to mention them again. The first one that I mentioned to you was implementation of the modernization of Medicare through the Balanced Budget Act. And that is what we are here to discuss today.

Secondly, implementation of the new historic Children's Health Insurance Program on which we have made a lot of progress in the last year, as I know you are aware.

Third, I thought it was important that we sharpen our focus on fraud, waste, and abuse. And in that area in particular, I have had particular help from many of the members of this committee, including Senator Graham who is here today.

And fourth, as you mentioned, Mr. Chairman, we had a big problem with the year 2000 computer challenge and our 60 carriers and intermediaries in the 78 computer systems that they run and getting those compliant so that we could make sure that there was no disruption in services to our beneficiaries.

So we had a lot on our plate over the last year. And today, I am here to talk about our progress in implementing the Medicare reforms in the Balanced Budget Act.

As you say, there were 335 provisions affecting our programs. We have already implemented more than half of those. And many more of them are partially implemented. And we have been providing you, as I believe I promised you when I appeared before you last year, with updates on where we are, which things have been delayed, and which things are moving forward.

I believe we have made steady progress in implementing important new benefits and fee-for-service payment reforms. We in fact issued 92 regulations last year which I think must be a modern

record. And all of that was in furtherance of implementing the Balanced Budget Act.

Some of the provisions of the Balanced Budget Act, as you are focusing on today, involve complicated, new, prospective payment systems and other complex changes. And I want to emphasize to all of you that we understand the need for refinement with changes of this magnitude. And we want to work with the committee and with providers to make sure that we protect beneficiary access to care and are fair to providers as we proceed.

We have also made solid progress in implementing the Medicare+Choice Program. We have converted the vast majority of Medicare HMOs to the new Medicare+Choice Program. As you know, Mr. Chairman, we had some surprises last fall, including in your home State of Delaware, with a number of plans who made business decisions not to participate for this year.

In the end, about 50,000 beneficiaries were affected and were left without another Medicare+Choice plan. We are on schedule to implement a fair and more accurate payment system that takes individual beneficiary health needs into account. And we are proposing some changes this year to the Medicare+Choice Program that we hope will make it easier for plans to participate. And we want to work with this Congress to get those implemented.

We are also in the process of implementing a carefully planned National Medicare Education Program to help beneficiaries make informed health care decisions.

I want to mention that we are on track to implement the competitive pricing demonstration for health plans that was called for by the Balanced Budget Act.

And in that regard in particular, I want to thank this committee and particularly Senator Breaux and Senator Mack who is not here and also Senator Graham for their work in fighting for this competitive demonstration which we think will help provide the objective data and actual experience that is needed to evaluate Medicare reform proposals that assume savings from competition among plans.

And at the same time, we have made some major strides in fighting waste, fraud, and abuse in Medicare. And in fact, we cut our payment error rate in half in just two years.

As I said at the outset, we are also tackling the most difficult year 2000 challenges in the government. And this has had to be our top priority over the last year. It has forced us, Mr. Chairman, to make some difficult decisions, including delays in some BBA provisions that I am prepared to discuss with you today.

The vast majority of the provisions in the Balanced Budget Act have not had to be delayed, but on the advice of some independent experts that I brought in, I made the difficult decision last year to delay a couple of the new provisions that could interfere with the year 2000 work.

We will make every effort to work with the Congress and to implement those provisions as soon as we can, as soon as we get the year 2000 work done. And we want to work with you to minimize the impact of any delays.

I think everyone here recognizes that implementing the tough, bipartisan choices that we had to make in the Balanced Budget Act

is an enormous task. And I appreciate that you have all been cognizant of the enormity of that task. I appreciate the support and advice that I have received from the committee.

And I want to mention that the Medicare Payment Advisory Commission in the General Accounting Office has also been very helpful in making suggestions to us along the way in helping us to make refinements. And we look forward to continuing to work with this committee and the Congress as we proceed. Thank you.

[The prepared statement of Ms. DeParle appears in the appendix.]

The CHAIRMAN. Thank you, Ms. DeParle.

Let me reemphasize what Senator Breaux has said about the concern we have that if the providers do not feel that they are adequately paid it reflects on the kind of service the beneficiary is to receive.

And for that reason, I would like to ask you, what is the basis for the administration's proposal to freeze the annual hospital update for fiscal year 2000? Does HCFA have additional information other than MedPACs 1996 data on margins regarding how hospitals are fairing under the Balanced Budget Act?

I am concerned that this freeze in hospital updates may ultimately affect beneficiary access to care. Has HCFA considered this problem?

Ms. DEPARLE. Well, sir, I do not believe that—first of all, we are attempting to monitor the impact of each of the changes that have been made in the Balanced Budget Act, whether it is to home health providers which is an area that this committee has had an interest in or hospitals or other areas.

At this point, I do not think I have any independent data other than the MedPAC data about hospital margins. And I believe that is what the administration's proposal is mainly based on. And that is the fact that in 1997 and in fact during the years when there had been reductions, hospital margins in the aggregate had been at an all time high.

Now, I understand and have talked to several members of this committee about the fact that looking at it in the aggregate does not necessarily capture what might be happening in any particular community. And I think it is important that we do that sort of analysis. And we will be providing that to others in the administration.

The CHAIRMAN. I think it is extraordinarily important because at lease some of the hospitals are advising us that the profit margins have substantially reduced, that they find it very difficult to continue under current practices. If you freeze it further, what kind of impact is that going to have?

I am also concerned about the stability of the Medicare+Choice Program. You mentioned the fact that a number of plans have withdrawn. I think something like 100 plans have withdrawn. In fact, in my own State Delaware, all three health plans left the program, although one new plan has recently joined or come back in to cover part of the State.

What steps are you taking within your authority to make sure this program works well for health plans and beneficiaries?

Ms. DEPARLE. Well, I want to say first, Mr. Chairman, you are exactly right, stability is very important in this program. And it is important to our beneficiaries. And that is a big part of what I want to try to achieve.

One of the things that we have done, and I have met with your insurance commissioner in Delaware and with other plans from around the country, is to try to make some changes within our authority and where we do not have the authority, to come to you and work with the Congress on where we can make some changes. And I think that you were working on some of those as I understand it right now.

One thing is moving the deadline when plans have to submit their information to us from May to July which we think will help plans to have a more of a sense of the marketplace so they will not have to be making last-minute decisions.

We have also, sir, delayed our—under the Balanced Budget Act, we were required to implement risk adjustment which over the long run, I think will be a very good thing for Medicare and for health plans because it will pay them more accurately and more fairly for providing the care. But because of the concern about stability that you mentioned, we are implementing it in a phased-in fashion over 5 years.

So those are just a couple of the things that we are doing. And we are open to working with you on other things.

The CHAIRMAN. Recently HCFA began the implementation of Oasis standards for home health agencies. And it is my understanding that these standards were created to address quality issues within the agencies. However, I am very concerned that this lengthy, 19-page questionnaire is burdensome to the agency and does raise some very serious confidentiality concerns.

I understand I have not had the chance to study it yet, but there are all kinds of questions about one's health that normally are private. How do you intend to address these problems of privacy?

Ms. DEPARLE. Well, sir, the Oasis instrument is something that was designed to meet a mandate of the Congress that every home health agency provide an assessment of the status, the health status of the people that they are caring for.

In order to minimize the burden on home health care agencies, when the Congress implemented or enacted the home health prospective payment system, the requirement that we do that, we decided to use the same instrument to collect information that will help us to design the payment methodology for the home health prospective system. So it is the same instrument.

And I have studied it myself, sir, as have the clinicians within the Health Care Financing Administration. You should know that it was developed I think starting back in 1988 through research by clinicians and others at the University of Colorado Health Policy Center. And they did a number of tests of this. Many home health agencies have already been using it.

And I think as a data collection instrument, it is a good tool. I think the issue that you are raising though is the privacy issue which I am very concerned about. It does comply with the Privacy Act as do all Medicare data collection instruments, but we are working on now looking at it to make sure that it in every way pos-

sible protects the privacy of beneficiaries because that is something that I feel very strongly about.

The CHAIRMAN. Nineteen pages, and this has to be filled out for everybody whether or not they are covered by Medicare?

Ms. DEPARLE. Yes, sir. And the reason for that is under the law, what are called the conditions of participation, the way that Medicare certifies providers to participate in the Medicare program are supposed to apply to all people who get cared for by a home health agency or hospital.

And the reason is that the Congress in setting up the Medicare program wanted it to improve the quality health care provided not just to people who happen to be beneficiaries of Medicare, but to everyone. You would not have a hospital that only had to meet standards for Medicare beneficiaries and not for everybody else. So it is the same thinking that led to this for the home health agencies.

The CHAIRMAN. Well, as I said, I have not had a chance to look at it carefully, but I find it very, very troublesome, you know. It says high-risk factors characterizing this patient, heavy smoking, alcohol dependency, drug dependency, none of the above. And these questions are to be answered I gather on all home health care patients. Is that correct?

Ms. DEPARLE. Yes, sir. And it is like what would happen if you go to the doctor today. The clinicians who work at HCFA advise me that those are the types of questions that a doctor is supposed to be considering. And they are relevant to how you would go about caring for a patient.

And frankly, sir, they are relevant to the concern that you raised at the beginning of this hearing which is the adequacy of payment to a provider. If a beneficiary has certain risk factors, then I could argue that a provider should get a higher reimbursement for caring for that beneficiary because it is more complicated.

The CHAIRMAN. Well, I just want to say that I am very much concerned. And we are going to have to look into this deeper because as I understand the questionnaire, it involves mental health, financial ability to pay and financial background. It is a very reaching document that I think many people will find repugnant to answer from the standpoint of their own privacy. So we will want to talk further.

Let me ask one further question. Over the past 6 months, Congress provided $200 million to HCFA for Y2K compliance in addition to the $82 million originally appropriated for fiscal year 1999. And despite these funds, the Medicare program has experienced costly delays to postponed implementation of the Balanced Budget Act provisions.

Could you please provide me with an update as to HCFA's status on Y2K compliance and discuss the differences between HCFA and GAO on the agency's readiness? I would also like to know what steps have been taken with respect to your contractors.

Ms. DEPARLE. Yes, sir. First of all, I want to thank the committee and the Congress for helping us on the year 2000 computer challenge and providing us the resources that we need to get the work done.

The $200 million that you mentioned, Mr. Chairman, is for repairing the contractor systems. We had 50 million lines of code that had to be renovated and tested in order to be sure that we can pay claims starting January 1, 2000.

The problem with the Balanced Budget Act that occurred last spring is that on GAO's recommendation—and I want to thank them for their help on this. One of the first things I did when I got to HCFA was meet with them. And they told me that I needed to hire an independent verification and validation contractor, an IV&V contractor to come in and basically look over our shoulders and over our contractor's shoulders as they did this work to make sure that it was really on track.

And I did that. And the IV&V contractor told me that the work was much more detailed and much more involved than we had thought and that if I did not stop implementing some of the Balanced Budget Act provisions and other things that we were doing that it would put our systems at risk of not being prepared for January 1, 2000.

So as I said, I had to make a very difficult choice. Believe me, the last thing I wanted to do was to delay implementation of the Balanced Budget Act provisions, but I had no choice.

So the funding that you have given us made it possible for us to make the progress that we have made. And we have made a lot of progress this year. And I believe GAO would agree with that.

The differences between us that you raised at the end have to do with in December, I had added a contract amendment for all of our contractors, requiring them to be Y2K compliant by the end of December. That is earlier, as you know, than the government-wide deadline.

All of the contractors submitted information saying that they were compliant. We reviewed their information and decided that only 54 of them really met our test. GAO disagrees with that and thinks that some of them did not really meet the test. And it has to do with whether they fully completed their future date testing. And we just have a disagreement there. but I think they would agree that we have made enormous progress.

And I will tell the committee that I can assure you this is our number one priority and that there is no disruption in services on January 1, 2000. And we will be ready to pay claims. And we hope all the providers will be ready as well.

The CHAIRMAN. Well, my time is up. I do have further questions, but we are going to keep the record open until 7:00 o'clock tonight for written questions.

Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman.

Ms. DeParle, could you just comment? You have had a little time to think about the question I asked of you with respect to the critical access facilities. I do not know if you have had a sufficient chance to dig into it.

Ms. DEPARLE. I actually know about this.

Senator BAUCUS. All right.

Ms. DEPARLE. And as you know, I have enjoyed spending time in Montana.

Senator BAUCUS. Right. And I want to thank you very much for taking the time to come to Montana, too. As I said earlier, it is long distance. And thank you very much.

Ms. DEPARLE. It is. And I have been from glacier down to where Senator Rockefeller spent some time. So I know that——

Senator BAUCUS. In that another State in the west, West Virginia?

Ms. DEPARLE. But you have to go all the way through Montana.

Senator BAUCUS. Well, that is West Virginia. Right.

Ms. DEPARLE. Well, no, I mean, the part of Montana and Wyoming that he spent some time. So I know what you mean about how rural it can be in the west. And I have met with our staff about the problem that the Montana facilities may have under the new critical access hospital provisions.

And I can tell you that my goal is to effectuate what Congress intended here. And that is what I am looking at in trying to make a decision about this.

Senator BAUCUS. Can I help you?

Ms. DEPARLE. I believe I know.

Senator BAUCUS. By telling you what Congress intended.

Ms. DEPARLE. I am very familiar with it.

Senator BAUCUS. So you do not have to worry about it.

Ms. DEPARLE. I would be happy to hear it.

Senator BAUCUS. Well, the statute is pretty clear. It says that States decide. And as far as I am concerned, the intention is to make sure that there is some kind of a critical access facility available to people who do live in very rural areas. And we just need to have regulations tailored to the State and tailored to the setting.

As you know, eastern Montana is very rural compared with western Montana. And you said you have been to Wyoming and Glacier Park and so forth. That is not eastern Montana. I do not remember if you made it out to, say, Jordan or Circle or Ecolacka or some of those towns in eastern Montana that have critical access facilities. I mean, they are really rural.

Just as a side line here, I took Senator Mitchell when he was majority leader to Montana several years ago to show him a VA facility in eastern Montana. And I met the plane in Williston, a little charter plane. We were putting across North Dakota and then into Montana. And Senator Mitchell had turned to me after a couple of hours in this twin engine prop plane. He says, Max, are you sure we have not passed Montana? [Laughter.]

Senator BAUCUS. We were supposed to land in Billings and drive back to Mile City. But it is very, very, very rural. Our State has a total population density of six people. We have about 150,000 square miles, about six people per square mile. And in eastern Montana, it is much less dense, fewer than six per square mile, many fewer. I would say about two or three per square mile.

And so if you could just go back and look at those regulations because when we talk about rural economic development and we talk about rural health care, again, there is rural and there is rural. Eastern rural is not western rural.

And it is does not rain west of the 100th meridian. It does not rain. Because it does not rain, there are not people. It is just a great distances. You cannot grow crops very well where it does not

rain. You cannot have towns and cities where it does not rain, you know. It is that fact of lack of rainfall west of the 100th meridian that dictates and causes this great sense of distance.

For example, here in Washington, DC, our annual precipitation is about 44 inches of precipitation a year. It would be close to 50. In eastern Montana, it is about 12, 10, 12. That is snow. That is rain. That is everything.

So if you go back and look at that and if I could get a report back from you, say in the next week or two as to what you can do to change that regulation according to the intent of Congress, I would appreciate it.

Ms. DEPARLE. I will do that.

Senator BAUCUS. Thank you.

And Mr. Chairman, thank you very much.

The CHAIRMAN. Your description of Montana reminds me of Delaware. [Laughter.]

The CHAIRMAN. But I have been there. I know.

Senator BAUCUS. And this will help you, too. Our illustrious chairman and I graduated from the high school. It is Helena, Montana.

The CHAIRMAN. And I always add the same year. [Laughter.]

Senator BAUCUS. And so he knows what we are talking about here.

Ms. DEPARLE. He does.

Senator BAUCUS. Thank you.

The CHAIRMAN. Senator Grassley.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. Thank you, Mr. Chairman. And on the point that Senator Baucus made, we may be less rural than his State is. But also, as we anticipated the Critical Access Hospital Program, we thought even in our State that there might be 10 hospitals that would qualify. And I think we are having the same problems that he is having with these regulations. So I would also back up what he says and ask you to look into it.

The first question is very broad, but it is pretty basic to correcting some of the mistakes that we made in the 1997 Balanced Budget Act. Some of them, I think we made. I think some your department made in the enforcement or carrying them out for reasons that you have already given that are probably reasons we could not even anticipate.

But regardless, this would be about the administration's thinking that we ought to take because CBO has published a new baseline on Friday. It projects that spending for some benefits is now estimated to be radically lower than the estimates made immediately after the enactment of the bill in 1997.

And obviously, this is very good news for Medicare solvency, but I am wondering whether or not you think it is bad news for seniors. So then, the question very broad, are there any areas in Medicare where you believe Congress or HCFA need to revisit the Balanced Budget Act policies in order to maintain access to service for beneficiaries?

Ms. DEPARLE. Well, there is one area. And I have already mentioned that with Chairman Roth which is in the Medicare+Choice Program. We have made a number of recommendations.

And I have been working with the committee and with the Congress on those to try to make the program work more the way we think Congress intended and to protect beneficiaries as well.

We are recommending some MediGAP changes that I know we have been talking to the committee about. So that is one area that I think we can already say we would like to work with you on.

As far as the baselines are concerned, Senator, I have studied the differences between the President's budget baselines and this new CBO baseline.

And it is interesting because both baselines have reduced, have been dropped quite a bit. And as you know, our actuaries estimate that Medicare spending last year, the spending growth was only 1.5 percent which is very low compared with the past averages.

And in general, I think it is very good news. And we are monitoring around the country what is happening with particular benefits to see whether there are problems with access. And we are also working with colleagues at GAO and other places that are looking at it.

So far, we are not seeing in the fee-for-service world particular problems.

Senator GRASSLEY. Well, can I——

Ms. DEPARLE. There may be some. And if there are some, we want to work with the Congress on them.

Senator GRASSLEY. Could I ask you then if you could comment maybe in three specific areas along the lines of my first question: hospital in-patient care, skilled nursing facilities, and home health care?

Ms. DEPARLE. Well, with hospital in-patient care, something interesting happened last year that is reflected I think both in the President's budget baseline and in the CBO baseline which is that for the first time ever in-patient care coding. What they call the case mix complexity dropped.

And the actuaries actually attribute that not to spending reductions, but to the increased emphasis on appropriate billing and something that you have been very interested in, fraud, waste, and abuse and frankly the efforts of our law enforcement partners in some pretty high-profile cases.

We are not seeing at this point problems in in-patient hospitals, but as I said we are looking at that and want to continue to monitor it because some hospitals are under enormous pressure.

I am sorry. The second area you mentioned.

Senator GRASSLEY. Skilled nursing facilities and also home health care.

Ms. DEPARLE. Skilled nursing facilities, again the data that we have shows that admissions are down. And that was something I was particularly interested in because you had a hearing last year in the Aging Committee on home health and asked us to look at that and see whether admissions were going to go up to nursing homes as a result of the home health reduction. So far, we have not seen that.

Two areas have been raised to my attention though that I should mention. One is that under the Balanced Budget Act, there are reductions made to what are called non-therapy ancillary services. And some of the nursing homes that treat high acuity patients are concerned that those reductions could affect their ability to care for those patients.

We are doing some more research in order to do some refinements to the prospective payment system for skilled nursing facilities to reflect that, but those nursing homes are a concern.

There are also some caps on therapy that you may be familiar with that were actually something that the House put in. There is a concern that those caps for therapies could have an effect on stroke patients and people who have particularly needs. It is $1,500 per year.

And as I said, I have gotten a few letters about that not from beneficiaries, but from the skilled nursing facilities.

And in home health, I think you know. As I said, we have been monitoring that. There are fewer home health agencies now, but the data that we have reflects both branch consolidation of the home health agencies.

And so far, we are not seeing a problem in access, but we will continue to monitor that. And we will work with you and with the Congress if that turns out to be a problem.

Senator GRASSLEY. My time is up. But just in Des Moines, Iowa, a community of 250,000 in our State capital, we had 23 home health agencies. And I think nine or 10 of those have gone out of business or consolidated, as you indicated which I do not know whether it has had a negative impact, but I think we need to be monitoring those sorts of happenings.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Grassley.

Senator Breaux.

Senator BREAUX. Thank you, Mr. Chairman.

Thank you, Nancy, for being with us. Let me just say that you have an impossible job. I mean, it is absolutely impossible to micromanage health care in the 21st century like Congress is requiring you to do every day and come up with anything that makes sense. I know you are doing a terrific job with the instructions that we give you. And then, after we give them to you, we change them. And after we change them, we change them again.

Give me an update, if you will. I mean, BBA said we are going to save $115 billion. And one of the ways we were going to do it was by slowing the growth rate for doctors and hospitals, but principally we were going to a prospective payment system for home health care, for rehab hospitals, and for out-patient departments.

Can you give me an update on the status of the PPS payments with regard to each of these, first skilled nursing facilities?

Ms. DEPARLE. Yes, sir. That one was mandated by the Balanced Budget Act to be implemented July 1, 1998. And we did that. There is one aspect of it, consolidated billing for Part B services that is on hold because of the computer changes that we have to make for the year 2000. But the rest of it, we have gone forward with implementing.

And as I was saying to Senator Grassley, there are a couple of areas where——

Senator BREAUX. You mentioned non-therapy ancillary services.

Ms. DEPARLE. Yes.

Senator BREAUX. But what are you going to do about that?

Ms. DEPARLE. Well, we are doing research right now to refine the resource utilization groups, the payment methodology so that it can we hope more accurately reflect the cost of high acuity patients.

Senator BREAUX. So you are going to use the RUGs system?

Ms. DEPARLE. Yes, sir. Yes, sir, that is what we have implemented. If the research does show that in fact the RUGs do not accurately reflect the cost of caring for these higher acuity patients, then we would make a change for that system. And we think we have the authority.

Senator BREAUX. What is your timing on that?

Ms. DEPARLE. I believe the research is scheduled to be back to us some time late this year. So a change would not be able to take effect until some time in 2000 I believe.

Senator BREAUX. What is the status with PPS for home health care?

Ms. DEPARLE. With home health, as you know, the original requirement was that we implement it in 1999, in October of this year. We could not do that because it was a very ambitious date to begin with. But with the year 2000 computer changes, it is very complicated to make these kind of computer changes. And we could not do it.

And I want to say that I appreciate the Congress last year making a change in that requirement in the Balanced Budget Act. And we are now mandated to have it implemented on October 1, 2000. And we are on track to do that.

Senator BREAUX. So you are still in your interim payment basis for home health care. And I got high-cost patients and low-cost patients. And my State tells me that everybody is going busted and broke. Your numbers are different.

What is the correct number on the number of home health agencies that have closed from your perspective?

Ms. DEPARLE. Well, I just looked at this yesterday. And you are right, the interim payment system was also changed last summer. So we implemented one retroactive to October 1, 1997. That was the BBA one. And now, we are implementing another one that was changed last summer.

What I understand is that there are about 1,000 fewer home health agencies today than there were in October 1, 1997.

Senator BREAUX. Do you have numbers on Louisiana?

Ms. DEPARLE. Yes, sir, I do.

Senator BREAUX. She handed you a sheet on your right there. I do not know if that is it.

Ms. DEPARLE. It is. Thank you. In fact, the reductions that have occurred, it appears that most of them occurred in four States: Texas, Oklahoma, Louisiana, and California.

And it is interesting because those are the areas where there was the most growth in home health agencies. And it looks like Lou-

isiana had 519 home health agencies as of October 1, 1997 when all this started.

Senator BREAUX. I mean, as a comparison, that is more than any other State in the Nation, except Texas and California?

Ms. DEPARLE. That is exactly right. That is exactly right.

Senator BREAUX. All right.

Ms. DEPARLE. Texas had almost 2,000. And California had 854. And in Louisiana, it looks like 112 have voluntarily closed. But as I said, Senator, our information about closure reflects both consolidations, closures of branches as well as actually shutting the doors. So it is hard to say from that.

Senator BREAUX. Industry tells me it is 250 that have closed. But you do not necessarily agree with that?

Ms. DEPARLE. You know what? I believe though I have talked to some of those folks because I met some of them when I was with you in Louisiana last year. And I think their data includes branches as well. So I am not certain. But our numbers show that about 8 percent of them have closed. And for the rest of the country, it is about 4 percent of agencies. So those four States are the places where most of it has occurred.

Senator BREAUX. All right. What is the status of rehab hospitals?

Ms. DEPARLE. On rehab hospitals, the Balanced Budget Act requires us to implement a prospective payment system on October 1 of 2000. We are in the middle of the research on this right now.

There are issues about whether we use a per diem system versus a per discharge system. And Dr. Berenson who is with me today and his staff are working on what the right way to go is on this. And we are reviewing the recommendations of the MedPAC and of the GAO on that. It is very complicated.

Senator BREAUX. Does anybody, Mr. Chairman, does anybody in Congress really understand any of this? I mean, this is just like the absolute bizarre micromanagement of health care that anybody could—if we tried to make it more complicated, we probably could not do it.

I mean, we are debating whether you are going to use the RUG approach to evaluating patients in rehab hospitals. Or whether we are going to use the FIM/FRG methodology which stands for the research utilization groups or the functional independence measure and functional relation groups.

I mean, does anybody wonder why people have problems with all of this, the way we are doing it? I mean, I am not criticizing you. We passed these laws. And then, we change them about every 8 months to make it even more complicated, confusing, and difficult.

So the final question is a follow-up. Are you going to do the RUGs or are you going to do the FIM/FRG type of approach on rehabs?

Ms. DEPARLE. We have not made a decision yet.

Senator BREAUX. When are we going to have a decision on that?

Ms. DEPARLE. Well, we are still doing the research. And we are on track to implement this system October 1, 2000. To do that, Senator, we have to publish a regulation by this fall to implement the system next fall. So between now and this fall, we would have made a decision. And I will commit to you that we will come up and consult with you all before we do that.

Senator BREAUX. The final point, I mean, we had CBO, Mr. Chairman, testify last week. I guess will be presenting testimony formally tomorrow, but made a presentation before the committee.

And one of the interesting things that CBO points out is that the average time for processing all these claims rose dramatically in 1998. I mean, there were reasons for it, computer problems, more compliance activities requirements, everything else.

But an increase in one week, for example, an average time for processing a claim from a company or a home health care or a hospital or a rehab out-patient, an increase of one week in making the payments from Medicare to these facilities reduces Medicare outlays for the fiscal year by 2.3 percent. I mean, that is a real problem for people who are depending on their payments. Can you comment on that?

Ms. DEPARLE. Yes, sir, but if I could just make a point. Medicare pays faster than virtually anyone in the insurance market. You require us under law to pay what are called clean claims within 16 days I think.

I do think though that it is important to understand that fast payment is not the only goal here. In fact, one of the reasons why we have had some of the fraud, waste, and abuse problems we have had is because we may have paid them a little too fast without looking at them.

So the key here is I know you know is striking the right balance. And we do not want any providers to go without their payment. And there have been instances in the last year where it slowed down too much I think, but on the whole I think that you want us to be careful and prudent stewards of the funds and looking at them.

Senator BREAUX. You have done a tremendous job in an impossible situation.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Breaux.

And next is Senator Graham of Florida to be followed by Senator Bryan.

OPENING STATEMENT OF HON. BOB GRAHAM, A U.S. SENATOR FROM FLORIDA

Senator GRAHAM. Thank you, Mr. Chairman. I would like to ask some questions about the withdrawal of health maintenance organizations from many communities around the country. I understand that the total number of Medicare beneficiaries who are impacted by those withdrawals was approximately 400,000.

Have you done an analysis of what were the characteristics of conditions that led to HMO withdrawals?

Ms. DEPARLE. We have been engaged in that, Senator. And it is interesting. As you said, 400,00 beneficiaries were affected. Only 50,000 of those were actually left without another health plan choice. And the interesting thing is almost half of those were in Utah where both plans withdrew back in May of last year which is before all this stuff happened in fall.

In looking at it, it appears at first I thought it had everything to do with our payment rates for Medicare which, of course, with

the Balanced Budget Act and the reductions in fee-for-service that has driven a lot of reductions also in managed care.

But when you actually analyze it, I looked at some data from Florida and from some other States where the interesting thing is that the plans pulled out in a parallel fashion from the Federal Employees Health Benefits Program. And the reason that is interesting is because in that program, they got a 5.4 percent or something like that increase.

So it is not just all the payment rates. When you get below it—and I have actually been meeting with a bunch of the plan CEOs myself. In fact, I am meeting with two of them each week. And they tell me that there are other things like the difficulties some of them are having now in putting together networks of providers. In some States that has been an increasing problem.

The increase in prescription drug expenditures has been a tremendous problem for a lot of these plans. Some of them in Florida even had unlimited prescription drug benefits, no cap or anything. And they have been very terrified frankly by the 16, 17 percent increases there. So it appears to be complicated.

I want to be clear that some of the changes in the law last year like the submission date of the ACRs I think had an impact on this. They pointed out to me some ways in which they think our regulations went too far. And we have made some changes to accommodate them because I agreed with them. So it is a complicated thing.

What we want to do is to work together with this committee to try to avoid that situation for next year the best that we can, but I think we all have to realize that when we are doing business with the private sector this way, they are going to make business decisions. And I think our role has to be to make sure that if those decisions are made that are beneficiaries are protected. And that is where I am trying to position us.

Senator GRAHAM. If we are moving towards a Medicare system that is going to increasingly emphasize the private sector as an intermediary as opposed to the traditional fee-for-service system, it seems to me as a predicate for that more privatized system, we have got to be able to ensure beneficiaries that at least for the vast majority there will be some access to such a private intermediary.

Given the analysis that you have done, what do you think the Federal Government should do in order to create an environment that will achieve that result of a private sector provider, intermediary provider in most communities in the country?

Ms. DEPARLE. Well, I do not want to over simplify this because it is very complicated. But in my discussions with both plan executives who are the ones making these decisions and with beneficiaries and their advocates, the key word that comes out to me is the one that the chairman mentioned at the beginning of this which is stability. They both need to know what is happening and when it is happening.

And so I think it is too early to say whether changes need to be made to the payment methodology. I do not think we know that. For one thing, this year is the first year that the blend that this committee authored to try to help plans move into the less populated areas, this is the first year that that will kick in. And it looks

as though it is going to promise higher payment rates for some of those areas. It is too early to say about that.

But I think that whatever we do that we need to work together to promote stability, both for beneficiaries and for the plan so that they know what to expect and what is going to be happening in the next year. In that way, we can prevent these sort of precipitous withdrawals that you had to deal with down in Florida.

Senator GRAHAM. One area that I would suggest you might look at is the question of what is the appropriate catchment area for differentials in payment. This seems to particularly arise where you have a core urban county surrounding a number of suburban or rural counties, but there where is a lot of movement of people who may live in the rural county, but work in the urban county. And they have difficulty understanding why they have a different relationship with their HMO, including what the HMO is paid for the services than does their co-worker who lives and works in the urban county.

Ms. DEPARLE. It is a big problem. I have relatives in Florida who live in the Sarasota area. And they have relatives who live in Miami. And they do not understand why their relatives in Miami do not have to pay a premium and they do. It is difficult.

And yet, when I talk to the plans, they tell me that it is very important that they have the flexibility. In fact, they tell me that they would not be in Miami if they were not able to cushion their costs in Sarasota by charging a premium.

So it is an extremely complicated area, but I would be happy to work with the committee on a better way of doing it.

The CHAIRMAN. Senator Bryan.

OPENING STATEMENT OF HON. RICHARD H. BRYAN, A U.S. SENATOR FROM NEVADA

Senator BRYAN. Thank you very much, Mr. Chairman.

And thank you very much for your testimony this morning. You do have an extremely difficult job, as Senator Breaux pointed out.

I will not try to out-rural the distinguished Senator from Montana, but let me make a point that sometimes in consolidating the data and looking as you must at the big picture, sometimes the conclusions are unhelpful and even misleading.

And let me just cite one example. And I will get some questions. Nye County in Nevada, the third largest county geographically was listed recently as one of the 10 fastest growing counties in America. It has a very small base, about 28,000, 29,000 people. Most of that growth, almost all of it is in the southern part of the State, about 60 miles from Las Vegas.

My point is in Tonopaw which is county seat, the medical facility there is hinging on insolvency. I mean, it is in very, very desperate straights as are many hospitals in rural Nevada. Those critical access payments are going to be very important.

And if you look at Nye County and you say, well, look, this is a rapidly growing county, everything looks fine there, my point being in the northern part of the county which is 206 miles from Las Vegas, they are experiencing a real economic decline.

So the general data or the conclusion is decidedly unhelpful, misleading, and inaccurate in portraying an area that is so far re-

moved from Paromp, that is the area in the south that is growing rapidly, that their circumstances there bear no relevancy at all in terms of access to health care in the northern part of the county, just as an observation, if I may.

Point two, you indicated that the growth rate of Medicare, 1.5 percent. Is that an aberration? Or are we likely to see that, say, over the next four to 5 years in your judgment?

Ms. DEPARLE. I think it is probably an aberration. I am not predicting that we are going to return to high growth levels, but our actuaries project that over the next few years, it will be going up to 5, 6 percent a year.

They think that this past year was an aberration I think for a couple of reasons: one because of the tremendous reductions in home utilization as a result in all of the changes that we made there.

They cite our increased emphasis on waste, fraud, and abuse as having had an impact. And they note in particular there that the aspect of the hospital in-patient utilization that I mentioned where for the first time ever instead of coding all the pneumonia cases as the most complicated kind, you know, $8,000 a pop, they are now coding them at the least complicated kind.

So we are seeing those kinds of changes. And I do not think we necessarily think those are going to be long-term changes.

Senator BRYAN. And let me say that I think that there is good news there. And I want to compliment you in your efforts in terms of the fraud, waste, and abuse issue. Most people do not understand. And Senator Breaux is right. Most of the Congress frankly do not understand all of the complexities of this program.

But the one thing the public does understand is fraud and waste. And that engenders considerable reaction, as you know. And your efforts in this areas I think are helpful.

I think much criticism can be directed to the Congress for not providing the resources to emphasize that. We have done a much better job with the BBA as well as the previous enactment of the Kennedy-Kassenbaum which provided I think about $150 million of additional Federal resources to focus on this.

How much further can we go? How much more out there is there that we might reasonably expect to achieve some savings from?

Ms. DEPARLE. Well, I think there is more. We have reduced the error rate in half. It is now, you know, down quite a bit. And I would hope, my goal originally when I got there was, to try to get from, I think it was, 14 percent when I got there down to 5 percent by 2000. I am now hoping I can do even better than that.

There probably is some irreducible minimum that we cannot get rid of, but I am encouraged by, we just did a project down in Florida actually, Senator Graham, where we did some provider education. We developed a computer module that physicians could use to learn more about how to properly bill and document their claims.

And we actually went into residency programs where the young doctors have not started billing Medicare, but are learning these things. And it showed 20 percent increases in their ability to do this properly.

So I think there is still room to make improvements here. And there is a lot that the Congress has done to help us. And I want to thank the committee again for that.

Senator BRYAN. Do we need to do more? Or we have provided the tools that you need to get the job done?

Ms. DEPARLE. Well, the administration is asking for some more enactments this year to close some more of the loopholes that we found while we are running these projects. So we always have more things that we can talk to you about. But in general, you have provided us with the resources we needed to make a big step forward. And we appreciate that.

Senator BRYAN. Let me ask you the question. My time is about to run out. The question in terms of the caps on the physical therapy, the speech-language therapy, I mean, either it is truly an egregious mistake we have made or they are the most effective lobby in America today. I mean, you cannot step off the plane. You cannot have office hours either in your State or here without a steady stream of these who make an impassioned argument. I am not suggesting that they are inaccurate.

Give us your sense in terms of the reimbursement the cap. I mean, is that something that we went too far? Or are you prepared to reach any judgments at this point on that?

Ms. DEPARLE. Well, into effect on January 1 of this year. And I do not think we know yet, but a $1,500 cap on therapy about now or soon thereafter is when you would start to see that kick in. And we will know.

I asked in fact to see the letters that we have gotten on it. And we have gotten a number of letters from providers. I would not say a huge number. We have gotten some letters from providers. I do not have any letters or communications from beneficiaries yet.

But I will say, Senator, this provision is something that sort of cropped up at the end of the BBA negotiations. And we had some concern about it at that time. So I want to monitor it. And I will be coming back to the committee to tell you what we found because I think I am concerned.

Senator BRYAN. Yes. At what point will you have kind of a handle on in terms of whether we did in fact make this terrible mistake that the providers certainly argue that we have? How much time do you need to make that judgment before you can say, look, here is my recommendation, I think we ought to modify it, change it or make some other arrangements?

Ms. DEPARLE. Well, our data is somewhat lagged. So I would say it probably would be early summer before we will have anything that you would want to make a judgment on.

Senator BRYAN. Thank you very much, Ms. DeParle.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Rockefeller.

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Nancy-Ann, I just want to say that I think you are absolutely superb, that the country is lucky to have you, and that every time you speak about some subject, your Rhodes scholarship background

shows up loudly and clearly and that you have unlike some of your predecessors, but not all by any means, an extraordinary ability to listen.

I was not here at the beginning. I think what is going to happen with the failure of the Medicare commission yesterday to pass an agreed-upon plan is that it will not end up making much difference, that the plan will be introduced into this Finance Committee and the Ways and Means Committee.

I think there was a fairly large ideological split on the commission. I am glad that it did not pass for reasons which I will allude to in a moment, but my prediction is that it will pass this committee because although this committee does not know as much about health care as it thinks it does, it will be greatly appealed to by the idea of if HCFA or if the Federal Government is not making the progress that it thinks it should be, that somehow the private sector always can do it better.

And this committee is dominated not in total, but in some slight majority by people who think that way. And that is a very interesting philosophical argument to me because I have watched.

In a sense, you talk about the deregulation of Medicare. That would be hyperbolic. But I have watched the deregulation of railroads and how that has clobbered the 20 percent of captive shippers in this country who have only one line to their factory or to their grain reserve or their coal mine and how therefore the price gets dictated actually against the law by railroads. It is meant to be set by the Surface Transportation Board, but they failed to do that.

So railroads can do whatever they want and have and in West Virginia hold about 30 percent of our economy hostage, literally hostage, but the world does not know. And the world does not care because the world is not really interested in railroads.

The airline is deregulated. And we had Eastern and United and American in West Virginia, all jets. And within a month, they were all gone. And so now, we have propeller planes that are very small. And my knees and my chin meet. [Laughter.]

Senator ROCKEFELLER. I do not mind that, but it just makes it very difficult to read or prepare or do work.

So that somehow the sense that if the Federal Government is not doing it or if the health care system is not working or Medicare is not working properly, and one can talk about that, or if it is not somehow ratcheting down for the future which in fact Medicare has a pretty good track record in doing, that the future is doleful, that what you then do is you turn to the private sector.

And it is an instinct and particularly I would say in a Republican Congress which is absolutely predictable. If you have a problem and it is under the general jurisdiction of the Federal Government and you are not exactly sure what to do, give it to the private sector or let the private sector take a part of it.

I remember when Senator Dole was here, he put forward the idea of MSAs. And that was just roaring through the Congress. And they have been a failure. They have lost money. People have not signed up.

Now, the idea is that you can turn more and more Medicare over to plans, to HMOs. And the idea is that there would be even in 20,

25 years, 50 to 75 percent of seniors who would have signed up for a plan even though in most parts of this country, those plans do not exist. In mine, there is one plan in my State, the whole State.

So the concept of let the private sector do it, I think has to be approached very, very cautiously and with trepidation.

Now, with that as a background and what I am in a sense predicting to you is that pretty much that side of the aisle, some on this side will pass that plan, but it will not be as good as the plan that we rejected yesterday.

It will be stripped back considerably to fit the political and ideological concepts of how the health care system ought to work. And it will go through the Senate. And it will go through the House. And it will land on the President's desk. And I just say that because I think those who listen need to understand that that possibility is quite probable.

My time is up, but I am still going to just ask this little question. The managed care industry last year got a number of people. Actually, this year they are saying that was only the tip of the iceberg and that they plan to see a lot more of that happening in Medicare, HMOs. And you say mostly or half of it was in Utah.

Should we expect more plans to withdraw from Medicare this year? Do you think that is correct? What do you think is going to happen this year?

Do you expect that if they do not withdraw that they will reduce benefits or that they will increase premiums? There will be a slight trend towards that or a large trend towards that or what is your thought?

Ms. DEPARLE. I do think there will be a trend towards increasing premiums and reducing benefits. If you had asked me that question in December, I would have said, yes, sir, I think there is going to be tremendous volatility and a lot of plans may leave based on what the CEOs were telling me.

I now see it a little bit differently because since that time, we have announced the payment rates for next year. And because the way the formula in the Balanced Budget Act works, the so-called blend will be triggered for the first time. And the payments rates look a little better.

We have also announced that we plan to use our authority under the Balanced Budget Act to phase in the risk adjustment which as I have said over the long term is certainly the right direction to go and it will pay plans more fairly for caring for the sicker patients, but it is something that the plans have been concerned about because some of them will see it as a reduction in their rates.

So those factors make me think perhaps we will not see the sort of pullouts that we have seen this year, but I have been also talking to the trade associations for the plans. And they are telling me that we are going to see it.

I am not sure at this point, but I do think that some of the changes that we are proposing to make and that I know that some of the members of the committee are working on could help to mitigate that. And I think that is what we need to do this year to try to make the system as stable as possible.

What I would hope that in whatever we do we do not lurch from one thing to the next because I think that is the most difficult to

manage and administer and the most difficult proposition for both health plans and providers for that matter because Medicare has always been a public-private partnership. Many people do not see it that way, but the truth is that is what it has been.

And most of all for beneficiaries. Even in areas as you say there is only one plan in West Virginia, although I have talked to someone recently who said they were trying to set up a PSO there. So maybe, there will be another one.

But even in West Virginia where beneficiaries were not directly affected by what happened in September, they all heard about it. And it undermines their confidence in Medicare. And that is not a good thing. So I would hope that whatever the administration and the Congress does, tries to promote stability and confidence in the system.

Senator ROCKEFELLER. Thank you.

The CHAIRMAN. Nancy, we still have hopes of persuading Jay to our side. [Laughter.]

The CHAIRMAN. Senator Kerrey.

OPENING STATEMENT OF HON. J. ROBERT KERREY, A U.S. SENATOR FROM NEBRASKA

Senator KERREY. Thank you very much. First of all, like Senator Rockefeller and others, I suspect before I heard them, I am going to join in complimenting you on your testimony. And it is very clear and obvious that HCFA has quite a challenge in trying to deal with the Y2K problem as well as all the things that we ask you to do in the Balanced Budget Act of 1997.

I am quite impressed with what BBA has been accomplishing. The new CBO evaluation of the HI trust fund is startling in its prediction of good things to come. I mean, it seems to me we have improved the fiscal situation for the hospitalization trust fund considerably.

At the same time, I think other members were talking about there is obviously some concern about is that going to produce a negative impact? Are there things that are going to happen as a consequence?

And let me, I am tempted not to say anything to Senator Rockefeller's comment, but I would associate myself with those who believe that the market can be used to accomplish very good things. I am not unwilling to intervene in the marketplace.

Indeed, Medicare, as you said is a substantial public-private effort all by itself that uses the marketplace on a daily basis. One of the things that we wrote into law is allowing a pilot project of competition in Florida. Competition is beneficial and will carry us so far. And there are some things that competition will not do. There are some things the market will not get done. But I am very impressed in many ways with what the market can do. And indeed, I think consumers are used to the marketplace.

Medicare beneficiaries are becoming more and more educated about what is available. I have met at length with beneficiaries in Nebraska. They are reasonably satisfied with the current program, but very knowledgeable about all the various GAP policies that are available. They know this program cold, what it provides, what it does not provide.

And I understand that there are people with diminished capacity, but they are using the marketplace. They are making informed decisions. And there is much that I think can be improved about it, but I do not put myself in the camp that says that we ought to just continue to have the government make all the decisions and not increasingly where it is possible and to produce a more desirable outcome allow consumer choice to improve both the quality and the cost effectiveness of the system.

I am hearing at the same time on the negative side, potential negative side from the BBA 1997 some concerns from hospitals especially in rural areas. We have shut down two in Nebraska so far this year. Now, that may be understandable and necessary consolidation as costs are rung out of the system.

But are you monitoring? Nancy, do you monitor the rural situation on a regular basis? Do you have any capacity to tell us what is going on out there and make some suggestions of what we ought to be doing with BBA 1997?

Ms. DEPARLE. We do try to monitor it, Senator, but I would say that I do not think we do as good a job as we should of focusing on rural areas. And in fact, I met with the Rural Health Care Association and someone from Nebraska actually a couple of weeks ago to talk about that.

There is a—and he does research on this and has offered to try to help us get better data on what is actually happening in rural areas. There are concerns about whether access to care could be jeopardized in rural areas. And we are trying to monitor that and want to work with you to continue doing it.

Senator KERREY. I wonder if—would like to do that because I respect your intellectual capacity and your knowledge of this program. And I very much appreciate any suggestions that you have. As you know, we are a low-cost area, all communities except for Omaha. And a low-cost area tends to have difficulty all by itself because reimbursement rates are quite low.

And it is almost entirely fee-for-service. I mean, there is not much managed care. I think we have 130,000 people under some kind of managed care plan in the State. It is a relatively small number. So there is not much choice out there other than straight fee-for-service and when reimbursement rates are already low.

But what I am hearing from rural hospitals is that BBA 1997 tightened the screws even further. And I very much would appreciate any response that you give back specific to what we might need to do without completely unraveling the Balanced Budget Agreement of 1997 which obviously has made the hospitalization trust healthier than it was prior to that action?

Ms. DEPARLE. Yes, I agree with you that this is all about striking the proper balance. And we want to work with you to try to do a better job of that.

Senator KERREY. Thank you.

The CHAIRMAN. Thank you, Senator Kerrey.

Nancy, as any number of the members of the panel have indicated, they feel very fortunate to have you. We look forward to working with you as you have suggested.

Let me express—well, before I do that, let me call on Senator Mack.

Senator Mack.

OPENING STATEMENT OF HON. CONNIE MACK, A U.S. SENATOR FROM FLORIDA

Senator MACK. Thank you, Mr. Chairman. And I apologize both to Nancy and to you for not being here earlier, but some of you may know that Mack is short for MacGillacuty. My real name is Cornelius MacGillacuty. And this being St. Patrick's Day, I took the opportunity to spend some time with the Prime Minister of Ireland. So I apologize for being late this morning.

I do have a couple of questions that I would like to pose, but I also would like to associate myself with the comments made by the chairman just a moment ago.

There is a small, very important program in Florida and several other States which provides care to the frail elderly living in nursing homes on a pre-paid or managed care basis called Evercare. The program is geared to keeping these elderly, largely female, and often mentally impaired nursing home residents well and out of the hospital. Hospital admissions for persons covered by Evercare are 40 percent lower than for similar populations.

My concern is that the proposed risk adjustment payment methodology does not take into account the needs of this population and will penalize the program financially due to the reduced use of the hospital.

On January the 15th, the HCFA notice provided a one-year exemption from this, but I want assurances that this program will not end up being the baby thrown out with the bath water.

Ms. DEPARLE. Well, I can assure you that we have spent a lot of time meeting with the folks who run Evercare. And in fact, Dr. Berenson who is with me today has personally spent a lot of time on this. And we do not want to affect them in that way.

Part of the problem, as you may know, is having the appropriate data from them in order to be able to adjust their payments accordingly. And we are trying over the next year to get that. So we will work with you on it. We think it is a good program.

Senator MACK. Great. I am glad to hear that. And I appreciate it. Next, the Medicare+Choice was heralded as a means of providing a choice of systems for Medicare beneficiaries to select. As I understand it, the expectation was that hospitals and physicians would get together and come up with locally run, risk contracting organizations that would be responsive to the needs of seniors in their communities and would maintain continuous relationships with providers.

This idealized version of what might happen did not occur as existing HMOs became Medicare+Choice providers and almost no new organizational entities came into the marketplace.

My concern is that we are about to get rid of AAPCC for an untested risk management system whose purpose is to lower payments to HMOs. And we do not really know whether we are over paying now. If we were, HMOs and new provider-run entities would be flocking to get into the Medicare HMO business.

I am concerned that the proposed risk management system created to prevent overpayment will create new problems for us yet unseen. And I would just like to get your reaction to that concern.

Ms. DEPARLE. Well, the risk adjustment system I think over time is the right direction to go in, but it is something that we need to move slowly on.

And that is the reason why, Senator, we have chosen to exercise our discretion under the law to phase it in so that for this year, we are only proposing to do 10 percent of the risk adjusted payments partly because we wanted to try to promote stability.

And I do want to say that I think it is too early to say. And I do not want anyone here to feel that Medicare+Choice Program has been a failure. I know some people do feel that way. I think it is too early to say.

We have to look back at what we did last year. We made—we changed every single thing almost about the Medicare program. The reductions, and I feel they were very necessary. And many of the changes we made, I think we are going to look back on them in 5 years and think they were very good things.

But this is a very difficult time that we are in. And I would hate to see us make another huge change this year until we see how this is going to work.

This is the first year that the payment system that you designed that moves away from the AAPCC is really going to go into effect because the blended rates will go into effect this year for the first time. And I think it is important to see how that works before I give you my judgment on, yes, we need to move to a new system.

But I will commit to you that we will continue to work with you and monitor this. And we have already made some suggestions to the committee on things we think we need to do to make this more hospitable for plans and therefore more stable for beneficiaries as well.

Senator MACK. Thank you very much.

Thank you, Mr. Chairman.

Senator BREAUX. Can I ask a question?

The CHAIRMAN. Yes, Senator Breaux.

Senator BREAUX. I meant to ask you about the risk adjusters for managed care. And I take it that while we are talking about phasing it in over 5 years, we are still using the risk adjustment based on in-patient hospital stays which I would think that some would make a very strong argument that that is an inaccurate reference because managed care is basically trying to keep people out of hospitals. And yet, we are going to be reimbursing them based on in-patient hospital costs. Do you have any comments on that?

Ms. DEPARLE. Well, if that were all we were going to do is base it on in-patient hospital data, I would agree with you, that is not adequate. But we had to start somewhere. And that was the data that we had and could collect from plans.

We are now beginning to collect them out-patient data. And we will be ready in the next couple of years to implement a system that is based on that out-patient data as well.

And I think it is one of those things, Senator, most people who have looked at this, most health policy experts, including I think our colleagues at MedPAC would say you have to start somewhere. We had to get a start on a more accurate and fairer payment methodology.

And because we know it does not fully encompass everything that managed care is doing, we are phasing it in a little bit at a time, only 10 percent this coming year for that reason because it does not fully encompass everything that they are doing.

Senator BREAUX. So that statement tells me that you still are evaluating the best basis to use for the reimbursement rate under the risk adjustment.

Ms. DEPARLE. We have a proposal out there. And we are starting with that. We want to start with that in January 1, 2000, but our proposal is to phase in. And we will be looking at this as we go along and working with the Congress on it as well and with the managed care plans.

Senator BREAUX. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Breaux.

The time is growing late. I do have some questions I want to ask of you, but we will do it in writing. Let me just make one comment. As I indicated earlier, we all think we are very fortunate to have a person of your intellect in this position and realize what an extraordinarily difficult job it is to do.

At the same time, there is a feeling that the bureaucracy is not enthusiastic about the Medicare+Choice Program and not anxious to see it succeed. And I would hope that you through your leadership would take whatever steps are necessary to motivate the bureaucracy because it is important that Medicare+Choice Program succeeds.

The whole program could rise or fall on that. And so it is disturbing to think that there are those who are not enthusiastic, but in a position to do harm if not good.

Ms. DEPARLE. Yes, sir, Mr. Chairman, you do have my commitment on that. And as I mentioned in my statement, one of the first things I did last year was bring in some new leadership, including at least two clinicians. One is a geriatrician and one is an internist who have worked in managed care plans and one who actually ran a managed care plan. And I wanted to bring in that expertise because I think it is so important that Medicare move in that direction.

The CHAIRMAN. I see our ranking member, Senator Moynihan is here. Would you like to ask any question?

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK

Senator MOYNIHAN. Well, thank you, sir. I have been getting my back repaired. [Laughter.]

The Balanced Budget Act of 1997 carved out direct graduate medical education payments from the managed care rates to address the issue that managed care plans do not necessarily contract with teaching hospitals. And it seems to me, if I understand it, these payments are still not getting to the graduate medical facilities. Is there a problem there?

Ms. DEPARLE. There were problems in the beginning of this, Senator. And in fact, I spoke with some of the hospitals about that. But recently, I have not heard from them. And I assume that our friend, Ken Rasky, would have been calling me if that were the case. So I am surprised to hear there is still a problem.

Senator MOYNIHAN. It is a fair assumption. But I guess, Mr. Chairman, that I will make the general point, as I have before, that as you get into a more rational, market-based system for providing health care, you have the problem of how do you maintain the teaching hospitals and the medical schools.

These are public goods, as economists say. And the market will not provide for them. And that is why you have among other things governments. And there is more at risk than we know just now. And I hope that as you go forward, you keep that in mind. I am sure you will, but it needs to be raised to a level of consciousness.

In the health legislation we had in 1993 and 1994, we were proposing to cut the number of doctors by a quarter in the Nation, right?

Ms. DEPARLE. I believe that is right.

Senator MOYNIHAN. Yes. Did you ever read it anywhere at the time? No. And we were proposing to cut the number of specialists by half. Is that about right?

Ms. DEPARLE. I believe that is right.

Senator MOYNIHAN. Yes. Well, what if anybody came along with a higher education plan that proposed to cut the number of chemistry professors in half? Would people say that is a good plan? That would really show the Japanese. [Laughter.]

Senator MOYNIHAN. But grown up people proposed that. And no one said, or at least asked, can we talk about this? It just went as a given. And I think—well, you know what I think. Thank you very much.

Thank you, Mr. Chairman.

Ms. DEPARLE. Thank you.

The CHAIRMAN. Thank you, Senator Moynihan.

Nancy, thank you for being here. And we look forward to continuing this dialogue.

Ms. DEPARLE. Thank you, Mr. Chairman.

The CHAIRMAN. It is now my pleasure to call forward Gail Wilensky and Bill Scanlon. It is a pleasure to welcome both of you. And we look forward to hearing your testimony.

Dr. WILENSKY, WE WILL BEGIN WITH YOU.

Dr. WILENSKY. Thank you.

The CHAIRMAN. Welcome again.

STATEMENT OF HON. GAIL R. WILENSKY, PH.D., CHAIR, MEDICARE PAYMENT ADVISORY COMMISSION, WASHINGTON, DC

Dr. WILENSKY. Thank you. Good morning, Chairman Roth, Senator Moynihan, and other members of the committee. I am pleased to be here to discuss the provisions of the Balanced Budget Act and to mainly dray on the recommendations of MedPAC's report which was sent to the Congress on March 1st. There are a lot of recommendations in there. I am not going to, of course, try to go over all of them.

What I thought might be useful was to break out my comments in a couple of pieces to indicate those areas where we think the Balanced Budget Act and/or actions by HCFA seem appropriate at least to date and other areas where we already have some concern either about responses from HCFA or about provisions that are in

the Balanced Budget Act and that you may want to take some further action on.

First, let me just go through some of the areas where we think at least to date you are not to make change yet, although in several of these areas, we think you ought to be very careful about what is going on. We pledge to monitor what is going on and to report back.

In terms of the basic payments to hospitals, particularly to inpatient, we recommend that you not make any changes to what was in the Balanced Budget Act. That has two implications. Continue as is law, but do not make further reductions as has been proposed.

There is a tremendous amount of change that is going on. A lot of the activity hospitals have gotten involved in like home care and skilled nursing facilities and the movement to out-patient are being affected by the Balanced Budget Act. We cannot really see yet the changes because the data lags a year or two.

We suggest that you not do any further reductions until we can see the effects of what you have already done.

Similarly, with regard to the HMOs, I want to reinforce some themes that Nancy-Ann raised with you. We do not recommend any change at the moment. We think the payment structure is at least as appropriate as we could recommend now, but we are worried about what is going on. We think it is very important that we monitor the changes, we see who continues to participate or withdraw.

We think that there are things that HCFA can do to make it easier to reduce the burdens, the regulatory burden, like the date that HMOs have to report their benefit payment structure and also to make sure that they can continue having the flexibility to charge different amounts or have different payment benefits in counties that receive different amounts of money from HCFA.

This is something that HCFA has been proposing to withdraw. We think they ought to continue that flexibility.

For now, we think that risk adjustment in the slow phase-in makes sense. It is to move relative payments right, but I am concerned about the withdrawals.

And I am concerned that the payments under the fee-for-service and the payments under the managed care plans are starting to grow apart. This is a bad idea. You probably are going to have to come in and make some change, but I think it is too early to propose such a change.

We also think the PPS for nursing homes is generally in the right direction, but there are a number of areas where we are very concerned. And let me just highlight some of them. I would be glad to talk about them in more detail during the question and answer.

For one thing, we are concerned about the amount of aggregation that is going on in out-patient payments. There are two reasons for this. In the first, there is a lot of variation of what goes on in the bundle. Some of the services that are provided are more expensive. And some are less expensive.

But equally importantly, we are going to be paying for what may be a very similar or the same service differently if it is provided

in the out-patient setting or the doctor's office or the ambulatory surgery center. And that is asking for trouble.

We think the payment should be as neutral as possible according to where the care is actually provided. In the doctor's office, we pay in a very disaggregated way for the service. And maybe, ancillary service is almost always provided with it.

And we think that is a more sensible model to use in out-patient, not so much because the same service is frequently provided in all three of these settings, but because it will become more so as we get technologically more sophisticated and we are able to provide outside of the institutional setting.

That same philosophy has a ramification in post acute. In general, we think it is important to use the same payment system if a service can be provided in different places.

And when it comes to rehab, we are proposing HCFA try to pay for rehabilitation services that are provided in the nursing home in the same way they pay them on a freestanding basis which we think should be on a discharge basis. This is different from what HCFA is now thinking about in terms of their proposal.

We also think some changes need to be made in terms of the acuity, the high acuity, the very sick patients in nursing homes. We are concerned that we are not providing enough resources. And that will either put some patients at risk or back them up into the hospitals and that we need to do some work on that to make sure we can pay appropriately.

And finally, there are some areas in terms of home care that we think need some further consideration, some clarification from the Congress in terms of their coverage and eligibility rules.

We continue to recommend a small co-payment, not for those who are on any type of Federal support because of their low-income status, to have a limit as to how much we charge them. And at the point they reach that limit, that they would get an independent assessment by somebody who was experienced and knowledgeable in geriatric care about the rest of their care plan program. So we balance off economic incentives with making sure that we take care of the patient's needs.

These are the main areas, although, of course, there are others where we have made recommendations. We would, of course, be glad to work with the committee. We are already working with your staffs to try to see whether we can help them as you consider further Medicare changes. Thank you.

[The prepared statement of Dr. Wilensky appears in the appendix.]

The CHAIRMAN. Well, thank you, Dr. Wilensky. We appreciate very much the service that you have been giving and look forward to continuing the dialogue.

Now, it is my pleasure to call on you, Dr. Scanlon.

STATEMENT OF WILLIAM J. SCANLON, PH.D., DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Dr. SCANLON. Thank you very much, Mr. Chairman. I am very happy to be here, and members of the committee. We are happy to

join as you discuss the implementation and the impact of Medicare's changes in the Balanced Budget Act. And the importance of these changes, as you have heard today, cannot be overstated.

The BBA's constraints on provider's fees, increases in beneficiary payments, and structural reforms will likely lower payments by several hundred billion dollars over the next 10 years.

Changes of such magnitude obviously will have a significant impact on beneficiaries and providers. The questions we should be asking are these impacts targeted correctly to improve program efficiency and are the associated burdens being distributed fairly?

It is still too early in BBA's short history to draw major conclusions about these issues. I would like to, however, share with you some observations from both our past and more recent work that will have relevance as you review this experience. I will focus first on the Medicare+Choice Program and then some of the payment changes for skilled nursing facilities and home health services.

Reforms of the payment methods for Medicare+Choice plans are underway as we have heard. They will address the methodological flaws that have led to billions of dollars in excess payments as well as wide disparities in payment rates across counties.

While we look to managed care enrollment to improve the efficiency of service delivery in Medicare, the reality has been that increasing managed care enrollment was costing the program more.

A faculty risk adjuster among other things was largely to blame, with risk adjustment being the mechanism to adjust managed care payments to reflect the health of the enrollees and better align those rates with the plan's likely cost.

In the past, we failed to achieve this alignment to the detriment of the taxpayer. In accord with the Balanced Budget Act, HCFA has developed a new interim risk adjuster based on the available data and is going to put it in place starting in the year 2000.

A more comprehensive risk adjuster awaits us in the year 2004. HCFA phased approach for implementing this risk adjuster makes sense. It recognizes the limitations of available data and will help to avoid any sharp payment changes that could affect the benefits that plans offer and thus diminish their attractiveness to beneficiaries.

There has been though a recent surge in plan dropouts from Medicare. Attention is focused on how much these may relate to changes in payment rates and the requirements of plans to participate in the program. The answer is not easy.

Our past work has shown that the relationship between planned participation and payment rates is not simple. Some areas with low rates have enjoyed expensive plan participation and others with high rates have had little.

We have been examining the factors involved in the recent withdrawals for both this committee and the House Ways and Means and Commerce committees and are finding that there is also no simple relationship between the recent withdrawals and the change in rates or the new requirements for participation.

The circumstances of individual plans and individual markets appear to play key roles. Indeed, as we have witnessed in these withdrawals, there are simultaneously a significant number of

plans which have entered new areas or have applications pending to do so.

Ultimately, as these rates and participation changes are assessed, we need to be sensitive to the balance between maintaining desired access to quality care for beneficiaries and making sure that the needed changes to plan payments are done to achieve program efficiencies.

In creating Medicare+Choice, the Balanced Budget Act also encompassed more than just plan payments. They included a mandate to develop an extensive consumer information campaign.

Over the last several years, we reported to Senators Grassley and Breaux several times about the importance of consumer information in fostering a competitive market for health care and the considerable difficulties that Medicare beneficiaries face in trying to assemble consistent comparative information about their health plan choices.

Informed choices are going to become particularly important as BBA phases out the beneficiaries opportunities to disenroll from a plan on a monthly basis and move towards the private sector practice of holding an annual open season.

HCFA has only piloted some of its information and campaign initiatives. And certain problems did develop. It is critical now that we refine these efforts to make them more useful and effective for beneficiaries.

On the program fee-for-service side, the Balanced Budget Act's mandate to replace cost-based reimbursement methods with respect to payment systems constitutes another major program reform.

The phase-in of prospective payments for skilled nursing facilities began on schedule, as you have heard, last July. However, flaws in the design of the rates and faulty data used to set the rate levels may compromise both the ability to slow spending growth and the assurance that facilities receive appropriate rates for beneficiary care.

HCFA's development of a prospective payment system for home health has fallen behind the original schedule, but the interim payment system with similar spending containment objectives is now in place.

We have been monitoring the impact of the interim payment system and are finding some data are instructive. More than 1,000 agencies, as you have heard, have closed since October of 1997. However, because of the dramatic expansion in the number of agencies occurring between 1994 and 1997, there are still a larger number of agencies participating in Medicare than there were in October of 1995.

Home health agencies serving Medicare beneficiaries currently number about 9,000. We have not detected any significant impact on beneficiary access to home health care from either the closures or the interim payment system.

Because an agency's capacity can increase quickly by adding staff, it is often possible the staff and the patients of an agency that closes. Nevertheless, because comprehensive data on home health are not readily available, we are continuing to monitor the situation for this committee, as well as for the House Commerce

and Ways and Means Committee and will provide you evidence on our results relatively soon.

In conclusion, I would like to mention that HCFA's efforts to put the BBA provisions in place have been extensive and noteworthy. They have made considerable progress. At the same time, they have encountered certain obstacles, such as the intense pressure to deal with the year 2000 computer problem and the need to cope with gaps in experience, expertise, and essential data.

Given the importance, however, of the success in achieving the objectives of BBA, we hope that HCFA can surmount these challenges and refine and build on its past efforts.

Thank you very much, Mr. Chairman. I will be happy to answer any questions you have.

[The prepared statement of Dr. Scanlon appears in the appendix.]

The CHAIRMAN. Thank you very much, Dr. Scanlon.

Dr. Wilensky, you just said that allowing the Medicare+Choice payments to grow apart from the fee-for-service payments is a bad idea. So would you recommend increasing the fee-for-service payments or the Medicare+Choice payments or both?

Dr. WILENSKY. Well, let me sure you understand why they are growing apart. It used to be that we paid for the HMOs, for the Medicare+Choice according to what the payments in the traditional Medicare program were. And that resulted in very wide differences in terms of, let's say, what Nebraska was paid versus what was paid in some parts of Florida, some parts of New York, some parts of California.

In an effort to try to bring that together, to reduce that variation, we put a floor. And we put the floor in place by slowing down the rate of growth to a very slow rate in the high-spending counties to 2 percent at a minimum.

So now what happens is traditional Medicare is growing at 5 or 6 percent per year. And the other payments are going to only grow 2 percent.

There are really two ways you can go about it. One is you can go back and put them together which, of course, would mean these wide variations. And the second is you can completely restructure how you think about paying and paying it in terms of what you are spending person. This gets into the kinds of changes that some members of your committee have been devoting a lot of time to.

The CHAIRMAN. Yes.

Dr. WILENSKY. I do not want to enter that fray voluntarily. But it is a different way of looking at how you spend for patients.

This is an issue I raised with the Congress, actually pleaded with the Congress not to do before you passed BBA, to set up a payment where what you spent under the Medicare+Choice or whatever you called was going to be much higher in some counties than traditional fee-for-service. That is true in Nebraska and Iowa.

And that fact that you have not had some plans come in is true for the moment. They will disrupt markets if they do. And equally important in Florida and southern California and some parts of New York, you are going to start seeing the HMOs growing at very slow payments, 2 percent on a reduced growth basis. That is really pretty unreasonable growth rate. At the same time, traditional

Medicare is going to be growing at 5 or 6 percent, even though this year it was very slow.

So it is either togo back to where you were or think about changing how you pay traditional Medicare in paying on a per capita basis. It will force you to recognize that Medicare, a national program pays very differently not because people have different health status and not because of cost of living differences, those are legitimate reasons to pay differently, but because how health care is delivered varies enormously across the country. This is not going to be an easy problem to solve.

The CHAIRMAN. Let me ask you this. There seems to be conflicting beliefs on whether current payments to Medicare+Choice plans are adequate. As we all know, there are a number of working elements of the payment formula that should be examined to determine this risk adjustment just being one.

Dr. WILENSKY. Right.

The CHAIRMAN. Can MedPAC adopt a comprehensive analysis of all the payment elements together to determine whether payment levels are adequate?

Dr. WILENSKY. Yes, we can. And we will in fact do that and report back to the committee. We do think that the comments that have been made that it is more than just payment which can drive plans to leave. Sometimes, they make bad decisions. There may be regulatory burdens that HCFA could lighten up on and not put beneficiaries at risk.

But we are concerned about the withdrawals that have occurred to date and that may occur in the future. And we will look at that issue and report back to you.

The CHAIRMAN. We would appreciate that very much.

Doctors, we may have some more questions we will submit in writing.

Dr. WILENSKY. Fine.

The CHAIRMAN. Dr. Scanlon of GAO has released a number of reports recently on home health care involving issues with respect to the interim payment system and on the role of surety bonds. Would you please discuss the use of surety bonds in the home health agencies? And in addition, would you please elaborate on your work on beneficiary access?

Dr. SCANLON. Yes, Mr. Chairman. The surety bond provision was included in the Balanced Budget Act. There was a requirement that HCFA have each home health agency obtain a surety bond of at least $50,000.

It was done at the time because there was considerable concern about the rapid growth in the numbers of home health agencies and the fact that the requirements for becoming a home health agency were some minimal. We were witnessing agencies becoming participants in Medicare care after having served only one patient and not having any confidence that they were really organized as solid businesses.

So the idea of a surety bond was proposed with the sense that the surety companies would provide a check in terms of assessing whether this really was a solid business before we let them into the program.

I think that that is something that the surety bond does provide is that there is a check as to whether or not these are businesses. It is not a check of whether or not they are going to be capable home health agencies.

The other concern we had was with the way HCFA instituted the requirement in that they did not limit themselves to requiring the $50,000 surety bond. It required that surety bonds be equal to $50,000 or 15 percent of an agencies Medicare revenue. Yet, there was no evidence that larger agencies were more likely to be engaged in—have a problem of defaulting sort of on repayment of overpayments.

As a result, we recommended that HCFA limit the bond to $50,000 which they have indicated that they will. We have also suggested to the Congress that you consider making the requirement that something as a temporary requirement that new agencies have to have, but once an agency has demonstrated they are functioning well as an ongoing business, that the requirement can be removed.

With respect to the studies that we have been doing of access, as I indicated, it is hard to do this work in part because comprehensive data are not readily available on who is using home health services and who is not. We have been interviewing in a number of areas where there have been more closure of agencies, where there has been changes in utilization, trying to identify if there are any access issues.

We have identified that there are some, but they are not related to the interim payment system. They are problems that have existed in the past for the most part. They are problems associated with very complex patients who need highly skilled services and there is a shortage highly skilled personnel in certain areas. And therefore, the agencies have trouble serving those individuals.

This work though needs to continue because as you have heard today, there is great diversity out there in terms of the circumstances of different areas in different States. And we are continuing to try and find to monitor to find any access problems that might exist.

Dr. WILENSKY. Mr. Chairman, if I might add?

The CHAIRMAN. Please.

Dr. WILENSKY. MedPAC is doing some data collection right now on this issue on home care access. We hope to have data available before the end of next month and included in our access section for our June report to the Congress, June 1st report. But we will be able to share some of the data by the end of next month.

The CHAIRMAN. That will be very helpful.

Let me ask you, Dr. Scanlon. It is my understanding, GAO has done a separate review of HCFA's readiness for Y2K. What is GAO's review right now of HCFA's readiness? Are there important differences in perspective between GAO and HCFA?

Dr. SCANLON. As Ms. DeParle indicated, we have been engaged in a review of their activities since last year. It is our Information Technology Group. And initially, we were very concerned about their preparation for the year 2000 in that there was neither sort of appropriate comprehensive plan to deal with it in terms of changing the computer systems nor sort of contingency planning to

deal with the event either internally or external systems that one needed to interact with had been modified and that there was still an imperative that one be able to pay claims and pay health plans.

We were heartened by their progress. They have under Ms. DeParle's leadership made considerable progress in addressing the Y2K problem. And as she indicated, their internal systems are compliant.

External systems though, our view is not as optimistic as HCFA's. And they have indicated that 55 of their 78 systems are compliant. They are substantially compliant, but in computers small differences can have a huge impact in terms of their operations. So fixing those last sort of elements to make them fully compliant is regarded as very important on our part.

Further, we think that they need to—once these systems have been fully modified, they need to be able to conduct a comprehensive end-to-end test to be able to understand are they all going to work in unison. That is key before we can be comfortable about the year 2000.

The CHAIRMAN. I assume you are going to be continuing your review.

Dr. SCANLON. We are continuing that work. It is being done at this point for the Aging Committee.

The CHAIRMAN. I would hope that you would let us know what progress is being made.

Senator MOYNIHAN.

Senator MOYNIHAN. All right. I have just two quick questions, but to Dr. Wilensky. We have heard that MedPAC is beginning to develop a report on graduate medical education.

Dr. WILENSKY. Yes.

Senator MOYNIHAN. Could you tell us something about that?

Dr. WILENSKY. Yes. One of our requirements when we were established as part of the Balanced Budget Act was to issue a report to the Congress in August of 1999 on graduate medical education. And we will have that to you in several months.

Senator MOYNIHAN. All right.

Dr. WILENSKY. So we are looking specifically at issues of payment rates and appropriateness for direct and indirect medical education and something about our view of the system that would result if they were changed according to various options. And we will have a report to you on that basis.

Senator MOYNIHAN. In August?

Dr. WILENSKY. In August.

Senator MOYNIHAN. Good. I mean, I hope you share my view that when you are dealing with this branch, this sector of the health care system, you are not dealing with a market arrangement, which is increasingly the case elsewhere and that we have to provide for this task to be done as you provide for the public good as a market commodity.

Dr. WILENSKY. We are certainly concerned about the comprehensiveness of the changes that are affecting teaching hospitals as well as other hospitals in trying to look at in terms of an in toto as to what is going on with these institutions and what would happen with any change.

Senator MOYNIHAN. Could I just offer the thought that there is no mystery about it? The cost of a teaching hospital is higher than the costs of other hospitals.

Dr. WILENSKY. Yes.

Senator MOYNIHAN. Then, therefore, HMOs make the rational market decision. And suddenly, you do not have a teaching hospital. You cannot have a medical school, etcetera, etcetera.

Dr. WILENSKY. No, but we are concerned especially to look at the two pieces because we think they are very separate. The indirect medical education which reflects the higher cost of teaching hospitals, there is no question that they do have higher cost, to look at that and whether or not we seem to be paying in a reasonable way and who else might pay and also to look separately at the issue of direct medical education in terms of the training. So we are trying to look at these as issues both in terms of Medicare, Federal Government obligations and other obligations.

Senator MOYNIHAN. Well, good. We look forward to your report in August.

And if I could just ask Dr. Scanlon, a matter that Senator Breaux has been concerned about, the managed care industry is saying that last year was just the beginning of what we should expect in the way of HMOs withdrawing from Medicare. Do you have any feeling for that?

Dr. SCANLON. Not a good prognosticator, but I do think we are involved in a major shift in the market. The Medicare program has signaled that it is not willing to continue the payment levels of the past which as I have indicated frankly ended up costing the program more. If beneficiaries had remained in fee-for-service, we would have saved money as opposed to when they did join HMOs. So we did need to make that kind of a change.

Now, what is going to be the consequence in terms of plans' willingness to serve as well as most importantly the benefits that they are willing to offer beyond the traditional package is something that we do need to be focusing on.

Beneficiaries still may find that when the benefits change and premiums are being charged that it is advantageous to be in a HMO as opposed to buying a MediGAP policy and remaining in the traditional program, but we have to acknowledge that we have changed what Medicare as the customer wants to buy.

Senator MOYNIHAN. You will keep your eye on that, will you not?

Dr. SCANLON. We certainly will.

Senator MOYNIHAN. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. Thank you, Mr. Chairman, I will try and be brief. Thanks to both of our witness for once again being with us and for their serious contribution to this discussion.

Gail, let me follow up with you Senator Moynihan's question about GME, graduate medical education. Is there a way that is being explored that would guarantee that there is a Federal obligation to assist universities in training medical professionals that could be achieved outside of the Medicare system?

Some of the ideas that have been explored is to say, all right, this is a national Federal obligation to do this. It is in the interest

of this country just like it is in the interest of us to have a strong national defense or a strong maritime industry. It is in the interest of the country to have good doctors. And therefore, it is an obligation to help pay for their training and education.

Is there a way to do it outside of Medicare which creates problems in many, many areas? Some discussion has been given to making it a mandatory entitlement which would be guaranteeing that there would be an appropriation that would be guaranteed by the government to in fact fund it which would mean that everybody in the country is participating in paying for it as opposed just to people in the Medicare program.

Dr. WILENSKY. We are definitely looking at the issue of Medicare continuing to pay as it has paid or Medicate paying in some other fashion versus the Federal Government taking on a role outside of Medicare.

I do not have a sense yet about where our commission is going to come down in terms of such recommendations. We obviously do not have too many more meetings until we have to try to see whether there is a consensus, but we will look at the issue of Federal non-Medicare versus Medicare.

I have been worried about having this in the Medicare program since I was HCFA administrator because the fiscal problems of Medicare have not been a secret. I mean, this was something we could all see coming down the pike. And therefore, what, if anything, it should suggest for graduate medical education is a longstanding issue. Again, I do not know where we will come.

Senator BREAUX. Is your commission required to have a super, super majority to make a recommendation? [Laughter.]

Dr. WILENSKY. It is not.

Senator BREAUX. Just a simple majority?

Dr. WILENSKY. It actually——

Senator BREAUX. A little like Congress.

Dr. WILENSKY. It has tried very much to have a consensus, but we have on rare occasions taken a vote. And do we have the ability if we choose to make a recommendation on the basis of——

Senator BREAUX. I tell you, I mean, I appreciate the work that you are doing. It will be well documented. I am concerned that it is not going to be here until August. I think that their recommendation may be very helpful to the Congress as we hopefully pursue an effort to do something on Medicare reform this year as opposed to the fruitless effort of trying to do next year. And we can really benefit from it as soon as you can get that to us because it may well be helpful, I mean, other means.

I mean, we have discussed this time and again. I mean, once again, we are right in the middle of the mess of trying to figure out how to handle BBA 1997. I mean, this is a short-term, in your face, right now problem. And we see it being extended.

And Nancy is having to phase it in over 5 years and looking at different risk adjustments. And all of this is just so terribly, terribly complicated. Once we get all of this in place, we are going to have it change it again. That is the unfortunate thing about it.

I really appreciate both of you and your departments being involved in monitoring and helping us to find out what is going on. I mean, you also helped HCFA in sort of watching what they do

and reporting it from an outside perspective. And that is very, very important.

I have underlined and colored and everything else everything both of you have said. So I thank you for your contribution.

Dr. WILENSKY. You are welcome.

The CHAIRMAN. Senator Breaux speaks for all of us appreciating your contributions. And we look forward to continuing to work with you. Thank you for being here.

Dr. WILENSKY. Thank you very much.

Dr. SCANLON. Thank you.

[Whereupon, at 12:08 p.m., the hearing was recessed.]

MEDICARE+CHOICE, OVERSIGHT OF RISK ADJUSTMENT METHODOLOGY AND OTHER IMPLEMENTATION ISSUES

WEDNESDAY, JUNE 9, 1999

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The meeting was convened, pursuant to notice, at 10:10 a.m., in room SD–215, Dirksen Senate Office Building, Hon. William V. Roth, Jr. (chairman of the committee) presiding.

Also present: Senators Chafee, Grassley, Moynihan, Baucus, Rockefeller, Kerrey, and Robb.

OPENING STATEMENT OF HON. WILLIAM V. ROTH, JR., A U.S. SENATOR FROM DELAWARE, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will please be in order.

Senator MOYNIHAN. Mr. Chairman, before the committee begins its formal program this morning, I wonder if I might offer the congratulations of our side to you on the announcement that you are going to run for a sixth term in the United States Senate. There must have been two or three people like that in our history. But within the limits of partisan prudence, we wish you every success, and the staff also.

[Applause.]

The CHAIRMAN. Thank you. Well, I appreciate those gracious remarks, Pat. And I will be sure to get you up to Delaware during the campaign. [Laughter.]

As I started to say, over the past several weeks, we have focused on preparing Medicare for future generations of Medicare beneficiaries. And I am very grateful for the interest and participation of the members of this committee and for the contributions that nearly 50 witnesses have made thus far in helping us lay the groundwork for the important legislation that hopefully we are about to begin drafting.

Today and tomorrow, we are taking a break from our series of hearings on the Medicare of the future to take a close look at the program serving Medicare beneficiaries now.

Nearly 2 years ago, Congress passed and the President signed into law the Balanced Budget Act of 1997 which made significant changes to the original Medicare Fee-for-Service Program, and which, of course, created the Medicare+Choice Program. And since

its passage, HCFA has issued rather numerous regulations implementing this law.

During our 2-day series, we will hear from a number of witnesses about the Medicare Program on how Medicare beneficiaries have been impacted by this law and the resulting regulations.

Today, we will focus on the Medicare+Choice Program, a program which I believe is serving as a laboratory for Medicare reform and which many believe is a foundation for what will be a reformed Medicare Program. For this reason, it is critical for us to assess how well the Medicare+Choice is serving its beneficiaries and to determine what steps, if any, are necessary to make Medicare+Choice work better for the 6 million and growing beneficiaries now enrolled.

Specifically, I have asked the witnesses invited today to discuss the impact on beneficiaries of the recent ongoing withdrawals from the Medicare+Choice Program and how the Health Care Financing Administration's proposed health-based risk adjustment methodology could worsen this impact.

Next, I am pleased to call on our ranking member, Senator Moynihan.

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK

Senator MOYNIHAN. Mr. Chairman, once again we thank you for the careful attention to the actual results of legislation as against the prospects. We passed the Balanced Budget Act in 1997. We made these changes. And how are they coming?

Dr. Scanlon will appreciate this. We have learned about the complexity of managing our National health system. We learned last week about the number of pages of regulations that HCFA had issued, about 150,000, or 3 times the length of the impermeable Internal Revenue Service Code which suggests it is a daunting issue. And it is not anyone's fault, but it may be a systemic problem.

I know that in my State of New York, we find the number of persons on Medicaid going down to be a good thing or inadvertently not. And we would like to hear from all of you. We very much respect your work. And we thank you for coming.

The CHAIRMAN. Thank you, Pat.

We are very pleased to welcome two panels of distinguished witnesses today. Testifying on our first panel is Michael Hash who is Deputy Administrator of HCFA; Steven Lieberman, Executive Associate Director of the Congressional Budget Office; and William Scanlon who, of course, is Director of Financing and Public Health Issues of the GAO.

Mr. Hash.

STATEMENT OF MICHAEL HASH, DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, DC

Mr. HASH. Thank you, Mr. Chairman. Senator Moynihan and distinguished members of the committee, we want to thank you for the opportunity to come here today and to discuss our progress in implementing the Medicare+Choice Program.

Successful implementation of Medicare+Choice is a very high priority for us at HCFA. We meet regularly with beneficiary advocates, industry representatives, and others to discuss ways to improve the Medicare+Choice Program. We have approved 15 new Medicare+Choice plans and have also approved 17 expanded service areas for existing contracting plans since last November. And the total Medicare+Choice enrollment is now 100,000 higher than it was before some plans decided to not renew their contracts last fall.

The Balanced Budget Act, as all of you know, put into place a new payment system which addresses problems with the old systems for paying health plans. The new system breaks the link to the fee-for-service payment system and fee-for-service costs. That link, as you know, has caused wide disparities in payments to plans across the country and the availability of plans to beneficiaries.

In the year 2000, calendar year 2000, the new payment system will begin to risk adjust payments to better account for the health status of the enrollees in each of the contracting plans.

Now, there is considerable evidence that we have and continue to pay health plans more than what is warranted by their enrolled population because our payments have not been adjusted for the expected costs of those Medicare enrollees.

One study put the magnitude of these overpayments at $2 billion a year. That is why risk adjustment will not be and cannot be budget neutral. The whole reason for proceeding with risk adjustment and specifically with risk adjustment that is not budget neutral is that Medicare has not been paying health plans accurately.

We are in phasing, as I think you know, our risk adjustment methodology over a 5-year period in order to provide for a smooth transition and to avoid untoward disruptions. Only 10 percent of our planned payments for next year will reflect the risk adjustment methodology.

How risk adjustment will change total payments to health plans depends, of course, on how the plans themselves react in terms of their enrollment. Risk adjustment significantly changes the incentives for plans and could well lead to the enrollment of beneficiaries with greater health care needs. That would result in plans receiving higher payments than they do today.

Payment changes will be further buffeted by an annual payment update of the rates for the year 2000 of 5 percent as well as the implementation of the blended payment rates in a very substantial number of the counties who were eligible for blended payments in the past. And that will provide substantially more funding in areas that have historically had lower health plan capitation payments.

As you know, some Medicare HMOs did not convert to the Medicare+Choice last year. And others in fact reduced their service area substantially. Some plans are likely to reduce service this coming year, as well. We are, of course, as I know you are, concerned about the business decisions that plans make to reduce participation in the Medicare+Choice Program, but it is important I think to put those decisions in a context.

The vast majority of Medicare HMOs did in fact convert and sign Medicare+Choice contracts last year. There are now, as I men-

tioned a moment ago, more Medicare beneficiaries enrolled in private health plans than there were before the withdrawal of plans last year.

And plans that withdraw do so I think for reasons well beyond the BBA payment policies. For example, many of them had weak market positions. They had commercial pressures for things like the increasing cost of prescription drugs or they found themselves in unfavorable contracts with their provider networks.

A comprehensive review by the General Accounting Office which I know Dr. Scanlon will be talking about confirms that many market factors contributed to plan withdrawals.

Moreover, it is our understanding that the Federal Employees Health Benefit Program had similar experience with plan pull-outs last fall. In several instances, plans that withdrew from the Medicare+Choice Program also withdrew from the same specific counties that FEHBP plans did last year.

This all suggests that plan withdrawals have more to do with internal plan and larger marketplace interest than with Medicare rates or regulation. In fact, a certain amount of market volatility is expected when you rely on the private sector participation in the program.

That is why it is essential to preserve a strong public sector fee-for-service program in Medicare. That is why the President's budget includes proposals to protect beneficiaries from disruptions if in fact plans withdraw from participation. And that is why we have provided for earlier notification of beneficiaries in the case of plan withdrawals.

We look forward to working with you, Mr. Chairman, and the committee on legislation that the President has proposed to broaden access of Medicare beneficiaries to supplemental Medigap policies if they lose their Medicare+Choice options and to allow new enrollees, including those with end stage renal disease to move to another Medicare+Choice plan if one is available.

We want to thank you again for holding this hearing. And I would be happy at the appropriate time to any questions that you or other members of the committee may have.

The CHAIRMAN. Thank you, Mr. Hash.

Mr. Lieberman.

[The prepared statement of Mr. Hash appears in the appendix.]

STATEMENT OF STEVEN LIEBERMAN, EXECUTIVE ASSOCIATE DIRECTOR, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC

Mr. LIEBERMAN. Thank you, Mr. Chairman. Mr. Chairman, Senator Moynihan, and members of the committee, it is a pleasure to be here this morning. I ask that you place my written statement on the enrollment and payment issues in the record.

The CHAIRMAN. All statements will be included as if read.

Mr. LIEBERMAN. Thank you. This morning, I will focus on three points that are described more fully in my written statement. First, I will summarize CBO's projection of Medicare+Choice enrollment. Next, I will analyze the role of financial incentives and the BBA payments in Medicare+Choice. And then I will conclude by discussing risk adjustment briefly.

In the years leading up to the Balanced Budget Act of 1997, enrollment in Medicare managed care plans grew explosively. The growth rate peaked at 36 percent in 1996. Since then, the growth in Medicare+Choice enrollment has slowed substantially. Currently, 16 percent of all Medicare beneficiaries have joined Medicare+Choice plans.

CBO projects that the proportion of beneficiaries in Medicare+Choice will almost double by the year 2009, reaching 31 percent. That projection assumes an annual growth rate of almost 9 percent. Although still impressive, that rate of growth is substantially below the pre-BBA experience.

Let me now turn to financial incentives. For enrollment to grow, beneficiaries must have incentives to switch from traditional fee-for-service to competing Medicare+Choice plans. If beneficiaries are given the choice of high-quality health plans that offer better benefits or lower cost than traditional Medicare, enrollment in Medicare+Choice will grow sharply. However, if consumers have no choice of plans or if the plans offer unattractive benefits, high cost, or poor quality, beneficiaries will remain with fee-for-service Medicare.

Many Medicare+Choice plans pay physicians and other providers by passing through a fixed percentage of the monthly Medicare capitation payment. Under capitation arrangements, physicians are cost centers. Providing more services increases only their costs, not their revenues. In contrast, under fee-for-service payment arrangements, physicians are revenue centers. Providing more services generates more fees.

As businesses, providers and health plans will participate in Medicare+Choice only if they can get an adequate return—at a minimum, if they can at least cover their costs. If payments are seen as inadequate, providers and health plans will tend not to participate in Medicare+Choice.

Lower payment updates will limit the extra benefits that health plans offer. If health plans eliminate prescription drug benefits or if they require hefty monthly premiums instead of zero premiums, fewer beneficiaries will enroll.

The BBA has substantially reduced the growth in Medicare+Choice payments by tying annual payment updates to the rise in fee-for-service spending. Reform of traditional Medicare+Choice has a secondary effect of lowering the payments to health plans.

In addition, the BBA specifically cut Medicare+Choice spending in three ways. First, the annual payment updates were reduced below the growth in fee-for-service spending from 1998 through 2002. Second, the amounts associated with graduate medical education are gradually being eliminated. And third, HCFA has reduced payments by about 0.2 percent to finance informing beneficiaries about coverage options.

To address the wide variation in local Medicare+Choice rates that Mr. Hash referred to, the BBA blended local and national payment rates. That blending provision substantially redistributes money from areas with high rates to those with low rates, but on a spending-neutral basis.

The BBA also directed HCFA to implement risk adjustment. Until this year, CBO had assumed that Medicare+Choice payments that would be adjusted for risk would be instituted on a spending-neutral basis, that is, without changing total outlays. But the principal inpatient/diagnostic cost group (PIP/DCG) risk adjuster being phased in by HCFA will reduce Medicare+Choice spending by 7.6 percent when it is fully implemented.

Starting in 2004, HCFA anticipates implementing the second stage of risk adjustment, which will further reduce payments. As planned, risk adjustment will reduce Medicare+Choice spending by 15 percent annually.

Payment reductions related to risk adjustment on the order of 15 percent would be likely to cause sharp drops in both participating plans and enrollment. Neither the CBO baseline nor enrollment projections assume full savings from risk adjustment.

The costs of providing services to Medicare beneficiaries vary enormously. The most expensive 5 percent of beneficiaries each have an average annual cost of over $70,000, which is more than 10 times the average cost for the typical beneficiary. That top 5 percent of beneficiaries cost almost as much as the remaining 95 percent of the program. Those enormous variations in cost make risk adjustment both extremely important and exceptionally difficult.

HCFA deserves credit for developing the PIP/DCG system. Although superior to demographic adjustment, PIP/DCGs have serious limitations. Achieving significant improvements will be a difficult and far from certain accomplishment.

An alternative to statistically adjusting payments is to adjust the level of risk borne by the payment pool. A variety of approaches are currently being used in other settings. They include partial capitation, disease or condition-specific carve-outs, and stop-loss or reinsurance coverage. Those approaches might balance incentives to overprovide services versus to stint on care. They also might operate better in a market dominated by small risk pools.

Thank you very much, Mr. Chairman. I would be happy to answer questions at the appropriate time.

The CHAIRMAN. Thank you, Mr. Lieberman.

Dr. Scanlon.

[The prepared statement of Mr. Lieberman appears in the appendix.]

STATEMENT OF WILLIAM J. SCANLON, PH.D., DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Dr. SCANLON. Thank you very much, Mr. Chairman. And Senator Moynihan and members of the committee, I am pleased to be here today to discuss the implementation of the BBA payment reforms in the Medicare+Choice Program. Through this program, the Balanced Budget Act furthers the use of a choice-based model of providing Medicare benefits and addresses some of the deficiencies of the former risk contract program. It encourages the wider availability of HMOs across areas and permits other types of health plans to participate in Medicare.

The BBA also seeks to pay health plans more appropriately than before under the old AAPPC formula which we and others have pointed out paid HMOs too much. The conundrum we have is how to balance appropriate payment with an opportunity for Medicare+Choice plans to prosper and to serve beneficiaries with a richer benefit package.

The HMO industry is concerned that BBA payment changes are too severe, citing plan withdrawals from Medicare+Choice last year as evidence of the BBA's adverse effects. Today, my comments will attempt to address these concerns, providing you some helpful information as you examine whether modifications to the BBA payment changes are needed.

First, there is the issue of what the rates paid Medicare+Choice plans have changed and why those changes were deemed important. At the outset, it is important to note that BBA payment reforms involve a mixture of changes. Some provisions actually raise payments, both in the aggregate as in the case of the BBA's fixing of the 1997 rates as the base for future payment, and certain localities as the result of the BBA floor rate for counties.

Using 1997 rates as the base means that a forecast error built into those rates created a $1.3 billion cushion that will be in the base for future health plan payments. Most attention is focused on the reductions that have or will occur due to the offsets of the annual increases, the new risk adjustment method, and the carve-out of graduate medical education payments .

The offsets in the new risk adjusters are meant to address the excess payment problems that have resulted from HMO enrollees being healthier on average than their fee-for-service counterparts.

As you have heard, considerable research has been done on this subject, both by ourselves and others. And as Mr. Hash indicated, the 1997 PBRC estimate pegged the level of overpayment at $2 billion annually. And our work show that the excess rather than decreasing as HMO participation grew, it was increasing.

The offsets to annual increases do remove some of those excess payments, but not totally. Further, they are across-the-board reductions. And excess payments vary considerably by area and plan. Implementing adequate risk adjusters will be the key to fully addressing the excess payments in a targeted way that is protective of both plans and beneficiaries.

The second issue is what impacts these rate changes will have even if they are appropriate to correct for favorable selection on plans and beneficiaries. Attention has focused on the plans' withdrawals last year and the changes in additional benefits that plans offered as well as the potential for future withdrawals and future benefit changes.

We have reviewed these changes and reported to you and the Commerce and Ways and Means committees on them. We found that the withdrawals, as Mr. Hash indicated, were clearly related to how the plan expected to fare in the Medicare+Choice Program given local market conditions.

The changes in Medicare+Choice rates undoubtedly played a role. However, plans withdrew from high-rate counties as well as low-rate counties and from counties which had experienced large increases in rates. Factors besides rates appeared to be important

as the withdrawing plans tended to leave markets in which they had recently entered, markets with strong competition, and markets where they had limited enrollment. A third of the time when plans left a county, they had fewer than 100 enrollees in that county.

We found that while approximately 100 plans withdrew or changed their service areas in 1998, subsequently 40 plans have been approved or applied to participate in Medicare+Choice. The net effect if all these plans participate will be that more beneficiaries have access to a managed care plan in 1999 than did in 1998.

The prospect of future withdrawals does exist. And some have been announced. Those that we have reviewed follow the pattern that has been observed last year. Multiple factors appear to have made staying in Medicare+Choice in certain counties unattractive. Some have speculated about the total number of plans likely to withdraw. At this point, those estimates seem to be largely speculation.

The second concern is that, what will happen to the additional benefits plans offer that have been so attractive to beneficiaries? We were able to analyze changes in whether plans offered particular benefits, such as prescription drugs or dental care. And we found very modest changes in the benefit offering.

However, our analyses could only determine whether a benefit was being offered, not the depth of coverage. In addition, plans had requested an opportunity to change benefit packages after their original May 1st ACR filings last year and were not allowed to do so.

Plans have offered additional benefits both for competitive reasons and because Medicare requires that when they can provide the traditional Medicare benefit package for less than the Medicare rate, those additional monies or savings must be given to enrollees in the form of additional benefits or escrowed.

Prior to BBA, plan-supplied information indicated that the savings averaged about 13 percent of payments in 1997. We have begun an analysis of the 1999 information to see how the BBA affected those savings. For Los Angeles County, one of the areas with high rates, the savings currently averaged 21 percent of Medicare payments. And plans are continuing to offer additional benefits valued at about $117 per member per month.

In closing, let me ask what are the overall conclusions to be drawn from this type of information? What should be our reaction in terms of how Medicare+Choice plans, beneficiaries, and taxpayers have been impacted?

Adjusting plan payments so that the program pays no more for a Medicare+Choice enrollee than for a traditional Medicare beneficiary with the equivalent health status is going to mean smaller payments and most likely lower profits for plans as well as fewer supplementary benefits for enrollees.

These consequences raise the question of whether the benefits of encouraging managed care warrant changes in BBA payments to protect plans and a fraction of the Medicare beneficiary population enrolled even when those increases result in Medicare spending

more on a Medicare+Choice beneficiary than on a traditional Medicare beneficiary.

Thank you very much, Mr. Chairman. I would be happy to answer any questions you or members of the committee may have.

[The prepared statement of Dr. Scanlon appears in the appendix.]

The CHAIRMAN. Thank you, Dr. Scanlon.

Mr. Hash, could you please discuss any work HCFA has done to assess the impact that proposed risk adjustment will have on Medicare+Choice beneficiaries, particularly during the second, third, and fourth year of the phase-in?

Mr. HASH. Mr. Chairman, in putting together the risk adjustment methodology, we did do assessments of the impact at the aggregate level of what the phase-in of the so-called PIP/DCG methodology would mean. As you know, for the coming year 2000, we will only be using 10 percent of risk adjusted payments for purposes of determining the capitation rate for our health plans.

What we are attempting to do as we design the methodology was to rule out those diagnoses that we were going to adjust for that were discretionary or did not involve hospitalizations. We ruled out any adjustment for 1-day hospitalizations.

We took a number of steps to ensure that the adjustment really focused on that subset of Medicare enrollees with the most significant health care cost which is something like 13 or 14 percent of the beneficiary population. So it is obviously focusing on that subset of Medicare beneficiaries who are expected to have very substantial health care costs.

The CHAIRMAN. Let me ask you this: what steps would you recommend to promote more growth in the Medicare+Choice Program?

Mr. HASH. Well, I think one of the key ingredients to increasing participation is our education program, that is to say making beneficiaries much more aware of what their choices are, what are the additional benefits, what the opportunities are to receive their Medicare benefits through private plans.

That is why we have obviously invested so much in the National Medicare Education Program because our evaluation of that effort revealed to us that many beneficiaries have very limited knowledge about Medicare+Choice as well as the basic the Medicare Program itself.

We found that over half of the beneficiaries in a survey that we conducted thought that going into a Medicare HMO meant leaving the Medicare Program. And we need to obviously do a more comprehensive job of educating the beneficiary community. And I think that will be very important in terms of increasing participation.

The CHAIRMAN. Let me turn to you, Dr. Scanlon, on this question. I understand that the GAO is also trying to determine if HCFA is adequately informing Medicare beneficiaries of their Medicare+Choice options. Do you think that this new program is easy to digest for most beneficiaries? And do you have any recommendations for HCFA in this area?

Dr. SCANLON. We have been looking at this question. In fact, we have been looking at with Senator Grassley as part of his work on the Aging Committee, and have reported to him and Senator Breaux many times on that.

Our concern is that regardless of what we try, this program remains complex. And there is going to be a variety of types of information that beneficiaries are going to need in order to be fully and appropriately educated about their choices.

While there are some initial steps that have been taken through the Medicare Information Campaign in terms of providing us some standardized information, we believe that it needs to be further established in terms of other information that beneficiaries receive from the plans themselves so that they are standardized and start to use terminology that are consistent across plans so that people can make true comparisons.

As Mr. Hash indicated, there is nothing that probably will promote this program better than good education because a strong market is built upon information. And we have not had that here up to this point.

The CHAIRMAN. Mr. Lieberman, could you please compare and contrast CBO's enrollment projections for Medicare+Choice at the point the BBA was passed with what your projections are now? And please, explain any changes.

Mr. LIEBERMAN. Yes, thank you, Mr. Chairman. At the time of the BBA's passage or shortly thereafter, we projected that in 2007, enrollment in Medicare+Choice would reach approximately 36 percent of beneficiaries. We have modified that number now to about 28 percent. So the growth rate is down from 36 percent, going from a 36 percent to a 28 percent share.

In terms of growth rates, the rate we had projected for the 10 years immediately after the BBA was about 13.5 percent. We are now down a little bit—below 9 percent—as the annual growth rate. We see three reasons for changing our projections.

The first reason is that, prospectively, we believe the effect of the risk adjusters in taking dollars out of the system means that there will be less attractive benefits being offered in some markets and that fewer plans will be participating.

The second is that the combined effects of the payment increases have been and are continuing to be somewhat lower than people had anticipated. And third—the reason we think is having the biggest effect in the short term—is we believe that beneficiaries have a heightened awareness of the fact that, as Mr. Hash said in his answer, the pressure of market forces means that plans can withdraw from the program. And that has disrupted some expectations.

The CHAIRMAN. Yes, Mr. Hash.

Mr. HASH. May I comment, Mr. Chairman?

The CHAIRMAN. Sure.

Mr. HASH. I would just like to emphasize that when we look ahead at the impact on the enrollment of the changes that are brought about by the BBA including the implementation of the risk adjustment methodology, the impacts that we are talking about are based upon an assumption that the current enrollee mix, the type of individuals who enroll in Medicare+Choice plans continues for the next 4 years, 5 years just as it is today.

If in fact the composition of the individuals who enroll in those Medicare+Choice plans becomes a group of beneficiaries with more and heavier health care needs, then in fact payments will increase to those plans. And these estimates about the impact of money

being removed from the Medicare+Choice Program will be overstated if in fact the enrollment characteristics change over the next four or 5 years.

The CHAIRMAN. Let me turn to you again, Mr. Lieberman. In your testimony, you did discuss some alternative risk adjustment methods. Would you please discuss some of these other approaches that may work better for Medicare?

Mr. Lieberman. In general, the question is, since it is so hard to get a prospective set of statistical adjustment payments, are there other approaches? Other approaches that have been tried include partial capitation. I note that HCFA has a demonstration project going on at the University of California at San Diego—the academic health center there—in which it is using partial capitation as a way to mitigate the risk that the health plan would bear.

The second alternative that is widely used in both Medicaid and, in fact, among Medicare HMOs is carve-outs of specific conditions, such as solid organ transplants. And a third approach that, again, is common in——

The CHAIRMAN. Could you explain how that works?

Mr. LIEBERMAN. Certainly. If, for example, for the entire risk pool, solid organ transplants are 2 percent of total costs, one would take 2 percent of costs—if one were to do this in an actuarially neutral way—out of the total payments. That would lower the average payment. Then when somebody needed a liver transplant or a heart transplant, you would pay for that separately.

The basis for payment could be entirely different from the prospective rate. There could be a case rate. One could use centers of excellence with competitively bid prices. One could pay a portion of cost. One could pay on the basis of DRGs. So it gives one greater flexibility.

Very briefly, the third approach is to use stop-loss or reinsurance coverages, which can operate at the individual level, so that you remove the cost of a catastrophically expensive individual from a small risk pool. And one of the problems that HCFA is facing—in the sense that it is common practice in many of the California, Arizona, and other western markets with substantial Medicare+Choice enrollment--is that the HMO's pass much of the financial risk down to their provider groups, which have relatively small risk pools. The problem HCFA faces is not just making the right payment to the health plan. At some level, HCFA has an interest in making sure the right amount of money goes down to the level that is bearing risks.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Thank you, Mr. Chairman. We have had wonderful, concise testimony. And I have understood about 10 percent of what I have heard which is about a 50 percent increase.

Just one question. I did not quite catch Mr. Lieberman, a remark you just made about persons with catastrophic costs for organ transplants. You spoke of centers for excellence where there would be competitive pricing. Would you help me there? I just did not quite hear you.

Mr. LIEBERMAN. I am sorry. I covered lots of ground without explaining. I apologize. Senator Moynihan, what I was referring to was that if, from an actuarial perspective, one pulled out the ex-

pected cost of solid organ transplants or heart transplants or whatever, HCFA could then set the average payment excluding the cost for the condition on a prospective basis. And then, when a specific member needed a transplant, HCFA could, in theory at least, have a wide range of alternatives that it could choose from to pay for it. One of the alternatives that HCFA might choose to use, which is built on some of the demonstrations it has done, would be to bid out the procedure using a set of criteria in which both price and quality would be very important elements.

Senator MOYNIHAN. To bid out?

Mr. LIEBERMAN. Yes, sir.

Senator MOYNIHAN. We go back to 1992. And we are holding hearings on the health care proposals and administration. And sitting over there are Dr. Scanlon with a Jesuit from Fordham who said that what you are witnessing is the commodification of medicine, and a fascinating epiphany there.

At the down end of the table, a gentleman where Mr. Hash is sitting who was the head of the UCLA hospital said, could I give you an example? In southern California, we now have a spot market for bone marrow transplants.

Mr. LIEBERMAN. Yes, sir.

Senator MOYNIHAN. Mr. Lieberman, you are nodding.

Mr. LIEBERMAN. I spent a couple of years running managed care operations for the University of California at San Diego. And I am familiar with our trying to bid to get—I would not quite call it a spot market, but it was, shall we say, a competitive market to do organ transplants.

Senator MOYNIHAN. Yes. This is a fundamental change in medicine. And we are accommodating to it, but I think the realization arrived here. This began on the west coast. And it moved to the east coast. And again, you are nodding. That meant that Washington was sort of behind. The event came rather late to Washington. But it is a profound change in medicine and in no way to be deplored, but to be comprehended as against the previous guild systems that we had.

Could you, sir, give us in writing just a little bit more about that because it is of profound importance I think?

Mr. LIEBERMAN. I would be happy to submit that for the record.

[The following information was subsequently received for the record:]

The "commodification" of medicine poses important new opportunities, although it also can raise serious concerns. Some medical goods and services—such as routine lab tests or many types of durable medical equipment—are commodities. Fee-for-service Medicare, however, generally doesn't pay commodity prices—it may pay more in a market than the prices paid by private purchasers (such as HMOs) that effectively use competitive forces. Creating mechanisms to allow fee-for-service Medicare to benefit from competition when purchasing commodities would save money, and the resulting changes should generally not be apparent to beneficiaries.

Many people would object if all medical services were treated as commodities. For example, individuals may have a very personal relationship with their primary physician. But many expensive procedures involve physicians and patients who have limited personal contact and virtually no ongoing relationship. Patients rarely spend much time with pathologists or anesthesiologists. Similarly, most people don't have ongoing relationships with a transplant surgeon or an oncologist before they are referred to one by their physicians. "Carving out" solid organ transplants or coronary artery bypass grafts from the regular program, competitively bidding the procedures, and channeling patients to "centers of excellence" selected on the basis of

quality and price could yield better outcomes for beneficiaries while lowering Medicare costs.

Senator MOYNIHAN. And, too, I would like to ask Dr. Scanlon and any other member to comment on the withdrawals of health plans. You heard that this year, there is not a reaction to BBA rate reductions alone. Market forces appear to have played a larger role. Can you expand on that, sir?

Dr. SCANLON. Certainly, Senator Moynihan. In looking at the distribution of the withdrawals, it was clear that the plans were withdrawing from markets in which they were not doing as well as they may have expected. The plans, they faced in many instances significant competition suggesting that other plans were finding that market attractive, finding the Medicare+Choice rates viable. Yet, a given plan did not want to compete against those plans.

We also found that plans were withdrawing from markets that they had just recently entered and much more likely to do that than in markets that they had been established in for a long period of time.

Senator MOYNIHAN. They would test the waters?

Dr. SCANLON. Test the market and potentially find—not that we had suggested Medicare+Choice rate changes do not matter, but that other things matter as well. And before we had the BBA enacted, if you were to discuss a managed care plan's strategy in terms of market development, you would understand that it was very much of a business strategy in terms of trying to identify the conditions under which they as a particular plan, not necessarily as an industry, could find it——

Senator MOYNIHAN. They as a particular business?

Dr. SCANLON. As a particular business, but find it advantageous to then enter a country or an area. At some subsequent point in time, they might find that areas that they had rejected earlier, they would now feel that they were areas in which they would like to enter.

And I think we can expect to see that again. There is volatility now. Plans are reassessing their participation in different markets, but we find that either sometimes new plans come in and replace plans that have exited or at some future point a plan may decide that a market is now ripe enough for them to participate.

Senator MOYNIHAN. Thank you very much. It is very clarifying. I am sorry. My time has run out.

Mr. Chairman.

The CHAIRMAN. Please proceed.

Senator MOYNIHAN. I will just note how common it is to have experienced officials here talking about markets.

The CHAIRMAN. That is right.

Senator MOYNIHAN. Thirty years ago, we would not have talked about markets.

The CHAIRMAN. That is right.

Senator MOYNIHAN. It has changed. Thank you.

The CHAIRMAN. Thank you, Senator Moynihan.

Senator Grassley.

Senator GRASSLEY. Thank you, Mr. Chairman. My first two questions would be of Dr. Scanlon, but if either of the other two panelists would like to participate, they are welcomed to do it.

Your testimony emphasized that there are other factors accounting for plans withdrawing in addition to the payment rates. And so I was especially interested in your observation that an unusually large number of plans withdrew from the Federal Employees Health Benefit Program in 1998 because we are obviously looking at that program as a model for Medicare reform.

What do you know of the reasons for those withdrawals? And why do you consider them relevant to our decisions about Medicare+Choice programs?

Dr. SCANLON. Well, Senator, I think that while we look to the FEHBP Program as a potential model and in part because we recognize the advantages of plans having to compete on the basis of price that is going to be charged to enrollees, we recognize that also, again as Senator Moynihan indicated, this is a market in which there are dynamics of plans coming in and out depending on a lot of different circumstances.

Managed care generally speaking has been in more turmoil in the past year and a half, 2 years than it was in the past. After a period of significant growth, there has in some respects been some market shake-out as they discovered that competing for enrollees by offering lower premiums is not going to be a sustainable strategy for the longer term. They are going to have to raise premiums. This produces a reaction on the part of buyers. And so there is a give and take that is occurring.

We have noted, as Mr. Hash said, that the pull-outs in FEHBP in some respects mirror the pull-outs in Medicare in terms of the areas. We have not looked in detail in terms of the economics of any particular plan. In other words, what was the level of enrollment? What was the level of competition that they faced? We did the detailed analysis only in the Medicare Program.

Senator GRASSLEY. Mr. Hash, did you want to comment?

Mr. HASH. I think Dr. Scanlon really identified the generic factors that we have seen. I think one factor that increasingly comes to our attention is that plans are talking about having increasing difficulty in their negotiations with the providers to get contracts with them for the provision of services that are within the bounds allowed by their income from capitation.

So I think in some marketplaces for new entrants, as Dr. Scanlon indicated, being able to establish through contracts a provider network that is appropriately priced from the plan's point of view has been a challenge for many of them that has not worked out successfully and has resulted in their decision to non-renew their Medicare contract.

Senator GRASSLEY. Dr. Scanlon, you made it very clear in your comments that a major goal in 1997 was to make Medicare+Choice an option and to do that for seniors all over the country, but also we wanted them to know that we wanted to do that for rural areas as well.

I know your testimony today focused primarily upon 1998. But what lessons can we draw from that experience as we try to decide whether the program will work in those low-payment rural areas in the future? And if payment rates are only one of a number of factors that influence behavior, does that mean that even the Bal-

anced Budget Act improvements will not be sufficient to get rural seniors into the program or to have the program for rural seniors?

Dr. SCANLON. Right. We recognize very clearly the difficulties of establishing a managed care organization in rural areas. I mean, the fact that managed care in part is built upon being able to utilize the most efficient providers and to negotiate with providers to accept sort of more efficient rates, so to speak, and that in rural areas with the limited provider community that those opportunities are not as significant. Also, the limited populations mean that it is harder spread risks. So all of those things are problematic in terms of setting up a managed care plan.

Now, the BBA in establishing the floor did provide a major step in terms of encouragement of managed care in rural areas. I think it is too early to determine whether or not—I should not say whether not, but how sufficient a step it has been in terms of what areas does that floor sort of make it attractive and adequate for a managed care plan to operate.

The regulations that were applied to Medicare+Choice plans were issued in June of 1998. And it is really sort of too soon to determine sort of exactly what the experience is going to be in terms of plans organizing and locating sort of in different areas. I think we need a little more time to be able to judge.

And then, beyond rates, we do need to identify what are the barriers and decide whether or not they are going to be something that could be overcome.

Senator GRASSLEY. Mr. Chairman, thank you.

The CHAIRMAN. Senator Kerrey.

Senator KERREY. Thank you very much, Mr. Chairman. First, I would like to say again, but perhaps a little more clearly than I have in the past especially now that part of the President's proposal for a new benefit has been released to the public, I am getting requests from Nebraskans to support that new benefit.

And I want to make it clear that my first order of business is to evaluate BBA 1997 and try to determine whether or not any modifications need to be made there. I am not sure any do, but if they do I am prepared to make them.

This is a very complicated system. It is very hard for us to tell whether or not a change in the law is going to produce everything that we want it to. And I hear these gentlemen saying that in general terms, we are enrolling more people in managed care. We are seeing an increase in the number of enrollments.

And, Mr. Lieberman, you predict that 35 percent—what do you predict by 2007 or 2008?

Mr. LIEBERMAN. Twenty-eight percent in 2007.

Senator KERREY. So we are seeing that desired effect. Now, the question is, are we seeing cost controls? Now, we have reduced the budgetary projections for Medicare substantially as a consequence of those changes.

And I just want to make it clear to you, Mr. Chairman, that I think my first order of business is to try and evaluate whether or not any changes need to be made in BBA 1997 before we go on and start adding more benefits that might be politically fun, but might be enormously expensive and might reduce our capacity to maintain high-quality care in the rest of the system.

Mr. Lieberman, you have used a figure that I have heard before, although you stated it in a way that I found it a little easier to both understand and then retell. Approximately 5 percent of Medicare beneficiaries which would be roughly 1.8 million or 2 million, somewhere in that range cost about what the remaining 95 percent or 35 million or so beneficiaries cost, so roughly $70,000 per beneficiary, about $120 billion and change and about $120 billion for the rest of them. How does that compare to private sector insurance pools?

Mr. LIEBERMAN. Senator Kerrey, my sense is—and I want to go back and check this—but my sense is that in commercial insurance, typically the top 5 percent of enrollees—the most expensive people—would account for anywhere from 30 percent to 45 percent of total costs. So it is a little more skewed in Medicare but not substantially.

Senator KERREY. I will ask all three of you. Since I only have a limited amount of time, if you could answer it briefly. Is part of the problem that we have inadequate data? Are we dealing with inadequate data when you are trying to determine—when we are trying to make risk adjustment work?

And I am just talking about risk adjustment. You are trying to make risk adjustment work. We are using inpatient hospitalization data. It seems to me that part of the problem both in evaluating that as well as other things having to do with Medicare is just an insufficient amount of data to determine what is going on out there. I mean, that is what you do, you evaluate these programs at the GAO, at the CBO, and at HCFA. Do you have good data when you are evaluating it? Could that data be better? Is there anything we could do to make it better?

Dr. SCANLON. The data could certainly be better. And the data are often the major limitation. I mean, in the area of risk adjustment, we are starting now and the HCFA is starting now with hospitalizations because those are the only data available.

If we move to a situation where they have information on other health services, even once you have done that and you have got to worry about the processes that Mr. Lieberman's testimony indicated about making sure those are clean valid data.

Subsequent to that though, you are still basing your decision as to what the health of an individual is based on the services that they use. Ideally, we would move to a situation where we could measure their health directly. We are very limited in virtually everything that we do by the information that is available.

Senator KERREY. Well, could you three gentlemen at a later time make a recommendation, especially Mr. Lieberman, you and Dr. Scanlon make recommendations on what we could do with law to improve the quality of the data so that both we as policymakers could make better decisions and HCFA, they try to make risk adjustment work?

[The following information was subsequently received for the record:]

Some data that are important to policymakers should be relatively straightforward to produce. For example, HCFA used to produce data annually on fee-for-service spending at the county level but has stopped doing so. Those data are critically important for understanding and evaluating Medicare trends in specific mar-

kets. Because HCFA already has the underlying information, producing the data would not impose additional burdens on providers or beneficiaries.

In contrast, getting data to improve risk adjusters may involve imposing an added burden on the private sector because data that are not now routinely collected would have to be reported to HCFA. In the past, attempts to collect data that are not produced in the normal course of business (such as complete reporting of health care encounters) have experienced significant practical problems.

Yet even if additional data could be reliably produced, experts believe that risk adjustment can only account for a fraction of the variation in health care costs. As I discussed in my testimony, limitations in both data availability and statistical methods highlight why alternative approaches to adjusting prospective payments for risk might be worth considering.

Senator KERREY. Basically, what they are trying to do is set the rates so that, on the one hand, they are not excessively high; on the other hand, they are not excessively low. You do not want them excessively high for the 95 percent. And you do not want them excessively low for the 5 percent or you will skew the decision that the market is making and decrease the incentives that are there for people to legitimately go to managed care. And if you are operating only on inpatient data, I mean, I think the complaint that I have heard that is most persuasive is that inpatient data is all by itself not the best measurement to use.

Mr. HASH. If I could comment briefly on that, Senator Kerrey. The reason—you are right. We agree that inpatient hospital data is not adequate to base a full risk adjustment methodology on. The reason we started it at that point is that the BBA actually set forth a requirement that we could only begin to collect data for risk adjustment on hospitalization use first and then move to outpatient and encounter data second.

But as Dr. Scanlon indicated, there are lots of questions about making sure the data that we are getting are accurate and valid and they have been audited. And there is this delicate balance between how much burden to put on the reporting end, meaning the health plan and the health provider end versus our need for good and accurate data to manage and operate the program.

Senator KERREY. And I do not want to make this sound like it is rocket science. I know and understand that I mean I could add either a genetic or an external accident that occurs shortly after this hearing. And I could be at $70,000 a year. I could be costing a substantial amount. It is very difficult to predict that. In fact, it is impossible to predict a genetic or an external accident. And as a consequence, it is very difficult to predict with even 50 percent certainty what is going to happen.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Mr. Hash, it is my understanding that the HCFA actuaries, that there was a technical error in the BBA which is profoundly—it is very interesting what you just said in fact, that we require you and then we complain about what you then do. But due to a technical error that you are actually apt to—the plans will receive an increase in payment of 4.2 percent that is since 1997, that they have received that kind of an increase.

Now, leaving aside the medical inflation rates for the moment, you verified that by nodding your head. But can you comment on what is the history of this and how that happened?

Mr. HASH. Yes, Senator Rockefeller, I will be happy to. And in the BBA or I should say prior to the BBA, each and every year, the law required that the rates for managed care plans be updated based on a projection that involved a number of estimates in advance of the year to which they would apply. But the law also provided for corrections of those estimates at the end of the actual period so that in future updates, you would adjust for any under or over estimate based on actual experience.

In the BBA, the Congress in establishing the base for the Medicare+Choice rates picked 1997 as the base year and did not provide for any adjustment for the estimates related to the 1997 rates.

Once we got past 1997 and actually analyzed the real experience with the updates, it was determined that those rates for 1997 were overstated by the 4.2 percent and we could not correct for that with subsequent updates. So that 4.2 percent applies to each and every year after 1997 and is a built inflator to those Medicare+Choice rates.

Senator ROCKEFELLER. I appreciate that. The HMOs tend to claim that using inpatient data will undermine the principles, so to speak, of managed care. Now, risk adjustment is based upon more than just inpatient data. Yet, this is again what they tend to focus on.

Is it not true that data for outpatient encounters is not yet available, number one? In addition to inpatient data, is HCFA not also taking demographic characteristics, such as age, sex, Medicaid eligibility, and disability into account? Will these factors help lessen the potential disincentive caused by using inpatient data?

Mr. HASH. Well, let me take pieces of that and answer it the best I can, Senator Rockefeller. With regard to outpatient data, we have not yet begun to collect it, but we expect to actually announce in the fall the specifications for the outpatient data and a schedule for beginning to collect it because as you pointed out, we do need to base a comprehensive risk adjustment on both inpatient and outpatient service data.

With respect to other adjustments that are made to the Medicare+Choice rates, you are correct. And it is historic. Under the prior statutory provisions, there were so-called demographic adjustments just like the ones you just cited. They continue to apply to the adjustment of rates now. And on top of them, we are providing for a phase-in of a risk adjustment in addition to those demographic factors.

Senator ROCKEFELLER. Others can respond.

[No response.]

Dr. Wenberg, to you, Mike also, he testified before this committee in April. He said there is a tremendous variation the way physicians practice medicine in the United States. Of course, he is famous for his work on that at Dartmouth. And he says where there are more hospital beds, there tend to be more hospitalizations. In other words, in market terms, supply drives demand.

Is it not true that providers have in fact a lot of discretion in whether or not to hospitalize patients? And did HCFA not take this into account when developing the risk adjustment system by excluding discretionary hospitalizations? And can you give therefore

examples of non-discretionary hospitalizations and discuss how your proposed system will avoid unfairly discriminating against managed care?

Mr. HASH. That is an excellent, Senator Rockefeller. I mentioned in my opening statement that we in fact made a series of adjustments to what diagnosis we would actually use for the inpatient hospitalization adjustment. And we did exclude discretionary admissions. And we also excluded admissions that are less than a 1-day stay.

In terms of non-discretionary, the sort of subset of diagnosis that require hospitalization obviously runs the gamut from things like hip fractures, folks with emphysema, or obstructive pulmonary disease, heart conditions of one kind or another and cancer.

These would conditions that would give rise to hospitalizations and therefore would generate a higher payment under the risk adjustment methodology in the subsequent year because the data and the evidence show that if you have a hospitalization for one of these non-discretionary reasons, you are likely to implicate very substantially increased costs in the future to manage the course of the illness or disease that occasioned the hospitalization.

Senator ROCKEFELLER. Risk adjustment is neither an art or a science nor potentially perfectly possible.

Mr. HASH. I would agree with that, Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Chafee.

Senator CHAFEE. Thank you very much, Mr. Chairman.

Mr. Hash, I understand there has been some discussion here regarding the reasons why managed care plans have withdrawn from Medicare. And one of the reasons given is the cost of prescription drugs. And I wonder if you could elaborate on that particularly in view of the fact that people are now—it is now being suggested by the President and others that we contemplate a Medicare prescription drug benefit. What do you foresee?

Mr. HASH. Well, I would say with respect to managed care plans and the kind of reasons they have reported to us for withdrawing or non-renewing in the Medicare Program, some last year cited the very substantial increase in the cost of prescription drugs which they were covering as an additional benefit as a reason for withdrawing or not renewing their contract.

With regard to the future, I think obviously as the President has said on several occasions, he is committed to a drug benefit that is a part of the basic Medicare benefit package and that the management presumably of that drug benefit in terms of its cost would be something that we are continuing to review in our work for the President on his proposal.

But I think he is very sensitive to the potential cost and is having us examine the range of options out there in the private marketplace where other plans that cover prescription drugs, how they are dealing with the issue of the rising cost of prescriptions drugs to make sure that any plan he recommends is informed by that private sector experience.

Senator CHAFEE. Did I read that the suggestion is that it is not going to be that expensive because it is going to save a lot of money

in hospitalization and nursing homes. And I personally think that is wishful thinking. I mean, every time, we have gotten mixed with prescription drugs, we have found it very, very expensive. What do you say about, oh, it is going to be a wash, the cost will be offset by the reduced hospitalization and reduced nursing home requirements?

Mr. HASH. Senator Chafee, we are trying to make sure that we review the literature and the experience with regard to the effects of certain pharmaceuticals on the need for other kinds of services, including hospitalizations and the like. We do not have yet a complete analysis to indicate to what extent there may be offsetting savings.

I think it is a very complicated area because some of the advancements in pharmaceutical treatments are clearly ones that increase the cost of care while others in fact may have substitution effects that reduce the overall cost of care, but what the net of that is I think I am not prepared to give you a full answer on today.

But I think we all know examples of the one that comes immediately to mind is in the case of HIV and AIDS where the drug therapy, although quite expensive has significantly reduced the need for hospitalization for many individuals who have HIV/AIDS. But whether the net effect of that is a savings over prior therapy that was available including a lot of hospitalization, the literature is not completely in on that.

But I think it is this kind of analysis that is important. Whether or not on balance prescription drug benefits will overall reduce the cost of care to Medicare I think is a question we still have not answered.

Senator CHAFEE. I would not be too optimistic over it. I will just quickly, my predecessor, the Secretary of the Navy, had the Ignatious law which was when you buy more aircraft, it is more expensive per plane. When you buy fewer aircraft, it is more expensive per plane. [Laughter.]

That is the Ignatious law. Thank you.

The CHAIRMAN. Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman. My question really goes to risk adjustment and the various ways we adjust and which seems to make the most sense. I understand that HCFA has experimented with its PIP/DCG, whatever it is. I would like to have more.

Mr. HASH. Principal Inpatient Patient/Diagnostic Cost Group.

Senator BAUCUS. Now, how do you say that?

Mr. HASH. PIP/DCG.

Senator BAUCUS. All right. Anyway, as I understand, it is the top 17 groups. There are 17 groups that are the most expensive that are looked at.

Mr. HASH. Fifteen, I am told.

Senator BAUCUS. Fifteen. All right. And that lower payment then for those that are not in the 15?

Mr. HASH. Standard payment.

Senator BAUCUS. Standard payment. Right. Now, just using your best guess here, this is all pretty technical, which of the various alternatives do you think probably tend to work better? You men-

tioned solid organ transplant, a different way to pay for adjusting risk.

And are you experimenting with partial capitation? What is probably going to tend to work better and what should we focus on both to refine the most? Or are there going to be three or four different ways to do this, all operating simultaneously? And you pick one that seems to work the best or blend?

I am just trying to get a sense of where you think we are going because I think risk adjustment is going to be critically important here as we come up with Medicare reform.

Mr. HASH. I agree, Senator Baucus. It is a very difficult question. Mr. Lieberman has referred several times this morning to opportunities to in effect carve out some procedures or services from the risk pool and either reinsure them or pay for them separately or some other way that they are removed from having to be covered by the capitated payment itself.

I think that is why we have some demonstrations underway looking at alternatives to risk adjustment to see whether they are in fact more effective, more easy to implement, or whatever. And I think the jury is still out on those demonstrations as to whether they are proving to be effective or not.

In the meantime, our best reading of the direction in the Balanced Budget Act about what we should do with regard to risk adjustment to start with is to begin a comprehensive or a risk adjustment approach based on hospital inpatient data and then move to more comprehensive data.

Senator BAUCUS. Right.

Mr. HASH. Now, we have provided for a transitional implementation of that because we also recognize that this is a very significant change. We have not had a lot of experience with risk adjustment. And we wanted to do it on an incremental basis which gives us some opportunity and you as well some opportunity to evaluate and make whatever——

Senator BAUCUS. What is the reasonable goal to shoot for? What percent in variability is reasonable to shoot for? From my understanding, now it is about 1 percent.

Mr. HASH. Right.

Senator BAUCUS. Are you trying to get 7 percent or something like that? Some suggest 25. What is a good solid—I am not an enemy of the good here. But what is a good solid variability number that we should aim for?

Mr. HASH. I am far from the expert on this as I suspect that you are not either, Senator Baucus.

Senator BAUCUS. Right.

Mr. HASH. So I am hesitant to give you a quantitative answer, although I just asked one of my colleagues. And I am told that sort of a maximum that the literature would be I think in terms explaining variations in health costs would be about 25 percent. As you can see, we are some distance from that. The tradeoffs are, of course, ultimately things like how much information do we have to collect?

Senator BAUCUS. I understand that.

Mr. HASH. And what is the cost of that to get to the level of precision.

Senator BAUCUS. Right. It is usually 25 percent is about the reasonable maximum?

Mr. HASH. I do not know. My——

Senator BAUCUS. I would like to ask Mr. Lieberman and Dr. Scanlon.

Mr. HASH. I would like to yield to them on that point.

Senator BAUCUS. Sure.

Mr. LIEBERMAN. Senator Baucus, let me make a couple of comments. On the one hand, clearly, the PIP/DCG is better than its predecessor. On the other hand, by most standards, it is not very good. The man problem with the current system is how difficult it would be to improve it. And although I think HCFA is making serious efforts to do that, it is an enormously difficult undertaking. There are, as we discussed earlier, both data problems and data manipulation problems.

The other part of the PIP/DCG question, though, is that there is some very preliminary evidence that the current system not only suffers from a limited ability to explain variations in cost but in some limited or specific ways, it may—and I underscore that this is very preliminary—it may systematically disadvantage some plans that have enrolled sicker-than-average patients.

Senator BAUCUS. Mr. Lieberman, my question really is, is 25 a good number to shoot for?

Mr. LIEBERMAN. That is what the literature says.

Senator BAUCUS. What do you think?

Mr. LIEBERMAN. I think that we are going to be a long time getting there. And therefore I would suggest that we need to think about other ways to——

Senator BAUCUS. All right. It sounds like it is quite difficult. But does that suggest in the meantime we should work harder to develop incentives for quality in care?

Mr. LIEBERMAN. Absolutely.

Senator BAUCUS. And how far along are we there? I mean, risk adjustment is fairly recent it seems. What about quality incentives?

Mr. HASH. Well, one of the important parts of the BBA, Senator Baucus, was the inclusion of very specific requirements about holding managed care plans and the Fee-for-Service Program to a standard of quality improvement that is measurable.

And so in our regulation that we published last June, we set forth some standards that we announced in terms of data, performance measures that we are collecting, and the requirement for our contracting plans to actually engage in performance improvement projects at least two a year that have measurable outcomes that show improvement. And we actually think on the quality for purposes of our Medicare+Choice Program, we have put into place some very strong measures to make sure the bar of performance is high and that we have continuous quality improvement.

Senator BAUCUS. Well, my time has expired. This is just a subject which I think we are going to have to work a lot harder on and develop a lot better than we have thus far. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Well, thank you very much for being here, gentlemen. We appreciate the excellence of your testimony. And we will, I am sure, be in contact soon. Thank you very much.

I will now welcome our second panel. We will hear from Robert Cumming, Principal with the actuarial firm of Milliman & Robertson who is here today representing the American Academy of Actuaries. We will also hear from Seven deMontmollin with AvMed Health Plan who will testify on behalf of the American Association of Health Plans. And finally, Peter Smith who is Chief Executive Officer of Ralin Medical.

Mr. Cumming, we will start with you if we may. Please proceed.

STATEMENT OF ROBERT CUMMING, PRINCIPAL, MILLIMAN & ROBERTSON, INC., ON BEHALF OF THE AMERICAN ACADEMY OF ACTUARIES, MINNEAPOLIS, MN

Mr. CUMMING. Good morning, Chairman Roth and members of the committee. My name is Bob Cumming. I am a Principal with the actuarial consulting firm of Milliman and Robertson located in Minneapolis. I am appearing today in my capacity as a member and representative of the Risk Adjustor's Work Group of the American Academy of Actuaries.

Our volunteer work group was formed at the request of the Health Care Financing Administration. The purpose of our work group was to perform an actuarial review of the health status risk adjuster developed by HCFA. This risk adjuster will be used starting in the year 2000 to adjust payments to Medicare+Choice health plans.

The analysis of our work group is summarized in a report which was released by HCFA to Congress in March of this year. As described in our report, the adoption of a new health status risk adjustment payment system is a significant change for HCFA and for the health plans. And it may have a significant impact on the health plans, on contracting health care providers, and on Medicare beneficiaries.

There is a substantial risk for the Medicare system if the risk adjustment methodology does not work as intended. The possible negative consequences of this include the withdrawal of Medicare+Choice plans from the marketplace, financial problems or insolvency of health plans, and the reduction of benefits for Medicare beneficiaries.

Our work group concluded that the methodology that has been developed by HCFA is actuarially sound, but with certain qualifications and concerns. On balance and with the phased-in approach which has been recommended by HCFA, we believe the new risk adjustment is a reasonable first step in what should be a long-term evolutionary process.

Based on a review of the information and data provided by HCFA, our work group did note a number of concerns in qualifications. The concerns mentioned in our report include, first of all, there is a potential bias against managed care plans. That is there is a possibility that managed care plans may be paid less than is appropriate due to the new risk adjustment system. This is due to the fact that the risk adjuster is based only on hospital inpatient admission data.

This may penalize managed care plans that are more efficient in managing care. It may also penalize managed care plans that are

more efficient at preventing health care problems that would otherwise require a hospital inpatient stay.

For example, if a health care plan is able to prevent some type of flare-up of a disease or condition, they may prevent a hospital inpatient admission, but the end result is that they would be paid less money by so doing, by that preventive effort. This is an unintended and undesirable consequence.

The phase-in of the risk adjusters does to mitigate this concern in the first year. However, we feel that this issue should be analyzed further as you move forward. Also, the work group recommends that the implementation of a risk adjustment system be done, including both ambulatory or outpatient services as well as the hospital inpatient services as soon as is feasible.

Our second major concern relates to the administrative feasibility of implementing the new system while assuring data quality and appropriate accuracy of the information. As mentioned, the new payment system is a significant change for HCFA and for health plans.

The processing by HCFA and health plans of large amounts of new data and the completion of complex calculations to determine the new payment system introduces certain uncertainty and the potential for data problems. To be actuarially sound, the new payment system needs to be carefully implemented with appropriate audits and data quality checks.

Our opinion, as I mentioned, was a qualified opinion of actuarial soundness. Our opinion was qualified since we were unable to fully analyze HCFA's proposal because of incomplete available data and the fact that HCFA was continuing to implement the risk adjustment as we were doing our analysis.

While HCFA has done much work in a short period of time to develop the new risk adjustment system, much additional work remains. The work group believes that HCFA should further modify the risk adjustment model with additional information gained over the next few years.

Our report to HCFA includes a number of recommended changes to the risk adjustment methodology that the agency should consider as they go forward. The work group would like the opportunity to provide further comments on the new system as it is implemented.

And I would be glad to answer questions of the committee at the appropriate time. Thank you.

The CHAIRMAN. Thank you.

And now, we will call on Mr. deMontmollin.

[The prepared statement of Mr. Cumming appears in the appendix.]

STATEMENT OF STEVEN DEMONTMOLLIN, VICE PRESIDENT AND GENERAL COUNSEL, AVMED, INC., GAINESVILLE, FL

Mr. DEMONTMOLLIN. Mr. Chairman and members of the committee, thank you for this opportunity to testify on issues relating to the implementation of the Medicare+Choice Program. I am Steve deMontmollin, Vice President and General Counsel of AvMed Health Plan based in Gainesville, Florida.

AvMed is Florida's oldest and largest not-for-profit HMO serving nearly 80,000 Medicare members which, Mr. Chairman, would make us the 17th largest Medicare HMO in the country by enrollment. We have participated in the Medicare Program since 1981. Florida has about 768,000 Medicare+Choice beneficiaries of a total Medicare population of 2.7 million or 28 percent of the total Medicare enrollment.

Now, you have heard Mr. Lieberman this morning talk about getting to 28 percent penetration by the years 2007. Florida is there presently. I will suggest, however, that unless changes are made mid-course in the Medicare+Choice Program, neither Florida or the U.S. will be at the 28 percent in the year 2007.

The growth rate into managed care during the 1990's has reached as high as 36 percent per year from the fee-for-service system into the managed care system. For the years 1997 and 1998, there were rates of growth of about 10 percent and 8.5 percent, respectively.

It is important to understand that for the year 1999, the first year of the implementation of the Balanced Budget Act, that growth rate was at 1.7 percent. Regardless of how that number is dressed up, the amount of growth into this program has been dramatically reduced.

I am testifying today on behalf of the American Association of Health Plans whose membership includes most Medicare+Choice organizations. I will begin by emphasizing that millions of Medicare beneficiaries are counting on Congress to guarantee the future success of the Medicare+Choice Program.

They are the ones who have the most at stake in this debate. Medicare beneficiaries may not care much about risk adjustment and other complex policy issues, but they clearly understand the fundamental concept of fairness. I believe many Medicare beneficiaries would be seriously concerned if they knew about the unfairness of the Health Care Financing Administration's approach to implementing the Medicare+Choice payment system.

An analysis of projections of the Medicare+Choice rates in each county over the next 5 years shows a significant reimbursement gap, often more than $1,000 opening up between the Fee-for-Service Program and the Medicare+Choice Program. For example, this gap will exceed $3,500 in the year 2004 for Dade County's more than 128,000 Medicare+Choice enrollees.

And I think that it begs the question to this committee, if the Federal Government is going to have to spend as much as $3,500 more for each fee-for-service Medicare beneficiary in the year 2004 than it is spending on the 128,000 current Medicare+Choice beneficiaries, is that a good value for the Federal Government.

For nearly half of these enrollees, the Medicare+Choice reimbursement will be between 72 and 85 percent of fee-for-service Medicare payments in 2004, significantly exceeding any estimates of alleged favorable selection by plans. Even in the smaller markets that plans were expected to expand into, nearly half of Medicare+Choice enrollees live in areas where the fairness gap will be $1,000 or more in the year 2004.

This reveals a fundamental unfairness in the Medicare+Choice payment system. No one should kid themselves that managed care

plans will be the only ones hurt by this disparity. The stark reality is that Medicare+Choice enrollees, especially lower income enrollees will suffer if payments to their health plans are inadequate to cover their health care costs.

We urge the committee to consider approaches that would help reduce the fairness gap and restore stability to the Medicare+Choice Program. These approaches would include at a minimum making the risk adjuster budget neutral, as was Congress' intent I believe, as well as setting a floor below which payments could not fall, or eliminating the legislative reduction in the Medicare+Choice payment growth rate.

We must also recognize that physicians and other health care providers are affected by inadequate payments to Medicare+Choice plans. HCFA's risk adjustment methodology will exacerbate this problem. Every dollar identified by HCFA as Medicare savings is actually a dollar that cannot be used to pay providers or to finance prevention initiatives and quality improvement programs.

Let me now focus on the implementation issues that are largely responsible for these alarming payment disparities. HCFA's risk adjustment methodology would achieve tremendous savings at the expense of Medicare+Choice plans and enrollees, $11.2 billion over the next 5 years, though a system that Congress intended and the CBO previously scored as budget neutral.

We are also concerned that HCFA's risk adjustment methodology reflects a strong bias against managed care. By relying solely on inpatient hospitalization data, HCFA penalizes plans that reduce hospitalization through disease management programs that improve care for chronically ill patients.

Moreover, excluding 1-day stays will result in a distorted picture of beneficiaries' health causing certain Medicare+Choice enrollees to appear healthier than they actually are. The end result of this poorly designed methodology is that payment for the Medicare+Choice population will be inadequate to cover the cost of beneficiaries health services.

Without Congressional action this year, beneficiaries may find access to their health plans jeopardized and that few choices are available to them. Last year, AvMed sustained significant losses in the Medicare Program and found it necessary to withdraw from 7 of the 25 counties in which we previously offered Medicare services, affecting some 6,500 beneficiaries.

A large part of our not-for-profit mission is to serve the Medicare and Medicaid populations. And we are hopeful that it will not be necessary to withdraw from additional counties for the year 2000.

I urge the committee to act now to ensure that the Medicare+Choice Program remains a viable foundation for long-term structural reform.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

[The prepared statement of Mr. deMontmollin appears in the appendix.]

Mr. Smith?

STATEMENT OF PETER SMITH, CHIEF EXECUTIVE OFFICER, RALIN MEDICAL, BUFFALO GROVE, IL

Mr. SMITH. Mr. Chairman and members of the committee, my name is Peter Smith. I am the Chief Executive Officer of Ralin Medical, Inc., located in Buffalo Grove, Illinois. It is a pleasure to come before the Finance Committee this morning to discuss some concerns that we have with the proposed risk adjustment payment methodology developed by HCFA.

In order to understand our concerns with HCFA's proposed methodology, Mr. Chairman, I think it is first important for the committee to understand how these changes affect organizations like Ralin which provides health care services to some of the Nation's sickest patients, those with chronic illness. These are the 5 percent mentioned earlier today that constitute about 95 percent of the medical expenses in the system.

Ralin is the largest disease management company in the United States. We have developed a very successful model for delivering health care services in the managed care sector to patients suffering from congestive heart failure, coronary artery disease, chronic obstructive pulmonary, and diabetes.

With over 130,000 patient months of experience, we have a track record in delivering better medical care to patients at less cost to our customers. The vast majority of our patients are Medicare aged and are enrolled in Medicare risk plans.

Our disease management system is called MultiFit which was developed at Stanford. It is primarily a telephonic program in which our nurse interacts with the patient and the patient's physician to extend what the physician can do between office visits, to manage pharmaceutical compliance, diet, and lifestyle.

This is accomplished through contact with the patient and the physician using various, well-tested tools validated and developed by Stanford. We do retain the capability to do home encounters with patients based on our relationship with over 90 home health agencies which we subcontract with nationally.

The simple value proposition that we offer is that a managed care can pay our fees with the result of better patient care, improved medical management, patient and physician satisfaction, and enough cost savings to cover our fees and still more. The financial savings that are achieved have definitely been through improved clinical results at the same time.

In a survey of 5,000 Medicare risk heart failure patients over a 3-year period, we achieved a 62-percent reduction in hospital days, a reduction of total medical expenses by 52 percent, the number of patients eligible but not receiving appropriate medications decreasing by 30 percent, functional status increasing by 10 percent, and most importantly 97 percent of all the patients were satisfied with the overall quality of care and services by the program.

As a result of these types of outcomes since 1994, we have developed over 50 relationships with national, regional, and local managed care plans. Our customers have been the early adopters of a significant change in the health care delivery system. Most often, we are at risk to improve historical financial results, plus clinical quality of life, and patient satisfaction results.

We are here today to express our basic agreement with the risk adjustment concept as developed and presented by HCFA. The intention to reimburse more for sicker and costlier patients seems very appropriate.

However, we have two basic concerns. First, plans that have been leaders in the development of health promotional programs will be penalized during the initial risk adjustment phase because they exhibit a low number of hospitalizations relative to the health status of their population. Second, going forward, plans would have very little incentive to start or to continue health promotional programs due to poor incentives.

Simply stated, the more hospitalizations occurring, the higher the reimbursement under the risk adjustment methodology. The fewer number of hospitalizations occurring due to health promotion programs, such as ours, the lower the proposed reimbursement. This creates the same financial result for a plan not investing in disease management as for a plan that does make such an investment. This clearly rewards those with no programs and penalizes those who have initiated programs.

We have presented this concern to officials of HCFA on April 28th along with an independent analysis we used, using a live data base to confirm our own internal review. This analysis and examples to illustrate the point are pare of the longer testimony that I submitted as part of the record. I would be happy to comment later on.

I believe it is fair to say, Mr. Chairman, that while HCFA was not prepared to agree on the spot with our conclusions, they agreed it might make sense to reevaluate their methodology in the context of the issues we raised. And they agreed to consider our recommendation.

We proposed one possible remedy. Under our proposal, if a patient is in a plan that meets HCFA's program standards for a specific risk adjustment category into which the patient has been indexed, then as long as the plan continues to meet HCFA's standards, the patient would remain in the specific PIP/DCG regardless of hospitalization.

Conversely, if the plan's program at any time fails to meet HCFA's program standards for the specific category, the patient's reimbursement could be reduced until the plan again meets the standard. This would involve HCFA actually using its quality standards under their own quality improvement system for managed care, QISMC guidelines.

Many possibilities exist, Mr. Chairman. We would like to work with the committee and HCFA to adopt an appropriate methodology, pilot testing these suggestions during the phase-in would avoid irreparable harm to the promotion of a worthwhile disease management program.

One last point, it is worth reemphasizing. The appropriate risk adjusted methodology to promote good health maintenance programs should be based on incentive, aligning these incentives properly. When they are aligned properly, both the patient and the health care system would benefit.

I welcome any questions.

[The prepared statement of Mr. Smith appears in the appendix.]

The CHAIRMAN. Thank you, Mr. Smith.

Let me ask you, Mr. Cumming, on a comment Mr. Smith just made, would you and other members of the academy feel more comfortable if HCFA were to try the new risk adjusters in a few markets, as a demonstration program, before going Nationwide?

Mr. CUMMING. Our work group did look at that particular issue and made a number of observations and recommendations. There are certainly tradeoffs to that type of phase-in approach.

The potential issues related to that would involve making sure that the markets that you do look at include a broad cross section of the markets out there, including urban and rural, high cost and low cost, high managed care penetration and low managed care penetration.

Another issue relates to the managed care plans that are in the particular markets where it is phased in. They may feel that they have a unfair advantage versus other managed care plans that are not in markets where there is such a phase-in.

The CHAIRMAN. If you have a demonstration program what would be the period of time necessary to make them effective?

Mr. CUMMING. Our work group did not look at that particular issue, but we would be happy to get back to you with some written comments on that.

The CHAIRMAN. Mr. Smith, do you have any comment on that?

Mr. SMITH. We made a proposal that basically said that between now and the end of this year that you could take certain PIP/DCG categories and establish quality standards using the QISMC basis and that then during the first half of next year, you could evaluate the plans using the standards that have been achieved.

And by the time you came to the end of the year 2000, you would be able to actually implement our proposal. And then, from there on, it would become a rolling program over the next 3 years is basically what we were suggesting.

The CHAIRMAN. Let me turn back to you a minute, Mr. Cumming. HCFA claims that Medicare+Choice plans are overpaid by 7.6 percent which the agency is attempting to correct through the current risk adjustment methodology. In assessing the appropriateness of this risk adjuster, did the academy work group verify this overpayment figure?

Mr. CUMMING. The academy work group did not look at the level of possible overpayment. We do agree that HCFA's analysis shows that if they do fully implement the hospital inpatient risk adjustment system they have proposed that that would lead to about a 7 to 8-percent reduction in the payment levels to health plans.

The work group does believe though that the HCFA should move as quickly as possible to a system that incorporates not only hospital inpatient data, but also physician data and other ambulatory information to build a comprehensive risk adjustment system. And that may certainly have somewhat different results, but we have not analyzed that at this point.

The CHAIRMAN. Mr. deMontmollin, what are the principal obstacles to private plan participation in the Medicare Program?

Mr. DEMONTMOLLIN. I think that Mr. Lieberman addressed a number of them. And I thin that they were also addressed by the GAO witness. And that is the inability under the BBA and also the

HCFA administrative guidelines for flexibility to design benefits and supplemental premiums from county to county, the inability to recognize the difference in the payment rate in a particular county, and the difference in the ability or the feasibility of contracting with providers in those counties.

We are going to be talking about something called provider push-back. The managed care backlash has resulted in providers becoming embolden to demand amounts of money for reimbursement, reimbursement that they expect to be made whole from the cuts in the Balanced Budget Act. They feel like they are going to make up 22 percent at the hospitals by going to the HMOs and demanding much higher increases in their payments.

The payment rate itself. Last year, a 2-percent payment increase with a one-half of 1 percent taken back because the 16 percent of managed care plans were paying the entire cost of the education program, some $95 million. That resulted in taking back one-half of a percent of the increase of 2 percent to our plan.

The provider push-back, I have talked about. Drugs in my plan increased by 33 percent last year. We expect increases of 22 percent in the commercial area and in excess of 35 percent in the Medicare area.

The percentage point reduction which is the double whammy that currently is being reduced in the capitation payment, the Medicare+Choice plans is exacerbating the reduction from 20 percent that BBA provides for managed care plans.

The risk adjuster, you have heard some reasons why plans like ours that has a congestive heart failure disease management program where we say to a patient when we find out that she has congestive heart disease, that we say to her we want to make sure that you are Lacex or the other appropriate medication. Do you have a scale? If you do not have a scale, we are going to provide you one because your weight within range is very important, not because this is going to save us money, but because we know that if that patient goes in the hospital three times with a diagnosis of congestive heart failure, her chances of surviving 6 months after that third hospitalization are cut in half. It is a quality of care issue that I think Mr. Smith addressed very well.

The graduate medical education reduction in the capitation payment to HMOs is another perfect example. Our headquarters is in Gainesville, Florida, the home of the fighting Florida Gators at the University of Florida. It has a tremendous health care teaching hospital and medical school.

Our contract with that hospital did not go down to reflect GME payment reduction. In fact, it went in excess of 30 percent. We can make the same statement at the University of South Florida and the University of Miami Medical School.

So the issue is are we talking about business decisions that we are worried about? These are all business decisions. How do we stay in business given these circumstances?

Two-thirds of all HMOs in Florida, 26 of 34 fail to make a 2-percent solvency requirement required by the Department of Insurance in Florida last year. As of September 30, 1998, the aggregate losses in managed care in Florida was $60 million. We are talking

about an industry that is beleaguered, not an industry that is flushed and is feasting on the rest of the health care industry.

The CHAIRMAN. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman.

I just want to comment on the statistics you have Mr. Smith. Your pages are unnumbered, but I think it is about page 3. They are remarkable. And as I understand, this all stems from this telephonic association that you have. Could you just briefly explain how this thing works?

I mean, if you are able to save money like this primarily coming from the reduction of hospital admissions, I take it, and the length of hospital stays, it is really remarkable. How does this system work?

Mr. SMITH. I would be glad to comment on it. First of all, most of our relationship has been with managed care. And one comment I would make is because the system is fundamentally telephonic, the Health Care Financing Fee-for-Service Program does not pay for this type of assistance.

If you look at most congestive heart failure patients, about 70 percent of them are in the fee-for-service side, but the model has been developed in managed care because they had the ability to adopt the program. What happens is we make a contractual relationship with a managed care customer. They began to look into their data base for patients who have heart failure as an example. And they also look for the names of the physicians of those patients.

We then begin an enrollment process where we contact the physician, explain our program, and gain their endorsement to enroll the patient. So all patients are enrolled with the endorsement of the physician.

Within 24 hours, we do a home visit to the patient which consists of both a physical and an environmental assessment. That information is dunned through one of our subcontracted home health agencies.

At this point, all that information is then passed to our nurse who is an employee of our company who works with the patient and the doctor on a long-term basis. It's almost like having a personal and a coach who is an expert because all of our nurses are specialists in critical care nursing.

And they work over the phone with the patient, using the MultiFit management system. There are patient education materials as part of MultiFit. There is a chronological time line that dictates what actions should be taken at various intervals with the patient with the knowledge and support of the physician.

And what you are really doing is you are saying the patient should be on certain medication. Sometimes, they are on other medications that they should not be on. So we are working with the doctor to sort that out. We are making sure that the patient complies with the medication once they are on it and that they get to a targeted dosage level which means they will not have side effects.

And we also work on their diet and their lifestyle. And they know at any time day or night they can reach us. We are basically a safety net. And we encourage them to become very involved in their own disease, for example, identifying themselves the symp-

toms that can lead to trouble, learning how to comply with their diet which is not as easy as one might think.

So the philosophy is a long-term relationship with the patient over time. And I agree with you. These results have been remarkable, but the best thing about it is the quality of life for the patient is so dramatically increased that our patient's satisfaction levels are up. The physicians are happy because they have a much better patient. And at the end of the day, we are saving considerable amounts of money for the system.

Senator CHAFEE. Well, I would think so.

Thank you very much, Mr. Chairman. I appreciate the opportunity.

The CHAIRMAN. One final question, Mr. Smith. Could you please describe briefly the analysis that your company conducted that you believe indicates that the proposed risk adjustment methodology rewards plans that do not adequately manage an illness?

Mr. SMITH. I would be happy to do that. We created what I would call scenario A and scenario B. In scenario A, we actually took our own data base and worked with an independent company in Boston that actually worked with HCFA to develop the PIP/DCG.

And in that, we found about 1,000 patients that would be able to have 12 months of medical data so that they could go through the indexing process on a simulated basis. And all 1,000 of these patients ended up in the DCG category for heart failure.

And then, these patients had 12 months of additional data so that we could actually follow what happened to these patients in our program. And the interesting thing was there was a dramatic decrease in hospitalization because of the program.

And as a result of that, there was a certain amount of reimbursement associated with these patients. And you could look at the reimbursement and you could look at the lower cost. And you could find out how the health plan came out. And so we had a certain result of going through that whole process.

In scenario B, we simply took all the available medical literature which basically indicates that in any group of patients who have heart failure, if they're in an unmanaged program, about 50 percent of them will be re-hospitalized within 6 months.

And we have redistributed the patients into the DCG bucket which meant that there were more hospitalizations and higher reimbursements, but the costs were also equally as high.

So when you took the difference between the reimbursement and the cost under scenario A and you took the difference between the reimbursement and the cost under scenario B, the bottom line to the plan that was involved was the same.

And that really mathematically indicated that the plan had no great incentive to try to avoid these hospitalizations and run this kind of program. And that is what is in the detail of the record. And we were able to show that.

And one other interesting comment, although all of the outpatient data is not completely there, there is some outpatient data methodology. And we asked our group to apply that. And it did improve the results of the health plans, but only marginally. And

when we met with HCFA, that data was also presented. And they recognized that issue.

The CHAIRMAN. Well, gentlemen, the hour is growing late. We appreciate your being here. Undoubtedly, as we proceed with the work in this area, we will be in contact with you, but I want to express my appreciation to all three of your providing very valuable testimony.

The committee is in recess.

[Whereupon, at 11:53 a.m., the hearing was recessed.]

IMPACT OF THE 1997 BALANCED BUDGET ACT PROVISIONS ON THE MEDICARE FEE-FOR-SERVICE PROGRAM

THURSDAY, JUNE 10, 1999

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:05 a.m., in room SD–215, Dirksen Senate Office Building, Hon. William V. Roth, Jr., (chairman of the committee) presiding.

Also present: Senators Chafee, Grassley, Mack, Moynihan, Baucus, Breaux, Conrad, Graham, Bryan, and Kerrey.

OPENING STATEMENT OF HON. WILLIAM V. ROTH, JR., A U.S. SENATOR FROM DELAWARE, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. Good morning. The committee will please be in order.

Today the committee will continue addressing the impact of the Balanced Budget Act on Medicare, focusing specifically on the fee-for-service program.

Approximately 85 percent of the 39 million beneficiaries in Medicare are enrolled in fee-for-service. The Balanced Budget Act created well over 150 changes affecting providers and beneficiaries in traditional Medicare.

Four main prospective payment systems were mandated by the Balanced Budget Act, affecting skilled nursing facilities, home health agencies, outpatient services, and rehabilitation hospitals. With Medicare annual growth rates at 10 percent prior to the BBA, the prospective payment systems are a major step towards controlling the growth in Medicare spending.

It is through the many provisions in the Balanced Budget Act that projected solvency dates for the Hospital Insurance Trust Fund were originally extended. Although it is important to evaluate and monitor implementation of the BBA provisions in the fee-for-service program, it is equally important to assess the impact these provisions have had on providers and beneficiaries.

During the hearing, the committee will examine the major BBA provisions more closely and identify key issues on which the committee should focus. It is important that the issues identified can be fully substantiated. In addition, in each case it is necessary to

identify whether HCFA can exercise its administrative authority or whether statutory changes are needed by Congress.

Senator Baucus?

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thank you, Mr. Chairman.

All of us have heard about problems created by the Balanced Budget Act and the concern that perhaps the cut back in payments to providers have gone too far. I think it is very important for us today to listen to those concerns and, with the panel, explore the degree to which that has happened.

Second, in some sense, and in my judgment even more important, is to try to find some kind of a framework, some kind of benchmark or criteria which would help us not only now, but in the future, answer these kinds of questions.

It is one thing for a provider to say, we need more money. That very well could be true in many cases. But it is something else to try to determine what I think is more important, namely, how we make those decisions and what the criteria are and what the structure formulation might be.

It is very clear to me that the cuts have had a disproportionate effect in different parts of the country, and certainly for rural States, very much. I hear it constantly when I am home, and in the data provided to me it seems quite clear.

So my strong hope, Mr. Chairman, and it is my expectation and my belief, that when we finish today and the other Medicare hearings which I think you might have scheduled, that we would be in a much better position to know just how valid those claims are.

I think there is validity in a lot of the claims, in how much we restore and what criteria we use, which will provide us with guidance not only today, but hopefully more in the future.

The CHAIRMAN. Thank you, Senator Baucus.

It is now my pleasure to welcome the witnesses from our first panel. Dr. Bob Berenson is director of the Center for Health Plans and Providers at HCFA; Dr. Paul Van de Water is associate director for Budget Analysis at the Congressional Budget Office. I sort of feel I do not have to introduce Dr. Wilensky or Dr. Scanlon. We appreciate their willingness to be here on many occasions, and welcome them once more.

We ask that each witness limit his testimony to five minutes. The full statement will be included as if read.

Dr. Berenson, would you please begin?

STATEMENT OF ROBERT A. BERENSON, M.D., DIRECTOR, CENTER FOR HEALTH PLANS AND PROVIDERS, HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, DC

Dr. BERENSON. Thank you, Mr. Chairman. Thank you for inviting us to discuss the impact of the Balanced Budget Act on Medicare fee-for-service beneficiaries and providers.

The BBA expands preventive benefits and it includes payment reforms that are critical to strengthening and protecting Medicare. We have implemented now more than half of the BBA's 335 provisions affecting our programs at HCFA, including the new preven-

tive benefits such as diabetes education and a prospective payment system for skilled nursing facilities.

In most cases, the statute prescribes in great detail the changes we are required to make. We are committed to affording providers maximum flexibility within our limited discretion.

Change of this magnitude always requires adjustment. It is not surprising that market corrections would result from such significant legislation. Our first and foremost concern must be the effect of policy changes on access to affordable quality health care for beneficiaries.

We are proactively monitoring the impact of the BBA to ensure that beneficiary access to covered services is not compromised, but we should be cautious about making changes to the BBA until we consider information and evidence of problems in beneficiary access to quality care.

We are increasing our activity in monitoring the impact of the BBA to ensure that access is not compromised. Currently, we are working hard to gather data from media reports, beneficiary and provider groups, area agencies on aging, State Health Insurance Assistance programs, our various contractors, State health officials. We are examining information from the SEC and Wall Street analysts on the circumstances that companies face.

We are monitoring Census Bureau data on trends and profits in each service industry. We are monitoring Bureau of Labor Statistics on employment trends. The HHS Inspector General's Office will be working immediately to study the impact of the rehabilitation therapy caps. I would add that some of the work done by some of the other organizations here is also helpful in this monitoring activity.

They will also study whether hospital discharge planners are having trouble placing beneficiaries in home health care or skilled nursing facilities, and we have established a work group to develop an ongoing strategy for monitoring home health access.

It is clear that the BBA is succeeding in promoting efficiency in extending the life of the Medicare trust fund. However, the BBA is only one factor contributing to changes in Medicare spending.

Our actuaries tell us that low inflation from a strong economy and aggressive efforts to pay correctly and fight fraud, waste, and abuse are having a significant impact on total spending.

We have significantly decreased the number of improper payments made by Medicare. For the first time ever, the hospital case mix index is going down due to efforts to stop upcoding. Some of the slow-down in spending growth results from slower claims processing and payment during the transition to new payment systems.

The BBA also is only one factor contributing to provider challenges in the rapidly-evolving health care marketplace. Efforts to pay correctly and promote efficiency may mean that Medicare no longer makes up for losses or inefficiencies elsewhere.

We are concerned about reports about the financial conditions of some providers. However, it is essential that we delineate the BBA's impact from the effects of excess capacity, discounted rates to other payors, aggressive competition, and other market factors that are not caused by the BBA.

We look forward to continuing to work with this committee to identify problems. We will keep you up to date on the status of our implementation of the BBA, as well as this new focus on monitoring its impact. I thank you for holding this hearing and I will be happy to answer questions.

[The prepared statement of Dr. Berenson appears in the appendix.]

The CHAIRMAN. Thank you.

Dr. Van de Water?

STATEMENT OF PAUL VAN DE WATER, PH.D. ASSISTANT DIRECTOR FOR BUDGET ANALYSIS, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC

Dr. VAN DE WATER. Thank you, Mr. Chairman. I am pleased to represent the Congressional Budget Office at this hearing on the impact of the Balanced Budget Act on Medicare's fee-for-service program.

In August 1987 when the BBA was enacted, CBO estimated that it would reduce Medicare spending by a total of $112 billion over the 1998–2002 period, compared with prior law.

Taking into account the effects of the BBA, we then projected that Medicare spending would grow from $189 billion in 1997 to $200 billion in 1998 and $210 billion in 1999.

In the nearly 2 years since the BBA was enacted and CBO made those estimates, Medicare's spending has grown much less rapidly than CBO projected in August 1997. Actual outlays in 1997 and 1998 were $1 billion and $9 billion, respectively, below those projections. Spending for the current fiscal year, 1999, is on a course that would put it about $20 billion below CBO's 1997 projections.

What has caused this unexpectedly slow growth in Medicare spending? Although the data do not provide a clear answer, CBO believes, as Dr. Berenson has indicated, that a key factor is improved compliance with Medicare payment rules.

Our 1997 projections did not fully anticipate the effects of Operation Restore Trust and other of the Medicare program's efforts to combat fraud. Medicare's contractors have screened claims more rigorously, and the Departments of Justice and Health and Human Services have pursued a wide range of health care providers through investigations and lawsuits.

A second factor in the slow-down is an increase in the time Medicare takes to process claims. The expanded compliance activities, combined with major efforts to prepare computer systems for 2000, have contributed to longer payment lags, which exert a substantial influence on Medicare outlays.

Does the substantial shortfall in spending also reflect an underestimate of the effects of the Balanced Budget Act? For the most part, we believe the answer is no. With one possible exception, CBO's estimates of the Medicare provisions of the BBA still seem reasonable.

The one policy for which CBO may have underestimated savings is the interim payment system for home health agencies. Like other elements of Medicare, home health spending has been affected by stronger antifraud initiatives and longer payment lags. In addition, however, home health agencies appear to have shown an

unexpectedly cautious response to the per-beneficiary limits under the interim payment system. That limit applies to aggregate payments. Payments for individual beneficiaries may exceed the limit as long as the average payment for all beneficiaries served by a home health agency does not exceed the per-beneficiary limit. But some agencies apparently believe that the limit applies to each beneficiary and may be cutting off services to patients who have reached the per-beneficiary limit. Thus, the average payment per beneficiary is well below the allowable amount.

CBO is currently updating our projections of Medicare spending, and we will release them in a few weeks, on July 1, as called for in the budget resolution.

Because the rate of Medicare spending through May of this year has been lower than CBO's most recent projection and about 2.5 percent below that for the first 8 months of last year, our July projections of Medicare spending for the current year, 1999, and next year will probably be several billion dollars below our previous estimates.

Medicare will replace the interim payment system for home health services with a prospective payment system in 2001. Because that system will remove much of the uncertainty about payments that may have contributed to the current apparent drop in utilization, spending for home health services could well rebound in 2001 and subsequent years.

Therefore, CBO does not now anticipate significantly revising its projections of spending on home health or on other categories of Medicare services beyond 2000. CBO expects that total Medicare spending will resume growing at an average rate of 7 to 8 percent a year in the decade after 2000.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Van de Water appears in the appendix.]

The CHAIRMAN. Thank you.

Dr. Wilensky?

STATEMENT OF GAIL WILENSKY, PH.D., CHAIR, MEDICARE PAYMENT ADVISORY COMMISSION, WASHINGTON, DC

Dr. WILENSKY. Thank you, Mr. Chairman. Thank you for inviting me to appear before you and the rest of the members of the committee. My name is Gail Wilensky, as you indicated, and I am here as the chair of the Medicare Payment Advisory Commission.

We have a number of recommendations that have been included in our March report on payment, and on the June report that was released last week on broader issues in Medicare.

I would like to summarize several of the recommendations that we make as they affect hospitals, skilled nursing facilities, home care, and physicians. Detail about that is both in my testimony and, of course, in the reports themselves.

The first point, is there clearly has been a slow-down that has been greater than has been anticipated. We agree with the comments that my two colleagues who have spoken previously made as to why that slow-down has occurred, that has been greater-than-anticipated response to fraud and abuse efforts by the Department

of Justice and the Inspector General, and also the slow-down in the payments.

Most people believe that the slow-down will not be a permanent part of Medicare throughout the 5-year budget period. Therefore, while we believe that there are some targeted changes that would make the Balanced Budget Act better, we urge caution in terms of the kind of changes that you make.

We certainly are not in any way suggesting a wholesale redo of the Balanced Budget Act, but, rather, we have suggested some areas where, if you are going to make changes, we think you could improve the functioning of the Balanced Budget Act. I would just like to summarize a few of those areas.

With regard to inpatient hospital, we believe that the payments that exist under the Balanced Budget Act are within the range that MEDPAC would have been recommending to the Congress, using the protocols that had been used in the predecessor commissions.

So, while we know there has been concern raised, we think it is very important to monitor the effects. We acknowledge that our latest data, and the latest data anyone else has available as well, is from 1997, which is before all of these changes occur.

We believe that the change that is in place, the recommendation that would be about a 0.9 percent increase in the amounts paid to hospitals, is consistent with what we would recommend for inpatient spending.

With regard to outpatient spending, however, we have some different concerns. As we have already indicated to you in our earlier report, we think the prospective payment system that has been suggested by the Health Care Financing Administration is too aggregative.

What that means, is there will be some payments that will be more than appropriate and some payments that will be less than appropriate for procedures in a classification.

Particularly when you compare it with the fee schedule that we use for physicians, which is where a lot of the services would otherwise be performed if they were not performed in the outpatient department.

We also recognize that it appears that the slow-down in spending that will come under prospective payment is greater than what was initially projected. Initially, it was thought to be about 3.8 percent. Current projections are about 5.7 percent. That is a significant increase.

In general, what we have recommended is to phase in payment changes to try to minimize the impact in any one year and allow for some kind of recovery, or mid-course correction, if that appears to be appropriate.

So it is an issue that, if the operational details can be worked out, we think that the Congress should consider with respect to the implementation of the outpatient PPS.

Let me talk a minute about the skilled nursing facilities. A lot has been written anecdotally about problems that people are having getting into skilled nursing facilities. We do not have timely data about what is happening.

We have, however, recognized that there is concern and some preliminary evidence that the resources required to take care of the

sickest patients in nursing homes, the so-called high-acuity patients, does not get matched by a differential or an increased amount of payment.

We have recommended that there be a refinement to this payment system. We have cautioned that, if that does not happen, you might see access problems developing, particularly for the sickest patients. We think this is an area, if you are going to make changes, that you might give some serious consideration to.

With regard to home care, our concerns are about the reported declines in the number of services being provided to users, but we are very frustrated in the difficulty we have in making a recommendation because of the lack of information about the clinical needs of patients and the inability that means to devise a reasonable payment system.

We have suggested that because we think that it is likely that the Health Care Financing Administration will not be able to implement the prospective payment for home care in a timely way, that home care providers be allowed to exclude a small number of their patients, maybe in the neighborhood of 2 percent, from the current limits of the interim payment system in order to protect the very sickest patients while some of the changes are worked out.

We would like to remind the Congress also that, while we have seen some declines being reported, it is after a 10-year period of very rapid increases in both the number of people being served and the number of services being provided.

Since we do not have good clinical criteria to compare use and clinical characteristics of patients, we are more in the position of knowing that there had been very rapid increases, and now we have seen some declines and we do not know a whole lot more than just that.

Let me finish by saying that we have some smaller technical corrections that we have suggested with regard to the physician payment, particularly with regard to the sustainable growth rate. There is no ability to make corrections for errors and projections. That is not a good idea. It would require a relatively small change.

Again, let me caution you that, while it is not surprising that, given the magnitude of the changes in the Balanced Budget Act, that there would be some areas that would be suggesting themselves for revision, that that is not the same as doing wholesale changes to the Balanced Budget Act, and you would find yourself back to where you were pre-1997.

[The prepared statement of Dr. Wilensky appears in the appendix.]

The CHAIRMAN. Thank you, Dr. Wilensky.

Now, Dr. Scanlon. It is always good to have you here.

STATEMENT OF WILLIAM J. SCANLON, PH.D., DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Dr. SCANLON. Thank you very much. It is a pleasure to be back. I am very pleased to be here today, Mr. Chairman and members of the committee, as you consider the implementation of the fee-for-service portions of the Balanced Budget Act.

The BBA set into motion significant changes that both attempted to modernize Medicare's payment methods, as well as to reign in spending. Those reforms continued the movement away from cost-based reimbursement towards prospective payment for services, adopting the model that has been successful in terms of curbing acute care hospital spending.

I would like to focus today in my remarks on the changes affecting skilled nursing facility and home health agencies, on which we have either reported to you or are doing work currently.

The Balanced Budget Act directed the development of similar prospective payment systems for other types of fee-for-service providers, but the reforms are furthest along for these two types of providers.

Concerns by both the SNF and home health industries has been raised about the changes' impact on the financial viability of providers, and they also have asserted that the beneficiaries' access to services may have been compromised. How valid are these concerns?

The BBA made necessary and fundamental changes to Medicare's payment methods for both SNF and home health agencies to slow spending growth, while appropriately protecting beneficiary care.

Prior to the Balanced Budget Act, spending on both services was growing rapidly. No analyses supported why it should be growing rapidly, and there were significant concerns that fraud and abuse played a role.

While refinements may be required to make these payment systems more effective, their design intentionally makes inefficient providers change their practice patterns to remain in the Medicare business.

We believe that the industry concerns about the financial viability of SNFs operating under a prospective payment system need to be investigated and we are undertaking such a review for you.

At this point, though, the concerns are not substantiated. I would note several factors that suggest that the prospective payment system's impact on the viability of SNFs may be less severe than has been claimed by providers.

Medicare is a small portion of most SNF's businesses. Furthermore, only one-quarter of Medicare's reimbursement is currently based on the prospective payment system. The remainder of the payment reflects the facility's own historical spending, spending that may be inflated due, in part, to excess provision of ancillary services in the past.

Indeed, prospective rights may have been set too high, on average, rather than too low, and providers are over-compensated rather than under-compensated. Nevertheless, it seems certain that modifications to the prospective payment system are appropriate.

There is evidence, as Dr. Wilensky indicated, that payments are not appropriately targeted to patients requiring extensive, costly care. The potential access problems that may result from this under-paying for high-cost cases will likely result in some beneficiaries staying in acute care hospitals rather than foregoing care. This should provide some safety net while modifications are made.

HCFA is aware of this problem that payments are not adequately targeted to high-cost patients and is working to address it.

The impact of payment reforms on home health agencies has been more noticeable because Medicare is such a major share of these agencies' business. The IPS, interim payment system, was implemented without a transition. The number of Medicare-certified home health agencies has declined by 14 percent since October 1997.

Utilization has returned to 1994 levels, which was the base year for the interim payment system, since the number of home health agencies had virtually doubled between 1990 and 1997 and beneficiaries are still being served by other 9,000 agencies, approximately the same number that were available in 1996.

Agency departures were heavily concentrated in a few States and in urban areas. In each instance, many agencies remained to serve beneficiaries. Concern exists about rural areas, where only a few agencies may have initially existed.

Our interviews with home health agencies, advocacy groups, and others in rural areas that lost a significant number of agencies indicated that the recent decline in agencies had not impaired beneficiary access.

The drop in utilization does not appear to be related to home health closures. It is consistent with the interim payment system's incentives, however, to control the volume of services provided to beneficiaries.

In short, after years of substantial increases in visits, much of which has proved to be inexplicable, the interim payment system has curbed the growth in home health spending.

Our interviews suggest that some of the decline in utilization appears to involve greater sensitivity to who qualifies for the home health benefit. The sense is that some who do not qualify, but who may have been served in the past, are not receiving services now.

While access generally has not seemingly been impaired, there are indications, however, that some beneficiaries who are likely more costly to serve are having more difficulty in obtaining home health services.

This is because the revenue caps imposed by the interim payment system are not adjusted to reflect variations in patient needs, a problem that should be ameliorated with the implementation of the prospective payment system.

It is essential that HCFA, in designing the prospective payment system, adequately adjust payments to account for the wide differences in patient needs. We agree with MEDPAC that if the prospective payment system cannot be implemented promptly, some mechanism to protect access for these patients is important.

In conclusion, I would note that the BBA made necessary and fundamental changes to Medicare's payment for both skilled nursing facility and home health agencies in order to slow spending growth while preserving appropriate beneficiary care.

Further refinements are probably required to make these systems more effective. However, the intentional design of these systems is to require inefficient providers to adjust their practice patterns to remain viable.

It is important that the implementation of these payment mechanisms is monitored to ensure that the correct balance between appropriate beneficiary access and holding the line on Medicare spending is being achieved. In addition, thorough analysis or a fair trial of the provisions over a reasonable period of time is critical before fundamental modifications are made.

Mr. Chairman, that concludes my statement. I would be happy to answer any questions that you or others have. Thank you.

[The prepared statement of Dr. Scanlon appears in the appendix.]

The CHAIRMAN. Thank you, Dr. Scanlon.

Dr. Berenson, you have heard Dr. Wilensky and Dr. Scanlon talk about the problem of access experienced by medically complex patients, both in skilled nursing facility and home health care.

Could you please discuss what steps HCFA is taking to address this, and provide any further recommendations Congress should consider to ensure beneficiary access?

Dr. BERENSON. Yes. In the area of SNFs, skilled nursing, there is the concern about patients who are ventilator-dependent or have other subacute needs, more so than the lower acuity nursing home patient.

I would, first, point out that the payments that do go to the nursing homes include those payments, but it may be that the case mix system that is currently in place underestimates the special needs of those patients.

So we have a contract out now with APT Associates. We expect the results by the end of the year and we will be in a position to recommend what changes in the relative weights we could put into place for next year if we find that, in fact, we are under paying. There may well be a problem there, and we are doing the research now to look into that.

With regard to home health care, in the system that we are preparing, and we really are confident that it will be ready by October 1 of next year, as required, that we will be case mixing appropriately.

Part of that does depend on our ability to get OASIS data, based on patient assessments, to complement the research that we are doing. But we share with the others the concern about case mix, the need to capture costs associated with high acuity patients.

The CHAIRMAN. Let me ask you this. Recently, HCFA reported a 5.7 percent reduction in spending, approximately $4.5 billion over 5 years to hospitals under the outpatient prospective payment system.

Would you please describe the source of this reduction and HCFA's plan, if any, to address the cut administratively?

Dr. BERENSON. Yes. We do not think we have a lot of discretion. The statute basically requires us to set a target aggregate payment for the outpatient system to determine the conversion factor that will be applied to the groups of services that we pay for.

The law provides that we use an estimate of the sum of the total payments that would be payable from the Medicare trust fund under the current payment system in 1999, and the beneficiary copayments that would have been made under the new payment system in 1999.

Under the new payment system, beneficiary co-payments are tied to the median of charges rather than the mean of charges. The median of charges is significantly below. So, the estimate is a combination of what Medicare would have paid out of trust funds and what beneficiaries would pay under the new system.

There have been some discussions about the possibility of ignoring that language, that we could perhaps not do it. But our general counsel really thinks that the clear intent of the law is to decrease beneficiary cost sharing.

They already now, under outpatient, pay nearly 50 percent of charges because of the historical way in which payments had been made in outpatient. The law was designed to, over a period of time, reduce the cost sharing by beneficiaries. .

So the bottom line is, it results is $5.7 billion. We think that is what the statutory meaning is. We do not think we have the administrative discretion to ignore that.

The CHAIRMAN. Let me turn to you, Dr. Van de Water. Your testimony highlights a number of reasons why projections of Medicare spending are much lower today than originally anticipated.

Could you please identify differences between 1997 and 1999 baselines for skilled nursing care and home health care, and discuss the reasons for these differences?

Dr. VAN DE WATER. Yes, Mr. Chairman. As I indicated in my statement, in the aggregate, CBO's current projections, and actual spending for 1997, 1998, and 1999, are substantially below what we projected.

Now, the comparisons between the 1997 estimates and the current estimates, on the basis of particular categories of services, are rather fugitive. That is, we did not prepare 1997 estimates by category of service.

Many of the provisions of the Balanced Budget Act that appeared to be directed at one type of health care provider, in fact, affected many different categories of providers. So it is really not possible to compare actual spending, say, on home health services with spending projected in 1997. The overall sources of difference, the two biggest ones that I mentioned, pertain specifically to home health and skilled nursing facilities as well as to other categories of services.

Those two general explanations are, first of all, the unexpected benefits, if you will, of HCFA and Justice's efforts to combat fraud, waste, and abuse, and second, the increased time lag between when the service is rendered and the time that Medicare makes payment.

In the case of home health services, I could give you a few specific examples. Since the 1997 baseline was prepared in January of 1997, several months before the BBA was enacted, there have been many additional investigations and prosecutions of home health providers, including the incarceration of at least one provider.

Background checks for home health employees have been implemented. Operation Restore Trust has been expanded from a demonstration to a nationwide program, and there has been a temporary moratorium on new home health agencies entering Medicare. Those are just some examples of how this general point applies to home health services.

Similarly, in the case of payment lags, home health agencies have been affected not only by many of the factors that affect providers generally but also by a special factor known as sequential billing, in which payment is made for a particular service only if all prior claims have been resolved. That has further delayed reimbursement in the home health area.

So, to summarize, the general reasons that I gave—namely, the expanded antifraud efforts and the increases in payment lags—we believe apply equally to home health services and payment for skilled nursing facilities.

The CHAIRMAN. Thank you.

Dr. Wilensky, could you please discuss the rationale behind the per-episode versus per diem payment system for rehabilitation hospitals?

Dr. WILENSKY. The recommendation we have made is to go to a per-episode rather than a per diem reimbursement. We think there are a couple of reasons to do this for rehabilitation hospitals. For one thing, the activities tend to be on the basis of an episode.

When you have a payment on a per diem, what you do is encourage what goes on on a daily rate when you might be able to better service a rehabilitation patient by having as much rehabilitation occur in concentrated times or over delayed times, depending on what is best for the patient. This is a preferred way, in general, to do a payment.

In some areas, we do not have enough information. We do not have a medical classification system that will support a discharge or an episode base. But, in general, as in the hospital, we moved away from a per diem to a per-discharge basis of payment.

Whenever you can have a classification system that supports that, I think it is generally preferable. The one that is in use is a functional measurement system. It seems to do a pretty good job in distinguishing the needs of various types of patients.

Even though we cannot foresee at the moment a similar system in existence for home care, although there is some discussion about that, we think that is not a good reason to not go to the per-discharge basis, or episode basis, where we can in rehabilitation spending.

The CHAIRMAN. Dr. Scanlon, it is my understanding that the skilled nursing prospective payment system may not adequately reimburse for the medically complex, which, of course, we discussed at considerable length.

Could you please discuss any evidence to support this, and describe other findings regarding the impact of the prospective payment system on skilled nursing facilities?

Dr. SCANLON. Well, Mr. Chairman, at this point, the evidence is largely anecdotal about both the access problem for complex cases, as well as the impact on the financial status of the skilled nursing facilities.

I think it is very understandable, in looking at the prospective payment system itself, that there may be an access problem developing for the most expensive patients, that the top category in the case mix system just may not be sort of adequate to deal with the very expensive patient.

Really, what needs to be done is to have that category broken potentially into pieces, so that you have very expensive cases and then lesser expensive cases, and you're paying accordingly. That way, you encourage the facility to admit, sort of, the very expensive cases.

In terms of the impact on the financial viability and status of nursing homes, this is something, again, where we are largely at this point operating on the basis of anecdote.

This is what we are trying to investigate for you, to look into using some of the same kind of information that Dr. Berenson reported, information that comes from the SEC, information that comes from cost reports, information that comes from the facilities and the organizations themselves to understand exactly what is happening with respect to prospective payment and their financial operations.

It is important also, I think, to take into account that it is not just prospective payment that has influenced these organizations that supply either nursing home care or other types of ancillary services—which is often something that some of these businesses do both of, they are both nursing home and ancillary service businesses—because BBA affected them through things like the $1,500 outpatient therapy cap and will affect them.

As nursing homes move to consolidated billing, they may not be able to secure the same relationships with other nursing homes that they have had in the past. So, we need to look into all of these various aspects of the change that has happened in the marketplace to really understand what has happened to these organizations.

The CHAIRMAN. Thank you, Dr. Scanlon.

Senator Moynihan?

Senator MOYNIHAN. Thank you, Mr. Chairman.

Again, to a theme that I hope is not tedious, but it is, I believe, real, and that is the condition of teaching hospitals in the aftermath of the Balanced Budget Act.

There was an article in the New York Times not long ago that starts, "The fiscal knife that has begun to cut into teaching hospitals in Boston and other cities has not yet had the same dire effects, layoffs and widespread operating deficits, as hospitals around New York State."

Ken Raskey, who is president of the Greater New York Hospital Association, said, "The carnage which is created by the Balanced Budget Act will totally disrupt the health care system in New York when it is fully implemented. It goes at the heart of the infrastructure."

I wonder if I could get some response to this. It is true of teaching hospitals, nationwide, and Boston seems to have been impacted earlier. But, sooner or later, it seems to be the situation.

Dr. Wilensky?

Dr. WILENSKY. We will be doing a specific report to the Congress on our recommendations with regard to graduate medical education later this summer. But we are not able to observe responses that support the kinds of descriptions you have just provided.

As best we can tell for the numbers for 1998 with regard to medical costs, these medical costs for hospitals in general—not teaching

hospitals specifically—appear to be less than some of the reports that have been circulated around Washington would suggest, based on the National Panel of Hospitals data, but we do not have full data yet.

One of the real problems we have, is we do not have good information about what has happened to hospitals in 1998, and obviously not in 1999, since this is June.

The information that we have is not consistent with the dire reports that have been given, but I cannot say they are wrong. I can only say that it requires careful monitoring and an ability and willingness by the Congress to step in if it appears that there are observable problems.

In some areas, like some of the issues with regard to home care, or more particularly skilled nursing facilities, where there appears to be a problem with regard to the construction of how you make a payment or the therapy cap that was mentioned which was not related in any way to the clinical characteristics of the patient, even without data you can say that this is a payment design that is likely to lead to problems.

I do not think we can say that with regard to the hospital, and particularly the teaching hospital, but I think we should be vigilant to monitor the changes as they go on.

We clearly are seeing greater effects from spending reductions from the Balanced Budget Act than was initially expected by the Congressional Budget Office and by others in Washington. So, I do not see that being supported by empirical information, but it is possible that it is out there and we just do not have the information to see it.

Senator MOYNIHAN. I hope you will be diligent in seeking it out. It has been commented that, yes, crime and poverty has been a normal pattern in hospitals, in my city, for example. But now it is real because of the different nature, the special nature, of the teaching hospital and the whole medical profession. I would just hope we could pay attention to this.

Dr. Berenson, did you want to say something?

Dr. BERENSON. Just a couple of comments. I, first, should say, as a graduate of the Mt. Sinai School of Medicine, I am not indifferent to the issue that you raise. The inpatient margins, at least the last data we had in 1997 for teaching hospitals, were very good for teaching hospitals.

The initial impacts on the outpatient payments suggest that teaching hospitals may in fact be, under the current design—and the rule is still open for comments so we do not know ultimately what it will be—impacted significantly. Some of that may have to do with coding issues. Once that gets corrected, those impacts may decline.

The final point I would make, is we have started at HCFA to meet with some of the executives from some of the hospitals. Dr. Theer, from Partners in Boston, has been in. We are trying to understand. His basic point was, 1997 and 1999 are like two different eras.

Senator MOYNIHAN. That is what we are saying. Yes.

Dr. BERENSON. We are trying to, because we do not have systematic data, work with a few institutions and try to understand what

is going on. So, we have heard it, we are concerned about it, but we really do not know at this point.

Senator MOYNIHAN. Thank you very much. Thank you all.

The CHAIRMAN. Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

I would like to move from Manhattan, New York to Manhattan, Montana. I am curious. We have heard lots of data on the aggregate. Just as Senator Moynihan is concerned about the tyranny of the averages and the aggregate, so are we in the State of Montana.

So, Dr. Berenson, I wonder if you might indicate the degree to which your analysis shows that rural areas are hurt more, rural home health care, for example, or rural skilled nursing facilities.

Dr. BERENSON. Yes. In fact, I would defer, to some extent, to the GAO. In fact, MEDPAC has done some of this analysis. As I said in my opening remarks, we are now engaged in a very comprehensive effort to understand impacts. We are going to be talking to doctors.

Next week, I am going to be talking to the Practicing Physicians Advisory Committee. We are going to be talking to discharge planners at hospitals. The point is, we need to have a special effort to get a rural problems because a normal sample will not get there.

Senator BAUCUS. When do you think you might get there?

Dr. BERENSON. This is an immediate short-term activity. We are talking weeks.

Senator BAUCUS. Thank you.

Dr. Wilensky or Dr. Scanlon, do you have any data on that?

Dr. WILENSKY. One of the areas where we have noted is the greater effect that is likely to occur if the prospective payment for outpatient services is implemented as the rule suggested.

It would be that rural hospitals, as well as some of the cancer hospitals, would be disproportionately impacted by this change. As I have indicated, we think there are some problems with the way the prospective payment system has been put together.

We think it is obviously, from HCFA's own projections, going to result in a substantially greater reduction than was initially thought, 5.7 instead of 3.8 percent. At the very least, we think it should be phased in and we think some changes ought to be made as to how it is constructed.

Senator BAUCUS. Dr. Scanlon?

Dr. SCANLON. In our work, we were very concerned about what was happening in rural areas, because when we looked at urban areas we found that, despite the number of large home health agency withdrawals, that there were still many, many home health agencies left.

So we concentrated, in all the qualitative information that we gathered, on the rural areas because the quantitative information is not adequate at this point to really understand.

We did not find a significant problem in the rural areas that we looked into. What we found, was that when an agency was not existing in an area, there was always an agency, at least one and sometimes several, from the surrounding counties that were serving it.

We found in terms of overall utilization that the utilization declines were highest, or largest, in the areas where utilization had

been the highest to begin with. That did not include many of the rural areas. That often was very urban areas that were having the bigger utilization declines.

Senator BAUCUS. Now, do you distinguish between eastern rural and western rural? Because there is a difference.

Dr. SCANLON. We try to deal with all types of rural.

Senator BAUCUS. I am beginning to think we should have one, because there is a huge difference.

Dr. SCANLON. I have been here before, so I have been educated on that point. [Laughter.]

Senator BAUCUS. We have got to get you out there.

Dr. SCANLON. Right. I have also had the privilege of doing that one, too.

Senator BAUCUS. I know Dr. Wilensky has.

Dr. SCANLON. But we did look at areas where there was a larger loss of agencies in rural areas. I would say from Montana, fortunately, there was a small loss of agencies. When we looked at information as of January 1999, there had only been two agencies that had withdrawn from Medicare in Montana, therefore, that was not one of the States that we included in our focus. But we were very sensitive to eastern rural versus western rural in the study.

Senator BAUCUS. I would appreciate that, very much.

Is there any validity in perhaps reimbursing some of the most rural, smaller home health care agencies, or maybe even SNFs, on some kind of a cost reimbursement, as we have, say, with medical assistance facilities, a new concept of health care delivery in very remote, rural parts of the country. Does that make any sense?

Dr. SCANLON. I think we certainly need to take the cost of delivering services into account in setting rates. While we have been very focused on how we vary rates with respect to the patient's characteristics, we may need to also at times think about, what are the provider characteristics.

So when you have a home health visit that involves an incredible amount of travel, as I am sure would happen in Montana, that is something that we need to be concerned about in our system.

Senator BAUCUS. I wondered, during the earlier presentation some of you have mentioned that the slow-down in BBA payments is due partly to better enforcement of the antifraud provisions, and so forth.

The second reason, was an increased delay due to claims processing. Could you break that out? Is that 50/50 or is that 25/75? What is the proportion of each of the two major areas that the two of you, at least, suggested?

Dr. VAN DE WATER. We really do not have a whole lot of detail about that. We are already running a bit on a wing and a prayer to have identified the antifraud activities and the payment lags.

Senator BAUCUS. But you must have some sense, a gut sense of some kind. One percent versus 99, 50 versus 50? You have got to have some feel.

Dr. VAN DE WATER. My personal guess would be that it is a bit more attributable to the antifraud activities than to the payment lag.

Dr. WILENSKY. I think the payment lag issue is something that will catch up over time. It has introduced a slow-down in payment for every month of change or delay that occurs.

But if you settle down to a steady, slower payment, that will go away in terms of the impact, whereas, I am not sure the change in behavior with regard to how you bill or how you code hospital payments or other payments is something that is not a one-time change. So I think it is really a different issue. This is something that shows up, but, unless they keep increasing the delay in payment, which I have not heard suggested, it will go away as an explanation.

Dr. BERENSON. If I could, I would like to say, in fact, we are going to be decreasing. For home health agencies, we have made a couple of administrative changes that should speed up cash flow, to some extent. There was a disproportionate impact of medical review on some of the home health agencies, where as much as 20 or 30 percent of their claims might have been held up.

We changed that last year, so it cannot be any more than about 10 percent that could be held up for medical review. The other thing is, we have now found alternatives to the sequential billing requirements. We still encourage the agencies to send us claims in the order of service, but we can work around that, if necessary. So, if anything, that should go the other direction. There will not be decreased delay times.

Senator BAUCUS. I just have one comment, Mr. Chairman. Frequently this morning we have heard references to, well, we do not have sufficient data. The best we have is 1997, and perhaps even some of that is a little sketchy.

In this modern world we are now in of globalization, with capital traveling the speed of light and not respecting boundaries, I just have some sense that there ought to be a better way to get more timely data.

It needs some kind of, maybe, 5-day instant background check. We got it for guns, maybe we can get it for providers, or something. Obviously, we cannot, because the data is not there. My time has expired. But it just strikes me that one of the big problems here is the untimeliness of data.

The CHAIRMAN. Senator Chafee?

Senator CHAFEE. Thank you very much, Mr. Chairman.

This question is directed to Dr. Wilensky and Dr. Scanlon. I find in my State great concern over the home health payments and home health agencies are going out of business. I know that you put this in the category of untested evidence. But the case that really has them upset is the 15 percent cut that is coming on October 1, 2000. They are terribly disturbed over that, and repealing that provision is their number one priority.

I wonder if you could comment on that and how you foresee this 15 percent cut coming up on October 1.

Dr. WILENSKY. We attempted to do some analysis to try to get around this problem of not knowing where we are because of untimely data. We did some interviews of some home care agencies and we talked to some of the advocates and other people involved with the delivery of home care.

We attempted to do an analysis of the claims data from HCFA, but there has been a problem with the very earliest data, which we understand will be able to be resolved around July. So, we think we will be able to get a better sense of reviewing claims data in the next month or so. We are still struggling to figure out how much change has occurred and what impact it has had on the delivery of services.

If you talk to individuals who are involved in either being advocates or are providing care, they are reporting an unwillingness, on some occasions, to take new Medicare patients, particularly the very sickest, and the advocates are reporting some concerns as well. So, it is hard. Although we do not have a good clinical basis to say what would be a good use of home care services, we certainly are hearing reports about concerns.

The biggest issue, the one that Dr. Berenson referenced, is that we need to have some clinical information available on the patients, as well as the services that they are being provided, to know how to make a better classification system.

There has been some concern about the particular OASIS system because of the amount of data and the intrusive nature of some of the data. But the issue it is directed at is very important, otherwise we are left with having very arbitrary ways to try to slow down payment.

I think Dr. Van de Water mentioned a particularly frustrating issue. Some home care agencies are applying the beneficiary limit as though it applies to each and every beneficiary, when it was meant to be for the average of all of the people in the nursing home. It has artificially lowered the amount of services home care agencies are providing.

We have recommended to HCFA that they have got to get the payors, the fiscal intermediaries, to be much clearer about how these payment limits have to be enforced, because that is just making what is a difficult situation much worse.

Let me go back and remind you that we have just gotten through a decade of what I have called, because I think it is a fair term, explosive growth in home care services, a more than 30 percent increase in expenditures every year from 1988 to 1996. We are seeing a slow down, but it is hard to say.

What we should be looking at is an ideal payment system because we do not have the clinical indicators of the patient, we do not know enough about what services are being delivered. It is hard to make a sensible recommendation.

Senator CHAFEE. Dr. Scanlon?

Dr. SCANLON. I would like to pick up on exactly that point, that we came out of a period, when the BBA was enacted, of incredible growth, and growth that we could not understand.

We had a significant number of States in which home health utilization was declining before the Balanced Budget Act, States where we were not hearing complaints about access to services.

We had others that were having astronomical growth and we did not understand what that growth really entailed because we did not understand the patients, what their needs were, and whether those needs were being met appropriately or being over-served.

So one of the things about the BBA, is trying to bring that under control. But critical to this is bringing it under control in a targeted way. The 15 percent cut in the context of a prospective payment system that redistributes funds in accordance with patients' needs is very different than a 15 percent across-the-board cut which simply changes the historical patterns by reducing them all evenly. We know the historical patterns were not appropriate.

Senator CHAFEE. Well, my time is up. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Breaux?

Senator BREAUX. Thank you, Mr. Chairman. Thank the panel for this discussion. It is like, here we go again. We have all been here before. I have got the political theory that, in even years we cut Medicare, in odd years, we put the money back. We have been here before. We will continue to do this as long as we have a system where Congress micro manages it all from Washington.

Here we are, sitting and talking about, we thought we were going to cut it $103 billion. It came out to be about $220 billion worth of provider cuts. Now we are going to put some more money back in, and where are we going to put it?

This is the greatest example of micro managing a multi-billion dollar health system that is totally inefficient the way we try to do it. This is almost to the point of ludicrousy. Dr. Van de Water, we thought we were going to do $103 billion worth of provider cuts. How much do you think we actually did?

Dr. VAN DE WATER. Well, as I indicated in my statement, we are not convinced that the slow-down in spending has resulted from changes in BBA. BBA may, in fact, have saved a bit more than our earlier estimate indicated.

Senator BREAUX. A bit more. Define a bit. All the people coming after you are going to define it and they say it is a lot of money more than we thought. Do you disagree with that? Do you think when we said $103 billion, that is what they are receiving in terms of cuts?

Dr. VAN DE WATER. Again, following Senator Baucus's suggestion to go from instinct, I would say we might be talking about a total of 10 percent or so.

Senator BREAUX. So you are saying that the actual cuts are only 10 percent more than we intended.

Dr. VAN DE WATER. At most, I would say. The reasons for this slow-down, I think all of the witnesses here this morning agree, are, first of all, the success of the antifraud efforts, which I know all of us were——

Senator BREAUX. Well, you are going to get a lot of dispute on that when the next panel gets up here.

Dr. VAN DE WATER. I am sure we will.

Senator BREAUX. All right. Say it is 10 percent. Say we need $10 billion more, and Senator Roth is very generous and reduces his tax cut by $10 billion, and we put it back.

The CHAIRMAN. Wait a minute, now.

Senator BREAUX. Just a suggestion. [Laughter.] Just a thought. Then the next question in this micro managed operation that we run up here, where do we put the $10 billion? Do we put it in hos-

pitals, do we put it in nursing homes, do we put it in home health care?

We are going to be charged with dishing out $10 billion. Who are we going to believe? So what is the suggestion out there of what we do? Say we get $10 billion more. Where are we going to put it? Who are we going to believe?

The problem is, the data comes in after everybody is out of the business. I mean, you are telling us that we notice some pain out there, but the only thing we have got is stories, nursing homes shun Medicare patients and nursing homes say no, hospitals feel pain, and home health care; how many have gone out of business, 10,000, I guess? Maybe a lot of them should have gone out of business. We have 10,000 home health agencies out of business.

So how do we divvy up $10 billion, if that is what we are going to do? You tell us we do not have the information, but then we have got to make the decision this year. We have one big mess on our hands about how to fix the problem, which I think argues for the point that the system is the problem. We are going to do this every other year. We are going to cut 1 year and say we saved it. We are going to come back the next year and put the money back into the program and say, well, we fixed it.

Then the next year, we are going to have to cut it again. Just as sure as the sun rises, we will be back the year after that trying to put more money back in. This is a system that is not sustainable, the way it is going on. That is just a statement. It is obviously not a question.

But the real point is, where do we put money back? Gail, you have some suggestions. You talked about serious nursing home patients which are high drug therapy and higher costs. We have, what, a cap on it? That is not working.

Dr. WILENSKY. Those are two separate areas. You have a cap on therapy spending and there is a problem with the sickest nursing home patients.

Senator BREAUX. All right. So we put a little bit more money back into those. I mean, how much do we need there? We do not have the information, right? Right? Right. All right. I will take that as a unanimous agreement.

But it just points out how bad the problem is. We know that the cuts were more than they should have been, more than we thought they were going to be, but we do not know how bad they are. We know we need more money. We do not know where to put it because we do not have the information of where it should go.

It is absolutely unsustainable, which is why we need to look at reform rather than just continuing to micro manage it as we try to do, and not very well.

Thank you.

The CHAIRMAN. Thank you, Senator Breaux.

Senator Kerrey?

Senator KERREY. Thank you, Mr. Chairman.

First of all, I would associate with what Senator Breaux said. I do think that systemic reform is needed, otherwise Congress is going to continue to sort of shoot in the dark. But, as long as we are shooting in the dark, it seems to me we have to take, if you do not have the data, if HCFA does not have accurate data of what

is going on exactly, the data that is the more appropriate to us. That is, what do we hear from home? In Nebraska, just like Senator Baucus was saying earlier, we are west of the 99th and we have got several conditions out there that create serious problems in our health care community. We have got low payments to begin with. Even though we have a uniform premium, we do not have local costs being used to determine what the premiums are going to be. We have a national premium set up, so we have a low level of reimbursement to begin with into the State for providers.

A hospital will have a very high percent, especially in rural areas, of not only Medicare patients, but a very high percent of non-reimbursable expenses. We had two rural hospitals shut down in 1998 as a consequence.

There is lower general income in the rural community, a higher percent of uninsured in the rural community. Right now, as a consequence of low commodity prices, we have got downward pressure on income as well.

When I talk to providers in Nebraska, they say we have got a real crisis. Even if we accept that a piece of it comes from the BBA, and a piece of it comes from the antifraud effort, and a piece of it comes from delaying payments, whatever the reason, they say to me, Senator, in 1997 when you voted for BBA, you voted to spend $200 billion in 1998, $210 billion in 1999, $220 billion in 2000, $241 billion, $247 billion, and that would save $112 billion from the providers.

By the way, in 1997 we heard everybody come up and say there was a problem. At the end of the day, the only people we could get any money out of was providers. Nobody else made any contribution. So we took $112 billion of savings out of the providers.

I appreciate that you are saying that CBO's estimate is that still only $112 billion is going to come from that, but the spending is going to be considerably less than that. You tell me whether or not you agree with what I am saying. When I voted in 1997, I voted to spend $200 billion in 1998, and $210 billion in 1999.

Right now, you are saying we are going to spend $20 billion less in 1999. At the $210 billion level, I am still taking money out of the providers. I am still generating $112 billion worth of savings.

I am saying this because right now the political context is, we may vote this year to put $20-30 billion out for prescription benefits. All in favor, say aye. On that one, it is going to be a hard vote no. There is a lot of momentum building to spend $20-30 billion on a prescription benefit.

I think part of that comes because of this 5 percent/95 percent situation, 5 percent of the sickest people using as much as 95 percent of the non-sick individuals. The non-sick individuals are pretty well organized.

So I wonder if you would comment, from CBO's perspective, when I voted in 1997, did I vote for spending $210 billion in 1999, and we are only going to spend $191 billion? I voted to generate savings below baseline. $210 billion was below the net baseline. That is a net number, net of premiums and net of total outlays, discretionary and mandatory.

Dr. VAN DE WATER. Needless to say, Senator, I would not want to say what you intended to vote for when you voted for the BBA.

That was your decision. I am certainly not in your shoes. If I were, I think what I would have thought I was voting for was a particular set of benefits and payment rules.

Now, it has turned out that those benefits and payment rules have resulted in less aggregate spending than we estimated, but it is not clear that anyone is getting less than beneficiaries or providers——

Senator KERREY. Dr. Van de Water, that gets back to the problem that Senator Breaux identified.

Dr. VAN DE WATER. Exactly. Indeed, it is.

Senator KERREY. The only way I can produce the savings is to get into the different payment mechanisms that we have at HCFA. But what we were dealing with in 1997 was the question, how do we balance our budget? That is what BBA stands for. So we are going to balance our budget and we need savings from Medicare to do that. So we have $112 billion worth of savings that we had, and I could go home to my providers and say, that means I am going to spend $200 billion in 1998, $210 billion in 1999, $220 billion, and on, and on, and on.

What I am saying is, regardless of how it occurred, whether it was done by BBA or terrific antifraud effort, which I appreciate that you have done, or delayed payments—although, if you extend that one out, if you really want to produce some savings, why do you not delay payments for a couple of years? I mean, we could really generate some savings then. I do not know that I would brag on that one too much.

One way or the other, I am spending less than what I needed to spend in order to balance the budget. That is what we said we were doing in 1997. We were going to balance the budget and we needed savings from Medicare. Now, for whatever the reason, we are producing more savings than we promised we were going to produce in 1997 when we voted for it.

Dr. VAN DE WATER. If I could comment, though. I think it does, indeed, go back to Senator Breaux's point. If spending is $20 billion below the projection, the problem is to figure out, as both you and he have said, why is that the case? If, hypothetically—and this is purely hypothetical—that $20 billion shortfall were to have resulted solely from squeezing additional fraud out of the system, that, I would think, you would consider to be an unlikely reason to want to put an extra $20 billion back.

Senator KERREY. No, no. Dr. Van de Water, I would disagree with that presumption. Again, the purpose of BBA 1997 was to balance the budget. What we decided was, we needed $112 billion worth of savings to get that done. Through a combination of other things, we produced a lot more savings.

Again, back to what Senator Breaux was saying, the system is so complicated it is difficult to know what is going to produce savings and what is not going to produce savings.

I understand there are lots of other things going on. We had an August 1997 score from you saying, this is what the baseline looks like for the next 5 years, and if you make these changes it will produce $112 billion worth of savings. Well, it did not produce $112 billion worth of savings. That, and lots of other things unknown to us at the time, produced considerably more savings than that.

What we did, I voted to spend more money than we are actually spending on patient care. I am saying to you, in the absence of your data, I can take you out to Nebraska and show you a real and present crisis in our health care system that I did not vote for in 1997, and I do not want to be a party to.

The CHAIRMAN. Next, we have Senator Mack.

Senator MACK. Thank you, Mr. Chairman.

The CHAIRMAN. We are going to have to try to keep within our limits because we have another panel.

Senator MACK. Can I have back the 15 seconds I just lost, then?

The CHAIRMAN. Tomorrow. [Laughter.]

Senator MACK. I share the frustrations that have been expressed by everyone here. I am as frustrated not knowing exactly how we are going to proceed, as well. But we are doing what we are supposed to be doing. We are expressing the concerns that we are hearing from folks in our State that both represents patients as well as providers.

I, again, share the concern that Senator Moynihan has raised with respect to teaching hospitals. According to what they have said to me, it is not just what we have done with respect to graduate medical education, but it is also the effect of the BBA in other areas of savings.

In addition to that, they have an increased case load of charitable cases because, as people moved off welfare, they are not covered by Medicaid so they have a larger amount of uncompensated cases. HMOs are trying to drive down prices as best they can.

So when we listen to these things, we try to be rational about them and try to understand which ones are accurate and which ones are not. All we are saying is, while you might not have the data, my concern is that, as we kind of debate about whether there is data or not data to do it, these numbers could be very significant and it could have severe impact on certain segments of our health care delivery system. I am really not looking for a response. You all have had to respond or try to react to everyone. I am just voicing my concern as well.

I do, though, however, want to ask Dr. Berenson a couple of questions having to do with what are referred to as APCs.

One of the things that I do now, which is almost standard procedure when I go home, because of my involvement in the fight against cancer, I go to hospitals, local hospitals, teaching hospitals, and listen to what the concerns are as far as treatment for cancer is concerned.

One of the issues that I hear over and over again has to do with chemotherapy. I am concerned about the ambulatory payment classification and how they will impact cancer care. Many patient groups have expressed reservations that these new classifications will limit patient access if many higher-cost drugs have been excluded or the payment for them is so low, hospitals cannot afford them to outpatients.

What is HCFA's response to this?

Dr. BERENSON. We are obviously hearing the same concerns. The time for comments on the rural has not closed yet, and we expect there will be extensive comments in this area. Clearly, the issue of new drugs is one that has been mentioned, and we will respond.

There is, at least to some extent, we think, a little bit of confusion in that we have APCs for administration and separate APCs for the actual cost of the drug. At least some cancer centers are just coding one, not knowing that they have the opportunity for coding both and, indeed, if there are multiple units of a drug, to code multiple times.

So there may be a very real problem. We will review the comments, and at the same time I think there is an education issue that would have to happen if, in fact, we would not make substantial changes. We will have to look at it, but we are certainly hearing from the same groups.

Senator MACK. I have been told that $52.70 is the proposed amount for cancer treatments under the APC. Is that the chemotherapy portion of it?

Dr. BERENSON. Well, there are four different categories of chemotherapies. There are four different groups being proposed in the proposed rule, so it varies from that number to a much higher number. I do not have those details with me.

Senator MACK. The last point in this area then would be, a process is being set up, I think, for updating APC so that new drug infusion therapies can be included. But I have also been told that that could take as long as four to four and a half years.

I find that very troubling, in the sense that, with the money that we are investing in developing new drugs and new technologies to treat cancer, that a process would take four and a half years to update is——

Dr. BERENSON. I do not know about the four and a half years. I will personally look into that and see. That does not sound reasonable to me either. I just do not know that detail, but I will look into it.

Senator MACK. All right. Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Grassley?

Senator GRASSLEY. I will start with Dr. Wilensky. I think I hear you saying that we should not do wholesale changes to the Balanced Budget Act unless and until we see some real evidence of access problems. Of course, I think that is a sensible approach. But I also hear you supporting targeted fixes where there are demonstrated problems.

So I would like to ask a specific one in which you stated that the $1,500 caps on speech, physical, and occupational therapy that were enacted were arbitrary and probably bear no relation to clinical characteristics. While you have not proposed any specific policies regarding these caps, you have raised concerns on several occasions about this.

I have introduced legislation to try to address the problem, and I think we are at the point where MEDPAC needs to go beyond expressing concerns to proposing a solution.

So do you have a proposal to rectify the situation?

Dr. WILENSKY. I do not. Unfortunately, MEDPAC did not specifically look at this issue during the course of our deliberations. I am confident that, if we had, because the limit does not in any way take account of the clinical characteristics of the patient, we would have concluded concern about the arbitrariness and we may or may

not have raised some issues about the direction that we would like to go.

We are actually going to be meeting this summer. I will be glad to specifically raise the issue with the commissioners. If you would like, outside of my MEDPAC role, I would be glad to give you some assessment of the legislation that you have proposed. I am not familiar with the specifics. I knew that you had proposed it.

Senator GRASSLEY. All right. You could comment just on my legislation, but I am not looking just for comment on my legislation. I am looking for what we can do to solve where I think we have some real problems.

Dr. WILENSKY. I think there are a couple of issues here. One, is because there are safety valves, but the sickest patients cannot make use of them. That is, if you can go to the outpatient, you are not affected by the cap.

If you can move to other providers, HCFA does not have the systems in place to actually implement the cap. But if you are in a nursing home and have a major stroke and you cannot be moved easily, you are going to be subjected to the cap.

Obviously, I think that you need to work with HCFA to think about specifically what would make sense, whether there is a way to differentiate, target, or attach it to some characteristics from the Resource Utilization group, distinctions that are in place and that we may know about some of the patients. The question is, how can you quickly try to link it to something about the clinical characteristics of the patient?

Senator GRASSLEY. My bill does a medically necessary waiver.

Dr. WILENSKY. Dr. Berenson would have to respond if that is possible.

Dr. BERENSON. I am not sure of that. We are looking at a number of possibilities here. There were caps for independent professional therapists in place, and there was not a lot of sort of verbalized concern about that. I think it may be that the caps then got extended and were done without understanding the clinical characteristics or the implications on patients.

I want to reemphasize the point that Gail made about the nursing home patient, who may be the patient with the stroke who does not have an opportunity to take advantage of the work-arounds to get to the outpatient department, or to go to different therapists, who may be particularly impacted by these caps.

We are looking at whether the combination of speech and physical therapy in a single cap makes sense, whether the limit itself can be modified, and we are also looking at the issue of whether we can identify clinical characteristics. I do not know how easy that is going to be, but we are certainly open to working with you to try to understand that.

Senator GRASSLEY. All right. I will go on to another point, and my last question. I believe that all of you have noted the big hospital outpatient cut that HCFA's proposed rule would require. HCFA invited suggestions on how to lessen the impact on rural hospitals because they relied so much on outpatient care.

Several of us on this committee introduced a comprehensive rural health care bill which would simply exempt sole community hospitals from the outpatient prospective payment system. Could

any of you—and at least hopefully a couple of you—comment on the approach or suggest a better one, particularly Dr. Berenson?

Dr. BERENSON. I actually cannot comment on that now. We will review those comments as they come in. I am really not prepared to tell you at this moment.

Senator GRASSLEY. Would you please prepare a written response for my question for this?

Dr. BERENSON. Yes, I will.

Senator GRASSLEY. Anybody else can comment on that.

Dr. WILENSKY. We noted that the outpatient provisions, as they are currently defined, particularly impact both rural and cancer hospitals. We think there are ways, including phasing in and maybe a more disaggregated construction of the prospective payment, that would benefit, although it would have to be assessed as to whether it would benefit.

In general, as a former HCFA administrator, I am uneasy about wholesale exemption, but I think you would need to look at whether there is some modified system or other modifications that could be more reasonable.

Senator GRASSLEY. Thank you all very much.

The CHAIRMAN. Senator Graham?

Senator GRAHAM. Thank you, Mr. Chairman.

I want to express my appreciation to this very thoughtful and informative panel. I think there has been a theme that has gone through many of the questions that have been asked.

That is, in the absence of structural reforms to the Medicare system, but the need to restrain costs, we have gone to the softest area of the program, which is cutting provider reimbursement. As Senator Breaux suggests, now that we are in the odd-numbered year we are seeing the backwash of that decision.

So I would like to focus on some of the ways in which we might get out of this cycle of cutting providers, then coming back and restoring funds to at least some providers.

Stuart Butler of the Heritage Foundation spoke at one of our panels recently, and he had a suggestion that Congress should try to disengage itself from the detail of micro management.

His proposal was to have some entity established of people who had scientific and policy backgrounds to qualify them to do this who would constantly be reviewing the Medicare program, and then make recommendations to Congress which would be treated analogous to the Base Realignment and Closure Commission, which is a system that requires us to consider it, but to do so on an up or down vote.

Recognizing that Congress has the con .itutional responsibility to legislate, therefore, as much as some would like, we cannot be totally excluded from this process.

Is that an approach that you think has some efficacy or would you have some other recommendations as to how we could get out of this current morass of trying to decide the most detailed issues of health care provision.

Dr. WILENSKY. I was also testifying at that hearing with Mr. Butler and agree with the notion of having something like a separate Medicare board to decide certain kinds of activities.

The real question is whether, at the same time, you are willing to restructure and reform the nature of the Medicare program, which is, of course, also part of his recommendation.

Traditional Medicare, by its nature, involves having the government make decisions on the price of individual services, the appropriateness of individual services, the quality of individual services. As long as that is the role that the government has chosen to take, someone in a governmental position will be making many, many, many micro decisions. Whether it is the Congress depends on the Congress.

I think, in a modernized fee-for-service Medicare system, you will need to delegate to HCFA, or somebody, more discretion and a Medicare board ought to be providing oversight on the bigger issues, as he suggested, with regard to benefits, enrollment, and information. So, I think it is a good suggestion, but I think it needs a broader context in terms of the rest of reforming Medicare.

Senator GRAHAM. Any other comments on that?

[No response.]

Senator GRAHAM. In an effort in the BBA to try to deal with cost in a way other than just straight reduction in provider benefits was the introduction of concepts of competitive bidding, as an example, on disposable medical equipment.

Today we have a system in which there is a price list for everything from wheelchairs to oxygen, and that price list is relatively stagnant and generally above what the market would indicate the appropriate pricing should be. So we recommended a series of demonstration projects on using a competitive bid model for DME, and similarly, a competitive bid model for some of the managed care plans.

Any comment as to the potential usefulness of that approach?

Dr. BERENSON. Well, it was certainly something that was in the BBA and we are taking very seriously. As you well know, in Lakeland, Florida we are making progress on the DME bidding process. There has been a legal challenge, as these things happen, but we think we have gotten over that hurdle. We are right in the middle of, or are about to have the selections made as to who will be participating in that area. If we get some experience from that, we plan to expand the DME bidding.

We have also, and this may have come up yesterday, I am not sure, the competitive pricing demonstrations for Medicare+Choice. I think the Congress wisely set up an independent committee, called the Competitive Pricing Advisory Committee, to select the sites because none of the HMOs want to be first in this area.

But we are proceeding in Kansas City and in Phoenix, with some different success. Kansas City has been much more amenable to proceeding. We think this is a very important demonstration and HCFA is committed to seeing it through.

Senator GRAHAM. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Graham.

Senator Bryan?

Senator BRYAN. Thank you very much, Mr. Chairman. I am struck, listening to the questions, by the difficulty that we confront. BBA was focused on trying to reduce the payments for providers.

Maybe we did not strike that balance appropriately. Dr. Wilensky, you commented not only today but previously about that balance. In trying to craft where that balance is, we need data. That data is not available. We rail against the Medicare system and say, look, they ought to have more flexibility.

Yet, on occasion when the Congress has provided that, the very provider groups that urge us to be more flexible come to us and say, no, no, that is not what we contemplated. Heaven forbid, do not do that. That is awful. So, it really is quite a difficult dilemma.

Since your very thoughtful comments, Dr. Wilensky, I think every provider group in my State has come and indicated that they, too, are under compensated.

So I guess my observation would be that, for those who fear that the entrepreneurial spirit in America is languishing in the health care industry, it is alive, flourishing, and doing extraordinarily well.

I would like to shift the focus of the question just a little bit, because one of the other things we did in BBA was to expand upon the antifraud provisions, which were, as I recall, in the Kennedy-Kassebaum we built some of those in.

You will recall that a few years ago, I believe it was, the Inspector General opined that we had as much as $20 billion of fraud, as they characterized it. There is not a senior in my State, and I suggest in my colleagues' State, that did not read the Reader's Digest article that emphasized that, and we heard a lot about that.

To the extent we have been able to extend the solvency of Medicare to the year 2015, can any of you give us any insight as to whether or not you think that the antifraud provisions have been a part of that extended solvency, have been effective, have hit the mark right?

Do we need to do something more or did we go too strongly on that? As you know, some of the provider groups have come to us and said, this was a terrible thing that you have done. Now you have all subjected us to terrible potential criminal prosecution.

Could you give us some insight into that, please?

Dr. SCANLON. I think that there is no question, as Dr. Van de Water has indicated, that the antifraud efforts have paid off in terms of reduced spending, so we can see that in the projections for the future.

There are also concerns about sort of the degree of vigor in which some of those efforts have been pursued. In fact, you have asked us to look at the Justice Department's efforts to use the False Claims Act with respect to health care fraud efforts.

The Justice Department, since last June, has been using guidelines to try and make sure their efforts are measured, valid, and reasonable in terms of pursuing these kinds of cases. We will be trying to make sure for you that this is occurring Nationwide, so you can feel reassured on those grounds.

So I do think these efforts are having an impact. There is no evidence at this point that they have gone too far. There have been some very reasonable settlements of a number of cases. Then there are other areas where there are issues that need to be resolved because of the complexity of medical care, and what constitutes an

inadvertent error versus an abusive claim is something we need to sort of be able to draw the line.

I would like to go back to the first part of your question, or actually maybe it is more your statement, with the issue about viewing the BBA as cutting payments to providers. I think of the BBA more as attempting to pay efficient prices for the appropriate access to services. That is really what we were talking about, because we changed systems that we knew were inefficient, and we tried to substitute systems that are efficient.

At the same time, these current systems may not have enough money in them or may not be targeted appropriately, and that is really what we are talking about, I think, today, is trying to get them targeted appropriately, with adequate funds.

Senator BRYAN. Any other comments? Yes, Dr. Wilensky.

Dr. WILENSKY. I think, just briefly, there had been concern prior to the Kassebaum-Kennedy legislation that there was not a way to fund payment safeguard and fraud and abuse efforts because of the appropriating mechanism, and that this was an important way to provide some additional funding.

No one that I know of would suggest that it is better to have fraud and abuse go on in the Medicare program. I think it is helpful that the guidelines were issued by the Department of Justice. There has been concern raised in the provider community to me in my MEDPAC role about whether or not the False Claims Act is being used in increasingly creative ways. It is important that people providing services feel like they have a fair stake in how they are being treated as well.

Senator BRYAN. Could you give us your own response before we get the next gentleman on the panel: any evidence, in your judgment, that the BBA antifraud provisions have gone too far or that they been unfair?

Dr. WILENSKY. None that I am aware of. There is certainly a lot of concern about it in the provider community, and it may have been related to this issue of home health, providers using the limit at the individual beneficiary level and not in the aggregate, as was intended. Correct information can fix that.

Senator BRYAN. Thank you.

May Dr. Berenson respond? He had his hand up and I cut him off. He wanted to respond.

Dr. BERENSON. I just wanted to make a brief point, a different point. Often, waste, fraud and abuse is recited as a mantra, as if it is all one thing. What we are trying very hard to do at HCFA is to distinguish fraud, which is real and needs to be prosecuted, from paying correctly.

We have a very complex payment system. I am a physician. I have to deal with 7,000 potential CPT codes, even more than that. Mistakes get made. We are trying very hard to make it clear that our efforts to pay correctly, to save trust fund money, does not necessarily equate into viewing every physician as a potential criminal or every good provider out there as committing fraud. So, I think the government's efforts have been in both areas, and I think fairly successfully.

Senator BRYAN. I thank you very much.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you. Let me thank the panel for the excellence of their presentation. We have called on you many times before and will continue to do so. Thank you.

It is now my pleasure to welcome the witnesses from our second panel. Dr. Scully is president and CEO of the Federation of American Health Systems; Dr. Smith, who I am particularly happy to welcome since he comes from my State of Delaware, and is president and CEO of Christiana Care Corporation. He is here today on behalf of the American Hospital Association.

Dr. Ted Lewers is vice chairman of the American Medical Association. Ms. Bailis is co-chairman and co-CEO of Solomont Bailis Ventures. She is here on behalf of the American Health Care Association.

Ms. Suther is president and CEO of the Visiting Nurses Association of Texas, here today on behalf of the National Association of Home Care.

We thank you all for joining us today. We will begin with Mr. Scully, please.

STATEMENT OF THOMAS A. SCULLY, PRESIDENT AND CEO, FEDERATION OF AMERICAN HEALTH SYSTEMS, WASHINGTON, DC

Mr. SCULLY. Thank you, Mr. Chairman and members of the committee for inviting me to testify today. My name is Tom Scully. I am president of the Federation, which represents 1,700 privately-owned, investor-owned and managed hospitals across the country.

I am going to focus, as you can probably guess, briefly on this chart to my right this morning.

As you discussed earlier, the BBA, in 1997, was intended to cut $103 billion. That is a net number. You cut $114 billion and spent some money back. It was intended to slow, in the early 1990's, the inflation rate of about 10 percent a year to an inflation rate of about 5.5 percent a year.

The fact is, the inflation rate for Medicare is negative 1.6 percent, and the inflation rate for Part A of Medicare, which is where hospitals and nursing homes are, is a negative 5.2 percent.

So I think, arguably, we have way overshot the mark on the BBA and I think research, which I will get into, shows that it has had a pretty significant negative impact on health care providers.

Providers were to kick in $103 billion, which was the vast bulk of all the savings in the BBA in 1997. Now if you look at the real numbers, which I would argue is the blue number at the bottom, the Treasury numbers, it looks like $220 billion over 5 years is a much more realistic estimate.

One of the problems with the way BBA works, is it is a one-way ratchet. The top line was the pre-BBA estimates of Medicare spending, the middle line was what you hoped and expected to hit and was written into the law as the estimate in 1997, and the green line is where CBO was in March, and the blue line is where Treasury is right now.

What happens is, it is a one-way ratchet. If you misguesstimate by $100 billion, the money is gone, never to be seen again. That is the dilemma we have.

If you look at just a snapshot for 1999, your target for 1999 and Medicare savings was $15.5 billion when the bill passed 18 months ago. And CBO said, and I think Paul Van de Water said earlier, CBO now estimates you have exceeded that by $19.4 billion for this year, and Treasury would pile another 5.6 percent on top of that.

So instead of saving $15.5 billion this year, you have saved $40.5 billion this year, which is $25 billion more than you expected 18 months ago, and there is an 11 percent lower rate of spending in the Medicare program this year than what you expected when you passed the bill in November of 1997.

What has that meant for providers? Both the Federation, through Ernst & Young, HCIA, and the AHA through Lewin, have put out fairly significant studies on this. We worked very closely with MEDPAC on working on that study.

We found that hospital margins this year, 1999, overall, are 0.1 percent, which is the lowest they have been in years. Outpatient margins, which is the number one issue I am going to raise that we should hopefully address this year, are negative 17 percent this year, and falling to negative 28.7 percent under the BBA by 2002.

That is before we get into the HCFA rule that is coming out, which is an additional yet unscored and unconsidered 5.7 percent cut. That is another $1 billion a year that is not figured in those numbers.

Rural hospital margins, which I know Senator Baucus was worried about, are 4.2 percent for fiscal year 98, and they will fall under the BBA to negative 5.6 percent by 2002.

If you look at the investor community reaction to this, if you look at nonprofit hospitals and health plans, bond ratings are in the tank for anyone who is nonprofit.

If you look at the investor world—and I attached an attachment to my testimony—the average health care stock, whether it is hospitals, nursing homes, providers, information companies, is down about 40 percent since the BBA passed, and that is obviously in a market where virtually every other sector of the economy has boomed.

What would our priorities be for repairing the BBA? First, by far, would be outpatient PPS. I am not sure this is HCFA's fault or Congress' fault. Outpatient prospective payment was a mess for years. HCFA, the providers, and Congress worked very closely from 1994 to 1997 to put together a proposal that was included in your bill.

Unfortunately, though the House and Senate bills were identical, word for word, the conference agreement included some minor changes that were never scored, never considered by CBO, never understood by us, never understood by HCFA until a year after the bill passed, that now result in a 5.7 percent additional cut that was never scored. That is $900 million a year that are not in these numbers additionally out of the outpatient side.

Our number one goal for this year for the Federation, for our hospitals, is to fix that, whether HCFA can do it administratively, and we believe they can, or whether Congress has to come back and repair it. As you can imagine, $900 million a year in a reconciliation bill is lot.

Our second, would be transfer policy. I think most of you are familiar with that. Our view is that the transfer policy runs totally counter to the idea of prospective payment and health care. We think it is totally unfair in the way it has worked. It has turned out to save three to four times as much as was estimated in the BBA.

We also find the places that are penalized most are hospitals in areas that have average lengths of stay that are lower than the national mean. So if you are in a hospital that happens to discharge a stroke or hip replacement patient faster than the national mean, you lose money. So, it completely runs counter to what you did in 1983, which we supported, which was a move to prospective payment.

Our final request for an adjustment in the bill would be bad debt. This is a greatly misunderstood policy. It is generally the near-poor, non-Medicaid, non-Medigap patients, about 10 percent of the Medicare near-poor, that do not get their hospital deductible of $768 covered.

At some point, Medicare used to pay us 100 percent of that. That may not have been a rational policy, but that was the case. It was cut to 55 percent in the BBA, which we think is way too far and we think that should be adjusted back upward.

Most unfairly, it was intended in the BBA to apply to all Part A providers. Due to what I believe everybody now considers a drafting error, it only applied to hospitals. So, no other Part A providers were hit. We think that hit went too far and affects primarily hospitals serving poor patients.

To wrap up, Mr. Chairman, we have a lot of concerns on this bill. We look forward to working with the committee to address some of the excesses we think are in the BBA. One-third of the hospitals in this country are operating in the red right now. That is 55 percent more than when the BBA passed.

I think there is abundant evidence out there that the BBA went too far. We know you do not have a lot of money to fix it, but we hope you can find at least a few Band-Aids to put back on in this Congress.

[The prepared statement of Mr. Scully appears in the appendix.]

The CHAIRMAN. Dr. Smith, please.

STATEMENT OF CHARLES M. SMITH, M.D. PRESIDENT AND CEO, CHRISTIANA CARE CORP., ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, DC

Dr. SMITH. Thank you, Mr. Chairman. I am Charles Smith and I am president and CEO of Christiana Care Corporation in Wilmington, Delaware. I am here today on behalf of the American Hospital Association. We appreciate the opportunity to present our views.

Christiana Care is a not-for-profit coordinated health care system that provides the entire spectrum of health care services to patients in a four-State area. As such, the Balanced Budget Act of 1997 and the changes that it has brought about in Medicare reimbursement affect all of our services.

Before I begin, let it be said that the Balanced Budget Act represents landmark legislation. Medicare must be protected and

health care providers must be forced to provide health care in the most cost-effective way possible.

It is not the intent of this act that causes concern, but the unforeseen and unintended consequences for patient care and medical education that need prompt and definitive correction.

Although it is tempting for me to focus on the money, instead, as a physician and health care administrator, I want to talk about the effects of the changes in Medicare reimbursement on the community and people served by my organization.

I will also show how, in a patient-focused system, changes in one part of the system surge like a tempest throughout its entirety because of the extreme interconnectedness of all of the components of health care.

The post-hospital care part of the system cannot provide adequate care to home health and nursing home patients because of the Balanced Budget Act's reduction in reimbursement for those services, particularly for complex patients.

As a result, a genuine Catch-22 situation has been created for hospitals. Hospitals are unable to discharge Medicare patients, and at the same time are being penalized for not doing so.

We now have an ever-increasing number of patients in our hospitals awaiting placement. Recently, this number reached 80 as opposed to about 20 prior to the Balanced Budget Act. This creates significant problems. The most important problem is that hospitalization for the elderly, when not needed for acute care reasons, is bad patient care.

Older people manifest dramatic physical and mental deterioration during periods of hospitalization, and some never recover their previous functional state.

It is also a problem for the operation of the hospital. We now have beds filled with patients who do not need to be in the hospital. The fact that these beds cannot be used for the care for which they were intended impedes the admitting process and interrupts the normal flow of patients through the hospital, causing medical gridlock.

In this specific instance, ironically, the financial consequences of all of this is to actually increase the cost of health care. Of course, these costs are largely uncompensated and will result in losses to hospitals because Medicare, quite appropriately, pays only for necessary hospitalization.

The medical education programs at Christiana Care are very important for providing medical manpower in our State. As many as 45 percent of our graduating primary care residents stay in our State to practice. Without our residency programs, it would probably be impossible, and certainly much more expensive, to continue providing the enormous amount of uncompensated care that we provide now to the under-privileged and uninsured.

Balanced Budget Act reductions and support for medical education have already affected our programs and we are very worried about the effect of future changes on access and service to our community.

Because Christiana Care provides so much outpatient care, we are also worried about the changes in the prospective payment sys-

tem. We are already losing money in the care of outpatient Medicare patients, and this would only add to that.

We feel that we do need relief. Primarily, we feel we would like to have relief with repeal of the transfer provision, as proposed in Senate Bill 37. This provision this year will cost us $1.2 million.

We would like to see reductions eased in the proposed outpatient PPS by establishing a stop-loss program that would protect hospitals from large reductions, and by convincing HCFA to reverse their plan to further reduce payments by 5.7 percent.

We would like to see restored adequate reimbursement for skilled nursing facilities by establishing an outlier pool to compensate for extensive expensive cases. Other suggestions for relief have been submitted with my written testimony.

In conclusion, Mr. Chairman, the Balanced Budget Act is now causing real pain for real people. Thank you.

[The prepared statement of Dr. Smith appears in the appendix.]

The CHAIRMAN. Thank you, Dr. Smith.

I regret we have a vote taking place, so we are going to have to recess temporarily. I think there are two votes and there is 5 minutes left on this.

Senator MOYNIHAN. We will be back.

The CHAIRMAN. We will be back. The committee is in recess.

[Whereupon, at 11:55 a.m., the hearing was recessed to reconvene at 12:18 p.m.]

The CHAIRMAN. I apologize to the distinguished panel, but this is the way the Senate works.

Ms. Bailis, we will go down to you, if we may.

STATEMENT OF SUSAN S. BAILIS, CO-CHAIRMAN AND CO-CEO, SOLOMONT BAILIS VENTURES, ON BEHALF OF THE AMERICAN HEALTH CARE ASSOCIATION, BOSTON, MA

Ms. BAILIS. Thank you, Chairman Roth and members of the Senate Finance Committee. My name is Susan Bailis, and I have overseen the operations of nursing homes and SNFs for more than 13 years. I have also served on ProPAC, the predecessor to the Medicare Payment Advisory Commission. I speak today on behalf of the American Health Care Association.

Controlling Medicare spending is a laudable goal, but the unintended consequences of the most recent cuts in Medicare have been severe. A change from cost-based reimbursement to a prospective payment system has been dramatic.

With a transformation of that magnitude, the need for corrective adjustments along the way is inevitable. I come before you today to relay our concerns, and more important, to propose solutions. Comprehensive data has been difficult to come by, as we have heard this morning, because the PPS is relatively new.

However, one startling fact has emerged. That is that SNFs have experienced an average reduction in their daily Medicare payments of $50 per day, per patient. The study also shows that Medicare beneficiary use of skilled nursing facilities has dropped by more than 10 percent, and patient length of stay has decreased by nearly 15 percent.

These numbers tell an important story. Nursing homes are reevaluating the extent to which Medicare resources will allow them

to appropriately care for the sickest patients. The result is a very real access problem to skilled nursing facilities which is causing backups in hospitals throughout the country.

The squeeze has puts SNFs in a difficult situation. We are concerned about the impact it will have on Medicare beneficiaries, specifically high acuity patients. Naturally, SNFs will be hard-pressed to continue to provide service when patients' cost of care exceed the resources available.

I want to share with you an example of the difficulty SNFs are experiencing under PPS. Reports from the front lines, if you will, in the skilled nursing field to illustrate the seriousness of the problems we face and the real threat of reduced access to skilled care.

In Florida, Ms. Y, 89 years of age, arrived at a Lakeland SNF on March 25 to recover from pneumonia and a chronic urinary tract infection. Due to her weakened condition, she needed respiratory, physical, occupational, and speech therapy, plus IV antibiotics, to gain the strength she needed to go home.

Mrs. Y returned to her home on May 17, thanks to the excellent care that she received at the skilled nursing facility. However, the Medicare system failed to reimburse the skilled nursing facility $20,000 worth of direct and ancillary care that was provided to the patient so that she could return to health.

This included $3,000 in pharmacy costs alone. Even though the patient was in a high Medicare reimbursement category, she consumed over $350 more a day in respiratory, IV, and other therapies than Medicare paid for. Yet, if she did not get that care, she would have used up her Medicare days, flipped to Medicaid, and probably stayed in the nursing home indefinitely.

Staff at the center report that nearly half of their Medicare discharges in a typical month consume an average of $8,000 to $10,000 worth of services and supplies, more than the center receives in compensation.

Since their policy is to take all Medicare recipients regardless of acuity level, the center's viability is continuing to be severely impacted by the BBA.

The Medicare cuts that are denying Medicare beneficiaries access to care are not just affecting Medicare beneficiaries, but are also affecting employees as well. The bleak outlook for SNFs, the open season on caregivers mentality that seems to prevail in some quarters, is turning away high-quality professional staff. These deep cuts force layoffs of tens of thousands of employees.

Mr. Chairman, the job of a skilled care staff is challenging under any circumstances, but I can say with certainty that these dramatic reductions add a new degree of difficulty in providing access to high-quality care that Medicare beneficiaries expect and deserve.

These examples I have cited today show the PPS, for a whole host of reasons, is threatening quality, continuity of care, and access. We have some recommendations on this to what we believe are fair solutions to four critical challenges, solutions that take into account the constraints of Congress and HCFA in implementing change.

First, we propose that HCFA replace the current market basket update for SNFs with an output economic index that better reflects the changes in intensity and mix of resident services.

Second, Congress, HCFA, and MEDPAC all recognize that the new payment system for SNFs fails to account for certain Medicare beneficiaries with medically complex conditions. I already talked about some of those patients. We propose a patient condition-based payment modifier targeted to these patients.

Third, PPS rates are based on cost reports going back to 1995. We recommend that providers have the option of maintaining the current blended rate for the second year of PPS, or moving to the Federal rate immediately.

Fourth, and finally, we believe residents would benefit if Congress addresses the problems posed by the $1,500 annual cap on outpatient rehabilitation services. The committee is urged to support S. 472, which would create criteria to trigger exceptions to the caps for the sickest and most vulnerable Medicare beneficiaries.

Mr. Chairman, as I conclude my remarks, I would like to convey to the committee that we know the constraints that exist. These solutions can only be achieved in a bipartisan fashion, and we look forward to your leadership.

I thank you for the opportunity to be here today.

[The prepared statement of Ms. Bailis appears in the appendix.]

The CHAIRMAN. Thank you.

Now, Dr. Lewers?

STATEMENT OF D. TED LEWERS, M.D., VICE CHAIR, AMERICAN MEDICAL ASSOCIATION, WASHINGTON, DC

Dr. LEWERS. Thank you, Mr. Chairman. I am Ted Lewers. I am a nephrologist and internist from Easton, MD. I serve as vice chair of the American Medical Association Board of Trustees.

While I am also a MEDPAC commissioner, I want to make it very clear that I am here today speaking and representing for the AMA and not MEDPAC.

The AMA appreciates the opportunity to provide this committee with our views on needed improvements to the sustainable growth rate system which is the basis for Medicare physician payment updates.

The SGR enacted under BBA 1997 is a target rate of spending growth for physician services. There are serious problems with the SGR formula and with its administration to date.

MEDPAC has recommended four improvements in the SGR. We are here today to urge Congress to enact these refinements into law this year. The physician community is united in recommending the following.

First, HCFA should correct projection errors used in calculating the 1998 and 1999 SGR and should be required to correct projection errors each year as actual data becomes available. The law requires HCFA to make projections to calculate the SGR target before actual data is available. As a result, the projections that have been made to date were wrong.

For example, HCFA's SGR target for 1998 was based on erroneous projections of GDP growth and changes in fee-for-service enrollment. Because these errors have not been corrected, the 1999 payment update is about $645 million lower than actual data would require.

We urge Congress to direct HCFA to immediately rectify this problem. Our view is also in accord with MEDPAC's recommendation.

In addition, in establishing the 1999 SGR, HCFA estimated that fee-for-service enrollment would decline by 4.3 percent in 1999. This is despite a slowing rate of increase in Medicare managed care enrollment over the last one and a half years, and an actual decrease in December of 1998 and January of 1999.

HCFA based the 1999 SGR on a projected increase in managed care enrollment of 29 percent. Over time, due to the cumulative nature of the SGR, uncorrected projection errors will short-change physician service payments by billions of dollars.

Second, the SGR should be set at GDP plus 2 percentage points to take into account increased expenditures and utilization of services due to technological innovation.

Under the SGR, health care utilization is held to the rate of GDP growth. CBO forecasts indicate that real per capita GDP growth over the next decade will be far below historical rates of Medicare utilization growth. Thus, the SGR system guarantees that Medicare physician payments will decline.

MEDPAC, and its predecessor, PPRC, both recommended that the SGR include an add-on to GDP for cost increases due to improvements in medical capabilities and advancements in scientific technology. We strongly agree.

We also urge that Congress consider a long-term approach to setting an appropriate growth target. For instance, Congress could require the AHCPR, with its experience in practice guidelines and technological advances, to work with MEDPAC in estimating the impact of improvements in technology, changes in the characteristics of fee-for-service enrollees, and shifts in sites of service on utilization growth.

Third, payment updates under the SGR must be stabilized. Currently, MEDPAC, HCFA, and the AMA project that the SGR will produce extreme volatility in payment levels. This prevents predictability in the budget process for either the Federal Government or physicians.

The AMA agrees with MEDPAC's recommendation that Congress should stabilize the SGR by moving it to a calendar year system. Further stabilization could be achieved by narrowing both the upper and lower limits on payment updates and changing from annual GDP growth to a rolling 5-year average.

Fourth, and our final point, Congress should reestablish payment preview reports, as recommended by MEDPAC. HCFA should provide Congress, MEDPAC, and physician organizations with quarterly physician expenditure data and an estimate of the next year's payment update.

The physician community, surgeons and primary care alike, is concerned that payment cuts due to flaws in the SGR, on top of more than a decade of previous cuts, could threaten beneficiary access and our ability to continue to offer our Medicare patients the benefits of the finest medical care available.

The SGR must be fixed. The AMA urges the committee to consider the recommendations we have discussed. Further details are in our written testimony, and we greatly appreciate the commit-

tee's work in this area. We are ready to answer any questions and to help in any way. Thank you, sir.

[The prepared statement of Dr. Lewers appears in the appendix.]

The CHAIRMAN. Thank you very much.

Next, we will call upon Ms. Suther, please.

STATEMENT OF MARY SUTHER, PRESIDENT AND CEO, VISITING NURSE ASSOCIATION OF TEXAS, ON BEHALF OF THE NATIONAL ASSOCIATION FOR HOME CARE, WASHINGTON, DC

Ms. SUTHER. Thank you for the opportunity to testify here today. My name is Mary Suther. I am the president and CEO of the Visiting Nurse Association of Texas, which is a very large home care agency that serves both rural and urban patients. It is a charitable organization. We have been in business over 65 years.

The Medicare home health benefit has undergone tremendous change as a result of BBA and recent program requirements. Many providers have left the program, and I know that HCFA testified they did not know exact numbers. I do have a copy that I will give you. In Texas, prior to the BBA, we had 15 counties that were not served. We now have 40 counties that are not served. Two of those counties are over 4,500 square feet in area and they are bordered by counties that——

Senator MOYNIHAN. No, ma'am. I think you may mean square miles.

Ms. SUTHER. I am sorry. You are absolutely right. [Laughter.] Square miles. And they are bordered by contiguous counties that also have no home health agency. I will give you detailed information on that.

There is a decreased number of patients receiving fewer services. Some areas of the country have no Medicare agencies. Infrastructure necessary for implementing PPS is being eroded. Even though studies have shown that the home care problems that exist are not of crisis proportion, why do we have to wait until there is a crisis?

This is extremely important to note, that GAO and MEDPAC found that, even in the first quarter of 1998, before the main effects of BBA were felt, because many home health agencies had not even started with IPS, beneficiaries were already losing access. Even so, home care was back to 1994 levels.

The current situation is much worse. We have examples attached in our written testimony of specific cases of real people who are in need of care and are going without home care. Many of them are being admitted to institutions. You heard earlier testimonies that institutions are full and are having problems with accepting some of them.

The IPS is the most devastating change for home health agencies under BBA. The severe payment reductions, coupled with other HCFA initiatives that increase costs, have had severe effects on health care providers, thus, beneficiaries.

Approximately 2,000 agencies have gone out of business. Surviving agencies have had to decrease staff, therefore, have had to limit admissions of medically complex patients or patients that live a far distance from the facility.

In my own agency, we had losses of over $1 million as a result of this, and our community donations have subsidized this. We have a very generous community, but they do not want to subsidize the Medicare program with charitable donations.

Some of the major problems are related to the medically complex patients. A study done by the Center for Health Policy Research of Georgetown University found IPS curtails access to covered services for the sickest, most frail Medicare patients.

CVA used an unprecedented 66 percent behavioral offset and thus directed Congress that it would have to cut home health $48 billion to save $16 billion over five years. It is now painfully clear that that was completely unnecessary. This has had devastating effects.

Contrary to the previous remarks of panelists, home health agencies, in general, do understand the aggregate per-beneficiary cost. There may be an occasional home health agency that does not. That is not the point. The point is, the payment level is too low.

My particular agency was $7 million under cost caps the year for baseline for BBA. We also have a lower utilization rate than the Nation and other home health agencies in our State. We have still be adversely affected by this.

Per-visit cost limits were reduced by 14 to 22 percent. Home health, under BBA, could not win. If an agency had a high cost per visit and a low per-beneficiary cost, too bad. If they had a high per-beneficiary cost and a low cost per visit, again, too bad.

No consideration was given to technological or regulatory changes or population changes, the aging of the population. No mention was made to age adjusting for the changes in Medicare. Just, bam, back to 1993 and 1994 cost data.

These changes were especially devastating to rural beneficiaries and inner city beneficiaries due to the extra costs incurred in caring for those beneficiaries. Over-payments is another issue. BBA 1997 went into effect October 1, 1997, and HCFA was not required to publish visit limits until January 1998, and per-beneficiary limits until April 1998.

Thus, agencies were blindly continuing to operate and provide services to patients. Many agencies found themselves in an over-payment situation because HCFA continued to pay them at the higher rate.

It will result in those agencies, if they have to pay this money back, many of them, in going out of business, restricting access for more beneficiaries and further erosion of the infrastructure that has taken us 30 years to build.

On February 5, venipuncture was removed as a qualifying service, and that had a devastating effect. We believe that Congress must target resources to ensure beneficiary access.

The vital home health infrastructure must be stabilized by providing some type of outlier for medically complex, high-cost, heavy needs patients, by eliminating the 15 percent additional cut scheduled for October 1, 2000, and to provide relief from financially disabling over-payments to preserve infrastructure.

These proposals are in keeping with GAO and MEDPAC concerns. The effects of the BBA produced many unintentional con-

sequences. We are relying on your leadership to make the necessary changes. Thank you.

[The prepared statement of Ms. Suther appears in the appendix.]

The CHAIRMAN. Thank you, Ms. Suther.

Mr. Scully, let me turn to you. Could you please elaborate on why the Medicare inpatient margin is not a good indicator of a hospital's financial viability? What other indicators would you suggest we use?

Mr. SCULLY. Well, hospital inpatient margins are one piece. Obviously, inpatient, as a percentage of a hospital's revenues, is generally shrinking and outpatient is growing.

While our inpatient margins have generally, in our study, concurred with MEDPAC, then probably 16 to 17 percent in the last couple of years. We have not proposed any adjustments, at least in our recommendations, on the inpatient side.

They have been negative 17 percent, growing to negative 28 percent on the outpatient side. On the margins on SNFs, home health, other businesses, and other hospitals are also very negative.

In addition, when you look at the costs—and this is according to MEDPAC data, if you look at what a hospital receives relative to its costs, we receive roughly about 98 percent of our costs from Medicare as a payor, while the average private payor, who is usually an HMO, is about 117 percent of cost. That margin has narrowed, so Medicare has become a relatively better payor. But the HMOs are not getting easier.

You look back two or 3 years, and the HMOs paid us 130 percent of cost. Now they pay 117 percent. So we have no place left to turn. Our inpatient margins in Medicare are better than they are on the outpatient side, they are better on the home health side, and the SNF side.

But our overall Medicare margins, as I mentioned, are 0.1 percent this year. No hospital I know of, in net, makes any money on Medicare. You do the best you can on Medicare and you try to get whatever you can out of the private payors, which is why we are having such a tough time.

The CHAIRMAN. Dr. Smith, as we well know, Christiana Care furnishes many kinds of health care services. MEDPAC has raised an important question of how organizations respond to the combined effects of different payment policy changes in the BBA. Could you tell us how Christiana Care has dealt with this issue?

Dr. SMITH. Yes, sir. I can certainly try to do that. First of all, as you know, the timing of the implementation of elements of the Balanced Budget Act varies. So the major impact on our system at this point in time has come in the area of post-hospital care, with some in-hospital as well as medical teaching impact, but those will be coming more in year 2002.

The response that we have mounted to cope with this have been really to do everything we can to increase our revenues wherever we can find them. We are doing everything we can to reduce our costs. However, most of our costs are personnel costs.

Contrary to what a lot of people think, our occupancy is still very high. We were running over 90 percent occupancy and we, therefore, cannot eliminate clinical positions, but we are responding by trying to reduce our costs.

In addition to that, we are doing everything we can to modify utilization. So, we are responding the way the Balanced Budget Act wants us to respond, but we have had negatives.

Our nursing home this year, as a result of the Balanced Budget Act, has lost $700,000 at this point in time. I believe we are the only nursing home in the State that will take complex patients, and this is resulting in a loss for us. We have had to decrease home health care services. This year, which is just about now completed, we, on our medical clinical services, will have a deficit of $1.2 million. That is inpatient and outpatient combined.

Senator MOYNIHAN. That is a lot for them.

Dr. SMITH. Sure, it is.

The CHAIRMAN. Let me ask you to discuss the hospital transfer policy and any adverse incentives this policy has created, particularly in rural areas.

Dr. SMITH. I think the hospital transfer policy does, in my view, penalize health care providers for doing what might be best for the patient. As I have mentioned, it is not good to keep a Medicare patient in the hospital. Certainly, they should be discharged just as quickly as possible.

However, the financial incentives or economic incentives brought on by the transfer policy are to keep them there until they have stayed out their DRG, and that is clinically unsound and not in the best interest of patients.

Senator MOYNIHAN. Clearly. Clearly.

Dr. SMITH. Therefore, we are being penalized for doing what we feel is best for patients. The penalty to Christiana Care for this fiscal year will be $1.2 million.

The CHAIRMAN. Let me ask you, Ms. Bailis. Would you discuss the impact of therapy limits on patients in the outpatient and skilled nursing settings, and whether consolidated billing requirements are making the problem worse?

Ms. BAILIS. I will be glad to talk about the impact the therapy caps are having on residents in facilities. The actual consolidated billing provisions have been delayed because of Y2K issues and we will not have information on that until that actually is implemented.

But the therapy cap is clearly having an impact on residents. A study done of 32,000 Medicare beneficiaries showed that 4 percent of beneficiaries had already exceeded the cap, that it is anticipated that 13 percent will have exceeded the cap by the end of the year, and 28 percent of beneficiaries have expended half of the cap.

In addition, patients are beginning to ration their therapy so they can be sure that there is enough for them throughout the year. The cap particularly discriminates against very sick patients that suffer from stroke, cardiac problems, hip fractures, Parkinson's disease, cancer, diabetes, and respiratory diseases. So there is no question that the cap is having a significant impact as we sit here.

The CHAIRMAN. Dr. Lewers, I would like to go to the innovative technologies that are such an important key to a successful practice by physicians. This is especially true in an age where many services, once performed in the hospital, are now being performed in a physician's office.

Could you discuss your ideas on how to explicitly recognize the cost of new technology and annual updates to the physician fee?

Dr. LEWERS. Well, you have hit a very key point and it is one that PPRC recommended back in 1995, I guess—I was a commissioner on PPRC at that time as well—on how do you recognize that? I think it was very clear, and I think it remains very clear, that we need to find some way to recognize that we have to be able, in some manner, to afford technological advances or we stagnate and the quality of care will decrease.

At that point in time, I remember extensive debates in PPRC regarding, how do we do this? It was felt that there had to be a percentage point added on to the SGR. That was when we created the SGR. They felt that was the best way to do it. I am aware of concerns that that is not the best way to do it. But we feel that definitely we need to do something to make sure that that continues so that stagnation does not occur.

It is also one of the reasons why we have recommended to you today that AHCPR basically take this on as a study, we are thinking, in the terms of 3 years of a process in working with MEDPAC to try to come forth with a long-term solution. I think what we have recommended is probably a short-term solution and one that would correct that. But we cannot continue to fund, as you have wisely done, the NIH and other agencies to help in research and to grow.

To think that when I was a medical student, a cataract patient had bags around their head for three weeks. I remember those days. I hate to admit that I do, but I do. I remember when we could not do colonoscopy. I remember a lot of these factors. I do not want to see us, in 10 years, saying, gee, I wish we would have found some way to do this.

So we urge you to help us with this. We really feel that the AHCPR can help us. Their innovation and all the work they have done in recent years, I think, makes them idea to do this study for a long-term fix.

The CHAIRMAN. No question about it, it is important. We will call upon you to help us, too.

Dr. LEWERS. I will ask our people to take a look at this and to see if there are other areas that they think we can do, and certainly we will advise you of their findings. I will make those calls this afternoon.

The CHAIRMAN. Thank you, sir.

Ms. Suther, like all of the members of this panel, we are very much concerned with maintaining home health care access for the sickest beneficiaries. The implementation of the prospective payment system next year is, presumably, a major step to alleviate this problem. In the interim, however, are there any ideas Congress should consider that would specifically target reimbursement to medically complex patients?

Ms. SUTHER. Yes, there are. I think there is some preliminary information from the studies that were done for PPS that might give some hints as to some indices for medically complex patients. Obviously, if you are a small agency and you admit one medically complex patient, it could devastate you. If you are a large one, like mine, you could accept a larger number of those.

I think there needs to be some way of determining which patients are medically complex. We do not have a good method of doing that. Now, hopefully PPS will come forth with that, but we have not been privy to the information that they are going to utilize PPS yet, except in very brief detail.

We do not know whether it will work. But I think that people doing that research have some ideas as to how they could determine which agencies are seeing patients that are sicker and that are more complex than other agencies.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Thank you, Mr. Chairman.

This has been wonderful testimony. I am sorry we had to break it up. I would tell you, our committee has many concerns, but one of them is what Dr. Lewers describes. We are in a great age of medical discovery and innovation. We do not want the management of our Federal insurance system to inhibit, much less to impair, that.

In this context, with the rise of HMOs and such, we are going to have to begin thinking of teaching hospitals at public goods, in the terms economists would use. A public good is one in which everybody shares the benefits, so no one will pay. That is why you have governance, in effect.

It appears sometimes that all the new science does is add to the complexity and cost. Consider your cataract patient. Cataract operations are done in offices and take 15 minutes now with laser development, and such-like. There are many such equivalents of what were once very difficult medical procedures becoming much simpler thanks to research.

I would just ask one general question. Mr. Scully, in your testimony you made a rather startling proposition, that more than one-third of all hospitals are facing bottom lines in the red due to the Balanced Budget Act of 1997. One-third.

So might I ask Dr. Smith, who represents hospitals here today, would you share that assessment, and if not, what would your assessment be?

Dr. SMITH. I do not have specific information on that. What I have read is, 20 to 25 percent of hospitals will have operating margins in the red for this fiscal year.

Senator MOYNIHAN. Does that startle you?

Dr. SMITH. I am sorry, sir. Does what startle me, that one-fifth to one-quarter are——

Senator MOYNIHAN. Yes. Yes. Is that something new or is that just the way hospitals exist?

Dr. SMITH. It does not startle me. I am not sure that I would, however, classify it as the way hospitals exist. It is a balance between revenue and expenses. I think that the number of hospitals where the operating margins are getting smaller are definitely going up, and that is a real concern, particularly when some of these hospitals are in areas where they may be the only providers of care.

Senator MOYNIHAN. Mr. Scully?

Mr. SCULLY. Senator, if I might. Dr. Smith probably does not spend as much time running his hospital as Christiana. But that data is from an HA study, so actually the HA produced that data.

Generically, if you look back over the last 15 years, you are obviously going to have some hospitals that always do poorly and lose money. The general numbers run between about 17 and 22 percent over the years. The fact that the number is up to 33 percent is a pretty significant change since the BBA.

Senator MOYNIHAN. Dr. Lewers, would you care to comment?

Dr. LEWERS. On hospitals?

Senator MOYNIHAN. Yes.

Dr. LEWERS. No.

Senator MOYNIHAN. No.

Dr. LEWERS. Not on hospitals. [Laughter.] I know when to put my foot in and not. But I will comment on your efforts with the teaching hospitals, and commend you for that. It is very well known.

The AMA is very concerned about what is going to happen to teaching hospitals, to teaching facilities, as we move into the outpatient areas. Following the trainees as they move into the other areas, the complexity, all of this is, in a sense, very frightening. I spend a fair amount of my time traveling in some of the teaching hospitals and working with residents and working with students.

It is an area that we have to come to some decision on. I look forward to the debate on graduate medical education that we will have at MEDPAC. As I said, I am not here speaking for MEDPAC. But we have been working on that now since the BBA and since MEDPAC formed, and every meeting we spend time on this. We are getting down to the fish-and-cut-bait time now. We have a report to do in August. The AMA basically will be working with us and assisting MEDPAC in whatever endeavors it has.

We have policies on this that you are very well aware of. The teaching hospitals, the academic medical centers, are ones that, throughout this country, are, when you talk about margins, really on the margin. We must do something to solve that problem.

Senator MOYNIHAN. Well, I just could not be happier with all of those responses. These are good problems. If you have market systems that are moderating costs, that is good. If that leads a certain segment in difficulty, it is a difficulty that is in the larger context of innovation and price moderation.

My heavens, the beginning of this decade we thought costs would be going up about 19 percent a year and they would be up around a quarter of GDP right now. It did not happen. But if there is a side effect that affects hospitals, we will take care of that, too.

We will look forward to that August report. Thank you all very much. Thank you, Mr. Chairman.

Dr. LEWERS. Thank you.

The CHAIRMAN. On that optimistic note, we will call the committee to an end. I want to thank each one of you again for being here today. We appreciate your most helpful testimony.

Senator MOYNIHAN. Thank you so much.

The CHAIRMAN. The committee is in recess.

[Whereupon, at 12:56 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF SUSAN S. BAILIS

Thank you, Chairman Roth and Members of the Senate Finance Committee, for this opportunity to share the concerns of skilled nursing facility (SNF) providers as we navigate our way through the recently implemented prospective payment system (PPS)—and other changes brought about by the Balanced Budget Act of 1997 (BBA).

Let me state for the record that my name is Susan Bailis, and I am the co-chairman and co-chief executive officer of a company that develops innovative health care services and provides consulting with a specialty in eldercare. I have overseen the operations of nursing homes and SNFs with 5,000 beds for more than 13 years. I have served on ProPAC—the predecessor to the Medicare Payment Advisory Commission—and I am also a clinical social worker. I speak today on behalf of the American Health Care Association (AHCA), a federation of 50 affiliated associations representing over 11,000 non-profit and for-profit assisted living, nursing facility, and subacute providers nationwide.

Mr. Chairman, let me express our sincere appreciation for the opportunity to share with you our concerns regarding the implementation of the SNF PPS and its impact on residents for whom we have the privilege to care. Controlling Medicare spending is a laudable goal, but the unintended consequences of the most recent cuts in Medicare have been severe. A change from cost-based reimbursement to a prospective payments system (PPS) has been—by definition—dramatic. With a transformation of that magnitude, the need for corrective adjustments along the way is inevitable. Hearings like this one demonstrate this Committee's willingness to recognize that Congress must redress some of the unintended problems that have emerged from the BBA. In that same spirit, I come before you today to relay our concerns—and more important, to propose solutions.

Comprehensive data has been difficult to come by because the PPS is relatively new. However, based on recent data collected among the SNF community by Muse and Associates—a Washington, D.C.-based research firm—one startling fact has emerged, and that is that SNFs have experienced an average reduction in their daily Medicare payments of $50 per day per patient. The study also shows that Medicare beneficiary use of skilled nursing facilities has dropped by more than 10 percent, and patient length of stay has decreased by nearly 15 percent. These numbers tell an important story. Nursing homes are reevaluating the extent to which Medicare resources will allow them to appropriately care for the sickest patients. The result is a very real access problem to skilled nursing services, which is causing backups in hospitals throughout the country. This squeeze has put SNFs in a difficult situation, and we are concerned about the impact it will have on Medicare beneficiaries—specifically high-acuity patients. Naturally, SNFs will be hard-pressed to continue to provide service when patients' costs of care exceed the resources available.

I want to share with you a few examples of the difficulties SNFs are experiencing under PPS—reports from the front-lines, if you will, in the skilled nursing field—to illustrate the seriousness of the problems we face, and the real threat of reduced access to skilled care.

In Florida, Mrs. Y (89 years of age) arrived at a Lakeland SNF on March 25th to recover from pneumonia and a chronic urinary tract infection. Due to her weakened condition she needed respiratory, physical, occupational and speech therapy plus IV antibiotics to gain the strength she needed to go home. Mrs. Y returned to her home on May 17th thanks to the excellent care she received at the skilled nursing facility; however, the Medicare system failed to reimburse the skilled nursing

facility $20,000 worth of direct and ancillary care that were provided to Mrs. Y, so that she could return to health. This included $3,000 of pharmacy costs alone. And even though Mrs. Y was in a high Medicare reimbursement category, she consumed over $350 more a day in respiratory, IV and other therapies than Medicare paid for. Yet, if she did not get that care, she would have used up her Medicare days, then flipped to Medicaid and probably stayed in the home indefinitely. Staff at the center report that nearly half of their Medicare discharges in a typical month consume an average of $8,000 to $10,000 worth of services and supplies more than the center receives in compensation. Since their policy is to take all Medicare recipients regardless of acuity level, the center's viability is continuing to be severely impacted by the BBA.

In Delaware, Mrs. D, an 85 year old woman, who was recently recovering from an infection and heart problems in a Delaware hospital found out about the shrinking number of Medicare beds in her state. She was ready for nursing home placement but, given Medicare's inability to provide adequate resources, she had difficulty locating a SNF, and, as a result, she had no choice but to stay in the hospital an extra two weeks. Eventually, a provider offered to take her to a center in neighboring Maryland despite the fact that she needed an expensive IV antibiotics at a cost of $410 a day. Her Medicare level dictated the center would only be compensated $260 a day for her care. Since then her doctor has prescribed a $1,700 knee brace that the center will provide as part of her routine care costs.

In the state of Washington, a locally-owned and managed independent provider operates a 30-bed skilled nursing facility with a nearby hospital. The facility primarily serves short-term (usually less than 20 days) high-acuity patients—many of whom were patients in the hospital's oncology department. The facility enabled patients to be treated by the hospital's doctors and eliminated the need for these very sick patients to travel between facilities.

The result of PPS on this facility is unmanageable losses of between $20,000 and $40,000 per month. The unit is well-managed and has provided uninterrupted high quality care, but it cannot overcome the fact that so many of its patients are very high acuity and require, in many cases, expensive treatments and medications that are not compensated for by the PPS rate. If the financing system is not changed, the facility anticipates it will be left no choice but to close its doors creating access problems for its local Medicare beneficiaries. Additionally, its functions will have to be assumed by another facility several miles away.

The Medicare cuts that are denying Medicare beneficiaries access to care are not just affecting Medicare beneficiaries, but also affecting our employees as well. The bleak outlook for SNFs—the "open-season on caregivers" mentality that seems to prevail in some quarters—is turning away high quality professional staff. These deep cuts have forced layoffs of tens of thousands of employees. Mr. Chairman, the job of skilled care staff is challenging under any circumstances—but I can say with certainty that these dramatic reductions add a new degree of difficulty in providing access to high-quality care that Medicare beneficiaries expect and deserve.

As you know, we are concerned that the situation has worsened to the point that many facilities will opt out of Medicare altogether. These cuts are forcing both independent providers and large national corporations to make difficult choices of whether to provide services in a system that does not provide adequate resources for care. This means that Medicare beneficiaries will have less access to quality care. If you think things are bad now, imagine how much more the situation will deteriorate if 1,000-plus facilities go out of business. Congress and the Administration should not stand by—forcing our states to make contingency plans for the care of hundreds of thousands of elderly residents needlessly uprooted from the facilities and the caregivers they've come to know. This would create a logistical nightmare, the most pressing problem being transfer trauma—which has been proven to increase mortality rates among the elderly.

The examples I've cited today show that the PPS, for a whole host of reasons, is threatening quality, continuity of care, and access—the very goals we share for the elderly and infirm Americans for whom we care. Mr. Chairman, the bottom line is that the deep cuts in Medicare create a clear and present danger to the well-being of our nation's elderly. The problems are critical and require immediate attention. To that end, I would like to outline what we believe to be fair solutions to four critical challenges—solutions that take into account the constraints of Congress and HCFA in implementing change.

First, we propose that HCFA replace the current market basket update for SNFs with an output economic index that better reflects the changes in intensity and mix of resident services. Simply put, HCFA should replace the current inflation rate update factor for SNFs with a more accurate measurement of the cost of services they are required to provide. This current market basket grossly understates the actual

market conditions for SNFs because it understates the annual change in the costs of providing an appropriate mix of goods and services produced by SNFs. SNFs have changed dramatically the services we provide and the acuity levels of the patients we care for. Additionally, this more accurate index exists within the Bureau of Labor Statistics. This change could be made by HCFA under existing law. Using the new index would restore funding back into the system and would help to alleviate the crisis SNFs are experiencing. HCFA has the authority to make this change, and Congress should encourage them to do so.

Second: Congress, HCFA and MedPAC all recognize that the new payment system for SNFs—Resource Utilization Groups III [RUGs III]—fails to account for certain Medicare beneficiaries with medically complex conditions. That is especially true for patients with high utilization of non-therapy ancillary services, such as prescriptions, respiratory care, IV antibiotics and chemotherapy. AHCA has proposed a patient-condition based payment modifier targeted to those patients most likely to fall outside the reimbursement system. In other words, if a patient comes into a SNF with a condition, such as ventilator care needs or advanced stage pressure ulcers, the facility treating that patient would be eligible for additional reimbursement to compensate for providing the required high cost services. This is the measure that we support, but we would certainly entertain other solutions.

Third, PPS rates are based on cost reports that date all the way back to 1995. Providers should have the option of maintaining the current blended rate for the second year of the PPS transition—currently 75% facility specific/25% federal—or elect to move to the full federal rate immediately. This would prevent facilities that changed the type and volume of Medicare services after 1995—the PPS base year—from being disadvantaged by the transition rate. Again, this is a matter of equity, and a means of easing the transition to PPS. We believe this can be done administratively by HCFA.

Fourth and finally, residents would benefit if Congress would address the problems posed by the imposition of $1,500 annual caps on Part B outpatient rehabilitation services. The BBA imposed these arbitrary and capricious caps without the benefit of data or of hearings. Mr. Chairman, I assure you—speaking from the frontlines of the skilled care community, no one who was part of this process could have intended this cap to create the kind of patient impact we're seeing. I urge this Committee to support S. 472, legislation sponsored by Senators Grassley and Reid, which would create criteria to trigger exceptions to the caps for the sickest and most vulnerable Medicare beneficiaries. Let me express our appreciation to Senators Grassley, Conrad, Hatch, Robb, Mack and Graham—for being early supporters of this legislation. But let me also challenge this Committee to translate that early support into immediate action.

Mr. Chairman, as I conclude my remarks, I would like to convey to the Committee that we know the constraints that exist. That is why we've worked so hard to put forward solutions that are reasonable and consistent with the aim of the BBA. Each of the four actions I've outlined today is realistic, responsible—and within reach. Each of the actions we recommend would restore funding that would ensure continued quality and access to Medicare beneficiaries. And that is why each of the actions we recommend should be adopted—for the sake of the patients entrusted to our care. These solutions can only be achieved in a bipartisan fashion, and we look to your leadership. Our nation's seniors expect and deserve no less.

Mr. Chairman and Members of the Committee, I thank you for the opportunity to be here today. On behalf of AHCA, I want to make clear our commitment to providing high quality care to America's frail and elderly. The situation is critical, but it will get worse unless Congress and the Administration work with providers to fix the system.

PREPARED STATEMENT OF ROBERT A. BERENSON, M.D.

Chairman Roth, Senator Moynihan, distinguished committee members, thank you for inviting us to discuss the impact of the Balanced Budget Act on Medicare fee-for-service beneficiaries and providers. The BBA includes important new preventive benefits and payment system reforms that promote efficiency and prudent use of taxpayer dollars. These reforms are critical to strengthening and protecting Medicare for the future. The Medicare Trust Fund, which was projected to be insolvent by 1999 when President Clinton took office, is now projected to be solvent until 2015.

We have implemented more than half of the BBA's 335 provisions affecting our programs, including the new preventive benefits such as diabetes education, and a prospective payment system for skilled nursing facilities. In most cases, the statute

prescribes in great detail the changes we are required to make. We are committed to affording providers maximum flexibility within our limited discretion as we implement the BBA.

Change of this magnitude always requires adjustment. It is not surprising that market corrections would result from such significant legislation. Our first and foremost concern has always been and will continue to be the effect of policy changes on beneficiaries' access to affordable, quality health care. We are proactively monitoring the impact of the BBA to ensure that beneficiary access to covered services is not compromised. Our regional offices are gathering extensive information from around the country to help us determine whether specific corrective actions may be necessary. We should be cautious about making changes to the BBA until we consider information and evidence of problems in beneficiary access to quality care.

It is clear that the BBA is succeeding in promoting efficiency and extending the life of the Medicare Trust Fund. However, the BBA is only one factor contributing to changes in Medicare spending. Our actuaries tell us that low inflation from a strong economy and aggressive efforts to pay correctly and fight fraud, waste, and abuse are also having an impact on total spending. We have significantly decreased the number of improper payments made by Medicare. And, for the first time ever, the hospital case mix index is down due to efforts to stop "upcoding," the practice of billing for more serious diagnoses than patients actually have in order to obtain higher reimbursement. It is also important to note that some of the slowdown in spending growth results from slower claims processing and payment during the transition to new payment systems.

The BBA also is only one factor contributing to provider challenges in the rapidly evolving health care market place. Efforts to pay right and promote efficiency may mean that Medicare no longer makes up for losses or inefficiencies elsewhere. We are concerned about reports about the financial conditions of some providers. However, it is essential that we delineate the BBA's impact from the effects of excess capacity, discounted rates to other payers, aggressive competition, and other market factors not caused by the BBA.

NEW PREVENTIVE BENEFITS

One set of significant changes brought about by the BBA is coverage of key preventive health benefits. We have:

- expanded coverage for test strips and education programs to help diabetics control their disease;
- begun covering bone density measurement for beneficiaries at risk of osteoporosis;
- begun covering several colorectal cancer screening tests;
- expanded preventive benefits for women so Medicare now covers a screening pap smear, pelvic exam and clinical breast exam every three years for most women, and every year for women at high risk for cervical or vaginal cancer; and,
- begun covering annual screening mammograms for all women age 40 and over, and a one-time initial, or baseline, mammogram for women ages 35-39, paying for these tests whether or not beneficiaries have met their annual deductibles.

PAYMENT REFORMS

The BBA made substantial changes to the way we reimburse providers in the fee-for-service program. We have made solid progress in implementing these payment reforms. For example, we have:

- modified inpatient hospital payment rules;
- established a prospective payment system for skilled nursing facilities to encourage facilities to provide care that is both efficient and appropriate;
- refined the physician payment system, as called for in the BBA, to more accurately reflect practice expenses for primary and specialty care physicians; and
- initiated the development of prospective payment systems for home health agencies, outpatient hospital care, and rehabilitation hospitals that will be implemented once the Year 2000 computer challenge has been addressed; and,
- begun implementing an important test of whether market forces can help Medicare and its beneficiaries save money on durable medical equipment.

MONITORING ACCESS

The payment reforms have created change for many of our providers, even though the percentage of providers who signed Medicare participation agreements increased by more than 6 percent to a record 85 percent for 1999. As mentioned above, our first and foremost concern continues to be the effect of policy changes on bene-

ficiaries' access to affordable, quality health care. We are proactively monitoring the impact of the BBA to ensure that beneficiary access to covered services is not compromised. In addition to these efforts, we are systematically gathering data from media reports, beneficiary advocacy groups, providers, Area Agencies on Aging, State Health Insurance Assistance Programs, claims processing contractors, State health officials, and other sources to look for objective information and evidence of the impact of BBA changes on access to quality care.

We are examining information available from the Securities and Exchange Commission and Wall Street analysts on leading publicly traded health care corporations. This can help us understand trends and Medicare's role in net income, revenues and expenses, as well as provide indicators of liquidity and leverage, occupancy rates, states-of-operation, lines of business exited or sold by the company, and other costs which may be related to discontinued operations.

We are monitoring Census Bureau data, which allow us to gauge the importance of Medicare in each health service industry, looking at financial trends in revenue sources by major service sectors, and tracking profit margin trends for tax-exempt providers.

We are monitoring the Bureau of Labor Statistics monthly employment statistics for employment trends in different parts of the health care industry. Such data show, for example, that the total number of hours worked by employees of independent home health agencies is at about the same level as in 1996. That provides a more useful indicator of actual home health care usage after the BBA than statistics on the number of agency closures and mergers.

We are being assisted by our colleagues at the HHS Inspector General's office. They have agreed to study the impact of the BBA's $1500 limits on outpatient rehabilitation therapy. They have also agreed to interview hospital discharge planners as to whether they are having difficulty placing beneficiaries in home health care or skilled nursing facilities. Results of that study should help provide information in addition to surveys done for the General Accounting Office and the Medicare Payment Advisory Commission of home health agencies. And, because home health beneficiaries are among the most vulnerable, we have established a workgroup to develop an ongoing strategy for monitoring beneficiary access and agency closures.

SPECIFIC BBA PROVISIONS

Home Health: The BBA closed loopholes that had invited fraud, waste and abuse. For example, it stopped the practice of billing for care delivered in low cost, rural areas for care from urban offices at high urban-area rates. It tightened eligibility rules so patients who only need blood drawn no longer qualify for the entire range of home health services. And it created an interim payment system to be used while we develop a prospective payment system. We expect to have the prospective payment system in place by the October 1, 2000 statutory deadline. We expect to publish a proposed regulation this October so we can begin receiving and evaluating public comments, and a final rule in July 2000.

The interim payment system is a first step toward giving home health agencies incentives to provide care efficiently. Before the BBA, reimbursement was based on the costs they incurred in providing care, subject to a per visit limit, and this encouraged agencies to provide more visits and to increase costs up to their limit. The interim system includes a new, aggregate per beneficiary limit designed to provide incentives for efficiency until the prospective payment system can be implemented.

Last year Congress raised the limits on costs somewhat in an effort to help agencies under the interim system. We are also taking steps to help agencies adjust to these changes, and in March we held a town hall meeting to hear directly from home health providers about their concerns. We are giving agencies up to a year to repay overpayments resulting from the interim payment system. And, effective July 1, we are ending the sequential billing policy that had raised cash flow concerns for some agencies. This rule was designed to help facilitate the transfer of payment for care not related to inpatient hospital care from Part A to Part B, but we have determined we can accomplish the transfer through other means. At the same time, we are implementing the Outcome and Assessment Information Set (OASIS). OASIS fulfills a statutory mandate for a "standardized, reproducible" home care assessment instrument. It will help home health agencies determine what patients need. It will help improve the quality of care. And it is essential for accurate payment under prospective payment.

To date, evaluations by us and the GAO have not found that reduced home health spending is causing quality or access problems. However, as mentioned above, because home health beneficiaries are among the most vulnerable, we are planning for ongoing detailed monitoring of beneficiary access and agency closures.

Skilled Nursing Facilities: We implemented the new skilled nursing facility prospective payment system called for in the BBA on July 1, 1998. The old payment system was based on actual costs and included no incentives to provide care efficiently. The new system uses mean-based prices adjusted for each patient's clinical condition and care needs, as well as geographic variation in wages. It creates incentives to provide care more efficiently by relating payments to patient need, and enables Medicare to be a more prudent purchaser of these services.

The BBA mandated a per diem prospective payment system covering all routine, ancillary, and capital costs related to covered services provided to beneficiaries under Medicare Part A. The law requires use of 1995 as a base year, and implementation by July 1, 1998 with a three year transition. It did not allow for exceptions to the transition, carving out of any service, or creation of an outlier policy. We are carefully reviewing the possibility of making administrative changes to the PPS, but we believe we have little discretion.

We held a town hall meeting earlier this year to hear a broad range of provider concerns. There were concerns that the prospective payment system does not fully reflect the costs of non-therapy ancillaries such as drugs for high acuity patients. We share these concerns and are conducting research that will serve as the basis for refinements to the resource utilization groups that we expect to implement next year. And we fully expect that we will need to periodically evaluate the system to ensure that it appropriately reflects changes in care practice and the Medicare population. We are concerned about anecdotal reports of problems resulting from the prospective payment system. As stated earlier, we have asked the HHS Inspector General to evaluate the situation.

Outpatient Rehabilitation Therapy: The BBA imposed $1500 caps on the amount of outpatient rehabilitation therapy services that can be reimbursed. We continue to be concerned about these limits and are troubled by anecdotal reports about the adverse impact of these limits. Limits on these services of $1500 may not be sufficient to cover necessary care for all beneficiaries. Because of our concern, our HHS Inspector General colleagues have agreed to study the impact of the BBA's $1500 limit on outpatient rehabilitation therapy to help us judge whether and how any adjustments to the cap should be made.

Hospitals: We have implemented the bulk of the inpatient hospital-related changes included in the BBA in updated regulations. We have implemented substantial refinements to hospital Graduate Medical Education payments and policy to encourage training of primary care physicians, promote training in ambulatory and managed care where beneficiaries are receiving more and more services, curtail increases in the number of residents, and slow the rate of increase in spending. We have implemented provisions designed to strengthen rural health care systems. And we froze inpatient hospital payments in fiscal year 1998, as required under the BBA, resulting in substantial savings to taxpayers and the Medicare Trust Fund.

The BBA also called for a prospective payment system for outpatient care, which we expect to implement next year. The outpatient prospective payment system will include a gradual correction to the old payment system in which beneficiaries were paying their 20 percent copayment based on hospital charges, rather than on Medicare payment rates. Regrettably, implementation of the prospective payment system as originally scheduled would have required numerous complex systems changes that could substantially jeopardize our Year 2000 efforts. We are working to implement this system as quickly as the Year 2000 challenge allows. We issued a Notice of Proposed Rule Making in September 1998 outlining plans for the new system so that hospitals and others can begin providing comments and suggestions. We are making data files available to the industry, and we have extended the comment period until June 30, 1999 so the industry and other interested parties will have sufficient time and information to comment.

We do have greater concern for rural, inner city, cancer, and teaching hospitals because our analysis suggests that the outpatient prospective payment system will have a disproportionate impact on these facilities. We are reviewing the many comments we have received on the proposed regulation and we are continuing to develop possible modifications to the system for inclusion in the final rule.

Physicians: As directed by the BBA, we have begun implementing the resource-based system for practice expenses under the physician fee schedule, with a transition to full implementation by 2002 in a budget-neutral fashion that will raise payment for some physicians and lower it for others. The methodology we used addresses many concerns raised by physicians and meets the BBA requirements. We fully expect to update and refine the practice expense relative value units in our annual regulations revising the Medicare fee schedule. We plan to include the BBA-mandated resource-based system for malpractice relative value units in this year's proposed rule. We welcome and encourage the ongoing contributions of the medical

community to this process, and we will continue to monitor beneficiary access to care and utilization of services as the new system is fully implemented.

We also are seeking legislation to refine the BBA's Sustainable Growth Rate for physician payment. Medicare payments for physician services are annually updated for inflation and adjusted by comparing actual physician spending to a national target for physician spending. The BBA replaced the former physician spending target rate of growth, the Medicare Volume Performance Standard, with the Sustainable Growth Rate (SGR). The SGR takes into account price changes, fee-for-service enrollment changes, real gross domestic product per capita, and changes in law or regulation affecting the baseline.

After BBA was enacted, HCFA actuaries discovered that the SGR system is unstable, and would result in unreasonable fluctuations from year to year. Also, the SGR target cannot be revised to account for new data. The President's fiscal 2000 budget contains a legislative proposal to deal with these issues.

CONCLUSION

The BBA made important changes to the fee-for-service Medicare program to strengthen and protect it for the future. These changes, along with a strong economy and our increased efforts to combat fraud, waste, and abuse, have extended the life of the Trust Fund until 2015. Change of the magnitude encompassed in the BBA inevitably requires adjustment and fine tuning. It is not surprising that market corrections would result from such significant legislation.

As always, we remain concerned about the effect of policy changes on beneficiaries' access to affordable, quality health care. We are proactively monitoring the impact of the BBA to ensure that beneficiary access to covered services is not compromised. Our regional offices are gathering extensive information from around the country to help us determine whether specific corrective actions may be necessary. And we welcome the opportunity to look at any new information regarding beneficiary access to quality care. We are committed to looking at possible refinements to the BBA that are within our administrative authority. However, we should be cautious about making changes to the BBA until we consider information and evidence of problems in beneficiary access to quality care. We look forward to continuing to work with this Committee to identify issues of concern, and we will keep you up to date on the status our of implementation of the BBA. I thank you for holding this hearing, and I am happy to answer your questions.

PREPARED STATEMENT OF ROBERT B. CUMMING

Good morning Chairman Roth and members of the committee. My name is Bob Cumming and I am a principal with the actuarial consulting firm of Milliman & Robertson in Minneapolis. I am appearing today in my capacity as a representative of the Risk Adjustors Work Group of the American Academy of Actuaries (Academy).[1] Our work group was formed at the request of the Health Care Financing Administration (HCFA) to complete an actuarial review of the health status risk adjustment methodology the agency will use starting on January 1, 2000 to pay Medicare+Choice health plans.

As you are aware, the use of a health status risk adjustment formula is required by the Balanced Budget Act of 1997 (BBA). That law directed HCFA to report to Congress on the proposed risk adjustment method and, further, provides for, "an evaluation of such method by an outside, independent actuary of the actuarial soundness of the proposal." (BBA, Section 1853). Last fall, the Health Care Financing Administration asked the American Academy of Actuaries to perform this evaluation. The Academy appointed a volunteer work group consisting of health actuaries who are either consultants to or staff members with health plans and health insurers to review HCFA's proposal. A list of the members of the work group is attached to my testimony. Our analysis was included as part of the agency's report to Congress which was issued on March 1. The Academy's work was provided pro

[1] The American Academy of Actuaries is the public policy organization for actuaries practicing in all specialties within the United States. A major purpose of the Academy is to act as the public information organization for the profession. The Academy is non-partisan and assists the public policy process through the presentation of clear and objective actuarial analysis. The Academy regularly prepares testimony for Congress, provides information to federal elected officials, comments on proposed federal regulations, and works closely with state officials on issues related to insurance. The Academy also develops and upholds actuarial standards of conduct, qualification and practice, and the Code of Professional Conduct for all actuaries practicing in the United States.

bono, although HCFA did reimburse the members for travel expenses associated with the meetings of the work group.

HCFA'S PROPOSAL

Currently, HCFA's payment rates for Medicare+Choice plans are adjusted to reflect the risk characteristics of the plans' participants as defined by the demographic factors of age, gender and the beneficiary's status (institutionalized or non-institutionalized; Medicaid recipient or non-Medicaid; employed or not; disabled or not). Beginning in the year 2000, HCFA is required by the BBA to supplement these demographic adjustments with a health status risk adjustor.

HCFA plans to assign a risk score to each Medicare beneficiary based on diagnosis information for that individual, taken from previous hospital inpatient stays. The risk scores were developed using a list of "principal inpatient diagnostic cost groups" (PIP-DCGs), which were developed for this purpose. The previous medical costs for inpatient hospital stays incurred by the individual are used to determine their expected future medical risk and, therefore, how much the Medicare+Choice health plan in which they are enrolled should be paid. New enrollees in Medicare will be assigned an estimated risk score based on HCFA's analysis of existing Medicare fee-for-service (FFS) data.

CONCLUSIONS

The new risk adjustment system represents a significant change for health plans, contracting providers, and health plan members. While the Academy work group believes the conceptual basis of the risk adjustment method proposed by HCFA is "actuarially sound," as we have defined it for this purpose, we have serious concerns about the method's implementation, operation, and impact. These issues include:

- Exclusions of certain risk categories from the risk adjustment methodology, such as one-day hospital stays, which may penalize health plans that effectively manage the delivery of health care.
- Lack of adequate testing of the potential impact of the new methodology on health plans and Medicare+Choice beneficiaries, although the phase-in will significantly soften the impact of changes in reimbursement levels from what it might otherwise be.
- Administrative feasibility of the implementation of the new system because of timing and data collection issues.
- The processing of extraordinary amounts of newly collected data and completing a series of complex calculations introduces an element of uncertainty that cannot be anticipated until health plans and HCFA have full opportunity to understand the implications.
- Use of only fee-for-service data as the basis for the development of risk adjustment weights.

There is a substantial risk for the Medicare system if the risk adjustment methodology does not work as intended. The negative consequences could include withdrawal of Medicare+Choice health plans from the market, financial problems or insolvency for health plans and the potential for a reduction in benefits provided to beneficiaries. Because of these concerns, the work group believes HCFA's decision to implement the new methodology under a phased-in approach is a sound one and will limit changes from the current payment system while HCFA and the health plans assess the impact of the new methodology.

While HCFA has done much work in a short time period to develop the new methodology and design implementation strategies, additional work remains to fully define HCFA's risk adjustment method and test application of the method to make sure it achieves the intended results. The work group recommends that HCFA further modify the risk adjustment model with the knowledge gained during the first year of operation.

DEFINITION OF ACTUARIAL SOUNDNESS

The Academy was asked by HCFA to evaluate the actuarial soundness of its proposal. For this purpose, there is no widely recognized definition of "actuarial soundness." The work group therefore analyzed HCFA's proposal in terms of: (1) established actuarial criteria for risk adjustment, (2) Actuarial Standards of Practice, and (3) the general principles and practices of actuarial science. Actuarial Standards of Practice are guidelines developed by the Actuarial Standards Board to help actuaries in their work. Specific actuarial goals and criteria for risk adjustment are described in the Academy's May 1993 monograph titled, "Health Risk Assessment and Health Risk Adjustment: Crucial Elements in Effective Health Care Reform." The criteria used to evaluate risk adjustment systems are:

Accuracy: Because payments to health plans will be determined based on the risk adjustment mechanism, accuracy and avoidance of statistical bias is critical.

Practicality and Reasonable Cost: The risk adjustment mechanism should not be so complex that implementation is extremely cumbersome, thereby adding significant cost to the system.

Timeliness and Predictability: Carriers setting premium rates should be able to predict the impact of risk adjustment on their premiums with a fair degree of accuracy and in a timely manner, in order to avoid solvency concerns and disruption to members.

Resistance to Manipulation: The risk adjustment mechanism should aim to make it impossible for specific carriers to benefit financially by "gaming" the mechanism.

The Academy's review took into account all aspects of the proposed methodologies that impact on its "actuarial soundness," including, but not limited to the proposed formulas, the availability, quality, and relevance of the data required, and the ability to be implemented as intended.

In addition, the Academy has evaluated the appropriateness of the proposed methods in relation to available alternatives (including non-administrative data models such as surveys, enhanced age/gender/status, and the status quo) and in light of the modifications being made to the underlying base rates by county over the same time period.

LIMITATIONS OF THE WORK GROUP'S ANALYSIS

It is important to note that the work group's analysis and conclusions relied on the information supplied by HCFA. During the review process, HCFA provided the work group with preliminary results of the potential payment impact of the risk adjustment methodology on Medicare+Choice plans. However, the work group was not able to verify the accuracy of the data collected by HCFA or the calculations used by HCFA to determine the impact on health plans.

In addition, HCFA did not provide the work group with an assessment of the impact of the risk adjustment methodology on beneficiaries, and the scope of our opinion is similarly limited.

HCFA's risk adjusted payment system is still a "work in progress", and it should be understood that our opinion on the actuarial soundness of HCFA's proposals are based on the system as they were described to us at the time we performed our review.

The work group was not able to undertake a detailed analysis of the mathematical formulas used to develop the risk adjustment methodology, but rather focused its review on the conceptual and theoretical basis of the system. Because HCFA is still working on the proposed methodology and there are a number of unresolved implementation issues, our report is a qualified review of the actuarial soundness of the proposal.

ANALYSIS AND RECOMMENDATIONS

The new methodology for making health status risk adjustments to Medicare payments appears to meet the requirements of the Balanced Budget Act of 1997, provided the system is implemented carefully. On balance, and with a phase-in, the proposed risk adjustment method appears to be a reasonable first step in what should be a long-term evolutionary process. HCFA is to be commended for the progress to date and for recognizing the limitations of the proposal arising from the available data, timing requirements and areas for future improvements.

In general, the work group believes the PIP-DCG risk assessment methodology developed by HCFA meets the goals of risk assessment I outlined earlier in my testimony. However, there are a number of concerns about the health risk assessment formula that the work group raised in its report:

Using Only Inpatient Data: A significant component of the PIP-DCG model is the restriction of the risk adjustment method to conditions identified by inpatient hospital claims. This feature has both advantages and disadvantages. As one positive factor, this requirement matches well with the information currently available to the Medicare program. Currently, hospital claim information is more accessible and easier to audit than ambulatory care data, and requires less additional work by health plans to report to HCFA.

However, there are several drawbacks to a system that uses only inpatient data. A major feature of managed care has been the measurable shifting of inpatient care to outpatient sites and the substitution of less invasive therapies to treat a given condition. When the risk assessment system is restricted to inpatient claims, the members subject to effective managed care can appear healthier than average, because of limits on what is measured.

If outpatient (ambulatory) data is added to the inpatient claims information, a better picture of the potential "risk" of each individual Medicare beneficiary is obtained. We have therefore recommended that outpatient data be included in HCFA's methodology as soon as it is feasible to do so.

Exclusion of One-Day Hospital Stays: The risk adjustment methodology does not "give credit" for one-day hospitalizations, under the assumption that including them may result in "gaming" of the system by health plans. If included, plans could "game" the system by ordering unnecessary one-day stays for minor medical conditions, in order to include beneficiaries in the health status risk adjustment process, and thereby increase payments the next year.

The underlying concept of excluding one-day admissions does have merit. It can reduce gaming of the system by requiring each hospitalization to be of a certain severity (measured by a length of two days or more) and plans would not have an incentive to hospitalize a patient overnight just to receive "credit."

However, the exclusion of one-day stays may unduly penalize plans which efficiently manage the delivery of health care. This is because effective care management tend to reduce stays to one day which might otherwise be two or more day stays. Since those stays would then be excluded from the risk adjustment process, this would penalize plans for their efficiency.

According to the report from Health Economics Research (HER), which assisted HCFA in designing the PIP-DCGs, excluding one-day stays reduces the predictive power of the health status risk adjustment methodology. Also, it might be noted that excluding one-day hospitalizations shifts the issue of "gaming" from whether to hospitalize someone at all to a question of whether to keep the patient for a second hospital day.

The work group suspects that the disadvantages of excluding one-day hospitalizations may outweigh any possible gain. It would be appropriate to analyze the risk adjustment methodology based on whether it is easier to "game" admissions or to "game" length of stay and any resulting adverse incentives for health plans.

HCFA may want to consider either using one-day stays as part of the risk adjustment formula or giving a partial credit or other adjustments for those hospitalizations in structuring payments to health plans.

Principal Diagnosis: The PIP-DCG model measures conditions by capturing the principal diagnosis recorded on each inpatient claim. The use of the principal diagnosis for the PIP-DCG model is based on existing coding practices for inpatient claims used by hospitals. Since only the principal diagnosis is generally used, it is possible that not all appropriate information is collected or used. A qualifying condition could be listed as the secondary (or other) diagnosis, which could be a contributing factor leading to the need for hospitalization.

Alternately, there is a common belief that many secondary conditions currently reported are not as reliable and should not be included in the measurement system. Since the initial stages of the risk assessment system will be using data that was recorded without the presence of direct coding incentives, it may be reasonable to use only principal diagnosis information. However, as the PIP-DCG system is implemented, the restriction to using only principal diagnostic groups should be re-evaluated.

Number and Development of the PIP-DCG Groups: Health Economics Research developed the diagnostic groups using a HCFA survey of Medicare FFS data which sampled 5% of Medicare beneficiaries. The claims information for this sample fell in the two-year interval from January 1, 1995 through December 31, 1996. Beneficiaries who were not alive and enrolled in Medicare for the entire time period were excluded, as were individuals who would not have been eligible for the Medicare+Choice program for various reasons. Because of these limits, the actual sample represents roughly a 3.5% sample. We have included some technical recommendations in our report, which can be included as HCFA revises the methodology.

Excluding Discretionary Conditions: The base cost group (those individuals who are not assigned health status risk scores) also includes Medicare beneficiaries with diagnoses that were determined by HER to be discretionary, vague, or only occasionally resulted in inpatient admissions. The exclusion of those "discretionary" conditions has the beneficial effect of reducing potential bias in the formula against Medicare+Choice health plans with well managed care delivery systems by not giving credit for discretionary admissions and by removing the incentives to hospitalize a patient for minor illness.

However, we suggest that the diagnoses included in the base cost group should be reviewed in the future as coding practices change under the PIP-DCG system. If hospitals become more aggressive in their coding in the future, the percentage of claims falling into a PIP-DCG may change and weights would need to be recali-

brated, particularly if the PIP-DCG method is used beyond the currently planned three-year period.

Chemotherapy: HCFA has indicated that beneficiaries who are undergoing chemotherapy will be placed in a diagnosis category based on the patient's secondary diagnosis (most likely cancer). Since the medical conditions underlying the need for chemotherapy represent high-cost, ongoing conditions that are predictive of future medical expenses, it is appropriate that they be included in the risk assessment model. The work group believes including chemotherapy as part of the diagnosis groups will increase the ability of the methodology to predict future health care costs.

Exclusion of Indirect Medical Education Costs: The model developed by HER excludes indirect medical education (IME) costs from the Medicare FFS data used to calculate the relative weights used in this system. The IME costs are approximately two-thirds of the total graduate medical education costs currently paid through Medicare (the FFS data does include direct medical education expenses). While it is technically incorrect to include any graduate medical education costs (since medical education costs will be paid outside of the capitation rate in the future), any distortion is likely to be small. However, it is possible there will be some internal inconsistencies in the model since high-cost conditions captured in the PIP-DCGs may more likely be treated in a tertiary care or teaching hospital.

Factors for Newly Enrolled Medicare Members: HCFA decided to develop a special set of risk scores for those individuals who are eligible for Medicare for the first time and do not have any previous encounter data in the Medicare system. HCFA used FFS data to construct average expenditures for categories of newly eligible members (beneficiaries who become eligible for Medicare because of age or disability, or members who were previously eligible for coverage but deferred entry into the Medicare system). Newly eligible members will be assigned an estimated risk score based on HCFA's estimate of their predicted medical expenditures. The validity of these risk scores is unclear. The work group suggested that HCFA review its risk scores for the newly eligible once current data is available.

Additional Testing: Health Economics Research performed a number of tests on the PIP-DCG risk adjuster methodology to determine how accurately it predicts total expected medical costs. The recommendations made by HER regarding several key components of the model such as the use of inpatient data only, exclusion of one-day stays and the number of PIP-DCG groups to be used, appear to be reasonable based on the FFS data which was reviewed. While the HER report discusses potential bias against managed care organizations that deliver care more efficiently than fee for service providers, HER did not have managed care data to determine what, if any, bias exists.

HCFA has completed some preliminary testing of the potential impact of the new risk adjustment methodology on Medicare+Choice plans, including managed care organizations. In order to understand the impact of the new system on the marketplace, the work group suggests that HCFA update these tests as additional data is available, and as health plans gain more experience with the operation of the risk adjustment mechanism.

Cost-Benefit Analysis: The proposed system is relatively new and it is likely that there will be difficulties in implementation. It would be very helpful to establish more accurate estimates of the cost of implementing the PIP-DCG methodology and any modifications (such as using ambulatory data) and to determine the benefits to be derived from these systems before final decisions as to implementation are made. We suggest that consideration be given to producing a cost-benefit analysis of the PIP-DCG methodology and any subsequent modifications. The analysis should specifically include the costs incurred by health plans due to changes to the system.

Actuarial Oversight: HCFA apparently plans to conduct additional analysis of the impact of the PIP-DCG methodology on managed care plans. It is unclear what form that impact analysis will take. In addition, there is a need for continuing monitoring and testing of the system and future modifications. The work group suggests that additional actuarial review be included as the system and subsequent changes are implemented.

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PREPARED STATEMENT OF STEPHEN J. DEMONTMOLLIN

I. INTRODUCTION

Mr. Chairman and members of the Committee, thank you very much for the opportunity to comment on issues related to implementation of the Medicare+Choice program. I am Steve deMontmollin, Vice President and General Counsel of AvMed Health Plan. Based in Gainesville, Florida, AvMed is Florida's oldest and largest not-for-profit HMO, serving some 400,000 members, including nearly 80,000 Medicare members, throughout the state. AvMed has participated in the Medicare program since being awarded demonstration project status in 1981. AvMed contracts with close to 7,000 private physicians and 126 hospitals, is federally qualified, and is privately accredited by the National Committee for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Healthcare Organizations.

Last year AvMed sustained significant losses in the Medicare program and found it necessary to withdraw from seven of the twenty-five counties in which we previously offered Medicare services affecting some 6,500 beneficiaries. A large part of our not-for-profit mission is to serve the Medicare and Medicaid populations and we are hopeful that it will not be necessary to withdraw from additional counties for the year 2000.

I am testifying today on behalf of the American Association of Health Plans (AAHP) which represents more than 1,000 HMOs, PPOs, and similar network health plans. AAHP's membership includes most Medicare+Choice organizations. Together, AAHP member plans, which provide care for more than 140 million Americans nationwide, have strongly supported efforts to modernize Medicare and give beneficiaries the same health care choices that are available to working Americans.

AAHP and its member plans have had a longstanding commitment to Medicare and to the mission of providing high quality, cost effective services to beneficiaries. Today, more than 16 percent—or 6.1 million beneficiaries—are enrolled in health plans, up from only 6.2 percent five years ago. Recent research indicates that health plans are attracting an increasing number of older Medicare beneficiaries, and that Medicare beneficiaries are remaining in health plans longer. In addition, near-poor Medicare beneficiaries are more likely to enroll in health plans than are higher-income beneficiaries. These health plans offer Medicare beneficiaries many benefits that are not covered under fee-for-service Medicare, such as expanded hospital benefits or prescription drug coverage.

The Medicare program was enacted 34 years ago and reflected private sector insurance coverage at that time. Much has changed since then—but prior to the enactment of the Balanced Budget Act of 1997 (BBA), Medicare had taken few dramatic steps to modernize the program. In the past 34 years, health plans have learned how to organize and deliver health care services in ways that improve coverage and quality while better controlling costs. But Medicare had been slow to take advantage of these improvements. As a result, while more than 80 percent of work-

ing Americans with health insurance coverage now receive their care through health plans, only one out of every six Medicare beneficiaries is a health plan member.

With passage of the BBA two years ago, Congress took significant steps to provide Medicare beneficiaries with expanded choices similar to those available in the private sector and ensure the solvency of the Medicare trust fund. The establishment of the Medicare+Choice program, which AAHP supported, is the foundation for a program design that can be sustained for baby boomers and future generations of Medicare beneficiaries. Unanticipated events, including the more than 800 pages of regulations for the program and HCFA's plans to implement a risk adjuster that will result in significant payment reductions, however, have endangered this foundation and created structural issues that must be resolved quickly.

As you debate changes to the Medicare+Choice program, AAHP members urge the Committee to consider the following five principles, which we expand upon later in this testimony:

- First, Congress must ensure that Medicare+Choice payments are adequate, stable, and fair compared to those in fee-for-service Medicare. Federal contributions to Medicare+Choice organizations should be adequate and predictable to promote expanded choices for beneficiaries in low payment areas, while maintaining the availability of affordable options for beneficiaries in markets in which health plan options are currently well established. As is now apparent, the BBA payment formula, in combination with the Administration's risk adjuster, will not achieve this goal. Instead, AAHP analysis shows a dramatic gap opening up between reimbursement for beneficiaries in the Medicare+Choice program and their counterparts in fee-for-service Medicare.
- Second, mechanisms to improve payment accuracy should ensure that Medicare+Choice organizations are reimbursed appropriately. Much, though not all, of the gap between Medicare+Choice payments and fee-for-service payments result from the risk adjustment approach chosen by the Administration. The Administration's approach will cut Medicare+Choice payments by an additional $11.2 billion over a 5-year period and thus endanger the very choices, broader benefits, and out-of-pocket protections these seniors enjoy. AAHP urges that implementation of the new risk adjustment mechanism required under the BBA should only move forward on a spending neutral basis, as Congress intended.
- Third, beneficiaries need more information on the Medicare+Choice program that is accurate and timely. Beneficiaries should receive accurate information that allows them to compare all options and select the one that best meets their needs. Last year, HCFA conducted a costly beneficiary information campaign, funded for all beneficiaries through an assessment on the 15 percent enrolled in Medicare+Choice. This campaign did not meet congressional expectations. Many seniors received incorrect or confusing information and some plans were left out of the brochure altogether. AAHP urges Congress to ask HCFA for an accounting of its use of resources for educational purposes. We also urge Congress to adopt MedPAC's recommendation to fund this program through HCFA's operating funds rather than a tax on Medicare+Choice enrollees. AAHP continues to believe that the entire beneficiary information program should be re-evaluated and streamlined.
- Fourth, Congress must promote responsive government. To increase consumer confidence in all aspects of the Medicare program, HCFA should take immediate steps to improve administration and regulation of the Medicare+Choice program. During the first year of Medicare+Choice implementation, HCFA promulgated more than 800 pages of new regulations and issued countless operational policy letters. HCFA's implementation of the BBA highlights tensions between the agency's dual roles as purchaser and regulator. The conflict between these roles often prevents the agency from acting more nimbly in the best interests of beneficiaries.
- Finally, Congress must act now to ensure that the Medicare+Choice program remains a viable foundation for long-term structural reform. To that end, as the Committee considers fundamental reforms to Medicare, it needs to evaluate carefully what has occurred in the Medicare+Choice program and make necessary changes. AAHP believes that the success of the Medicare+Choice program, and the ability of this Committee to make mid-course corrections, will determine the nation's willingness to move to broader reforms.

II. ENSURE THAT MEDICARE+CHOICE PAYMENTS ARE ADEQUATE, STABLE, AND FAIR COMPARED TO THOSE IN FEE FOR SERVICE MEDICARE

The BBA limited the annual rate of growth in payments to health plans, producing $22.5 billion in savings from the Medicare+Choice program over five years. In

addition, the BBA reduced geographic differences in payment to encourage the development of choices in lower payment areas of the country in a way that was also intended to protect beneficiaries in already viable markets. AAHP supported the passage of payment reforms in the BBA and understood the need for health plans to contribute a fair share toward the savings necessary to stabilize the Medicare Trust Fund.

- Growing Funding Gap Does Not Serve Best Interests of Beneficiaries. AAHP is deeply concerned, however, that the Administration's decision to implement the risk adjuster in a way that takes further large cuts from payments on behalf of Medicare+Choice members and the growing funding gap between the two sides of the program do not serve the best interests of beneficiaries and were not intended by Congress. In 1998 and 1999, because of the low national growth percentage and the budget neutrality requirement, no counties received blended payment rates. Furthermore, HCFA has chosen to implement its new risk adjustment methodology in a manner that will cut aggregate payments to Medicare+Choice organizations by an estimated additional $11.2 billion over a five-year period. This is an administratively imposed 50 percent increase in the $22.5 billion savings Congress anticipated from the payment methodology as enacted in the BBA of 1997. In fact, the Congressional Budget Office (CBO) recently stated that it had "previously assumed" that risk adjustment in the Medicare+Choice program would be budget neutral.
- AAHP Analysis Finds Significant Medicare Fairness Gap. AAHP analysis of PricewaterhouseCoopers projections of Medicare+Choice rates in each county over the next 5 years shows that a significant gap opens up between reimbursement under the fee-for-service program and reimbursement under the Medicare+Choice program. This Medicare+Choice Fairness Gap will be at least $1,000 for two-thirds of Medicare+Choice enrollees living in the top 100 counties, as ranked by Medicare+Choice enrollment. This same Fairness Gap will exceed $1,500 in major Medicare+Choice markets, such as Chicago, Los Angeles, Miami, New York, Boston, Pittsburgh, Cleveland, St. Louis City, Dallas, and Philadelphia. In Miami, the Fairness Gap will be $3,500 in 2004 and in Houston the gap will exceed $2,500 in 2004. In New Orleans, the Fairness Gap will exceed $2,600 in 2004. The table below presents several additional examples of the Fairness Gap in Avmed's home state of Florida.

THE MEDICARE+CHOICE FAIRNESS GAP

County	M+C enrollment (aged 12/98)	Fairness Gap 2004
Broward	114,775	$2,586
Dade	128,303	$3,502
Hillsborough	43,233	$1,185
Palm Beach	83,416	$1,538
Pasco	31,603	$1,825
Pinellas	67,858	$1,242

Source: AAHP calculation from PricewaterhouseCoopers (PWC) analysis prepared for AAHP, March 1999. PWC analysis based on first stage of risk adjustment, which HCFA expects to reduce payments by 7.6 percent. PWC analysis does not reflect second stage of risk adjustment, which HCFA expects to reduce payments by an additional 7.5 percent in 2004. The Fairness Gap represents growth between 1997 and 2004 in the projected difference between county-level aged Medicare+Choice risk-adjusted per capita payments and FFS per capita payments.

For nearly half of Medicare+Choice enrollees living in the top 100 counties, the Medicare+Choice reimbursement will be down to between 72 and 85 percent of fee-for-service Medicare payments in 2004, significantly exceeding any estimates of alleged favorable selection by plans. When AAHP examined the top 101-200 counties ranked by enrollment, we continued to find a large Fairness Gap in the smaller markets that plans were expected to expand into under the policy changes implemented by the BBA. In these counties, nearly half of Medicare+Choice enrollees live in areas where the Fairness Gap will be $1,000 or more in 2004.

III. MECHANISMS TO IMPROVE PAYMENT ACCURACY SHOULD ENSURE APPROPRIATE REIMBURSEMENT FOR MEDICARE+CHOICE ORGANIZATIONS

A large percentage of the Fairness Gap is attributable to HCFA's risk adjuster. Contrary to ensuring predictability in the new Medicare+Choice program, the impact of this risk adjustment methodology will be to restrict new market entrants and leave beneficiaries with fewer options, reduced benefits and higher out-of-pocket costs. Furthermore, instead of using a spending-neutral redistribution to make more funds available for plans with sicker populations, HCFA's plans for implementing

the risk adjuster will result in fewer dollars to care for chronically ill persons and other Medicare+Choice members. AAHP has found that the impact of HCFA's risk adjuster on Medicare+Choice payments to rural and urban counties is similar—rural areas with Medicare+Choice beneficiaries are cut by about 6 percent, while urban areas are cut by about 7 percent.

This Committee has a number of means at its disposal for addressing the growing disparity between payments for beneficiaries in the Medicare+Choice program and payments for their counterparts in the fee-for-service program. We urge the Committee to consider the following possible approaches, which would help reduce the Fairness Gap and restore stability to the Medicare+Choice program: at a minimum, the risk adjuster could be made spending neutral; in addition, a floor could be set below which payments to Medicare+Choice organizations could not fall; or, the legislative reduction in Medicare+Choice growth rate could be eliminated. Taking action on these options is critical to reduce the Fairness Gap and restore stability to the Medicare+Choice program. These approaches are the least disruptive to the BBA Medicare+Choice payment structure, but other options could also be used to stabilize the program.

IV. PROVIDE ACCURATE AND TIMELY INFORMATION TO BENEFICIARIES

AAHP also is concerned that only health plan beneficiaries are funding the Agency's beneficiary education campaign. Given concerns about the effectiveness of this effort at a time of growing instability in the Medicare+Choice program, AAHP strongly urges that the program be scaled back and realistic goals set. AAHP urges HCFA to revisit its plans for the 1999 beneficiary education campaign and ensure that it provides beneficiaries with information that will educate, not confuse. HCFA?s 1998 beneficiary information and education campaign experienced numerous problems that confused beneficiaries and hindered access to the new Medicare+Choice program.

- In Omaha, Nebraska, Baltimore, Maryland and West Virginia, the Spanish language brochures were sent to areas with little Spanish-speaking population.
- In Eastern Washington and parts of Florida, the brochures were mailed with a statement that the information presented was incorrect and that the beneficiaries should call a toll-free number if they had any questions.
- The toll-free call centers were each expected to receive 15,000 calls per week per center (about 60,000 calls a month). However, during the month of November 1998, the total number of calls received by all centers was only 9,400. Most of the calls regarded HCFA?s mistake in sending Spanish language brochures and requests for additional brochures.

The expense of a newly developed information effort should be distributed proportionally across the entire system. Last year, Medicare HMOs and their enrollees represented 14.3 percent of the program but shouldered 100 percent of the cost of the information campaign. Requiring health plans and their members to bear 100 percent of this fee directly affects the premiums and benefits that plans can offer to their members. While AAHP supports disseminating information to all beneficiaries to enhance informed choice, we believe that an equitable funding mechanism is critical to the success of this effort. The goal of expanded choice is not served if the costs of underwriting the information campaign reduce the level of benefits that Congress sought to make available to more beneficiaries.

AAHP also is concerned about the costs of the education campaign that HCFA intends to implement. The President's proposed FY2000 budget requests that Congress appropriate $150 million, $50 million more than the amount allowed by the BBA. Given HCFA's inability to document use of fees collected thus far and given the glaring inaccuracies in and inadequacy of the handbook produced to date, it would be inappropriate to fund this effort at such a high amount. At a time of growing instability in the Medicare+Choice program, we are concerned that these user fees set a dangerous precedent and translate into reduced choices for beneficiaries. AAHP supports MedPAC's recommendation to fund the handbook through HCFA using administrative funds.

The success of the information campaign is also critical to gaining beneficiaries' confidence and comfort level with potentially broader changes in the future. AAHP and its member plans will continue to work with HCFA, beneficiary groups and others to develop an education campaign that provides accurate, timely and meaningful information to beneficiaries without compromising the services to which they have become accustomed.

V. PROMOTE RESPONSIVE, SMART GOVERNMENT

Below AAHP offers several examples that illustrate HCFA's need to become more responsive and smarter as it continues with implementation of the Medicare+Choice program.

- Tensions Between HCFA's Role as Purchaser and Regulator. HCFA's dual roles as purchaser and regulator are, at times, in conflict and prevent it from acting more nimbly in the best interest of beneficiaries. Nowhere has this conflict been more evident than in HCFA's implementation of the BBA. The situation plans faced in the fall of 1998 serves to illustrate the inherent conflict between HCFA's traditional role as a regulator and its changing role as a purchaser. Given all of the uncertainty surrounding the program and the unrealistic compliance timetable, plans across the country and across model types became deeply concerned last fall about their ability to deliver benefits promised under the originally mandated filing schedule. Furthermore, plans were locked into their benefit and premium offering prior to having reviewed the Medicare+Choice "mega reg" issued in June 1998. As a result, AAHP members requested that HCFA allow plans to resubmit parts of their adjusted community rate proposals. In some service areas the ability to vary copayments—even by a small amount—meant the difference between a plan's being able to stay in or being forced to pull out of a market.

While this request presented HCFA with a difficult situation, AAHP strongly believes that an affirmative decision would have been better for beneficiaries than the decision HCFA made not to allow any renegotiation. As a purchaser, HCFA had a strong motivation to maintain as many options as possible for beneficiaries by responding to health plans' concerns and adopting a more nimble approach to Medicare+Choice implementation. But as a regulator, HCFA would have had a difficult time coping with the predictable political fallout from reopening bids.

These role conflicts remain unresolved, even largely unaddressed. Until ways are found to reconcile them, however, they will stand in the way of designing and delivering a Medicare+Choice program that really works.

- HCFA Discontinues Flexible Benefits Policy. Prior to enactment of the BBA, Medicare HMOs were allowed to vary premiums and supplemental benefits within a contracted service area on a county-by-county basis, and to customize products—or offer "flexible benefits"—to meet beneficiary and employer needs and the dynamics of individual markets. The BBA and HCFA's Medicare+Choice regulations are both more restrictive than this policy, and require that Medicare+Choice plans offer uniform benefits and uniform premiums across a plan's total service area without regard to different county payment levels. The result is that plans are less likely to continue or begin serving lower-payment counties, just the opposite of expanding choice. HCFA developed a transition policy for existing contractors which allows Medicare+Choice organizations to segment service areas and offer multiple plans in an effort to mitigate the effect of moving away from the flexible benefits policy. Despite this transitional relief, uncertainty remains regarding the future of this policy. AAHP encourages the Committee to revise the statute so as to revert to the prior policy allowing flexible benefits within plan service areas. Maintaining this policy will best serve beneficiaries and the intent of the BBA in expanding choices and competition.
- HCFA's QISMC Standards Disregard Experience of Private Sector. One area of significant concern to AAHP member plans is HCFA?s Quality Improvement System for Managed Care (QISMC). QISMC is designed to establish a consistent set of quality oversight standards for health plans for use by HCFA and state Medicaid agencies under the Medicare and Medicaid programs, respectively. AAHP has long advocated coordination of quality standards for health plans in order to maximize the value of plan resources dedicated to quality improvement. While AAHP believes that QISMC holds the promise of contributing to this important goal, our members have a number of serious concerns regarding HCFA implementation of this program. We urge HCFA to engage in intensive dialogue with health plans contracting under the Medicare and Medicaid programs to permit full consideration of their outstanding concerns about the QISMC standards and guidelines. Furthermore, we are also concerned that the Medicare program is not providing equal attention to the overall quality of care furnished under the fee-for-service program.

One of our primary concerns is that QISMC lacks clear coordination with existing public and private sector accreditation and reporting standards. Rather than coordinate with existing standards, QISMC appears to establish an entirely new system of requirements, which are far more stringent and unreasonable in their time-

frames. Meeting two competing sets of standards adds to administrative cost while detracting from health care quality improvement.

VI. ENSURE SUCCESS OF MEDICARE+CHOICE PROGRAM SO THAT IT CAN SERVE AS FOUNDATION FOR BROADER REFORM

AAHP has summarized the crisis in the Medicare+Choice program because we believe its success will determine the nation's ability to move to broader reforms. This crisis was best illustrated by the health plans holding nearly 100 Medicare contracts that reluctantly reduced their service areas or withdrew from the Medicare program last year. These decisions resulted in disruptions in care, a loss of benefits, and increased out-of-pocket costs for more than 440,000 Medicare beneficiaries. Of these beneficiaries, 50,000 were left with no choice but to return to the fee-for-service program. Unless this Committee intervenes, further disruptions in the Medicare+Choice program are unavoidable. These disruptions will take the form potentially of plan withdrawals, reductions in benefits, and increases in cost sharing.

Without Congressional action this year, the promises made to beneficiaries with the passage of the BBA will remain unfulfilled, and the foundation for strengthening Medicare's future will crumble. Many issues raised by broad Medicare reforms such as a premium support approach are similar to those experienced under the controversial competitive pricing demonstration projects proposed in recent years for Baltimore and Denver, and HCFA's current efforts to implement similar demonstrations in Phoenix and Kansas City. Successful competitive pricing models in the private sector include all options available to enrollees; HCFA's competitive pricing demonstrations have not and do not include the fee-for-service Medicare program as an option alongside health plans. From the first proposed demonstration site, AAHP consistently has recommended that both sides of the program be included in a model to test competitive bidding.

The competitive pricing demonstration projects proposed for Kansas City and Phoenix would continue to experiment only on seniors who have chosen Medicare+Choice. These projects will lead to benefit reductions and disruptions for the provider community, which explains why in every community coalitions of physicians, hospitals, health plans, employers, and beneficiaries have joined together to raise seniors' concerns about these proposals. This experience provides important lessons for consideration of long term Medicare reforms such as a premium support model.

VII. CONCLUSION

For over a decade, health plans have delivered to beneficiaries coordinated care, comprehensive benefits, and protection against highly unpredictable out-of-pocket costs, but these choices are at risk. Congress and the Administration should act immediately to create a level playing field between the Medicare+Choice program and the fee-for-service program, and a regulatory environment that holds Medicare+Choice organizations and providers in the Medicare fee-for-service program equally accountable. We urge you to address the Fairness Gap, and the problems we have identified with HCFA's implementation of the Medicare+Choice risk adjuster, and with regulation of the program. We are in the process of conferring with the members of the Committee and your staff about AAHP's specific suggestions—some of which we have mentioned today—for solving these problems.

Without action this year, beneficiaries may find access to their health plans jeopardized and that few choices are available to them. In addition, employers and unions who have depended on health plans as a source of comprehensive and affordable retiree health care may find their choices severely limited. Finally, if the Medicare+Choice program erodes, it will seriously set back efforts in the Committee and throughout the Congress to preserve Medicare for future generations.

PREPARED STATEMENT OF NANCY-ANN DEPARLE

Chairman Roth, Senator Moynihan, distinguished Committee Members, thank you for inviting me to discuss the Health Care Financing Administration's (HCFA) progress in implementing Medicare payment reforms enacted under the Balanced Budget Act of 1997 (BBA). I would like to also thank the Medicare Payment Advisory Commission for its advice for ensuring that Medicare continues to make appropriate payments and protects beneficiary access to care.

Medicare is the nation's largest insurer, covering some 38 million of our nation's elderly and disabled. Medicare processes about 900 million fee-for-service claims

each year, is the nation's largest purchaser of managed care, and accounts for 11 percent of the federal budget.

We have implemented more than half of the 335 BBA provisions affecting HCFA programs, and many more are partially implemented. In the past year, we published 92 regulations and Federal Register notices implementing important Congressional directives, beneficiary protections, the Medicare+Choice program, and savings in the BBA that are critical to extending the life of the Medicare Trust Fund. We have made major strides in fighting fraud, waste and abuse, and cut our payment error rate in half in just two years. We also have converted the vast majority of Medicare HMOs to the new Medicare+Choice program and implemented a carefully planned National Medicare Education Program to help beneficiaries make informed health care decisions.

At the same time, we are tackling one of the most difficult Year 2000 computer challenges in government. This must be our highest priority. Unfortunately, meeting the Year 2000 challenge has forced us to make difficult decisions involving some BBA provisions. The vast majority of BBA provisions do not have to be delayed. However, on the advice of independent computer experts, we made the difficult decision last year to delay projects that could interfere with Year 2000 work. This included BBA provisions such as the hospital outpatient prospective payment system that we very much want to implement. We will make every effort to implement these provisions as quickly as our Year 2000 obligation allows.

I have brought a new team of leaders to HCFA to help us meet our BBA and Year 2000 challenges.

- Gary Christoph, Ph.D., a computer scientist and security expert from the Los Alamos National Laboratory, serves as our first-ever Chief Information Officer and heads our information technology team and Year 2000 efforts.
- Robert Berenson, MD, an internist who helped establish a private sector preferred provider organization health plan, now leads our Center for Health Plans and Providers.
- Jeffrey Kang, MD, a geriatrician who was a private sector managed care plan medical director, is our Chief Clinical Officer and heads our Office of Clinical Standards and Quality.
- Carol Cronin, Ph.D., a gerontologist who ran a private sector firm devoted to helping corporations educate their workers on health care, is leading our Medicare beneficiary education program.
- Marjorie Kanof, MD, a physician who has worked as a Medicare contractor medical director, is in charge of implementing much stronger oversight of Medicare claims processing contractors.

FEE-FOR-SERVICE BENEFITS AND PAYMENT REFORMS

The BBA includes important new Medicare fee-for-service preventive benefits, as well as payment system reforms that are critical to extending the solvency of the Medicare Trust Fund. We are making good progress in implementing these changes.

For the new preventive benefits, we have:

- expanded coverage for test strips and education programs to help diabetics control their disease;
- begun covering bone density measurement for beneficiaries at risk of osteoporosis;
- begun covering several colorectal cancer screening tests;
- expanded preventive benefits for women so Medicare now covers a screening pap smear, pelvic exam and clinical breast exam every three years for most women, and every year for women at high risk for cervical or vaginal cancer; and,
- begun covering annual screening mammograms for all women age 40 and over, and a one-time initial, or baseline, mammogram for women ages 35-39, paying for these tests whether or not beneficiaries have met their annual deductibles.

We have made solid progress in implementing fee-for-service payment reforms. For example, we have:

- modified inpatient hospital payment rules;
- established a prospective payment system for skilled nursing facilities to encourage facilities to provide care that is both efficient and appropriate;
- refined the physician payment system, as called for in the BBA, to more accurately reflect practice expenses for primary and specialty care physicians; and
- initiated the development of prospective payment systems for home health agencies, outpatient hospital care, and rehabilitation hospitals that will be implemented once the Year 2000 computer challenge has been addressed; and,

- begun implementing an important test of whether market forces can help Medicare and its beneficiaries save money on durable medical equipment. We are prepared to begin a test in Polk County, Florida of competitive bidding as a way to get the best quality and price for durable medical equipment and supplies. A toll-free hotline (888-289-0710) is available to answer beneficiary and provider questions about the project.

Inpatient Hospital Payment

We have implemented 74 percent of the inpatient hospital-related changes included in the BBA in updated regulations. These include substantial refinements to hospital Graduate Medical Education payments and policy to encourage training of primary care physicians, promote training in ambulatory and managed care where beneficiaries are receiving more and more services, curtail increases in the number of residents, and slow the rate of increase in spending.

We also froze inpatient hospital payments in fiscal year 1998, as required under the BBA, resulting in substantial savings to taxpayers and the Medicare Trust Fund. We notified Congress last year that we may need to postpone the payment update scheduled for October 1999 because of the Year 2000 challenge. However, if we sustain our current rate of progress in meeting that challenge, we may be able to implement the October 1999 update on schedule.

Physicians

As directed by the BBA, we have taken concrete action to refine and implement the resource-based system for practice expenses under the physician fee schedule. We published the final regulation in November 1998, and began implementing the new system in January 1999, with a transition to full implementation by 2002. We were required by the BBA to implement the new system in a budget-neutral fashion. This will inevitably cause some physicians to see payment increases while others see decreases.

The methodology we used addresses many of the concerns raised by physicians and meets the BBA requirements. We used the American Medical Association's actual cost data to reflect all of a specialty's practice expenses, not just those linked with specific procedures. Our expert accounting contractor, KPMG Peat Marwick, attests that our methodology followed reasonable cost accounting principles. The General Accounting Office also is largely supportive of our methodology. We fully expect to update and refine the practice expense relative value units in our annual regulations revising the Medicare fee schedule. We welcome and encourage the ongoing contributions of the medical community to this process, and we will continue to monitor beneficiary access to care and utilization of services as the new system is fully implemented.

The Balanced Budget Act also requires that we implement a resource-based system for malpractice relative value units. We currently are in the process of developing the system and plan to include it in this year's proposed rule.

We notified Congress last year that, in order to ensure that all Year 2000 work is done correctly we may need to freeze our computer systems during a critical period of Y2K work, and would therefore have to delay the January 1, 2000, physician updates. We will know more about whether we may be able to do these updates on schedule after we have reached the government's March 31, 1999, Year 2000 compliance deadline. We share physicians' concern about these possible delays, and we want to work with physicians and Congress to evaluate our options and ensure that any necessary delays do not create a hardship and that any interim measures fairly reimburse physicians.

Skilled Nursing Facilities

We have made substantial progress in implementing the new skilled nursing facility prospective payment system. The old payment system was based on actual costs. The new system uses mean-based prices adjusted for each patient's clinical condition and care needs, as well as geographic variation in wages. It creates incentives to provide care more efficiently by relating payments to patient need, and enables Medicare to be a more prudent purchaser of these services. The BBA mandated the implementation of a per diem prospective payment system for skilled nursing facilities covering all routine, ancillary, and capital costs related to covered services provided to beneficiaries under Medicare Part A. In accordance with the BBA, we implemented the new payment system July 1, 1998.

We fully understand the concerns raised by providers about this new system, particularly those related to outlier and non-therapy ancillary services. The new payment system is complex, and we are working with providers to address these concerns. We know that this is not a static system and that it will require ongoing refinements.

We strongly believe the Resource Utilization Groups (RUGs), which are a key component of the system, must be periodically evaluated to ensure they appropriately reflect changes in care practice and the Medicare population. We are working closely with an expert research contractor to examine potential refinements to the RUGs model, particularly those associated with medically complex patients and non-therapy ancillary services, such as medications. We expect to have the results of this research by January 1, 2000, and to be able to make refinements shortly thereafter.

In addition to this research effort, we plan to host a Town Hall meeting next month with interested industry and consumer stakeholders to seek their first-hand advice on refining the current RUGs model. We will take the suggestions of the industry and the results of our contractor's research into consideration as we make necessary refinements. I want to assure beneficiaries, providers, and Congress that we appreciate the importance of this task and are committed to fairness and ensuring continued access to care.

Home Health

The BBA mandated a number of changes in the way Medicare pays for home health services to curtail unsustainable spending growth and fight what was widespread fraud, waste, and abuse. These changes are vitally important and have been a long-standing priority for HCFA and this Administration. Medicare spending on home health more than tripled in the 1990s, while the number of beneficiaries receiving home health services doubled. The new payment systems create incentives to provide home health care efficiently as well as control spending growth.

Congress wisely postponed the final implementation date for the home health prospective payment system because of our need to address the Year 2000 computer problem. We are working hard to develop the prospective payment system and believe that we are on track to meet the October 1, 2000 implementation deadline. This October, we expect to publish a proposed regulation for the prospective payment system so we can begin receiving and evaluating public comments. We anticipate that the final rule will be issued in July 2000.

We know some providers continue to have concerns about the home health interim payment system. Last year, Congress made important changes to the interim system to address some of these concerns. However, given the magnitude of the changes in home health payment, it is understandable that other concerns remain. We are committed to working with providers and Congress to ensure fairness and protect access to appropriate home care services covered by Medicare as we proceed toward prospective payment. We are monitoring the impact of these changes on beneficiary access to care and, thus far, do not have evidence on whether access to care has been compromised.

Hospital Outpatient Departments

The Balanced Budget Act empowers us to move away from charge-based hospital outpatient coinsurance, which has long been a priority for the Clinton Administration. The increased costs the current system imposes on beneficiaries are unfair. Regrettably, implementation of the prospective payment system as originally scheduled would have required numerous complex systems changes that could substantially jeopardize our Year 2000 efforts. Therefore, we have postponed implementation and are working to implement this system as quickly as the Year 2000 challenge allows. In the meantime, we are willing to work with the Congress to see if an alternative solution can be developed that might more quickly move us toward our shared goal of reducing beneficiaries' out-of-pocket costs for these services.

We issued a Notice of Proposed Rule Making in September 1998 outlining plans for the new system so that hospitals and others can begin providing comments and suggestions. We are making data files available to the industry, and we have extended the comment period until June 30, 1999 so the industry and other interested parties will have sufficient time and information to comment.

We have also implemented a BBA provision that eliminates an anomaly in the law, known as the formula-driven overpayment, which caused taxpayers to pay too much for certain surgical, radiological, and other hospital outpatient services. We implemented this change just two months after the BBA was enacted.

Rehabilitation Hospitals

We are in the process of developing a prospective payment system for rehabilitation hospitals as required under the BBA. We have contracted with Muse and Associates, Dr. Brant Fries at the University of Michigan, and Dr. John Morris at Hebrew University to conduct research and aid in development of a case mix classification system for rehabilitation hospitals. This new system is scheduled for implementation over a two year period beginning October 1, 2000. We are currently analyzing

the positive and negative aspects of both a per-episode and a per-diem payment system based on a comprehensive assessment of each patient's condition and resource requirements. We have not ruled out either approach at this time. Our primary concern is to ensure that the system we adopt allows our beneficiaries to get the care they need and treats providers fairly. We appreciate the technical suggestions we have received from the industry in this regard, as well as the evaluation and advice provided by the Medicare Payment Advisory Commission and the General Accounting Office, and we will continue to work closely with them and Congress as this system is developed and implemented.

MEDICARE+CHOICE

Medicare+Choice allows private plans to offer beneficiaries a wide range of options, similar to those available in the private sector. Medicare+Choice and other changes enacted in the BBA require a massive and important new beneficiary education campaign. Medicare+Choice includes important new protections for patients and providers, as well as quality assessment and improvement requirements. And it initiates a fairer and more accurate payment system.

We are very committed to successful implementation of Medicare+Choice. We believe that managed care and other private plans are important voluntary options next to original Medicare. Medicare managed care enrollment has nearly tripled under the Clinton Administration, from 2.3 million when the President took office to 6.8 million now. We now meet regularly with beneficiary and industry representatives to discuss ways to improve Medicare+Choice, and have begun making refinements based on these comments and discussions.

We have converted the vast majority of former Medicare HMOs to the Medicare+Choice program and published all BBA-mandated Medicare+Choice regulations. Last month we published initial refinements to these regulations which improve beneficiary protections and access to information while reducing plans' administrative workload.

We launched a national education campaign and participated in more than 1,000 events around the country to help beneficiaries understand Medicare+Choice and other important changes to Medicare. And we are establishing a federal advisory committee to help us better inform beneficiaries.

Beneficiary Education

As mentioned above, we have launched the National Medicare Education Program to make sure beneficiaries receive accurate and unbiased information about benefits, rights, and options. The campaign includes:

- mailing a *Medicare and You* handbook to explain new benefits and health plan options;
- a toll-free "1-800-Medicare" call center with live operators to answer questions and provide additional print information on request;
- a consumer-friendly Internet site, www.Medicare.gov, which includes comparisons of benefits, costs, quality, and satisfaction ratings for plans available in each zip code;
- an alliance with more than 100 national aging, consumer, provider, employer, union, and other organizations who help disseminate Medicare+Choice information to their constituencies;
- enhanced beneficiary counseling from State Health Insurance Assistance Programs;
- a national media publicity campaign;
- more than a thousand individual state and local outreach events around the country in senior centers and town halls, on radio call-in shows and other venues, and in languages ranging from Vietnamese to Creole; and,
- a comprehensive assessment of these efforts.

In 1998, we tested the whole system in five states—Arizona, Florida, Ohio, Oregon and Washington. Unfortunately, the decisions by some plans to withdraw from the program or reduce their service area significantly complicated our task. We learned a great deal in this "dry run," and focus groups indicated that a majority of beneficiaries found the information in the Medicare & You handbook to be informative and useful. We are also conducting cases studies to evaluate the education campaign in five communities in the five pilot States and one community outside the pilot States. Preliminary results from our assessment efforts are already suggesting ways to make Medicare & You easier to use, and links we can add to help users find key information faster on our website. These and other findings will help us to refine efforts for a full-scale, national campaign before the November 1999 open enrollment period.

As mentioned above, we are establishing the Citizens Advisory Panel on Medicare Education, in accordance with the Federal Advisory Committee Act, as a formal mechanism to obtain public input for improving our education efforts. The Panel will meet quarterly to help:

- enhance our effectiveness in informing beneficiaries;
- expand outreach to vulnerable and underserved communities; and
- assemble an information base of "best practices" for helping beneficiaries evaluate plan options and strengthening a community infrastructure for information and counseling.

Panel members will include representatives from the general public, older Americans, specific diseases and disabilities, minority communities, plans and insurers, providers, and other groups.

We are also working to standardize plan marketing materials that summarize benefits so beneficiaries can make apples-to-apples comparisons. Our goal is to complete this work before the first annual coordinated open enrollment period in November 1999.

Reaching Out to Plans

We have taken several steps to encourage health plan participation in Medicare+Choice.

In addition to converting the vast majority of Medicare HMOs to the new program, we have added 12 new plans and expanded service areas for another 11 plans since last November, including the first provider sponsored organization with a Federal waiver from State licensure requirements. We are reviewing 24 new plan applications and 18 service area expansion applications.

Last summer we held outreach sessions attended by more than 1,500 plan representatives, and we continue to strengthen lines of communication with plans. We have named a senior official within HCFA, Tom Gustafson, whom plans can call directly if they have trouble resolving issues through normal HCFA channels.

As mentioned above, last month we published initial refinements to the Medicare+Choice regulation. The new rule:

- clarifies that beneficiaries enrolled in an M+C plan that withdraws or is terminated from Medicare are entitled to enroll in other remaining locally available M+C plans;
- specifies that changes in plan rules must be made by October 15 to ensure beneficiaries can make informed choices during the November annual open enrollment period;
- waives the requirement for an initial health assessment within 90 days of enrollment for enrollees who stay in the same plan when they age into Medicare and for enrollees who switch plans but remain under the care of the same primary care provider;
- allows plans to choose the form of the initial health assessment;
- allows coordination of care to be performed by a range of qualified professionals;
- limits the applicability of provider participation requirements to physicians; and
- aligns requirements for terminating specialists with the process for other providers.

We intend to publish a comprehensive final rule with further refinements this fall.

To further facilitate plans participation, the President's budget includes a proposal to give plans two additional months to file the information used to approve benefit and premium structures. This "Adjusted Community Rate" data would not be due until July 1, rather than May 1. July 1 is the latest we can accept, process, and approve premium and benefit package data, have the data validated, and still mail beneficiaries plan information in time for the November open enrollment period. Given legislative schedules and the need to act immediately, we informed plans that the required filing date this year will be July 1. We look forward to working with you to enact legislation necessary to support this change that is so important to Medicare+Choice success.

Payment Reform

The BBA requires Medicare to "risk adjust" Medicare+Choice payments starting January 1, 2000. That means we must base payment to plans on the health status of individual plan enrollees. Data on individual beneficiary use of health care services in a given year will be used to adjust payment for each beneficiary in a Medicare+Choice plan the following year. Risk adjustment represents a vast improvement over current payment methodology. It helps assure more appropriate payments and curtails the disincentive in the current payment system for plans to enroll sicker beneficiaries.

Risk adjustment will help beneficiaries feel more confident in their Medicare+Choice options. It assures beneficiaries that Medicare pays plans the right amount to provide all necessary care because payments take each enrollee's health status into account. That will help people with serious illnesses, such as cancer or cardiovascular disease, who can benefit most from the coordination of care health plans can provide.

Risk adjustment will help taxpayers by addressing the main reason Medicare has lost rather than saved money on managed care. Many studies show that health plans enroll beneficiaries who, on average, are much healthier and less costly than those who remain in traditional Medicare.

Risk adjustment will also help level the playing field among Medicare+Choice plans. It tempers the risk of significant financial loss when plans enroll beneficiaries who have expensive care needs. And it focuses competition more on managing care than on avoiding risk. It also will help plans by alleviating concerns among beneficiaries that plans have financial incentives to deny care.

The law requires us to proceed with risk adjustment starting January 1, 2000, and does not specifically call for a transition. However, we believe we must implement these changes in an incremental and prudent fashion, and are, therefore phasing in risk adjustment over five years to prevent disruptions to beneficiaries or the Medicare+Choice program.

It is essential to stress that risk adjustment will not and cannot be budget neutral. Risk adjustment was required in the BBA because of substantial evidence that Medicare has historically overpaid plans because managed care enrollees tend to be healthier than beneficiaries who remain in fee-for-service Medicare.

If risk adjustment were budget neutral, Medicare and the taxpayers who fund it would continue to lose billions of dollars each year on Medicare+Choice. Budget neutral risk adjustment would cost taxpayers an estimated $200 million in the first year of the phase-in, and $11.2 billion over five years if health plans maintained their current, more healthy mix of beneficiaries. Actual savings to taxpayers will depend on the extent to which less healthy beneficiaries enroll in plans. Total payment may be higher for some plans than it would be under the current system if their enrollment becomes more representative of the entire Medicare population. Overall, we project plan payment to change on average by less than 1 percent the first year. The phase-in substantially buffers the impact. The federal government is forgoing an estimated $1.4 billion in savings in the first year and as much as $4.5 billion over the full five years because of the phase in. Impact on plans will be further buffered by an annual payment update for 2000 of 5 percent, and by blended payment rates that we estimate will be paid to 63 percent of counties in 2000 and in many cases will be greater than 5 percent.

Competitive Pricing Demonstration

We will soon begin a test of competitive pricing for managed care, as called for in the BBA. This test will provide objective data and actual experience that is needed to evaluate Medicare reform proposals that assume savings from competition among plans. Managed care plans will compete to offer benefits at the most reasonable cost. A bidding process, similar to what most employers and unions use to decide how much to pay plans, will be used to set Medicare+Choice rates.

To ensure broad community involvement, a Medicare Competitive Pricing Advisory Committee, chaired by General Motors Health Care Initiative Executive Director James Cubbin, has made recommendations regarding key design features. It also has selected the markets of Phoenix, Arizona and Kansas City, Kansas and Missouri, as initial demonstration sites. We are establishing local advisory committees in these communities, and they will hold public meetings to ensure that local beneficiaries have a voice in how the test program will operate.

Ensuring Quality

The BBA raises the quality bar by requiring most plans to monitor and improve quality so beneficiaries can compare plans based on quality and we can use Medicare's substantial market leverage to be a prudent purchaser. We are working to incorporate quality assessment and improvement into original Medicare, as well. And we are committed to making measurable quality improvements throughout the Medicare program as part of our Government Performance and Review Act objectives for fiscal 2000.

All Medicare+Choice plans must report objective, standardized measurements of how well they provide care and services. They have been using HEDIS, the Health Plan Employer Data and Information Set, for reporting purposes since 1997. We also are using CAHPS, the Consumer Assessment of Health Plans Study, to objectively measure beneficiary satisfaction. We began requiring Medicare HMOs to con-

duct CAHPS surveys last year. This fall, we will conduct a CAHPS survey of beneficiaries who disenroll from plans, asking about the beneficiary's experience and why they left their plan, to give beneficiaries the perspectives of both those who left and those who stayed. And next year we will conduct a fee-for-service survey to provide beneficiaries with data on all options.

HEDIS and CAHPS results are being formatted so beneficiaries can make direct, apples-to-apples comparisons among their plan options, and are posted on our Website at www.Medicare.gov. Beneficiaries may also request HEDIS and CAHPS information through our 1-800-Medicare call center, and we will include this information in the 2000 edition of Medicare & You.

We recognize that it takes time for plans to adapt to the quality improvement requirements, and that a learning curve is involved. Therefore, we made several changes from our draft proposal to help plans comply. For example, we are:

- requiring plans to conduct two performance improvement projects per year, which is comparable to standards of private sector accrediting organizations;
- giving plans three years to achieve demonstrable quality improvements; and,
- giving plans discretion as to where they conduct site visits for provider credentialing.

Appropriate flexibility will be provided so plans with networks that are less structured than traditional HMOs, such as PPOs, can meet these requirements. Our quality improvement systems will be sensitive to different plan structures and their different abilities to affect provider behavior.

We are extremely impressed with the quality improvement project outlines submitted by plans. Most are very thorough and thoughtful. Many include detailed benchmarks and timetables. They make clear that plans are very capable of achieving what Congress envisioned in the BBA.

Market Volatility

As you know, some Medicare HMOs did not convert to the Medicare+Choice program, and others reduced their service areas last year. While we are concerned about the impact on beneficiaries who were left with no other managed care options, it is important to put those business decisions in context. Some of the plans that withdrew had market positions or internal management issues that made it hard for them to compete. And they faced rising prescription drug prices and other commercial pressures. Many of the disrupted beneficiaries had several other plans to choose from, and all but 50,000 had at least one other plan option.

It is our understanding that the Federal Employees Health Benefits Program experienced a similar rate of plan pullouts, often affecting the very same counties. The vast majority of Medicare HMOs converted to Medicare+Choice, and we have approved several new plan and service area expansions. This suggests that plan withdrawal decisions have more to do with internal plan and larger marketplace issues than with Medicare rates or regulations. In fact, a certain amount of market volatility must be expected when relying on the private sector.

To buffer against such market volatility, the President's budget includes proposals to protect beneficiaries from such disruption by broadening access to supplemental Medigap polices if beneficiaries lose their plan option and allowing enrollees with end stage renal disease to move to another plan. We also provided for earlier notification of plan withdrawals in our recent refinement to Medicare+Choice regulations.

CONCLUSION

We are making substantial progress in implementing the many Medicare changes in the BBA. They expand options and improve services to our beneficiaries; create better payment systems, and extend the life of the Medicare Trust Fund. Clearly, more work remains. We are committed to continuing to work to ensure that we are fair and prudent as we implement payment systems, and above all do not compromise beneficiary access to care. I am grateful for the advice and assistance this Committee and the Medicare Payment Advisory Commission have provided. I thank you again for holding this hearing, and I am happy to answer your questions.

PREPARED STATEMENT OF MIKE HASH

Chairman Roth, Senator Moynihan, distinguished committee members, thank you for inviting us to discuss our progress in implementing the Medicare+Choice program. Medicare+Choice allows private plans to offer a wide range of options available in the private sector. It requires a massive new beneficiary education campaign and includes important new statutory requirements for quality assessment and improvement.

It also initiates a five-year transition to a fairer and more accurate payment system that includes risk adjustment to take individual beneficiaries' health care needs into account. Risk adjustment helps assure that payments are appropriate and curtail disincentives for plans to enroll sicker beneficiaries.

Successful implementation of Medicare+Choice is a high priority for us. We strongly believe that managed care and other private plans are important voluntary options next to original Medicare. Medicare managed care enrollment has nearly tripled under the Clinton Administration, from 2.3 million when the President took office to now 6.8 million.

We meet regularly with beneficiary advocates, industry representatives, and others to discuss ways to improve Medicare+Choice. Based on these discussions, we published initial refinements to the Medicare+Choice regulations in February which improve beneficiary protections while reducing plans' administrative workload. We have given plans an extra two months to file the "adjusted community rate" information we use to approve benefit and premium packages. And, we are phasing in the risk adjustment system over five years to prevent disruptions to beneficiaries and health plans. We are eager to continue working with Congress and our other partners to ensure that beneficiaries enjoy the most that Medicare+Choice can offer.

BENEFICIARY EDUCATION

Helping beneficiaries understand Medicare+Choice is perhaps our most important challenge. We launched the National Medicare Education Program to make sure beneficiaries receive accurate, unbiased information about their benefits, rights, and options. The campaign includes:

- mailing a Medicare & You handbook to explain new benefits and health plan options;
- a toll-free "1-800-MEDICARE" [1-800-633-4227] call center with live operators to answer questions, and provide detailed plan-level information;
- a consumer-friendly Internet site, www.medicare.gov, which includes comparisons of benefits, costs, quality, and satisfaction ratings for plans available in each zip code;
- working with more than 120 national aging, consumer, provider, employer, union, and other organizations who help disseminate Medicare+Choice information to their constituencies;
- enhanced beneficiary counseling from State Health Insurance Assistance Programs;
- a national publicity campaign;
- more than a thousand individual state and local outreach events around the country; and,
- a comprehensive assessment of these efforts.

We tested the system in five States in 1998 and learned how to improve efforts for this November's open enrollment period, such as ways to make the Medicare & You handbook easier to use, and additional links on our website to help users find information faster. We are also standardizing plan marketing materials that summarize benefits so beneficiaries can more easily make apples-to-apples comparisons among plans in this November's open enrollment period.

To help us continually improve our education efforts, we are establishing the Citizens Advisory Panel on Medicare Education, under the Federal Advisory Committee Act. The panel will help:

- enhance effectiveness in informing beneficiaries through use of public-private partnerships;
- expand outreach to vulnerable and underserved communities; and
- assemble an information base of "best practices" for helping beneficiaries evaluate plan options and strengthening community assistance infrastructure.

Panel members will include representatives from the general public, older Americans, specific disease and disability groups, minority communities, health communicators, researchers, plans, providers, and other groups. We expect to announce members and meeting schedules soon.

REACHING OUT TO PLANS

We have taken several steps to encourage health plan participation in Medicare+Choice. As a result, we have converted the vast majority of Medicare HMOs—more than 300—to the new Medicare+Choice program, and added 15 new plans and expanded service areas for another 17 plans since last November. We are currently reviewing another 20 new plan applications and 10 service area expansion applications. And total Medicare+Choice enrollment is now greater than it was before some plans decided to leave the program last year.

Last summer, we held outreach sessions attended by more than 1,500 plan representatives, and we continue to strengthen lines of communication with plans. In February, we published initial refinements to the Medicare+Choice regulation that improve beneficiary protections and access to information, while making it easier for health plans to offer more options to beneficiaries. The new rule:

- clarifies that beneficiaries in a plan that leaves the program are entitled to enroll in remaining locally available plans;
- specifies that changes in plan rules must be made by October 15 so beneficiaries have information they need to make an informed choice during the November open enrollment;
- allows plans to choose how they conduct the initial health assessment;
- waives the mandatory health assessment within 90 days of enrollment for commercial enrollees who choose the same insurer's Medicare+Choice plan when they turn 65, and for enrollees who keep the same primary care provider when switching plans;
- stipulates that the coordination of care function can be performed by a range of qualified health care professionals, and is not limited to primary care providers;
- limits the applicability of provider participation requirements to physicians; and,
- allows plans to terminate specialists with the same process for terminating other providers.

We intend to publish a comprehensive final rule with further refinements this fall.

To further facilitate plans' ability to offer choices to Medicare beneficiaries, the President's budget includes a proposal to give plans 2 more months to file the information used to approve benefit and premium structures. This "Adjusted Community Rate" data would be due July 1, rather than May 1. July 1 is the latest we can accept, process, and approve premium and benefit package data, have the data validated, and still mail beneficiaries information about available plans in time for the November open enrollment. This move should help plans base cost and premium packages on more current marketplace trends and costs. Given legislative schedules and the need to act immediately, we have informed plans that the required filing date this year will be July 1. We look forward to working with you to enact the legislation necessary to support this change that is so important to the success of the Medicare+Choice program.

FAIR PAYMENT

The Balanced Budget Act put in place a new payment system which addresses many of the problems with the previous adjusted average per capita cost payment system. The new system will "risk adjust" payments to account for the health status of each enrollee. And it breaks the link between local fee-for-service costs and plan payment rates, which had caused wide disparities across the country in payment rates to plans and availability of plans to beneficiaries.

Under the BBA system, a rate for a particular county is the greater of three possible rates: a new minimum or "floor" payment; a minimum 2 percent increase over the previous year's rate, or a blend of the county rate and an input price adjusted national rate. The new system is phased in over five years, and therefore has several different moving parts. Medical education costs, which had been included in HMO payments under the old system, are carved out of county rates over the five-year transition and paid instead directly to teaching hospitals. The blend of county and national rates phases up to a 50/50 balance over the same five years. The national rate, local rates and the minimum payment amount are annually updated based on per capita Medicare cost growth.

There is considerable evidence that we have both overpaid plans and continue to overpay plans, because payments are linked to local fee-for-service spending and not adjusted for risk.

- The Physician Payment Review Commission, in its 1997 Annual Report to Congress, estimated that Medicare has been making up to $2 billion a year in excess payments to managed care plans. This Congressional advisory body notes that, unlike the private sector where managed care has slowed health care cost growth, managed care has increased Medicare program outlays. The Commission's 1996 Report found that those who enroll in managed care tend to be healthy and those who disenroll tend to be unhealthy, exacerbating Medicare losses.
- Mathematica Policy Research, which has conducted several studies of Medicare HMOs, says care of Medicare beneficiaries in HMOs costs only 85 percent as

much as care for those who remain in traditional fee-for-service Medicare. That is 10 percent less than the 95 percent of the average fee-for-service costs plans were being paid.

- The Congressional Budget Office has said managed care plans could offer Medicare benefits for 87 percent of Medicare fee-for-service costs, even though they were paid 95 percent.

RISK ADJUSTMENT

Payment to plans will become more accurate starting in January, 2000, when the law requires Medicare to "risk adjust" Medicare+Choice payments. That means we must base payment to plans on the health status of individual plan enrollees. Data on individual beneficiary use of health care services in a given year will be used to adjust payment for each Medicare+Choice beneficiary the following year. Adjustments are based on the average total cost of care for individuals who had the same diagnoses in the previous year. Risk adjustment represents a vast improvement over the current payment methodology. It helps assure that payments are more appropriate, and curtails the disincentive to enroll sicker beneficiaries.

The law requires us to proceed with risk adjustment starting January 1, 2000, and does not call for a transition. However, we believe we must implement these changes in an incremental and prudent fashion, as was done with other new major payment systems. We are, therefore, using flexibility afforded to us in the law to phase in risk adjustment over 5 years to prevent disruptions to beneficiaries or the Medicare+Choice program.

In the first year, only 10 percent of payment to plans for each beneficiary will be calculated based on the new risk adjustment method based on inpatient hospital diagnoses. The remaining 90 percent will be based on the existing method for calculating plan payments, which are flat amounts per enrollee per month based on the average cost to care for Medicare fee-for-service beneficiaries in each county and adjusted for basic demographic factors like age and sex. In 2001, 30 percent of payment amounts will be risk adjusted. In 2002, 55 percent of payment amounts will be based on risk adjustment. In 2003, 80 percent of payment amounts will be based on risk adjustment. By 2004, we and health plans will be ready to use data from all sites of care, not just inpatient hospital information, for risk adjustment. Then, and only then, will payment to plans be 100 percent based on risk adjustment.

During the first year of data collection for risk adjustment, both the statute and practical issues require that we use hospital inpatient data alone. About one in every five Medicare beneficiaries is hospitalized in a given year. Data on these hospitalizations are relatively easy to gather, easy to audit, and highly predictive of future health care costs. We will use the data to pay plans more for beneficiaries hospitalized the previous year for conditions that are strongly correlated with higher subsequent health care costs. While we will eventually be using a broader data base for risk adjustment, that is simply not feasible at this time.

The Balanced Budget Act clearly stipulated that more comprehensive data on outpatient, physician, and other services could be collected only for services provided on or after July 1, 1998. That was prudent, because it has been no small task for plans to learn how to gather the inpatient data we are using for the initial phase-in of risk adjustment. Requiring plans to provide additional data on outpatient, physician and other services would have been unduly burdensome.

This year, we will issue a schedule and guidance to plans for reporting other encounter data, such as outpatient information. The schedule will provide sufficient time for plans to gather accurate data and for HCFA to analyze and incorporate the data into accurate risk adjusted payments. We are now confident that by 2004 we will be using data on all health care encounters to assess beneficiary health status for risk adjustment. If we could base risk adjustment on more comprehensive data now, we would. But we cannot. The law requires us to move forward now with the data that is available, as stipulated in the statute. And, even with its limitations, this initial risk adjustment system based on inpatient data alone will increase payment accuracy 5-fold.

The initial risk adjustment system uses only the approximately 60 percent of inpatient hospital diagnoses that are reliably associated with future increased costs. For example, beneficiaries hospitalized for conditions such as heart attacks in aggregate are at higher risk of subsequent cardiovascular problems, and they consistently have higher health care costs in the subsequent year. Hospitalizations for such diagnoses will lead to higher payments to plans in the following year under risk adjustment. Hospitalizations for acute conditions such as appendicitis, however, rarely lead to increased subsequent care costs. They will not lead to higher payments under risk adjustment.

The 60 percent of hospital admission diagnoses that are clearly associated with increased subsequent care costs account for about 30 percent of all Medicare spending the following year. It is important to note that, while risk adjustment is initially based only on inpatient data, the risk adjustment payments account for all costs of care associated with each diagnosis. It is also important to note that risk adjustment is not cost-based reimbursement; it is reimbursement adjusted for projected need based on health status in the previous year.

The relevant diagnoses will be used to classify beneficiaries into 15 different cost categories. One category is for beneficiaries who were not hospitalized the previous year with relevant diagnoses. For beneficiaries included in any of the other categories, plans will receive an additional payment to cover the increased risk associated with diagnoses in that category.

Payment will continue to be adjusted for demographic factors, such as age, gender, county of residence, and whether a Medicare beneficiary is also a Medicaid beneficiary. We have revised these demographic factors for use with risk adjustment, for example, by no longer including institutional status because the risk adjustment methodology itself does a good job of predicting expenses for nursing home residents.

Medicare will calculate a score for each beneficiary to determine the payment that will be made if they choose to enroll in a Medicare+Choice plan. For example, Medicare's average payment per year to health plans is $5,800. Under risk adjustment, payment for an 85-year-old man will on average be $6,414. It will be an additional $2,060 if he is on Medicaid, another $1,207 if he is disabled, and $8,474 more if he was admitted to the hospital for a stroke the previous year, for a total of $18,155. The score for each beneficiary will be calculated annually, and will follow them if they move from one health plan to another.

Most health plans operate with integrity and play by the rules, and we doubt that plans will compromise successful medical management programs that keep patients out of the hospital in order to game the risk adjustment system. However, plans themselves have raised concerns that risk adjustment based on inpatient data alone could create perverse incentives for unnecessary hospitalizations. We, therefore, have taken solid steps to prevent gaming of the system with inappropriate hospital admissions or attempts to inflate the data submitted for use in risk adjustment.

The risk adjustment system does not include hospital stays of just one day, in order to help guard against inappropriate admissions. And it excludes diagnoses that are vague, ambiguous, or rarely the principal reason for hospital admission. In addition, we will use independent experts to assess the validity and completeness of data plans submit to us by conducting targeted medical record reviews and site visits. This will help ensure that plans do not "upcode," or claim that hospital admissions were for more serious conditions that would result in higher payment.

It is essential to stress that risk adjustment will not and cannot be budget neutral if we intend to protect the Medicare Trust Fund and be fair to the taxpayers who support our programs. The whole reason for proceeding with risk adjustment C and specifically with risk adjustment that is not budget neutral C is that Medicare has not been paying plans accurately. Congress also recognized that plans have been paid too little for enrollees with costly conditions, and too much for those with minimal care needs. The simple demographic adjustments made now for age, gender, county of residence, Medicaid and institutional status, do not begin to accurately account for the wide variation in patient care costs. Risk adjustment will.

The vast majority of beneficiaries enrolled in Medicare+Choice cost far less than what Medicare pays plans for each enrollee. Medicare fee-for-service statistics make clear why risk adjustment must not be budget neutral. More than half of all Medicare fee-for-service beneficiaries cost less than $500 per year, while less than 5 percent of fee-for-service beneficiaries cost more than $25,000 per year, according to the latest available statistics for calendar year 1996. The most costly 5 percent account for more than half of all Medicare fee-for-service spending.

Since Medicare+Choice enrollees tend to be healthier than fee-for-service Medicare beneficiaries, the ratio of high to low cost beneficiaries in health plans is even more stark. Clearly, care for the overwhelming majority of Medicare enrollees costs plans much less than what Medicare pays because our payments are predicated on the average beneficiary cost of care, calculated by county. This average includes the most expensive beneficiaries in fee-for-service, who generally do not enroll in managed care.

If risk adjustment was budget neutral, Medicare and the taxpayers who fund it would continue to lose billions of dollars each year on Medicare+Choice. Accurate risk adjustment inevitably and appropriately must change aggregate payment to plans. Budget neutral risk adjustment would cost taxpayers an estimated $200 million in the first year of the phase-in, and $11.2 billion over 5 years if health plans

maintained their current, mostly healthy mix of beneficiaries. It is important to stress that actual savings to taxpayers from risk adjustment will vary to the extent that less healthy beneficiaries enroll in Medicare+Choice plans, resulting in higher payments than health plans receive today.

The amount of payment change will vary among plans and depend on each plan's individual enrollees. Total payment may be higher for some plans as they enroll a mix of beneficiaries that is more representative of the entire Medicare population. As part of our Medicare+Choice March 1 rate announcement, we sent a letter to each health plan with an estimate of how payment will differ from what they are paid now, based on their current mix of enrollees.

Overall, we project that payment to Medicare+Choice plans on average will change by less than one percent in the first year. How it will change over time depends on the mix of beneficiaries in each plan. Risk adjustment significantly changes incentives for plans and could well lead to enrollment of beneficiaries with greater care needs. That could result in plans receiving higher payments than they do now. Phasing in risk adjustment also substantially buffers the financial impact on plans. Taxpayers are forgoing $1.4 billion in savings in the first year and as much as $4.5 billion over the full 5 years because of the phase in. Payment changes will be further buffered by an annual payment update for 2000 of 5.04 percent. This is substantially larger than projections that were made last year.

COMPETITIVE PRICING DEMONSTRATION

Bringing market forces to bear may further help set more accurate plan payment rates. We will soon begin a test of competitive pricing for Medicare+Choice plans, as called for in the BBA. This is an important step in our efforts to learn how to improve and protect Medicare. It will provide objective data needed to evaluate Medicare reform proposals that assume savings from rate-based competition among plans. In this demonstration, plans will compete to offer benefits at the most reasonable cost. A bidding process, similar to what most employers and unions use to decide how much to pay plans, will be used to set Medicare+Choice rates starting in 2000.

A National Medicare Competitive Pricing Advisory Commission of independent experts, chaired by General Motors Health Care Initiative Executive Director James Cubbin, has made recommendations regarding key design features. It selected the markets of Phoenix, Arizona and Kansas City, Kansas and Missouri, as demonstration sites. We established local advisory committees in these communities to set the local minimum benefit package on which plans will bid and ensure that local beneficiaries and stakeholders have a voice in how the test operates. The local advisory committee in Phoenix has raised concerns about the tight schedule for implementing the project. In response, the national advisory commission urged the local advisory committees to work with us to develop an alternative schedule that can implement this essential project no later than April 1, 2000. We have committed to following the Committee's recommendation.

ENSURING QUALITY

The BBA requires most plans to both monitor and improve quality. Eventually, plans will have to meet minimum performance standards. Beneficiaries will be able to compare plans based on quality, and we will be able to use Medicare's market leverage to promote competition based on quality. We are working to incorporate quality assessment and improvement into original fee-for-service Medicare, as well, so beneficiaries will be able to make truly informed choices about all their options. And we have committed to making measurable quality improvements throughout Medicare as part of our Government Performance and Results Act objectives for fiscal 2000.

All plans must report objective, standardized measurements of how well they provide care and services. They have been using HEDIS, the Health Plan Employer Data and Information Set, for reporting purposes since 1997. We also are using CAHPS, the Consumer Assessment of Health Plans Study, to objectively measure beneficiary satisfaction. This fall, we will survey beneficiaries who disenroll from plans, and next year we will apply HEDIS and CAHPS to fee-for-service Medicare so we can provide comparable data on all options. The results of both HEDIS and CAHPS are being formatted so beneficiaries can make direct, apples-to-apples comparisons among all their options, including the original Medicare program.

We recognize that it takes time for plans to adapt to the quality improvement requirements. Therefore, we made several changes from our draft proposal to help plans comply.

- We are requiring plans to conduct two performance improvement projects per year. This workload is comparable to standards imposed by private sector accrediting organizations.
- We are permitting waivers of mandatory participation in a national project each year, and allowing plans to substitute any related ongoing projects of their own.
- We are giving plans three years before they must achieve minimum performance level requirements and demonstrable improvement.
- We are giving plans discretion as to where and how they conduct site visits for provider credentialing, rather than mandating site visits to each provider location.

We are extremely impressed with the quality improvement project outlines submitted by plans. They make abundantly clear that plans are very capable of achieving what Congress envisioned. As a result, they should provide better care and value for taxpayers' dollars.

MARKET VOLATILITY

As you know, some Medicare HMOs did not convert to Medicare+Choice, and others reduced their service areas last year. We are concerned about the business decision that some plans made to reduce participation in the program, and especially the impact on beneficiaries who were left with no other managed care options, or who experience disruptions in their provider relationships. It is, however, is important to put those business decisions in context.

The vast majority of Medicare HMOs converted to the Medicare+Choice program. We have approved 32 new plan and service area expansions since November, and are reviewing applications from another 30 plans that want to get into or expand their role in Medicare+Choice. And there are now more beneficiaries in managed care plans than before last year's plan pullouts. Plans that withdrew often had weak market positions, commercial pressures such as rising drug expenditures, or internal management issues. Many of the disrupted beneficiaries had several other plans to choose from, and all but about 50,000 had at least one other plan option.

A comprehensive review by the General Accounting Office confirms that many factors contributed to the plan withdrawals. Reasons for withdrawals and service area reductions cited by the GAO include plan decisions that they were unable to compete because of low enrollment or large competitors, and problems in establishing provider networks. Withdrawals affected far more high payment rate counties (91 percent) than low payment rate counties (34 percent), according to the GAO. It is our understanding that the Federal Employees Health Benefits Program had a similar experience with plan pullouts. In several instances plans that withdrew Medicare service from specific counties also withdrew from FEHBP in those same counties.

This all suggests that plan withdrawal decisions have more to do with internal plan and larger marketplace issues than with Medicare rates or regulations. In fact, a certain amount of market volatility must be expected when relying on the private sector to serve beneficiaries. That is one reason why it is essential to preserve a strong, public-sector fee-for-service option in any Medicare reform proposal. It is why the President's budget includes proposals to protect beneficiaries from disruption by plan withdrawals. And it is why we have provided for earlier notification of plan withdrawals in our refinement to Medicare+Choice regulations. We look forward to working with you on legislation the President has proposed to broaden access to supplemental Medigap polices if beneficiaries lose their plan option, and to allow enrollees with end stage renal disease to move to another plan.

CONCLUSION

We are making substantial progress in implementing the Medicare+Choice program. We are incorporating lessons learned from our initial beneficiary education campaign to refine future efforts, and establishing an advisory committee to further help improve these essential efforts. We are working with plans to encourage participation, and refining regulations so plans will be able to offer beneficiaries more choices. We are proceeding with quality improvement requirements in a prudent manner that will meet the statutory mandate while giving plans reasonable time and flexibility to comply. And, while we are proceeding with essential payment reforms in a prudent manner, it is abundantly clear that payment to plans continues to be more than adequate, and that any comparison of plan payments to local fee-for-service rates is specious at best. I thank you again for holding this hearing, and I am happy to answer your questions.

PREPARED STATEMENT OF HON. ORRIN G. HATCH

[MARCH 17, 1999]

Thank you Mr. Chairman.

I will be brief, but I would like to say that I greatly appreciate your holding this hearing on the implementation of the Medicare provisions in the Balanced Budget Act of 1997.

As we all know, the BBA provided for some of the most sweeping changes to the Medicare program since its enactment into law in 1965.

Some of those changes were long overdue, particularly as we attempted to bring greater competition and choice into the system for Medicare beneficiaries.

The Medicare Plus Choice program is clearly such an example where we have attempted to afford seniors options in the delivery of health care.

In my state of Utah, however, Medicare beneficiaries do not have a choice. In fact, the two Medicare HMO plans that served nearly 20,000 Utah seniors and disabled throughout the entire state, terminated their contracts last year.

As a result, effective January 1, 1999, Medicare recipients will have no choice other than the traditional fee-for-service setting.

Surprisingly, at a time when we hear criticism about managed health care and the need for patient protection laws, nearly all those seniors who contacted me were very pleased with their Medicare HMO plan.

Another issue which is of great concern to me is the BBA's impact on home health care.

Prior to the enactment of the BBA, there were 106 home health care agencies in Utah.

Today, there are only 52 agencies currently in operation throughout the state.

More than half have gone out of business as a result of the limits imposed by the Interim Payment System which, as we know, is adversely affecting hundreds of agencies as well as the people who depend on home health services.

Mr. Chairman, I hope through your leadership this committee will revisit the home health provisions in the BBA as well as the changes we made last year in an effort to provide additional relief for these companies.

Finally, let me also take this opportunity to commend my colleague on the committee, Senator Breaux, for his leadership and courage in chairing the Bipartisan Commission on the Future of Medicare in what was clearly one of the most difficult jobs in Washington.

The members of this committee know all too well that difficult and unpopular decisions will have to be made if Medicare is to survive the extraordinary financial demands it will encounter in the next century.

It seems to me that our primary objective now is to ensure the BBA provisions are implemented consistent with Congressional intent. And, where intent is unclear, we need to make adjustments.

I welcome the Administrator of the Health Care Financing Administration to this hearing. I also would note that her agency has been very cooperative in briefing me and members on this committee on issues where there is ambiguity and disagreement.

I commend you and your staff for working with us over the past year on these very complex issues.

But I do believe adjustments to the BBA are in order, and I trust the Health Care Financing Administration will continue to work with us in resolving these matters.

Mr. Chairman, once again, thank you for your leadership on this important issue and for scheduling today's hearing.

PREPARED STATEMENT OF D. TED LEWERS, MD

The American Medical Association (AMA) appreciates the opportunity to present to this Committee our views concerning improvements to the Medicare sustainable growth rate (SGR) system for physicians' services, and appreciates the Committee's focus on this important issue.

In its March 1999 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) identified serious problems in the SGR system and recommended significant improvements to the SGR. The AMA and the national medical specialty societies share MedPAC's concerns and believe that improving the SGR is a critical component of efforts to ensure that the 85% of Medicare beneficiaries who are enrolled in the fee-for-service program continue to receive the benefits to which they are entitled.

Specifically, the physician community is concerned that the growth limits in the current SGR system are so stringent that they will have a chilling effect on the adoption and diffusion of innovations in medical practice and new medical technologies. Also, the Health Care Financing Administration (HCFA) did not revise the estimates it used in the 1998 SGR when data proved HCFA erroneous, nor will it correct 1999 SGR errors without a congressional mandate. These errors have shortchanged payments by $645 million in 1999 alone. The SGR could also cause future payments to be highly volatile and fall well behind cost inflation.

MEDICARE PHYSICIAN PAYMENTS AND THE BALANCED BUDGET ACT

Medicare payments for physicians' services are updated annually by HCFA. Payment rates are based on a relative value scale system, enacted under OBRA 89, that reflects the physician work, practice expense and professional liability insurance costs involved in each service. The relative value for each service is multiplied by a dollar conversion factor to establish actual payment amounts. The conversion factor is required to be updated each calendar year, which involves, in part, establishing an update adjustment factor (UAF) that is adjusted annually by the SGR.

The SGR system was intended to slow the projected rate of growth in Medicare expenditures for physicians' services.

MedPAC recommends that Congress revise the SGR system as follows:

- The SGR should include a factor of growth in real gross domestic product per capita plus an allowance for cost increases due to improvements in medical capabilities and advancements in scientific technology;
- The Secretary should be required to publish an estimate of conversion factor updates by March 31 of the year before their implementation;
- The time lags between SGR measurement periods should be reduced by allowing calculation of the SGR and update adjustment factors on a calendar year basis;
- HCFA should be required to correct the estimates used in the SGR calculations every year; and
- The SGR should reflect changes in the composition of Medicare fee-for-service enrollment.

THE SUSTAINABLE GROWTH RATE SYSTEM

The SGR system was enacted under the BBA and replaces the Medicare Volume Performance Standard system, which had been the basis for setting Medicare conversion factor updates since 1992. The SGR sets a target rate of spending growth based on four factors: changes in payments for physician services before legislative adjustments (essentially inflation); changes in Medicare fee-for-service enrollment; changes in real per capita gross domestic product (GDP); and an allowance for legislative and regulatory factors affecting physician expenditures. Growth in real per capita GDP represents the formula's allowance for growth in the utilization of physician services.

The target growth rate of spending growth is calculated each year and is designed to hold annual growth in utilization of services per beneficiary to the same level as annual GDP. Physician payment updates depend on whether utilization growth exceeds or falls short of the target rate. If utilization growth exceeds GDP, then payment updates are less than inflation. If utilization is less than GDP, payment updates are above inflation.

Although real per capita GDP growth has varied from as low as −3 percent to as high as +6 percent, average growth is only about 1.6 percent per year. At 5.9 percent, average annual per beneficiary growth in utilization of physicians' services was three to four times higher than GDP growth from 1981-1996. The BBA placed limits on annual changes to the Medicare conversion factor under the SGR. The conversion factor update in any year can be no greater than inflation (as measured by the Medicare Economic Index, or MEI) plus 3%, and the update can be no lower than inflation minus 7 percent. An "update" of MEI minus 7 percent would mean that, in a single year, physician payments were reduced by 7 percent below the rate of inflation in the costs of medical practice.

PROBLEMS WITH THE SGR SYSTEM

There are two major types of problems with the SGR system. The first set of problems arises from the way in which the current system is being administered by HCFA. To address these problems, MedPAC recommends that Congress direct HCFA to correct the errors in its SGR estimates when actual data are available. HCFA does not believe that it currently has the legislative authority to make such corrections. The second set of problems clearly requires a legislative solution to re-

fine the way the SGR system was designed in the BBA: GDP growth alone is inadequate; a variety of factors will lead to tremendous instability in Medicare payment levels over time; and there is not currently any means for anticipating and responding to problems in the updates before they occur.

Unlike some other Medicare payment issues, the problems with the SGR system and their solutions are a matter on which the physician community is unified. National organizations representing diverse medical specialties, including surgeons, primary care physicians and others, as well as organizations representing medical colleges and group practices, have been working closely together with the AMA to address these complex issues. On behalf of the entire physician community, we are asking Congress to take the steps necessary to assure that we can continue to afford to provide our Medicare patients with the best medical care available in the world.

The Projection Error Problem

The SGR formula requires HCFA to make projections about the factors used to calculate the SGR. Although HCFA initially had indicated it would correct any projection errors once actual data had become available, the agency now asserts it does not have the authority to make such corrections. We adamantly believe these projection errors must be corrected. If not, the SGR will continue to be based on erroneous projections that result in shortages in the payment levels that the law requires be paid to physicians. This problem is seriously compounded by the fact the SGR system is cumulative. Thus, any projection errors that are left uncorrected will carry over from year to year.

Even if HCFA's projections were to be based on the best available data, methods, and judgment, because of the uncertainty that will always exist at the particular time period when the statute requires the projections to be made, they will nearly always be wrong. As a result, actual changes in these factors will differ from what was projected.

Although HCFA initially stated in a Federal Register notice it would correct its projection errors in subsequent years when actual data becomes available, it currently is asserting that it does not have the statutory authority to make such corrections. We believe HCFA has the authority to correct its projections errors, and that it is imperative to do so. Failure to correct projection errors has and likely will continue to result in severe underpayments to physicians.

HCFA has already established an SGR for 1998 and 1999 that are based on erroneous projections. That is, to determine the 1998 SGR, HCFA, in late 1997, made projections of GDP growth and changes in fee-for-service enrollment. Because HCFA did not correct the error in the 1998 SGR, the 1999 conversion factor update of 2.3 percent is too low. Specifically, HCFA projected only 1.1 percent growth in real per capita GDP for fiscal year 1998, whereas actual growth was closer to 2.8 percent, according to federal government estimates. When combined with other, smaller projection errors in the 1998 SGR, HCFA made a net underestimate in the 1998 SGR of 1.5 percent. With Medicare spending on physician services currently at about $43 billion annually, the projection errors led HCFA to set the payment update for 1999 about $645 million lower than is otherwise required by law.

In addition, HCFA has already made at least one major error in estimating the 1999 SGR by projecting that fee-for-service enrollment would decline by 4.3 percent in 1999. Such a decline would require Medicare+Choice enrollment to increase by 29 percent during the same time period. In fact, with the exception of one month, the percentage rate of increase in Medicare managed care enrollment has already been declining every month since November 1997 through May 1999, and in December 1998 and January 1999, managed care enrollment actually decreased. Moreover, information from the first quarter of this year suggests HCFA's projection of GDP growth for 1999 will also be significantly understated. Over time, due to the cumulative nature of the SGR, even if HCFA made no further projection errors, simply leaving the 1998 and 1999 projection errors uncorrected would shortchange physician service payments by billions of dollars.

If the SGR system is to work at all, HCFA's projection errors must be corrected. Indeed, the statute was based on recommendations by the Physician Payment Review Commission (PPRC), an advisory body to Congress (and predecessor to MedPAC). In its 1995 and 1996 Reports to Congress, MedPAC recommended that projection errors in the factors used to calculate the SGR be corrected in subsequent years. In 1996, it stated that "[o]ver time, more Medicare beneficiaries are expected to enroll in risk contract arrangements. This will make it harder to project fee-for-service Part B enrollment growth. The resulting errors in projection could become substantial, significantly affecting the accuracy of the conversion factor updates." To address these problems, the PPRC stated that "[a]ny revision to the Volume Performance Standard system should annually correct for any projection errors in the

target growth rate from prior years . . . This limitation [projection errors] could be readily addressed by incorporating an adjustment into the sustainable growth rate that corrects for previous errors in the projection."

Because the SGR system was adopted at the PPRC's recommendation, we believe it is reasonable to conclude that Congress intended for HCFA to correct projection errors when actual data are available instead. Since HCFA has refused to do so, however, we strongly agree with MedPAC's recommendation that Congress should require HCFA every year to correct its projection errors made when calculating the SGR.

Specifically, to further implement MedPAC's recommendation, the AMA believes that Congress should require that HCFA immediately, or as soon as practicable in the case of 1999 projections:

- Adjust its SGR estimate for fiscal year 1998 to reflect actual data on real per capita GDP growth and Medicare enrollment changes, as well as estimates of allowed expenditures for physician services impacted by these erroneous SGR calculations;
- Correct the 1999 conversion factor to reflect the corrected SGR; since the correct 1999 conversion factor should have been implemented on January 1, 1999, HCFA should "prorate" the conversion factor correction so that total payments for physician services this year will equal the total amount of payments that would have been made over the course of the year had the conversion factor been implemented correctly on January 1; and
- Revise the 1999 SGR, as well as estimates of allowed expenditures for physician services, to reflect available data on GDP growth and enrollment changes prior to computing the update adjustment factor to be used in establishing the 2000 payment update.

The SGR Must Allow for Technological Innovations and Other Factors Impacting Utilization of Health Care Services

MedPAC has also recommended that Congress revise the SGR to include a factor of growth in real gross domestic product per capita plus an allowance for cost increases due to improvements in medical capabilities and advancements in scientific technology.

The system is currently designed to hold annual utilization growth at or below annual GDP growth. A common method for policymakers to evaluate trends in national health expenditures is to look at growth in health spending as a percentage of GDP, but this approach is replete with problems. There is no true relationship between GDP growth and health care needs. Indeed, forecasts by Congressional Budget Office and the U.S. Census Bureau indicate that real per capita GDP growth will average about 1.5 percent per year over the next decade. This is far below historical rates of Medicare utilization growth. If history is any guide, then holding utilization growth to the level of GDP growth virtually guarantees that Medicare physician payments will decline.

A primary reason for this lack of congruity between GDP and Medicare utilization is that GDP does not take into account health status trends nor site-of-service changes. Thus, if there were an economic downturn with negative GDP growth at the same time that a serious health threat struck a large proportion of Medicare beneficiaries, the consequences could be disastrous.

Secondly, GDP does not take into account technological innovations. The only way for technological innovations in medical care to really take root and improve standards of care is for physicians to invest in those technologies and incorporate them into their regular clinical practice. The invention of a new medical device cannot, in and of itself, improve health care—physicians must take the time to learn about the equipment, practice using it, train their staff, integrate it into their diagnosis and treatment plans and invest significant capital in it. Yet physician spending is the only sector of Medicare that is held to as stringent a growth standard as GDP and that faces a real possibility of payment cuts of as much as 5 percent each year. Keeping utilization growth at GDP growth will hold total spending growth for physician services well below that of the total Medicare program and other service providers.

To address this problem, as recommended by MedPAC, the factor of growth under the SGR relating to GDP must be adjusted to allow for innovation in medical technology. We believe to implement adequately MedPAC's recommendation, the SGR should be set at GDP + 2 percentage points to take into account technological innovation, as discussed further below. In addition, we urge that Congress consider a long-term approach to setting

an appropriate growth target that takes into account site-of-service changes, as well as health status and other differences between Medicare's fee-for-service and

managed care populations that lead to differential utilization growth. Thus, we believe that the Agency for Health Care Policy and Research (AHCPR) should be directed to analyze and provide a report to MedPAC on one or more methods for accurately estimating the economic impact on Medicare expenditures for physician services resulting from improvements in medical capabilities and advancements in scientific technology, changes in the composition of enrollment of beneficiaries under the fee-for-service Medicare program and shifts in usage of sites-of-service.

Technological Innovation

Congress has demonstrated its interest in fostering advances in medical technology and making these advances available to Medicare beneficiaries through FDA modernization, increases in the National Institutes of Health budget, and efforts to improve Medicare's coverage policy decision process. The benefits of these efforts could be seriously undermined if physicians face disincentives to invest in new medical technologies as a result of inadequate expenditure targets.

As first envisioned by the PPRC, the SGR included a 1 to 2 percentage point add-on to GDP for changes in medical technology. Ever-improving diagnostic tools such as magnetic resonance imaging, new surgical techniques including laparoscopy and other minimally-invasive approaches, and new medical treatments have undoubtedly contributed to growth in utilization of physician services and the well-being of Medicare beneficiaries. For example, a recent paper published by the National Academy of Sciences indicated that from 1982-1994 the rates of chronic disability among the elderly declined 1.5 percent annually.

With GDP projected to grow by 1.5 percent annually, the failure to allow an additional 1 to 2 percentage points to the SGR for technological innovation means that the utilization target is only half the rate that was originally planned. Technological change in medicine shows no sign of abating, and the SGR should include a technology add-on to assure Medicare beneficiaries continued access to mainstream, state-of-the art quality medical care.

Site-of-Service Shifts

Another concern that should be taken into account by the GDP growth factor is the effect of the shift in care from hospital inpatient settings to outpatient sites. As MedPAC has pointed out, hospitals have reduced the cost of inpatient care by reducing lengths-of-stay and staff and moving more services to outpatient sites, including physician offices. These declines in inpatient costs, however, are partially offset by increased costs in physician offices. Thus, an add-on to the SGR target is needed to allow for this trend.

Beneficiary Characteristics

The SGR should also be adjusted for changes over time in the characteristics of patients enrolling the fee-for-service program. A MedPAC analysis has shown that the fee-for-service population is older, with proportions in the oldest age groups (aged 75 to 84 and those age 85 and over) increasing, while proportions in the younger age group (aged 65-74) has decreased as a percent of total fee-for-service enrollment. Older beneficiaries likely require increased health care services, and in fact MedPAC reported a correlation between the foregoing change in composition of fee-for-service enrollment and increased spending on physician services. If those requiring a greater intensity of service remain in fee-for-service, the SGR utilization standard should be adjusted accordingly.

Stabilizing Payment Updates under the SGR System

The AMA strongly agrees with MedPAC's further recommendation that Congress should stabilize the SGR system by calculating the SGR and the update adjustment factor on a calendar year basis.

Instability in annual payment updates to physicians is another serious problem under the SGR system, as has been acknowledged by HCFA. Projections by the AMA, MedPAC and HCFA show the SGR formula producing alternating periods of maximum and minimum payment updates, from inflation plus 3 percent to inflation minus 7 percent. Assuming a constant inflation rate, these alternating periods could produce payment decreases of 5 percent or more for several consecutive years, followed by increases of similar magnitude for several years, only to shift back again. These projections are based on constant rates of inflation (2 percent), enrollment changes, GDP growth and utilization growth. There is a serious problem when constant, stable rates of change in the factors driving the targets lead to extreme volatility in payments that are entirely formula-driven.

A primary reason for this instability is the fact that there is a time lag in measurement periods for the SGR. Specifically, while physician payment updates are established on a calendar year basis, SGR targets are established on a federal fiscal

year basis (October 1 through September 30) and cumulative spending (used to calculate the SGR) is established on an April 1 through March 31 basis. These time periods must all be consistent and calculated on a calendar year basis to attempt to restore some modicum of stability to the SGR system.

Simulations by the AMA and MedPAC have also shown, however, that the change to a calendar year system will not, by itself, solve the instability problem. Additional steps would be needed. The wide range of updates that are possible under the current system, from inflation +3 percent to −7 percent, is one reason for the instability. The lower limit is also unacceptably low, and, assuming an MEI of 2 percent, represents an actual 5 percent cut in the conversion factor in a single year. These levels of payment cuts would be highly disruptive to the market, and likely would have the "domino effect" of impacting the entire industry, not simply Medicare fee-for-service. Many managed care plans, including Medicare+Choice and state Medicaid plans, tie their physician payment updates to Medicare's rates. Thus, payment limits under current law must be modified to assist in stabilizing the SGR system. We recommend that the current limits on physician payment updates (MEI +3 percent to MEI −7 percent) be replaced with new, narrower limits set at MEI +2 percent and MEI −2 percent.

Finally, use of the GDP itself also contributes to the instability of the payment updates since GDP growth fluctuates from year to year. Thus, we recommend measuring GDP growth on the basis of a rolling 5-year average.

Payment Preview Reports

Finally, MedPAC has also recommended that Congress should require the Secretary of the Department of Health and Human Services to publish an estimate of conversion factor updates prior to the year of implementation. We agree.

When the SGR system was enacted to replace the previous Medicare Volume Performance Standards, the requirements for annual payment review reports from HCFA and the PPRC were eliminated along with the old system. Without these reports, it is impossible to predict what the payment update is likely to be in the coming year, and it is impossible for Congress to anticipate and respond to any potential problems that may ensue from an inappropriate update or a severe projection error.

Changes in Medicare physician payment levels have consequences for access to and utilization of services, as well as physician practice management. These consequences are of sufficient importance that the system for determining Medicare fee-for-service payment levels should not be left unattended on a kind of "cruise control" status, with no "brake" mechanism available to avoid a collision.

The AMA, therefore, urges that the payment preview reports be reinstated. Specifically, we believe that HCFA should be required to provide to MedPAC, Congress and organizations representing physicians quarterly physician expenditure data and an estimate each spring of the next year's payment update. MedPAC could then review and analyze the expenditure data and update preview, and make recommendations to Congress, as appropriate.

PRACTICE EXPENSE REFINEMENT

With strong AMA support, the BBA directed HCFA to revise its resource-based practice expense proposal for the Medicare physician payment schedule. HCFA issued a June 1998 proposed rule and November 1998 interim final rule. In developing the new relative values, HCFA is also required, among other things, to "develop a refinement process to be used during each of the 4 years of the transition period."

The AMA is available and willing to work with HCFA in this refinement process. We are in the process of developing a new survey of medical practice cost data, to be pilot-tested in late summer of 1999 and implemented in 2000. Many experts and potential users of the data are being consulted in the development of this survey. We are also planning to meet with HCFA staff to discuss potential use of AMA survey data to refine and/or update specialty practice expense data.

Finally, we applaud the General Accounting Office (GAO) for its cooperation and oversight of this process, as embodied in its two reports on HCFA's development of the resource-based practice expense values. GAO's efforts have been enormously helpful, and we appreciate its contributions to this process. For example, the GAO recommended in its February 1999 report that HCFA develop plans for updating the practice expense relative value units that address "how to (1) assign practice expense [relative value units] to new codes, (2) revise the [relative value units] for existing codes, and (3) meet the legislative requirement for a comprehensive 5-year review . . ." The AMA agrees that such a plan for the refinement and updating process is critical and, because the current methodology relies significantly on data collected by the AMA, we have expressed to the HCFA Administrator our willingness to work

cooperatively with the agency in developing a comprehensive plan for future data collection and refinement.

The GAO has also recommended that HCFA "use sensitivity analysis to identify issues with the methodology that have the greatest effect on the new practice expense [relative value units] and to target additional data collection and analysis efforts." The AMA agrees. We have noted particular specialty society concern over the approach used by HCFA in its interim final rule for assigning relative values to technical component services, as well as HCFA's failure, to date, to incorporate corrections in the data into the relative values. Some of these corrections have been provided to HCFA on multiple occasions.

CONCLUSION

Enactment of the SGR system improvements recommended by MedPAC and completion of the practice expense refinements recommended by the GAO are critical to the continued ability of our nation's physicians to be able to offer our Medicare patients the benefits of the finest medical care available in the world. If these improvements and refinements are not put in place, the SGR system could lead to severe payment cuts in the Medicare physician fee schedule and payments for services that do not accurately reflect their costs. The cuts resulting from both the statutory design of the SGR system and administration of the system by HCFA would be in addition to more than a decade of cuts in physician payments. For example, in the six years from 1991-1997, overall Medicare physician payment levels fell 10 percent behind the rate of growth in medical practice costs. Many individual services and procedures faced even deeper cuts.

Recent survey data from the AMA's Socioeconomic Monitoring System indicates that these payment changes are having very significant effects on the practice of medicine. Of 2,450 randomly selected physicians that were surveyed from April-August 1998, 35 percent reported they are not renewing or updating equipment used in their office, are postponing or canceling purchasing equipment for promising new procedures and techniques, or are performing many procedures in hospitals that were formerly performed in the office. Three quarters of these physicians reported that Medicare payment cuts were an important factor in their decisions to defer or cancel these investments in capital.

With these kinds of changes already taking place in response to previous payment changes, we have grave concerns about the effects of the further reductions that could take place due to the SGR or incorrect practice expense values. In order for the medical innovations that will come from Congress' enhanced funding of biomedical research, FDA modernization, and better Medicare coverage policies to translate into ever-improving standards of medical care, physicians must be able to adopt these innovations into their practices. It is already clear that Medicare payment cuts are threatening continued technological advancement in medicine, and this is a threat that affects all of us, not just Medicare beneficiaries. Clearly, reversal of the trend to move services away from inpatient sites into ambulatory settings could also have severe consequences for health care costs, as well as patient care.

We appreciate the efforts of the members of this Committee to explore the problems presented by the SGR system, as well as the opportunity to discuss our views on this extraordinarily important matter. We urge this Committee and Congress to consider MedPAC's recommendations and the recommendations we have discussed today, and are prepared to engage fully in detailed discussions with this Committee and Congress as we work to achieve a workable and reasonable solution.

PREPARED STATEMENT OF STEVEN M. LIEBERMAN

Mr. Chairman, Senator Moynihan, and Members of the Committee, it's a pleasure to appear before you today to discuss the enrollment and payment issues confronting the Medicare+Choice program. The growth in that program's enrollment is closely linked to the adequacy and appropriateness of Medicare's capitated payments. The recent withdrawal of plans from Medicare+Choice, coupled with reduced growth in payments, has prompted some observers to worry about the future of the Medicare+Choice program.

My testimony discusses the Congressional Budget Office's (CBO's) projection of enrollment in Medicare+Choice plans over the next 10 years and the factors influencing growth in that enrollment. Financial incentives play a critical role in determining whether plans participate in Medicare+Choice, whether beneficiaries enroll, and whether providers deliver appropriate services in an efficient manner.

For Medicare+Choice to be a viable program, beneficiaries must have incentives to relinquish traditional fee-for-service and enroll instead in competing health plans. The challenge is to have a system that yields greater returns when it efficiently provides necessary, high-quality services and smaller returns when it provides inefficient, low-quality, or unnecessary services. Meeting that challenge requires that plans, providers, and beneficiaries each bear some degree of financial risk. Serious problems can result if Medicare payments do not bear a reasonable relationship to the costs of care for each group of beneficiaries for which plans and

providers accept risk. Payments to providers must be fair and, ideally, give incentives to control costs while rewarding quality.

If consumers have a choice of health plans offering various combinations of benefits and premiums, they can select the plan that best meets their needs. Enrollment in Medicare+Choice plans would grow if those plans offered better benefits or lower costs than traditional Medicare. If consumers have no choice of plans or if those plans offer unattractive benefits, high costs, or poor quality, beneficiaries will remain in fee-for-service Medicare.

ENROLLMENT IN THE MEDICARE+CHOICE PROGRAM

CBO projects that growth in Medicare+Choice enrollment will average 9 percent annually between 1999 and 2009. Though quite rapid, that rate of increase represents a sharp reduction from earlier trends.

The Balanced Budget Act of 1997 (BBA) established Medicare+Choice and changed payment provisions for both health maintenance organizations (HMOs) and fee-for-service providers. CBO had assumed that Medicare+Choice enrollment would continue to grow at the dramatic rates of the program it replaced. The annual rate of growth in enrollment in Medicare's risk-based plans peaked at 36 percent in

fiscal year 1996, however, and slowed in subsequent years. CBO projects that 31 percent of all Medicare beneficiaries will join Medicare+Choice plans in 2009, up from 16 percent this year (see Table 1).

TABLE 1. ACTUAL AND PROJECTED ENROLLMENT IN RISK-BASED HMO PLANS AND MEDICARE+CHOICE

Fiscal Year	Enrollees		Annual Growth in (Enrollment Percent)
	Number (Millions)	Percentage of Medicare Beneficiaries	
		Actual	
1992	1.4	4.0	n.a.
1993	1.6	4.5	13.8
1994	1.9	5.2	18.9
1995	2.5	6.7	29.7
1996	3.4	8.9	36.0
1997	4.5	11.7	32.4
1998	5.5	14.1	22.2
1999	6.2	15.7	12.7
		Projected	
2000	6.6	16.6	6.5
2001	7.1	17.7	7.6
2002	7.6	18.7	7.0
2003	8.4	20.4	10.5
2004	9.2	22.0	9.5
2005	10.1	23.8	9.8
2006	11.0	25.6	8.9
2007	12.0	27.4	9.1
2008	13.1	29.3	9.2
2009	14.1	30.9	7.6

SOURCE: Congressional Budget Office.

NOTE: HMO = health maintenance organization; n.a. = not applicable.

HMO Withdrawals

Last year, 99 HMOs announced they were either terminating or, far more commonly, scaling back their Medicare+Choice operations in certain counties. The potential disruption involved 407,000 enrollees, accounting for 7 percent of all Medicare+Choice enrollment. Plan withdrawals occurred in 406 counties—42 percent of the counties covered by Medicare managed care. Nonetheless, the overwhelming majority of the affected beneficiaries had the option to switch to a competing Medicare+Choice plan.

The unanticipated withdrawal of plans from the Medicare market has heightened awareness that plans can leave the market. That perception is likely to reduce the willingness of some Medicare beneficiaries to enroll in plans in the next few years. Although the effects of plans' withdrawal on Medicare+Choice enrollment seem relatively clear, explaining why plans withdrew appears more controversial.

In a recent report, the General Accounting Office concluded that most likely more than one factor was responsible for the withdrawals.

> No one factor can explain why plans choose to participate in particular counties. Although plans obviously consider payment rates, many other factors also influence their business decisions.[1]

> The current movement of plans in and out of Medicare may be primarily the normal reaction of plans to market competition and conditions. . . . Other factors associated with plan withdrawals—recent entry in the county, low enrollment, and higher levels of competition—suggest that a number of Medicare plans withdrew from markets in which they had difficulty competing.[2]

By contrast, the HMO trade group, the American Association of Health Plans (AAHP), attributes the withdrawals to inadequate payment rates, exacerbated by the administrative burdens imposed by the Health Care Financing Administration's (HCFA's) "MegaReg" for implementing the BBA's provisions. AAHP believes that without substantial revisions to Medicare+Choice, additional plans will withdraw from the program.[3]

Adverse publicity associated with the health plans' withdrawal from Medicare+Choice is likely to temporarily slow growth in enrollment. But over the

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1. General Accounting Office, *Medicare Managed Care Plans: Many Factors Contribute to Recent Withdrawals; Plan Interest Continues*, GAO/HEHS-99-91(April 1999), p. 22.
2. Ibid., p. 44.
3. Ibid., Appendix V.

longer term, that growth depends critically on the size of payment increases and the ability of plans to offer attractive additional benefits, such as prescription drugs.

Constraining Medicare+Choice Payments

Health plans, as businesses, will participate in Medicare+Choice markets only if the have an expectation of an adequate return—at a minimum, if they can reasonably expect at least to cover costs. If payments are perceived as being inadequate, health plans will tend not to participate in Medicare+Choice, especially if they foresee little prospect of Medicare payments becoming adequate.

A similar dynamic applies to providers. Regardless of mission or not-for-profit status, physicians and other providers cannot afford to participate indefinitely when their enterprises are losing money.

In addition to causing plans to withdraw, inadequate Medicare+Choice payments have another, compounding effect on enrollment growth. Reducing payment increases to Medicare+Choice plans will impede their ability to offer extra benefits or limit beneficiary cost sharing. Taking steps such as eliminating prescription drug benefits or requiring hefty monthly premiums instead of "zero premiums" will make Medicare+Choice plans less attractive to consumers. As a result, fewer beneficiaries will choose to join those plans.

Are Medicare+Choice payments inadequate? The adequacy of payments can be evaluated from five often-competing perspectives.

- Are plans able to provide appropriate services while remaining financially stable?

- Are payments fair, permitting (if not encouraging) plans and providers to serve sicker patients?

- Is there an adequate choice of health plans in both urban and rural parts of the country?

- Do the payments offered by Medicare+Choice plans attract physicians, hospitals, and other providers to participate in their networks?

- Do the payments help keep Medicare affordable for both beneficiaries and taxpayers?

Having well-established plans "vote with their feet" and withdraw from their key Medicare+Choice markets is an indication that payment and other conditions of participating in Medicare+Choice may be too stringent. But health plans have

powerful incentives to convince policymakers that Medicare+Choice payments need to be increased without having to withdraw from the program.

CHANGES TO MEDICARE+CHOICE PAYMENTS UNDER THE BALANCED BUDGET ACT

The BBA enacted six policies that affected Medicare+Choice payments.

- The BBA significantly reduces fee-for-service spending, which also slows the growth of payments to health plans because annual updates to Medicare+Choice payment rates are tied to the growth in per-enrollee spending in the traditional Medicare program.

- The BBA sets the annual increases in Medicare+Choice payment rates below the growth in fee-for-service spending from 1998 through 2002.

- The portion of Medicare+Choice payment rates that is attributable to fee-for-service spending for graduate medical education will be gradually eliminated.

- HCFA will withhold about 0.2 percent of payments to Medicare+Choice plans to pay for dissemination of information to beneficiaries about their coverage options.

- A blend of local and national payment rates will be phased in for Medicare+Choice plans. That blending provision redistributes money from areas with high payment rates to those with low payment rates.

- New payment risk adjusters will be implemented in two stages. Those adjusters are intended to more accurately reflect the expected costs of providing health care to enrollees in Medicare+Choice plans.

The first four policies were enacted with the expectation that they would slow the growth of Medicare spending. Those policies reduce the cumulative growth in Medicare+Choice payment rates relative to fee-for-service payments by 6 percent. The blending of local and national payment rates is purely redistributive, but particular counties will see substantial changes in payment rates. The new risk adjusters were not necessarily expected to lower average payments to Medicare+Choice plans but, as discussed below, they could yield substantial program savings when they are implemented.

Impact of the Payment Blend

Because of the blending of national and local payment rates, payment increases are projected to vary enormously from county to county. For example, some counties would experience such large increases in payment rates from 1997 to 2000 that the theoretically available Medicare+Choice payment rates—if any plans operated in the areas—would exceed 180 percent of the 1997 (pre-BBA) payment rates. In contrast, some counties with high payment rates would see only a 6.1 percent increase in their rates over the same period.

Historically, both the level of and increase in Medicare spending per beneficiary varied dramatically in different counties. HCFA, however, no longer produces those data on county-specific spending trends. If past trends continue, some Medicare+Choice plans will face payment rates that are projected to be substantially below both per capita fee-for-service spending and 1997 (pre-BBA) amounts.

Over half (52) of the 100 counties with the most Medicare+Choice enrollees are projected to have payment rates fall by 5 percent or more using as the standard of comparison the rates that Medicare would have paid if 1997 payments were increased by the national average growth in per capita fee-for-service spending and the BBA payment provisions were fully in effect. Using that methodology, the steepest reduction is estimated to be 12 perce.... In the top 100 counties, 88—home

to 78 percent of the enrollees—would experience declines in payment rates, compared with 1997 rates. These estimates do not include the lower payments resulting from HCFA's implementation of risk adjustment.

Impact of Risk Adjustment

Until 1999, CBO had assumed that Medicare+Choice payments would be adjusted for risk without changing total outlays. In January, the Administration published plans to phase in risk adjustment in a manner that would reduce payment rates for enrollees in Medicare+Choice plans. The first stage of risk adjustment would be based on the use of inpatient hospital services by individual enrollees. That change would reduce payments for existing enrollees by 7.6 percent when fully phased in—by 2004. The Administration also announced a second stage of risk adjustment that would be based on use of services in all settings. The Administration expects that such an adjustment would reduce payments by another 7.5 percent, beginning in 2004. If both plans are implemented as announced, the combined effect could reduce payments by about 15 percent.

Payment reductions related to risk adjustment on the order of 15 percent would be likely to cause plans to drop out of the program and enrollment in Medicare+Choice to drop sharply. Because of the magnitude of the planned

reduction and the discretion retained by the Administration in implementing the adjusters, the CBO baseline does not assume the full savings from risk adjustment. For the same reason, the projections of Medicare+Choice enrollment discussed in my testimony today explicitly do not reflect the full savings. Instead, CBO assumes that risk adjustments will ultimately reduce payments by lesser amounts.

RISK SELECTION AND RISK ADJUSTMENT

Risk selection occurs when groups of beneficiaries, such as those who enroll in a Medicare+Choice plan, have average costs that are systematically different from the average costs of beneficiaries who are treated as similar by the risk adjuster. When monthly payments are made on a fixed, prospective (or capitated) basis, those groups of enrollees are referred to as "risk pools." If Medicare+Choice enrollees tend to have lower costs than comparable fee-for-service beneficiaries, the result is known as "favorable" risk selection. Conversely, "adverse" risk selection occurs when groups or risk pools have costs that are higher than those of comparable fee-for-service beneficiaries.

Risk selection is incompletely understood and imperfectly measured. It can arise from many different sources.[4] If unchecked, risk selection can destroy an

4. Biased selection can occur without a clear basis. For example, in the early 1990s, Mathematica Policy Research conducted evaluations for HCFA and concluded that Medicare HMOs benefited from favorable selection. Yet Mathematica also suggested that how selection occurred was not well understood—and might have been the result

insurance system. Systematically selecting people who are healthier than average pays off handsomely: the returns on favorable selection can overwhelm any potential savings from operating an efficient system for managing care. Health insurance systems in which biased selection segments the risk pool are said to enter a "death spiral" if the problem is not fixed.

One goal of risk adjustment is to pay more fairly. In a fair system, the amounts paid for different risk pools would closely approximate the average cost of providing services to their members. Under that framework, a good risk adjuster would pay groups with sicker, more expensive people proportionately more and groups with healthier, less expensive beneficiaries proportionately less.

Medicare+Choice Risk Adjuster

There are a wide variety of potential approaches to mitigating the effects of risk selection. HCFA has adopted a mechanism for risk adjustment that relies on inpatient hospital admissions for specific diagnoses to trigger higher capitated payments in the following year. That mechanism, which is known as the principal inpatient/diagnostic cost group (or PIP/DCG), attempts to adjust payments statistically

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of enrollment decisions by beneficiaries. In one report, Mathematica concluded that a small underrepresentation of the most expensive group of beneficiaries in the HMO risk pools probably accounted for most of the favorable selection they identified.

to account for individuals with persistently high costs. On average, PIP/DCGs would reduce payments somewhat for most beneficiaries but increase them significantly for the minority of beneficiaries who were hospitalized in the prior year for specific conditions (such as congestive heart failure).

HCFA has had to overcome significant analytical and operational obstacles in setting up the PIP/DCG system. The agency appears to be successfully implementing that complex system, for which it deserves recognition. But it is important to understand the limitations of that system for adjusting payments.

Developing a Medicare Risk Adjuster

Although the PIP/DCG system is a significant improvement over demographic adjusters, it has had limited success in achieving the goal of "fair" payments—payments that are closely related to the costliness of beneficiaries (based on their health status). Two factors contribute to the difficulty of developing an adequate Medicare risk adjuster.

First, the health care costs for individuals are enormously difficult to predict. That difficulty is compounded when the predictions are based on the administrative data available from processing claims.

Second, Medicare spending is extremely skewed—that is, the sickest beneficiaries are extraordinarily costly. The most expensive 5 percent of Medicare beneficiaries cost almost as much as the remaining 95 percent of all Medicare beneficiaries. On average, those in the top 5 percent cost over $70,000 annually—more than 10 times the average annual cost for all Medicare beneficiaries.

The variation in cost per beneficiary has two critically important implications. On the one hand, it highlights the potential financial consequences associated with both risk selection and inadequate risk adjustment. On the other hand, assuming neutral risk selection—that a risk pool has an "average" population—the skewness of the distribution of costs may require relatively large numbers of participants for a risk pool to be stable. Very large risk pools are unlikely to be undermined by having one too many—or too few—million-dollar cases in a year. Small risk pools, however, could be seriously disrupted by having just one person who incurs catastrophic health care costs.

Large health plans may be able to assume full financial risk for their enrollees. Even without risk selection, small plans may not be well positioned to assume full financial risk. In many large Medicare+Choice markets, health plans base payments to physicians or other providers on a percentage of premiums, thereby passing risk on to the providers.

These compensation arrangements do not directly connect HCFA to provider payments. Yet HCFA remains vitally involved for two reasons. First, HCFA regulates the terms and conditions under which physicians may be placed at substantial financial risk, approving their contracts with Medicare+Choice plans. Second, HCFA has a vital interest in and regulatory responsibility for assuring that beneficiaries have adequate access to sufficient providers and receive high-quality care.

The numerous Medicare+Choice providers who are paid on a capitated, percentage-of-premium basis subdivide a health plan's risk pool. As a result, even relatively large risk pools at the health plan level may become too small at the provider level. PIP/DCGs may not be a desirable system for adjusting payments to small risk pools.

Problems with Using an Inpatient Risk Adjuster

The first phase of the PIP/DCG relies solely on inpatient hospital admissions and excludes care delivered in other settings. One can argue that the reliance on inpatient hospital admissions hurts managed care plans, many of which have reduced their use

of inpatient hospital services. Some plans have implemented effective disease management and other protocols that may alter the pattern of care, possibly minimizing the specific admissions that are rewarded by the PIP/DCG methodology.

What are the implications of the inpatient PIP/DCG payment system for a Medicare+Choice plan that has invested in developing sophisticated disease management systems for chronic conditions? Unlike acute episodes of care, chronic conditions, such as congestive heart failure, can frequently have high and recurring costs. Paradoxically, that makes such conditions ideal for both disease management interventions and for creating a PIP/DCG payment adjustment.

With chronic conditions, an HMO can identify who is at risk and develop intervention strategies to improve outcomes. Typically, successful interventions stress prevention, investing in patients' education, and gaining their compliance with protocols. Although such strategies do not "cure" chronic conditions, they improve patients' outcomes and frequently save money by avoiding hospitalizations. Success in avoiding hospitalizations, however, means that the Medicare+Choice payment rate is never increased to compensate for the beneficiary with high-cost, chronic conditions. Without a hospitalization for congestive heart failure, for example, the PIP/DCG system does not recognize that the beneficiary has the condition.

Is this "Catch 22" real? Preliminary findings from an analysis being conducted by John Bertko, a principal in the actuarial consulting firm of Redden & Anders, provide some guidance. A highly sophisticated Medicare+Choice plan appears to have implemented effective disease management protocols for several conditions, including congestive heart failure. By investing about $3,000 annually in each patient, that HMO has apparently managed to avoid about half the expected hospital inpatient admissions for congestive heart failure. Such an HMO could become the victim of its own success in managing care. In cases in which a beneficiary with congestive heart failure avoids hospitalization because of better medical management, for example, the HMO would forgo over $12,000 in higher PIP/DCG payments in the subsequent year if the system was fully phased in. Not only would the HMO's success in avoiding hospitalization preclude its receiving the higher revenues, but the plan would also have incurred higher expenses to finance the disease management program.

These findings are preliminary. But even if the completed analysis confirms the initial findings, it is unclear how many Medicare+Choice plans have the sophistication to implement comparable programs. It is also unclear how many conditions would be susceptible to disease management interventions that avoided hospitalizations that trigger higher PIP/DCG payments. However, sophisticated disease management programs for conditions such as diabetes with complications or chronic obstructive pulmonary disease might generate similar "Catch 22s."

Problems with Refining PIP/DCGs

The successful development of the second stage of PIP/DCG risk adjusters faces formidable obstacles. Relying on hospital inpatient data means that the data sets are, compared with the total volume of Medicare claims, relatively manageable. Expanding the adjustment system to include outpatient procedures markedly increases the number of claims to be analyzed. Including all Medicare services could further increase the number of claims by an order of magnitude. Simply manipulating the data will pose significant challenges.

Hospitals have long had strong incentives to precisely code inpatient admissions, making the claims and diagnostic information relatively reliable. HCFA may encounter significant problems with the reliability and validity of some of the data that would be used in the second stage of PIP/DCGs. The accuracy of hospital outpatient data, for example, might prove problematic for use in the more comprehensive risk-adjustment system.

ALTERNATIVE APPROACHES TO RISK ADJUSTMENT

The discussion earlier in my testimony highlighted some of the problems associated with devising and improving an adequate mechanism for adjusting payments for risk.

HCFA and others have funded extensive research in efforts to develop viable mechanisms. The inability to devise more effective tools underscores how difficult the challenge actually is.

An alternative to using a statistical approach to adjust payments is to alter the level of risk borne in the payment pool. Some payers, such as state Medicaid agencies, are using a variety of approaches that, in effect, adjust the risk pool, not the payments.

Under fee-for-service, physicians and other providers can be viewed as revenue centers: the more services they provide and bill, the more they get paid. That arrangement provides strong incentives to use more, rather than fewer, services. In stark contrast, under capitated payment arrangements, providers are cost centers: their revenue is fixed, so that providing services adds only to costs, not to payments. One explanation for the differing utilization patterns between fee-for-service and (capitated) managed care is that providers are converted from "revenue centers" to "cost centers."

In a *Health Affairs* article, Joseph Newhouse and colleagues have argued in favor of partial capitation.[5] They raise concerns about stinting on needed care when

5. Joseph P. Newhouse, Melinda Beeuwkes Buntin, and John D. Chapman, "Risk Adjustment and Medicare: Taking a Closer Look," *Health Affairs*, vol. 16, no. 5 (September/October 1997), pp. 26-43.

a provider must bear 100 percent of the marginal cost of providing services. That concern may be strongest where providers' risk pools are too small to be stable or where providers are thinly capitalized.

Payment systems that combine attributes of fee-for-service and capitation create incentives to avoid unnecessary services but not stint on needed care. Many such approaches are possible.

I will describe four generic types of hybrid payment systems that combine some capitation with additional payments as services or costs increase. Those approaches are currently used in commercial markets, Medicaid, or Medicare demonstrations. They all limit the amount of risk assumed by a risk pool by paying extra for high-cost cases; that permits smaller risk pools to be more stable, lessening their volatility and susceptibility to big financial swings. To keep such systems budget neutral, the average capitation payments must be reduced by the amount being "carved out" for separate payment.

First-Dollar Partial Capitation. HCFA is experimenting with partial capitation payments in a demonstration project with an academic health center at the University of California at San Diego (UCSD). For inpatient hospital services, HCFA pays the UCSD health plan half of the Medicare fee-for-service payment plus a capitated amount. In part because of the reduced risk associated with this payment system,

UCSD chose to offer a managed care plan that permitted direct access to the specialists on its medical school faculty.

Condition-Specific Carve-Outs. Pregnancy, acquired immunodeficiency syndrome (AIDS), solid organ transplants, and end-stage renal disease (ESRD) are all examples of disease or condition-specific carve-outs being employed by Medicaid agencies, HMOs, or Medicare. Some Medicaid agencies remove AIDS or other high-cost conditions from their capitation rates. Others exclude pregnancy-related costs from their normal capitated payments. Instead, special payments are made for each case or each delivery.

Such payment systems can easily be adjusted to promote specific objectives. For example, if a goal was to promote prenatal care and limit caesarian deliveries, a flat "bundled" payment could be made for all hospital and physician services. In contrast, paying separate, higher rates for C-sections and lower rates for vaginal deliveries would instill fewer incentives to avoid C-sections.

For decades, Medicare has separated individuals with ESRD into a distinct risk pool. Now, Medicare is experimenting with paying for ESRD beneficiaries on a capitated basis. Similarly, some HMOs carve out solid organ transplants from their capitation payments to providers, retaining the risk (and payment responsibility) at the plan level.

Individual (Specific) Stop-Loss Coverage. Many providers and health plans purchase private reinsurance to limit the costs of specific individuals or cases, which is often referred to as "specific stop-loss" coverage. Coverage thresholds, known as "attachment points," vary considerably. Some entities choose very high reinsurance thresholds, seeking to handle only catastrophically expensive cases. Others choose lower attachment points, seeking to reduce their financial exposure. The lower the attachment point, the higher the reinsurance premium—the amount carved out of the capitation rates—necessary to finance the costs.

Like the attachment points, the amount of excess costs reimbursed can also vary. In some cases, reinsurance pays 50 percent of costs in excess of the first threshold and 80 percent of costs above a second, higher threshold. Other policies pay 100 percent of costs in excess of a threshold. By varying both the attachment point(s) and the share of costs paid, specific stop-loss policies can significantly moderate risk. At the extreme, certain stop-loss policies approach first-dollar partial capitation. (That occurs if the initial payment threshold is the first dollar.)

Aggregate Stop-Loss Coverage. Aggregate stop-loss coverage is also a commercially available product. Typically, that coverage presupposes the existence of an underlying specific stop-loss policy. If the cost of services for all members of the risk pool exceeded a specific level, the aggregate reinsurance policy could reimburse those excessive costs.

For example, assume that a physician has 300 capitated Medicare beneficiaries in his or her risk pool and buys both specific and aggregate reinsurance. Any costs of physician services for an individual in excess of $7,500 would be paid by specific reinsurance. None of the amounts above the attachment point would be counted when calculating aggregate costs. However, all costs up to $7,500 would be included in calculating whether aggregate reinsurance payments would be triggered. In this example, two individuals might require extensive cardiac services and open-heart surgery, generating physician fees in excess of $10,000 each. The specific reinsurance policy would pay the costs over $7,500 in each case. Assume further that the average cost of physician services for each member of this physician's Medicare risk pool equals $1,800 (after excluding the catastrophic costs over the threshold) but that the physician only averaged a capitation payment of $1,440 per patient per year. Any costs averaging in excess of $1,728 per patient per year, which is 120 percent of the annual capitation payment, would qualify for aggregate reinsurance.

CONCLUSION

The success of Medicare+Choice is tied to how much, and how, Medicare pays. Low rates of increase in payments will tend to cause health plans to withdraw from or limit their presence in the Medicare+Choice market. Constrained payment rates will make benefit offerings less attractive to consumers, which will further slow growth

in enrollment. Even though it is an improvement over the prior demographic adjuster, the PIP/DCG is a flawed mechanism for adjusting for risk selection. HCFA is working to develop an improved method for implementing stage two that would take account of service use in all settings. Because of the difficulty in markedly improving mechanisms that adjust payments, however, the Congress may wish to consider other approaches that would limit the risk borne by a pool.

PREPARED STATEMENT OF WILLIAM J. SCANLON

[MARCH 17, 1999]

Mr. Chairman and Members of the Committee:

We are pleased to be here as you discuss the implementation and impact of the Medicare provisions in the Balanced Budget Act of 1997 (BBA). The BBA contains the most significant changes to Medicare since its inception more than 30 years ago. The Act's combination of constraints on provider fees, increases in beneficiary payments, and structural reforms is expected to lower program spending by $386 billion over the next 10 years. The importance of these changes cannot be overemphasized given the immediacy of Medicare's financial crisis and the upcoming demographic changes. The most fundamental BBA reform was the creation of the Medicare+Choice program, designed to modernize Medicare by offering beneficiaries a wider array of health plan choices comparable to some of the options available in the private insurance market. The fee-for-service component of Medicare underwent considerable transformation as well. Most notably, this legislation continued the movement away from paying for services on the basis of providers' incurred costs to using prospective rates where the program sets payment levels in advance and has more control over its spending on services.

The ramifications of these fundamental changes--affecting beneficiaries, their health care providers, and taxpayers--are substantial. Not surprisingly, some interest groups have expressed concerns about the impact of these changes and made calls to alter some provisions. In some cases, adjustments may be wise; in others, premature or imprudent. That is why it is critical that there be a thorough evaluation of these policies, singly and in their totality, to inform ongoing policy discussions.

My comments today will focus on the implementation of (1) the Medicare+Choice program, particularly the payment method and consumer information efforts and (2) prospective payment systems for skilled nursing facilities (SNF) and home health agencies (HHA) in Medicare's traditional fee-for-service program. Our work in these areas illustrate the importance of the BBA reforms, the difficulties in implementing reforms, and the pressures to dampen their impact. My remarks are based on previously issued products as well as our ongoing work in these areas.

In brief, changes of the magnitude of those in the BBA require significant efforts to implement well and are subject to continual scrutiny. We recently reported that the efforts of the Health Care Financing Administration (HCFA) to put the BBA provisions in place have been extensive and noteworthy, and the agency has made substantial progress in implementing the majority of the Medicare-related BBA mandates. At the same time, it has encountered obstacles. Intense pressure to resolve Year 2000 computer compliance issues has slowed HCFA's efforts. In addition, in undertaking certain major initiatives, the agency has had to cope with inadequate experience and insufficient information. Thus, achieving the objectives of the BBA will require HCFA to refine and build on its initial efforts.

Findings from our recent Medicare+Choice work focus on payments to health plans and HCFA's consumer information initiatives. Reforms of the payment methods for Medicare+Choice plans are underway. They will address the methodological flaws that

have led to billions of dollars in excess payments and inappropriate payment disparities. Recognizing the need to avoid sharp payment changes that could affect a plan's offerings and diminish the attractiveness of the Medicare+Choice program to beneficiaries, these changes are being phased in over several years. Nevertheless, the withdrawal of some managed care plans has raised questions about how to maintain desired access for beneficiaries while implementing needed changes to plan payments and participation requirements. HCFA has also initiated an information campaign to provide beneficiaries with new tools to make informed health plan choices and create stronger, quality-based competition. Some aspects of the campaign have only been piloted and certain problems did develop; refining these efforts to make them more useful and effective for beneficiaries is now critical.

On the program's fee-for-service side, the BBA's mandate to replace cost-based reimbursement methods with prospective payment systems (PPS) constitutes another major program reform. The phase-in of the PPS for SNFs began on schedule on July 1, 1998. However, design flaws and inadequate underlying data used to establish the payment rates may compromise the system's ability to meet the twin objectives of slowing spending growth while promoting appropriate beneficiary care. Insufficient oversight could compound these shortcomings and further jeopardize potential cost savings. Improvements to the system design and better monitoring are feasible, but may require assistance from the Congress. The interim payment system for HHAs, with the similar objective of controlling rapid expenditure growth for this benefit, is now in place. Implementation of the PPS has been delayed until 2001 but remains a considerable

challenge given the benefit's broad eligibility requirements. Concerns have been raised about the impact of the interim payment system as more than 1,400 HHAs have closed since October 1997. However, because the number of agencies had been expanding dramatically, more than 9,000 HHAs still participate in Medicare—a larger number than did in October 1995. We have not found evidence that the closures or the interim payment system has significantly affected beneficiary access to home health care. However, our monitoring of potential access problems is continuing as more data on any effects of the interim system become available.

The impact of BBA's significant transformations of Medicare could generate pressure to undo many of the Act's provisions. In this environment the Congress will face difficult decisions that could pit particular interests against a more global interest in preserving Medicare for the long term. We believe that it would be a mistake to significantly modify BBA's provisions without thorough analysis or giving them a fair trial over a reasonable period of time.

BACKGROUND

Medicare is the nation's largest health insurance program, covering about 39 million elderly and disabled beneficiaries at a cost of more than $193 billion. Between 1990 and 1997, Medicare experienced spending increases averaging 9.8 percent per year to make it one of the fastest growing parts of the federal budget, although this growth has slowed

somewhat in the past 2 years. The Congressional Budget Office projects that Medicare's share of gross domestic product will rise almost one-third by 2009.

This substantial growth in Medicare spending will continue to be fueled by demographic and technological change. Medicare's rolls are expanding and are projected to increase rapidly with the retirement of the baby boom generation. For example, today's elderly make up about 13 percent of the total population; by 2030, they will comprise 20 percent as the baby boom generation ages. Individuals aged 85 and older make up the fastest growing group of beneficiaries. So, in addition to the increased demand for health care services due to sheer numbers, the greater prevalence of chronic health conditions associated with aging will further boost utilization.

Congressional attention has recently been focused on the impending depletion of Medicare's Federal Hospital Insurance (HI) Trust Fund. Payroll taxes credited to the HI trust fund finance the bulk of Medicare's "hospital insurance," or part A, which covers inpatient hospital services as well as skilled nursing facility, hospice, and certain home health care services. Beneficiaries' premium contributions and general revenues finance Medicare's "supplementary medical insurance," or part B, which covers physician and outpatient hospital services, diagnostic tests, ambulance services, and other services and supplies. A BBA provision that shifted the financing of some home health services from part A to part B helped extend the HI trust fund's solvency.

Other BBA reforms, designed to slow program spending, address both Medicare's managed care and fee-for-service components. Medicare's managed care program covers the growing number of beneficiaries who have chosen to enroll in prepaid health plans, where a single monthly payment is made for all necessary covered services. About 6.8 million people – about 17 percent of all Medicare beneficiaries – were enrolled in more than 450 managed care plans as of December 1, 1998.[1] Most of Medicare's beneficiaries, however, receive health care on a fee-for-service basis, in which providers are reimbursed for each covered service they deliver to beneficiaries.

BBA'S CREATION OF MEDICARE+CHOICE

One way in which the BBA seeks to restructure Medicare is to encourage greater managed care participation. Under the Medicare+Choice program, a broader range of health plans, such as preferred provider organizations and provider-sponsored organizations, are permitted to participate in Medicare. BBA's emphasis on Medicare+Choice reflects the perspective that increased managed care enrollment will help slow Medicare spending while expanding beneficiaries' health plan options.

Our recent work has examined two aspects of the Medicare+Choice program—payments and consumer information initiatives. BBA provisions dealing with payments to Medicare+Choice plans acknowledge that Medicare's prior managed care payment

[1]About 90 percent of the 6.8 million Medicare beneficiaries are enrolled in managed care plans that receive fixed monthly capitation payments. The remainder are enrolled in plans that are reimbursed for the costs they incur, less the estimated value of beneficiary cost-sharing.

method for health maintenance organizations (HMOs) and other risk plans failed to save the government money and created wide disparities in payment rates across counties. The Act establishes a new rate-setting methodology for 1998 and future years, incorporating adjustment rates for the health and expected service use of managed care enrollees to avoid overpayment. It also guarantees health plans a minimum payment level to encourage them to locate in areas that previously had lower rates and few, if any, Medicare participating health plans. Other provisions addressing consumer information needs are designed to raise beneficiary participation in Medicare+Choice and promote more effective quality-based competition among plans.

Managed Care Payment Reforms

Context for BBA's rate-setting provisions: BBA modifications to Medicare's health plan payment method acknowledge the problem of flawed capitation rates that, historically, have been paid to HMOs. Our work has demonstrated that these rates have produced billions of dollars in aggregate excess payments and inappropriate payment disparities across counties.[2]

The fundamental problem we found was that HMO payment rates were based on health care spending for the average non-enrolled beneficiary, while the plans' enrollees tended

[2] Our 1997 study on payments to California HMOs, which enrolled more than a third of Medicare's managed care population, found that Medicare overpaid plans by about 16 percent in fiscal year 1995—accounting for about $1 billion in excess payments. The proportion of excess payments varied across counties. See Medicare HMOs: HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments (GAO/HEHS-97-16, Apr. 25, 1997).

to be healthier than average non-enrollees, a phenomenon known as favorable selection. Some analysts expected excess payments to diminish with increased enrollment. Instead, the excess continued to grow, since rates were based on the rising concentrations of higher-cost beneficiaries remaining in fee-for-service.

Risk adjustment is a tool to set capitation rates so that they reflect enrollees' expected health costs as accurately as possible. This tool is particularly important, given Medicare's growing use of managed care and the potential for favorable selection, which, if not taken into account, generates excess payments. Medicare's current risk adjuster--based only on demographic factors, such as age and sex[3]--cannot sufficiently lower rates to be consistent with the expected costs of managed care's healthier population. For example, a senior who was relatively healthy and another who suffered from a chronic condition, even if they were of the same age and sex, would have very different expected health care needs, but with the current risk adjuster, that difference would not be accounted for in the rates paid for these individuals.

To correct this problem, the BBA requires HCFA to devise a new risk adjuster that incorporates patient health status factors.[4] HCFA had to develop and report on the new risk adjuster by March 1 of this year and is required to put the method in place by January 2000.

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[3] The demographic indicators are age; sex; eligibility for Medicaid; employment status; and residence in an institution, such as a skilled nursing facility. Separate rates, using the same demographic traits, are calculated for beneficiaries who qualify for Medicare because of a disability (under age 65). Separate rates are also set for beneficiaries with end-stage renal disease (kidney failure).

Design, implementation, and impact issues: HCFA's proposed interim risk adjuster—to be implemented in 2000—relies exclusively on hospital inpatient data to measure health status. While not perfect, the proposed risk adjuster for 2000 does link the rates paid more closely to projections of Medicare enrollees' medical costs. Ideally, the risk adjuster would measure health status with complete and reliable data from other settings, such as physicians' offices, but these data are not currently available. Given the reliance on only hospital data, HCFA has taken steps to avoid rewarding plans that hospitalize patients unnecessarily or conversely penalize efficient plans that provide care in less costly settings. A "next generation" of risk adjustment based on the services beneficiaries receive in all settings is scheduled for 2004.

HCFA plans to phase in the use of the interim risk adjuster and, in so doing, will avoid sharp payment changes that could adversely affect beneficiaries and plans. Such changes could be detrimental to beneficiaries if plans, in response, substantially scale back their benefit packages or reconsider their commitment to the Medicare+Choice program.

Currently, there is concern about a recent surge in plan drop-outs from Medicare+Choice. As of January 1999, 99 capitated plans had withdrawn or reduced their Medicare service areas. Industry representatives have stated that plans may have dropped out partially in anticipation of reduced payments, which could result when the interim risk adjuster is implemented. Plans have also cited the administrative burden associated with some of

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[4] Technically, the law requires the Secretary of Health and Human Services to develop, report, and

the new Medicare+Choice regulations as a significant reason for their withdrawal decisions.

The issue of plan drop-outs is complex, however, since the reasons for plans' decisions are not clear cut. As we have previously reported, many nonpayment factors—such as commercial managed care enrollment levels—influence plans' Medicare participation decisions.[5] Some areas of the country with relatively low payment rates have many Medicare managed care plans and enrollees. Moreover, the extent to which new Medicare+Choice regulations could have precipitated the withdrawals is unclear since few managed care organizations withdrew from Medicare completely. Most plans that pulled out of certain geographic areas continue to serve beneficiaries in other areas. In response to plans' concerns, however, HCFA recently revised a number of the Medicare+Choice regulations to make them less burdensome. Finally, while some plans are dropping out of the program, others are interested in signing new contracts. In fact, 16 applications for new or expanded service areas have recently been approved and 44 more are pending.

Medicare+Choice Information Campaign

Context for BBA's information campaign provisions: Capitalizing on changes in the delivery of health care, BBA's introduction of new health plan options are intended to

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implement the health-based risk adjustment method.
[5] See Medicare Managed Care: HMO Rates, Other Factors Create Uneven Availability of Benefits (GAO/T-HEHS-97-133, May 19, 1997).

create a market in which different types of health plans compete to enroll and serve Medicare beneficiaries. The BBA reflects the idea that consumer information is an essential component of a competitive market. From the beneficiary's viewpoint, information on available plans needs to be accurate, comparable, accessible, and user-friendly. Informed choices are particularly important as the BBA phases out the beneficiary's opportunity to disenroll from a plan on a monthly basis and moves toward the private sector practice of annual reconsideration of plan choice.

The BBA mandated that, as part of a national information campaign, HCFA undertake several activities that could help beneficiaries make enrollment decisions regarding Medicare+Choice. Each October, prior to a mandated annual, coordinated enrollment period, HCFA must distribute to beneficiaries an array of general information on, among other things, enrollment procedures, rights, and the potential for Medicare+Choice contract termination by a participating plan. The BBA also required HCFA to provide beneficiaries with a list of available participating plans and a comparison of these plans' benefits. The agency must also maintain a toll-free telephone number and an Internet site as general sources of information about plan options, including traditional fee-for-service Medicare.

Design, implementation, and impact issues: The BBA-mandated information campaign is a first-time and massive undertaking for HCFA. The effort is well underway but relative to the ideal—a market in which informed consumers prod competitors to offer the best value—many challenges lie ahead.

We have reported that, unlike many enrollees in the private sector and individuals covered by plans in the Federal Employee Health Benefit Program (FEHBP), Medicare beneficiaries receive little comparative information on their health plan options. We have also reported that, unlike FEHBP, HCFA does not require that plans' marketing materials follow a consistent format or use common terminology, thus making plan comparisons difficult for beneficiaries. Standardized language on benefit and coverage definitions would facilitate HCFA's oversight functions to ensure accurate information, plans' compliance with reporting requirements, and beneficiary decisionmaking. HCFA intends to require plans to begin using a standardized format for some information in anticipation of the November 1999 enrollment period.

HCFA is also in the process of making summary data available through several sources. In 1998, as part of a five-state pilot project, HCFA provided beneficiaries with a handbook containing comparative information on the Medicare+Choice plans available in their area and access to a toll-free telephone line. It also established an Internet site with similar information about plans available nationwide. These efforts made important strides, but because of plan pull-outs late in the year, some of the information beneficiaries received was inaccurate.

Critical now is a thorough evaluation of these efforts to assure that the information provided is clear, sufficient, and helpful to beneficiaries' decisionmaking. Assessing how

to make these efforts cost-effective—that is, targeting the right amounts and types of information to different groups of beneficiaries—is also of vital importance.

SELECTED BBA REFORMS OF MEDICARE FEE-FOR-SERVICE

The BBA also makes fundamental changes to Medicare's fee-for-service component, which represents about 87 percent of program outlays and covers about 33 million beneficiaries. Mandated prospective payment systems will alter how reimbursements are made to SNFs, HHAs, hospital outpatient departments, and rehabilitation facilities. Rather than generally paying whatever costs providers incur, the objective is to establish rates, giving providers incentives to deliver care and services more efficiently. Our work on the SNF and home health benefits shows the importance of the design and implementation details of prospective payment systems to achieving expected BBA savings and ensuring that Medicare beneficiaries have access to appropriate services.

SNF PPS

Context for SNF PPS provisions: Medicare spending for SNF services rose at an average annual rate of 23.2 percent from 1990 to 1996, much faster than overall program spending growth. Medicare's SNF payment method has been cited as one reason for this. Before the changes mandated in the BBA, SNFs were paid the reasonable costs they incurred in providing Medicare-allowed services. There were limits on payments for the

routine portion of care--that is, general nursing, room and board, and administrative overhead. Payments for ancillary services, such as physical, occupational, or speech therapy, however, were virtually unlimited. These unchecked ancillary service payments have been a major contributor to significant increases in daily reimbursements to SNFs. Because providing more of these services generally triggered higher payments, facilities had no incentive to deliver services efficiently or only when they were necessary. The BBA called for phasing in a PPS for SNF care beginning after July 1, 1998, to bring program spending under control.

Design, implementation, and impact issues: Under the PPS, SNFs receive a payment for each day of care provided to a Medicare beneficiary. The payment, called a per diem rate, is based on the average daily cost of providing all Medicare-covered SNF services, as reflected in facilities' 1995 costs. Since not all patients require the same amount of care, the per diem rate is "case-mix" adjusted to take into account the nature of each patient's condition and expected care needs. Facilities that can care for beneficiaries for less than the case-mix adjusted per diem amount will benefit financially, whereas SNFs with costs higher than the adjusted per diem rate will be at risk for the difference between their costs and payments. The PPS is expected to control Medicare spending because the per diem rate covers all services, so SNFs have incentives to provide services efficiently and judiciously. Further, since payments vary with patient needs, the PPS is intended to ensure access to these services.

We are concerned, however, that the design of the case-mix adjuster preserves the opportunity for providers to increase their compensation by supplying potentially unnecessary services.[6] To reflect differences in patient needs that affect the cost of care, the SNF PPS divides beneficiaries into case-mix groups. Each group is intended to define clinically similar patients who are expected to incur similar costs. An adjustment is associated with each group to account for these cost differences. A facility then receives a daily payment that is the same for each patient within a group. Since the payments do not vary with the actual costs incurred, a SNF has incentives to reduce the costs of caring for the patients in each case-mix group.

The design of the case-mix groups allow a SNF to reduce its costs and increase its payments by manipulating service provision, rather than by increasing efficiency. Since the SNF groups are largely defined by the services the patient is to receive, a facility can provide only the minimum level of services required for placement in a particular group. This would reduce the average cost for the SNF's patients in that case-mix group, but not lower Medicare payments for these patients. Thus, expected Medicare savings may not be achieved.

We are also concerned that the data underlying the SNF rates overstate the reasonable costs of providing services and may not appropriately reflect costs for patients with different care needs. Most of the cost data used to set the SNF rates were not audited. Of particular concern are therapy costs, which are likely inflated because there have been

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[6] See Balanced Budget Act: Implementation of Key Medicare Mandates Must Evolve to Fulfill

few limits on these payments. Even if additional audits were to uncover significant inappropriate costs, HCFA maintains that it has no authority to adjust the base rates after the implementation of the new system. Further, the case-mix adjusters were based on cost information on about 4,000 patients. This sample may simply be too small to reliably estimate these adjusters, particularly given the substantial variation in treatment patterns among SNFs. As a result, the case-mix adjusted rates may not vary appropriately to account for the services facilities are expected to provide—rates will be too high for some types of patients and too low for others.

Under the SNF PPS, whether a SNF patient is deemed eligible for Medicare coverage and how much will be paid are based on a facility's assessment of its patients and its judgment. Monitoring these assessments and determinations is key to realizing expected savings from the system. Texas, which implemented a similar reimbursement system for Medicaid, conducts on-site reviews to monitor the accuracy of patient assessments and finds a continuing error rate of about 20 percent. HCFA has no plans to undertake as extensive an effort. However, without adequate vigilance, inaccurate, inappropriate, and even fraudulent assessments could compromise the benefits of the PPS.

Home Health PPS and Related Reforms

Context for Home Health provisions: Medicare spending for home health care rose even more rapidly than spending for SNF services – at an average annual rate of 27.9 percent between 1990 and 1996. Several factors accounted for this spending growth,

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Congressional Objectives (GAO/T-HEHS-98-214, July 16, 1998).
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particularly relaxed coverage requirements that, over time, have made home health care available to more beneficiaries, for less acute conditions, and for longer periods of time. Essentially, Medicare's home health benefit gradually has been transformed from one that focused on patients needing short-term care after hospitalization to one that serves chronic, long-term care patients as well.

To control spending while ensuring the appropriate provision of services, the BBA mandated key changes to the payment method and provider requirements for home health services. HCFA is required to establish a PPS for HHAs by fiscal year 2001.[7] Designing an appropriate system for HHAs will be particularly challenging because of certain characteristics of the benefit. Home health care is a broad benefit that covers a wide variety of patients, many of whom have multiple health conditions, and the standards for care are not well defined. Consequently, the case-mix adjuster and payment rates must account for substantial variation in the number, type, and duration of visits. Further, the wide geographic variation in the use of home health care makes it difficult to determine appropriate treatment patterns that must be accounted for in the overall level of payment. A final concern has to do with the quality and adequacy of services. Since the services are delivered in beneficiaries' homes, oversight is particularly critical when payment changes are implemented to constrain program outlays.

Recognizing the difficulty of developing and implementing a PPS, the BBA required HCFA to pay HHAs under an interim system. The interim system builds on payment

limits already in place by making them more stringent and by providing incentives for HHAs to control the number and mix of visits to each beneficiary.

Design, implementation, and impact issues: Under the interim payment system, which became effective October 1, 1997, HHAs are paid their costs subject to the lower of two limits. The first limit builds on the existing aggregate per visit cost limits, but makes them more stringent. The new limit caps total annual Medicare revenues based on the number of beneficiaries served and an annual per beneficiary amount. The later is based on agency-specific and regional average per beneficiary payments and aims to control the number of services provided to users. The blending of agency-specific and regional amounts is intended to account for the significant differences in service use across agencies and geographic areas.

There has been widespread concern about the impact of the interim payment system on HHAs and access to home health care.[5] Indeed, between October 1, 1997, and January 1, 1999, over 1,400 HHAs closed. However, historic growth in the home health industry has been such that there were still over 9,000 HHAs -- more than there were in October 1995 -- to provide services to Medicare beneficiaries. Further, half of the closures were in just four states--California, Louisiana, Oklahoma, and Texas--three of which had experienced agency growth well above the national average. It is possible that the closures were a

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[5] The BBA required the PPS to be implemented in fiscal year 2000. Subsequent legislation delayed this by one year.
[6] See Medicare Home Health Benefit: Impact of Interim Payment System and Agency Closures on Access to Services (GAO/HEHS-98-238, September 1998).

market correction for overexpansion in light of the BBA's signal that Medicare would not support the double digit increases in spending of the previous few years.

The closures alone are not a measure of any impact on access for Medicare beneficiaries to home health services—which is the predominant concern. Since home health agencies require little physical capital, it is possible for other agencies to quickly absorb the staff and patients of closing agencies.

We have attempted to monitor the impact of the interim payment system on access for this Committee as well as for the House Committees on Commerce and Ways and Means. Last fall, we reported that interviews with hospital discharge planners and local aging organization representatives in seven states with high numbers of closures had not indicated a change over the past year in the willingness or ability of home health agencies in their areas to serve Medicare beneficiaries. We are continuing this work, expanding the number of areas examined. Recently available claims information will allow us to extend this monitoring further—pinpointing areas where there has been a decline or leveling off of home health utilization. We will provide the Committee a report next month and another this summer on our ongoing work to assess access to home health care.

CONCLUSIONS

The brief experience with some of the major Medicare provisions of the BBA demonstrates the challenges to implementing meaningful reform. HCFA has fallen behind in instituting some changes and has had difficulty implementing others due to constrained resources, lack of experience, or inadequate data. At the same time, various provider groups have increasingly come to the Congress for relief. We believe that any significant alterations to key BBA provisions should be based on thorough analysis or sufficient experience to fully understand their effects.

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Mr. Chairman, this concludes my statement. I will be happy to answer any questions you or the Committee Members may have.

(101812)

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

Date: March 31, 1999

To: Alice Phillips, Senate Committee on Finance

From: Bill Scanlon, Director Health Financing and Public Health Issues

Re: Questions for the record for hearing on Wednesday March 17, 1999

Question. Dr. Scanlon, we have heard concerns from both beneficiaries and skilled nursing facilities regarding inadequate reimbursement under the new prospective payment system, especially for sicker patients requiring ancillary services. Does GAO have any concerns over the new reimbursement categories designed by HCFA for payments to skilled nursing facilities? Does GAO have any recommendations to address these concerns?

As we stated in our written testimony, we are concerned about the case-mix categories used in the skilled nursing facility (SNF) prospective payment system (PPS) and the level of payment under the PPS. The case-mix categories, used to adjust payments for different types of patients, are based largely on the services patients actually receive rather than on patient needs. This means that a SNF can increase its payments by manipulating service provision, which could threaten expected Medicare savings. Further, we are concerned that the data underlying the SNF payment rates overstate the reasonable costs of providing services. Most of the cost data used to set the rates were not audited, so inflated costs, particularly for therapy services, were incorporated in the PPS base rates. Finally, the case-mix categories may not appropriately reflect costs for patients with different care needs. They were based on a sample of patients that may have been too small to adequately estimate the average costs for each category. As a result, the case-mix adjusted rates may not vary appropriately to account for the services facilities are expected to provide—rates will be too high for some types of patients and too low for others.

We are examining the variation in non-therapy ancillary costs and whether these costs were adequately incorporated into the PPS rates. This work is being conducted for Mr. Thomas, chairman of the Health Subcommittee, Committee on Ways and Means.

PREPARED STATEMENT OF WILLIAM J. SCANLON

(JUNE 9, 1999)

Mr. Chairman and Members of the Committee:

We are pleased to be here as you discuss the impact of payment reforms in the Balanced Budget Act of 1997 (BBA) on the Medicare+Choice program. The BBA's creation of Medicare+Choice represents one important means of helping to address the growing challenge of financing the Medicare program. Collectively, BBA reforms are expected to lower program spending by $386 billion over the next 10 years.

In creating the Medicare+Choice program, the BBA furthered the use of a choice-based managed care model of providing Medicare benefits. Prior to the BBA, Medicare's managed care model was limited largely to health maintenance organizations (HMO).[1] The BBA expanded beneficiaries' health plan options, both by encouraging the wider availability of HMOs across areas and by permitting other types of health plans to participate in Medicare. The BBA also sought to pay health plans more appropriately than Medicare had done under the program's previous HMO payment formula. A decade of research by GAO and others found that, instead of saving the government money as intended, the managed care program that preceded Medicare+Choice overpaid health plans in the aggregate—estimated to be several billions of dollars beyond what would have been paid had the enrolled beneficiaries been served under Medicare's traditional fee-for-service program.

Some health plan and industry representatives believe that BBA's payment changes were too severe, citing plan withdrawals from Medicare+Choice as evidence of BBA's adverse effects. This hearing provides an opportunity to examine the overall effect to date of BBA payment reforms affecting Medicare+Choice plans. My statement today will focus on whether BBA reforms have improved Medicare's ability to pay health plans more appropriately and whether recent experience implementing these reforms suggests the need for modifications. These remarks are based on GAO's prior and ongoing work on Medicare+Choice.

In summary, the net effect of BBA payment revisions has been to reduce but not fully eliminate excess payments to health plans. Some of the provisions, such as the reduced annual updates, have already been implemented, while others, such as the health-based risk adjustment system, will be phased in over time.

Despite industry alarm over the increase in plan withdrawals in 1999, our work suggests that sweeping amendments to the BBA are not yet warranted for several reasons. First, the net effect of BBA reforms on plans has been modest to date. Cuts in rate increases, for example, have held down per capita payment growth by only a little more than 1 percent. Second, data submitted by plans themselves indicate that at least some plans can provide the traditional Medicare package of benefits, offer some additional benefits, and make a profit even if they are paid less than they are today. For example, according to their own data, plans serving the Los Angeles area can provide the traditional Medicare

[1]For the purposes of this statement, the term HMO refers to plans with Medicare risk contracts, which accounted for about 90 percent of Medicare managed care enrollment in 1997. Prior to the BBA, Medicare managed care plans also included cost contract HMOs and health care prepayment plans.

package of benefits for about 79 percent of what they are currently paid. Third, the withdrawals we observed this year were not a reaction to BBA rate reductions alone. Market forces appear to have played a larger role.

Because of cuts in rate increases and expected improvements in risk adjustment, the BBA's health plan payment reforms will reduce aggregate excess payments. As a consequence, some Medicare+Choice plans may reduce supplemental benefits and rethink their participation in the Medicare program. The continuing challenge for the Congress is to strike the appropriate balance between containing Medicare spending and fostering growth in Medicare+Choice.

BACKGROUND

Medicare's use of prepaid health plans, which typically have a financial incentive to hold down costs, is intended to save the government from unnecessary spending on Medicare services without compromising the provision of covered benefits. In addition, from the beneficiary's perspective, these plans can be an attractive alternative to traditional Medicare because they usually offer more benefits and lower out-of-pocket costs. All plans serving Medicare beneficiaries are required to provide Medicare's statutorily covered benefits, and many provide additional services—such as outpatient prescription drugs, routine physical exams, hearing aids, and eyeglasses—that are not covered under traditional Medicare. In exchange for these advantages, beneficiaries give up their freedom to choose any provider.

As of March 1, 1999, about 6.7 million people—or 17 percent of Medicare's 39 million beneficiaries—were enrolled in 300 health plans, most of which were prepaid.[2] Prepaid plans receive for each beneficiary a fixed monthly amount—called a capitation rate—regardless of what a beneficiary's care actually costs. The remaining 83 percent of Medicare beneficiaries receive health care on a fee-for-service basis, where providers are paid for each covered service they deliver.

Although Medicare's pre-BBA managed care program attracted an increasing number of beneficiaries, it had several serious shortcomings. First, it was overly expensive for the government. During the decade preceding BBA, a mounting body of research showed that government payments to HMOs for their Medicare enrollees exceeded spending for similar beneficiaries in the traditional fee-for-service (FFS) program, even though plan payment rates were discounted by 5 percent from estimated FFS levels. This excess spending resulted from faulty calculation of the base rate and inadequate adjustments to that rate for the healthier-than-average population enrolled in Medicare's prepaid plans. In addition, HMOs were not available everywhere. In 1996, more than 25 percent of beneficiaries lived in areas not served by HMOs. Widely disparate payment rates across geographic areas contributed to this variability in access and to sizable differences in supplemental benefits. Finally, the program did not include options, such as preferred

[2]About 90 percent of the 6.7 million Medicare beneficiaries were enrolled in managed care plans that receive fixed monthly payments. The remainder were enrolled in plans that are reimbursed for the costs they incur, less the estimated value of beneficiary cost-sharing.

provider organizations, that had become popular in the private sector because they offered cost management but were more flexible than HMOs.

The BBA changed the capitation rate formula used to compensate the prepaid plans. Among several changes, the BBA required that the Health Care Financing Administration (HCFA), the agency responsible for administering Medicare, improve Medicare's current risk adjuster—the mechanism designed to adjust a plan's capitation rates upward or downward to reflect the extent to which an enrollee's expected health care costs differ from the average beneficiary's. As we have previously reported, Medicare's current risk adjuster cannot sufficiently raise or lower rates because it is based primarily on demographic factors such as age and sex, which alone are poor predictors of an individual's health care costs. To illustrate: under Medicare's current risk adjuster, a plan would receive the same payment for two enrollees of the same age and sex, even if one is expected to incur only minimal health care costs for treatment of occasional minor ailments and the other is expected to require expensive treatment for a serious chronic condition.

Without the use of health status factors to make better adjustments, Medicare generally overcompensates health plans because they tend to enroll beneficiaries who are healthier than average. Our 1997 study on payments to California HMOs, which enrolled more than a third of Medicare's managed care population, found that health plan enrollees had expected costs that were more than 16 percent below those for demographically similar beneficiaries in traditional Medicare.[3] Such "favorable selection" by Medicare's prepaid health plans—that is, their tendency to attract healthier-than-average enrollees—is not surprising. People with chronic or severe illnesses may not be attracted to HMOs because they have established relationships with providers and feel a need for easy access to specialists. Moreover, given the inadequacy of Medicare's risk adjuster to lower—or raise—payments appropriately, plans could put themselves out of business if they attracted significant numbers of high-cost beneficiaries.

UNDER BBA, MEDICARE'S PAYMENTS TO HEALTH PLANS LIKELY REMAIN EXCESSIVE IN THE AGGREGATE

Beginning in 1998, BBA substantially changed the method used to set Medicare+Choice plan payments. Some of the new payment provisions will tend to reduce excess payments. The most important of these is a new health-based risk adjustment system, to be implemented in two stages, with an interim adjuster to be introduced in 2000 followed by a more comprehensive adjuster in 2004. Substantial excess payments may persist, however, because other BBA provisions tended to incorporate some of the excess that existed in 1997 into the current rates.

[3](Medicare HMOs: HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments (GAO/HEHS-97-16, Apr. 25, 1997). This is consistent with a 1996 study by HCFA researchers finding that health plan enrollees had costs roughly 12 to 14 percent below the average beneficiary's. (Riley and others, HCFA Review, 1996.)

One way the BBA will reduce the excess in Medicare's managed care payments is by holding down per capita spending increases for 5 years. Specifically, BBA sets the factor used to update managed care payment rates to equal national per capita Medicare growth minus a specified percent: 0.8 percent in 1998 and 0.5 percent in each of the following 4 years. Although these across-the-board reductions can help produce savings, the cumulative reduction of less than 3 percent is considerably smaller than the prior estimates of excess payments, which generally exceed 10 percent. Moreover, this approach does not address the problem that the excess payments can vary among geographic areas and plans. In our study of California plans, we found that excess payments tended to be much higher in some counties than others.

The BBA also provides for a methodological approach known as "blending," which is designed to reduce the geographic disparity in payment rates and encourage more widespread plan participation.[4] Blending will work to move all rates closer to a national average by providing for larger payment increases in low rate counties and smaller payment increases in high rate counties. According to a 1997 study by the Physician Payment Review Commission (now the Medicare Payment Advisory Commission), there is some evidence that excess payments are more likely to occur in high payment rate counties.[5] Thus, blending may indirectly reduce excess payments by holding down payment increases in high rate counties.

A more targeted reduction in plan payments resulted from the BBA provision to "carve out" of the rate that portion that previously constituted Medicare's subsidy to teaching hospitals for graduate medical education (GME). Beginning in 1999, the BBA removes an increasing portion of the Medicare capitation payment attributable to GME and instead requires HCFA to pay teaching hospitals caring for Medicare+Choice plan enrollees directly. This provision was designed to address the concern that the capitation rates incorporated Medicare payments designed to cover GME expenditures, even when plans did not pass such amounts along to teaching hospitals in their payments to these facilities.

When implementation of BBA is complete, however, excess payments may not be fully eliminated. Because the law specified that 1997 county rates be used as the basis for all future county rates beginning in 1998, the BBA froze in place prior excess payments. As we reported in 1997, HCFA's then current methodology resulted in county rates that were generally too high.[6] In addition, excess payments are built into the current rates because BBA did not allow HCFA to adjust the 1997 county rates for previous forecast errors. Such adjustments had been a critical component of the pre-BBA rate-setting process. HCFA actuaries now estimate that the forecast error resulted in 1997 managed care rates that were too high by 4.2 percent. While BBA permits HCFA to correct forecasts in future years, it did not include a provision that would have allowed HCFA to correct its forecast for 1997. Consequently, about $1.3 billion in overpayments were built into

[4]Because of BBA-mandated budget neutrality and minimum payment constraints, no county received a blended rate in 1998 or 1999. Blending will occur for the first time in 2000.
[5]Physician Payment Review Commission, 1997 Annual Report to the Congress.
[6]GAO/HEHS-97-16.

plans' annual payment rates for 1998. This error will be compounded as managed care enrollment grows.

BBA's mandated health-based risk adjustment system is the provision that most directly targets the excess payment problem. The BBA requires HCFA to implement, beginning January 1, 2000, a method to base plan payments on beneficiaries' health status. HCFA's proposed interim health-based risk adjustment method uses only hospital inpatient data to gauge beneficiaries' health status but still represents a major improvement over the current method.[7] For the first time, Medicare's prepaid health plans can expect to be paid more for serving beneficiaries with serious health problems and less for serving relatively healthy ones.

Nevertheless, HCFA proposes to phase in the new interim risk adjustment system slowly. In 2000, only 10 percent of health plans' payments will be adjusted using the new method. This proportion will be increased each year until 2003, when 80 percent of plans' payments will be adjusted using the interim system. In 2004, HCFA intends to implement a more finely tuned risk adjuster that uses medical data from physician offices, skilled nursing facilities, home health agencies, and other health care settings and providers—in addition to inpatient hospital data. This improved risk adjustment system cannot be implemented currently because many plans say they do not have the capability to report such comprehensive information. Although a gradual phase-in of the interim risk adjuster delays the full realization of Medicare savings, it also minimizes potential disruptions for both health plans and beneficiaries.

RECENT EXPERIENCE SUGGESTS SWEEPING ACTION NOT WARRANTED IN THE SHORT TERM

Announcements of plan withdrawals in the last year have prompted debate about whether to revise certain BBA provisions governing Medicare+Choice. As we recently reported, several factors suggest that such revisions could be premature.[8] First, although an unusually large number of managed care plans left the program in 1999, a number of plans have applied to enter the program or expand their participation. Data on approved and pending Medicare plans as of January 1999 show that, nationwide, beneficiary access to prepaid plans is likely to increase slightly this year. Although for some localities withdrawals have meant significantly diminished or no access, only 1 percent of previously covered managed care enrollees were left without any Medicare+Choice plan option.

Second, it would be inaccurate to conclude that lower payment rates alone were responsible for these plan withdrawals. The current movement of plans in and out of Medicare is likely to be a normal reaction to market competition and conditions. While

[7] Medicare Managed Care: Better Risk Adjustment Expected to Reduce Excess Payments Overall While Making Them Fairer to Individual Plans (GAO/T-HEHS-99-72, Feb. 25, 1999).

[8] Medicare Managed Care Plans: Many Factors Contribute to Recent Withdrawals; Plan Interest Continues (GAO/HEHS-99-91, Apr. 27, 1999).

new payment rates were certain to have been considered in plans' decisions to withdraw from certain geographic areas, other factors—including recent entry into the market, low enrollment, and the presence of large competitors—likely played a role as well. Supporting this conclusion is the fact that plan withdrawals were not limited to low payment rate counties: 10 of the 11 counties with the highest payment rates were affected by the withdrawals. Moreover, a number of new plans either have approved or pending applications to participate in the program. If all applicants are approved, slightly more beneficiaries will have access to a Medicare+Choice plan in 1999 than had access to one in 1998 before the withdrawals occurred.

Third, recent data show that, despite the BBA's lowering of rate increases, Medicare's payments to plans still exceed the plans' cost of providing the traditional Medicare package and plans can continue to provide benefits well beyond that. Most Medicare+Choice plans do not charge beneficiaries a separate monthly premium and charge only a small copayment for each outpatient service.[9] Nearly all plans offer coverage for routine physical, eye, and hearing exams. Most provide coverage for outpatient prescription drugs.[10] Some provide dental care. In contrast, Medigap policies—of which there are 10 standard types—generally cost beneficiaries about $95 or more a month in premiums, while 7 of the 10 standard Medigap policies do not cover outpatient prescription drugs. Those Medigap policies offering a drug benefit require a $250 deductible with a 50-percent copayment and an upper limit on payments.

Many prepaid health plans have had considerable latitude in offering benefits because Medicare pays more than it costs them to provide the traditional FFS benefit package, even after accounting for allowable profits.[11] Under Medicare's payment terms, when a plan's estimated cost to provide the FFS package of benefits is less than projected payments, the plan must use the difference—an amount known as "savings"—to enhance its benefit package by adding benefits or reducing fees.[12] In 1997, plan savings averaged nearly 13 percent of payments. Consequently, plans were required to provide additional benefits worth $60 per member per month.

Although the relationship between plans' costs and their Medicare payments may have changed since 1997, our analysis of 1999 data submitted by plans serving Los Angeles county suggests that their costs continue to be well below Medicare payments. On average, Los Angeles plans could provide the traditional package for about 79 percent of the current payment amount. They complied with Medicare's requirements by using the

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[9]Beneficiaries who wish to participate in the Medicare+Choice program must pay the Medicare part B premium of $45.50 per month.

[10]GAO/HEHS-99-91.

[11]The accuracy of the cost data submitted by plans is unknown. Recent reports by the Department of Health and Human Services Office of the Inspector General suggest that the administrative cost component reported by some HMOs may be too high. See Administrative Costs Submitted by Risk-Based Health Maintenance Organizations on the Adjusted Community Rate Proposals Are Highly Inflated (A-14-97-00202), Department of Health and Human Services, Office of the Inspector General, July 1998.

[12]Alternatively, plans may deposit the amount in a benefit stabilization fund for use in future years. Before 1998, plans had a third option of returning the savings to Medicare. Historically, however, plans have enhanced their benefit packages in an attempt to attract members.

approximately $117 per beneficiary per month difference between Medicare payments and their costs to provide additional benefits. This amount of additional benefits may be higher than the national average because of the historically high payment rates in the area. However, the example of Los Angeles illustrates that, 2 years after BBA's payment reforms were implemented, some plans receive payments that far exceed their costs of providing the traditional FFS benefit package.

Plans may choose, for competitive or other reasons, to exceed Medicare's minimum requirements and further enhance their benefit packages. In 1997 nationally, plans on average added more than $33 in extra benefits per member per month—in addition to the $60 in required additional benefits. The Los Angeles plans added an average of $21 per beneficiary per month in extra benefits during 1999. Although all Los Angeles plans offer some extra benefits, the dollar amount varies by plan from $0.43 per beneficiary per month to almost $80 per beneficiary per month. The ability of plans to provide additional benefits (both required and voluntary) suggests that planned cuts in rate increases are not likely to threaten the typical plan's ability to earn a profit while providing a benefit package that is more comprehensive than the one available in Medicare FFS.

CONCLUDING OBSERVATIONS

In creating the Medicare+Choice program, BBA substantially changed the way plan payments are determined. Some plan and industry representatives have suggested that BBA's payment reforms were too severe. They point to the recent plan withdrawals to back up their claims that the Medicare+Choice program is in danger of floundering. We believe, for a number of reasons, that these concerns must be viewed in a broader context, as follows:

- The effect on plan payments to date has been modest and, on average, has removed only a portion of excess payments built into the base rates.

- Data submitted by plans suggest that many of them can provide the FFS package of benefits, offer some additional benefits, and make a profit even if they are paid less than they are today.

- The withdrawals we observed this year appear to have been influenced by external market conditions not fully attributable to Medicare+Choice provisions.

Decisions to modify Medicare+Choice need to balance industry concerns about the BBA's changes to health plan payment rates against a reasoned assessment of the program's purpose and a systematic analysis of the BBA's impact. Medicare managed care was instituted to save the program money. Although HMO payments before BBA were discounted by 5 percent from what was paid for traditional Medicare beneficiaries, methodological shortcomings led to Medicare's HMO enrollees costing the program and taxpayers more. The excess payments benefited plans and their enrollees as plans offered additional benefits like prescription drug coverage.

Adjusting plan payments so that the program pays no more for a Medicare+Choice enrollee than for a traditional Medicare beneficiary with equivalent health status is going to mean smaller payments and most likely lower profits for plans as well as fewer supplementary benefits for enrollees. These consequences raise for the Congress the question of whether the BBA's payment changes should be modified to protect plans and the fraction of the Medicare beneficiary population enrolled—even if that protection results in Medicare's spending more on the Medicare+Choice beneficiary than for the traditional Medicare beneficiary.

* * * *

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or the other Members of the Committee may have.

Contact and Acknowledgement

For future contacts regarding this testimony, please contact William J. Scanlon at (202) 512-7114. Individuals making key contributions to this testimony included James C. Cosgrove and Hannah F. Fein.

(101857)

PREPARED STATEMENT OF WILLIAM J. SCANLON

[JUNE 10, 1999]

Mr. Chairman and Members of the Committee:

I am pleased to be here today as you discuss the effect of the Balanced Budget Act of 1997 (BBA) on the Medicare fee-for-service program. The BBA set in motion significant changes that attempted to both modernize Medicare and rein in spending. The act's combination of constraints on provider fees, increases in beneficiary payments, and structural reforms is projected to lower program spending by $386 billion over the next 10 years. Because certain key provisions have only recently or have not yet been phased in, the full effects on providers, beneficiaries, and taxpayers wrought by the BBA will not be known for some time.

My comments focus on the payment reforms for providers under the fee-for-service portion of the program. I will concentrate on the changes made to skilled nursing facility (SNF) and home health agency (HHA) payment policies. Although the BBA mandated similar reforms for other types of providers, the SNF and HHA changes are, at this time, farthest along in their implementation. These provisions were enacted in response to continuing rapid growth in Medicare spending that was neither sustainable nor readily linked to demonstrated changes in beneficiary needs. These provisions represented bold steps to control Medicare spending by changing the financial incentives inherent in provider payment methods to promote more efficient service delivery. Yet the Congress is coming under increasing pressure from providers to revisit these reforms. As additional BBA provisions are implemented, and other providers feel the effects of the mandated changes, calls for modifications may continue or even intensify. How responsibilities to current and future seniors, the American taxpayer, and the health care provider community are balanced will shape the resulting responses. Achieving the appropriate balance will require recognition of legitimate concerns about beneficiary access and the ability of providers to adjust to the new payment methods.

Calls by providers to moderate the effect of BBA changes come at a time when federal budget surpluses and smaller-than-expected increases in Medicare outlays may make it easier to accommodate higher Medicare payments. Indeed, many provider groups contend that BBA changes produced more savings than originally intended. The Congressional Budget Office has revisited and lowered its estimates of Medicare spending since BBA enactment. As a result of the lower projected spending, the estimated savings from the BBA provisions will represent a proportionately larger share of Medicare expenditures. Lower projected Medicare spending, however, does not necessarily mean that the effect of the BBA changes was greater than intended. Rather, it merely raises again issues of how much the federal government should pay for health care for the elderly and what payment levels are appropriate for the various provider groups.

The BBA mandated the continued movement of fee-for-service Medicare away from cost-based reimbursement methods and toward prospective payment systems (PPS). The goal is to foster more efficient provision and use of services to lower spending growth rates, replicating the experience of acute care hospitals after a PPS was implemented, beginning in the mid-1980s. The BBA mandated such payment systems for SNFs, HHAs, hospital outpatient services, and certain hospitals. On July 1, 1998, SNFs began a 3-year transition to a PPS.[1] An interim payment system (IPS) for HHAs was phased in beginning on October 1, 1997, and a PPS is scheduled to be implemented for all HHAs on October 1, 2001.[2]

In brief, both SNFs and HHAs have felt the effect of the BBA provisions, and both industries will need time to adapt, but the calls to amend or repeal the new payment systems are, in our view, premature. The SNF PPS was implemented with a 3-year transition to the fully prospective rates, and facilities are phased into this transition schedule according to their fiscal year; thus, the adjustment time has been built into the PPS schedule. Current concerns that the PPS is causing extreme financial pressures for some SNFs need to be systematically evaluated on the basis of additional evidence. Several factors suggest that the problem may be less severe than is being claimed by providers. Nevertheless, certain other modifications to the PPS may be appropriate because there is evidence that payments are not being appropriately targeted to patients who require costly care. The potential access problems that may result from underpaying for high-cost cases will likely result in beneficiaries' staying in acute care hospitals longer, rather than forgoing care. This is a safety net for beneficiaries while modifications are made. The Health Care Financing Administration (HCFA), which has responsibility for managing the Medicare program, is aware that payments may not be adequately targeted to high-cost beneficiaries and is working to address this problem.

As a result of the swift implementation of the home health IPS and the lack of a transition period, the BBA's impact on home health agencies has been more noticeable. The number of participating agencies declined by 14 percent between October 1997 and January 1999, and utilization has dropped to 1994 levels, the base year for the IPS. However, since the number of HHAs and utilization had both grown considerably throughout most of the decade, beneficiaries are still served by over 9,000 HHAs–approximately the same number that were available just prior to the

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[1]The SNF PPS will be phased in on the basis of facility cost-reporting years. During the transition, payment rates will be a blend of a declining portion of a facility-specific historical amount and an increasing portion of the national prospective rate.

[2]The BBA required the HHA PPS to be in place in fiscal year 2000. Subsequent legislation delayed the implementation by 1 year and eliminated the phasing in of the system.

recent declines. Our interviews with HHAs, advocacy groups, and others in rural areas that lost a significant number of agencies indicated that the recent decline in HHAs has not impaired beneficiary access. While the drop in utilization does not appear to be related to HHA closures, it is consistent with IPS incentives to control the volume of services provided to beneficiaries. In short, after years of substantial increases in home health visits, the IPS has curbed the growth in home health spending. Some of the decline in utilization appears to involve greater sensitivity to who qualifies for the home health care benefit, with some who do not qualify, but who may have been previously served, not receiving services now. There are indications, however, that beneficiaries who are likely to be costlier to serve than the average may have more difficulty than before in obtaining home health services because the revenue caps imposed by the IPS are not adjusted to reflect variations in patient needs. This problem should be ameliorated with the implementation of the PPS. In designing the PPS, it will be essential that HCFA adequately adjust payments to account for the wide differences in patient needs.

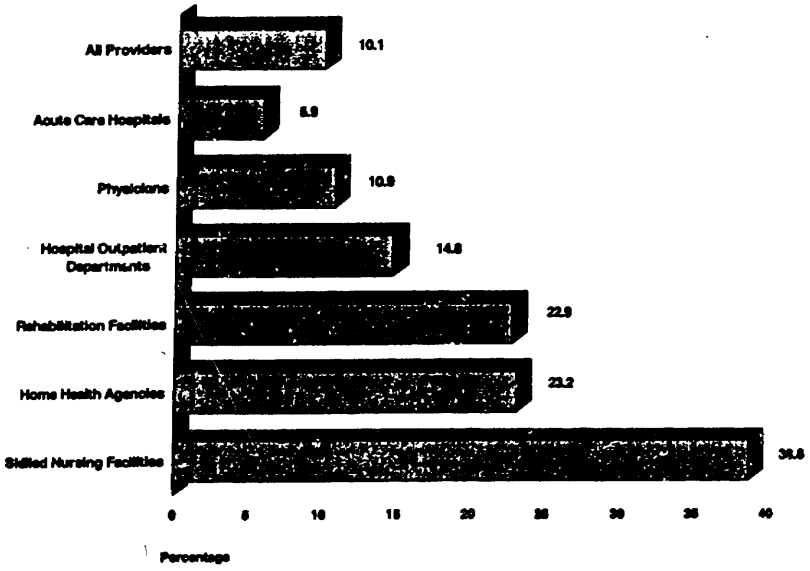
To date, the principal lessons to be drawn from the SNF and HHA payment reforms and their implementation are that

- the particulars of payment mechanisms largely determine the extent to which a reform option can control excess government spending while protecting beneficiary access to care and
- revisions to newly implemented policies should be based on a thorough assessment of their effects so that, at one extreme, policies are not unduly affected by external pressures and premature conclusions and, at the other extreme, policies do not remain static when change is clearly warranted.

BACKGROUND

Medicare is the nation's largest health insurance program, covering about 39 million elderly and disabled beneficiaries at a cost of more than $193 billion a year. The sheer size of this program during a period of particular concern over government spending made it the target of spending reforms. That Medicare was growing faster than the overall economy and the Medicare Hospital Insurance Trust Fund was facing imminent depletion only heightened attention on this program. Medicare expenditures had been rising at an average annual rate of 10.1 percent between 1985 and 1995 (see fig. 1). While the outlook for the federal budget has changed, with projected surpluses replacing deficits, the importance of ensuring that Medicare is an efficient purchaser of health services remains.

Figure 1: Average Annual Rate of Growth in Medicare Expenditures, 1985-95, by Type of Provider

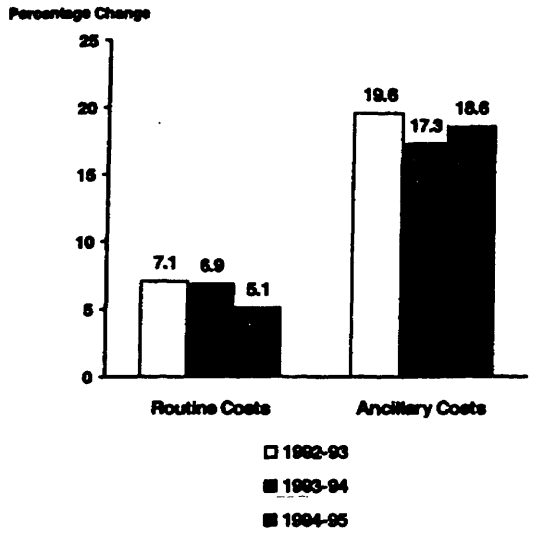


Despite significantly lower projected spending due to BBA reforms, there is a growing consensus among experts, including the trustees of the Medicare Hospital Insurance Trust Fund, that additional reforms are needed. As the baby boomers reach retirement age, the pressures on Medicare program spending will intensify. Fueled by medical technology advancements that allow more and better treatments for a larger portion of the elderly, Medicare spending growth will continue to be an important budgetary issue. The Congressional Budget Office projects that by 2009 Medicare's expenditures as a portion of the gross domestic product will rise almost one-third.

INDUSTRY AND OTHER CONCERNS ABOUT SNF PPS REQUIRE THOROUGH ANALYSIS

Prior to the PPS, SNFs were paid the reasonable costs they incurred in providing Medicare-allowed services. Although there were limits on the payments for the routine portion of care–that is, general nursing, room and board, and administrative overhead–payments for other costs–primarily ancillary services such as rehabilitative therapy–were virtually unlimited. Because higher ancillary service costs triggered higher payments, facilities had no incentive to provide these services efficiently or only when necessary. Thus, growth in ancillary costs far outpaced the growth in routine service costs between 1992 and 1995 and drove up overall Medicare payments to SNFs (see fig. 2). Moreover, new providers were exempt from even the routine caps for their first 4 years of operation, which encouraged expansion of the industry.

Figure 2: Percentage Growth in SNF Routine and Ancillary Costs per Day, 1992-95



Under the new PPS, facilities receive a payment for each day of care provided to a Medicare-eligible beneficiary. This per diem rate is based on the average daily cost of providing all Medicare-covered services, as reflected in facilities' 1995 costs, adjusted to take into account the nature of each patient's condition and expected care needs. By establishing fixed payments and including all services provided to beneficiaries under the per diem amount, the PPS attempts to provide incentives for SNFs to deliver care more efficiently and judiciously.

The PPS represents a major change to the previous incentives of cost-based reimbursement and, as a result, Medicare treatment patterns that were influenced by the previous payment method will need to be modified. Previously, SNFs benefited from providing more ancillary services, without regard to the price paid for those services, since Medicare's payment was based on each facility's actual costs. SNFs that boosted their Medicare ancillary costs–either through higher use rates or higher prices–will need to make more modifications than those that did not. Scaling back these services, however, will not necessarily affect the quality of care. There is little evidence to indicate that the rapid growth in Medicare spending was due to a commensurate increase in Medicare beneficiaries' needs. Further, practice pattern changes may not be very disruptive because Medicare patients constitute a small share of most SNFs' business. And, blending facility-specific costs with the national PPS rates during the transition will ease the adjustments for facilities that have a history of providing many ancillary services.

Recent industry reports, however, have questioned the ability of some organizations operating SNF chains to adapt to the new PPS. Indeed, claims of pending bankruptcies have been linked to the Medicare payment changes. It is likely, however, that a combination of factors has contributed to the poor financial performance of these businesses. For example, many of the organizations have other lines of post-acute-care services–including the provision of outpatient rehabilitation therapy and ancillary services to affiliated SNFs as well as independent SNFs. The PPS may have affected the demand for these services, but other BBA provisions likely have had an effect as well.[3] In addition, some of these organizations invested heavily in the nursing home and ancillary service businesses not long before the enactment of the PPS, both expanding their acquisitions and upgrading facilities to provide higher-

[3]The BBA applied a per beneficiary payment cap of $1,500 for outpatient physical and speech therapy and a $1,500 cap for outpatient occupational therapy, although neither cap is applicable to services provided through a hospital outpatient department. These limits will not apply to Medicare beneficiaries during a Medicare-covered SNF stay, but could affect Medicare SNF residents if their stay is not covered by Medicare. This provision, in combination with consolidated billing for all services under the PPS, could limit some providers' ability to sell therapy and other ancillary services to other SNFs.

intensity services. Yet HCFA had been developing a PPS for some time that would curtail unnecessary growth in ancillary payments. We are studying these issues and will provide more details later this year on the effect of the PPS on solvency and beneficiary care.

While we think that industry concerns about the financial viability of SNFs operating under PPS have not been substantiated and may be premature, we have identified three key PPS design issues that may affect Medicare's ability to realize program savings and may limit beneficiaries' access to care. First, we are concerned about the SNF case-mix adjusters, which are needed to ensure that facilities serving patients with more intensive care needs receive adequate payments and, conversely, that SNFs are not overcompensated for patients with lower care needs. The current case-mix adjusters preserve the opportunity for SNFs to increase their compensation by supplying potentially unnecessary services. A SNF can benefit by manipulating the services provided to beneficiaries, rather than increasing efficiency. For example, the payment for a patient who requires 143 minutes of therapy care daily is $286 per day, compared with $346 for a patient who requires 144 minutes (see table 1). Thus, by providing an extra few minutes of therapy to certain patients, a facility could increase its Medicare payments without a commensurate increase in its costs. Rather than improving efficiency and patient care, this might only raise Medicare outlays. We believe that HCFA needs to continue its research into a classification system that is less dependent on service use and more closely tied to patient characteristics and needs. It also must provide adequate oversight to ensure that providers properly classify patients and do not manipulate service provision to take advantage of the classification system.

Table 1: Comparison of Length of Average Daily Therapy and per Diem SNF Payments for Different Rehabilitation Case-Mix Groups

Rehabilitation case-mix groups	Length of average daily therapy (for 5 days per week)	Per diem payment (federal unadjusted rate for urban facilities)
Ultra high	144+ minutes	$346
Very high	100 to 143 minutes	286
High	65 to 99 minutes	259
Medium	30 to 64 minutes	239

Our second concern is whether the system adequately identifies the most expensive patients and adjusts payment rates accordingly. This concern emanates from limitations in the data HCFA had available to establish the case-mix groups and the rates. The classification system was based on a small sample of patients and, because of the age of the data, may not reflect current treatment patterns. As a result, the classification system may aggregate expensive patients with widely differing needs into too few groups to distinguish adequately among patients' resource needs. In addition, the classification system does not take into account varying nontherapy ancillary service needs and is likely to overpay SNFs for treating patients with low service needs and underpay those SNFs treating patients with high service requirements. These design weaknesses could result in access problems or inadequate care for some high-cost beneficiaries. Hospitals have reported an increase in placement problems due to the reluctance of some facilities to admit certain beneficiaries with high expected treatment costs, which will increase hospital lengths of stay for these patients. HCFA is aware of the limitations of the case-mix adjusters and is working to refine these measures to more accurately reflect patient differences.

Finally, we are concerned that the cost reports submitted to Medicare for the year on which payments are based (1995) include unreasonable costs and may establish payments levels that are too high. Most of the data used to establish these rates have not been audited and are likely to include excessive ancillary costs, because the prior system had no incentives to constrain such costs. Moreover, it is likely that the base year includes too many services and that the costs per service were inappropriately high.

HHA CLOSURES AND DECLINING UTILIZATION SIGNAL IPS IMPACT, BUT THERE IS LITTLE EVIDENCE OF IMPAIRED ACCESS

Medicare spending for home health care rose at an annual rate of 25.2 percent between 1990 and 1997. Several factors accounted for this spending growth, most notably the relaxation of coverage guidelines. In response to a 1988 court case, the benefit was essentially transformed from one that focused on patients needing short-term care after hospitalization to one that serves chronic, long-term-care patients as well.[4] Thus, Medicare may now be covering services that would previously have been paid for by Medicaid or by beneficiaries themselves. The loosening of coverage and eligibility criteria contributed to an increase in the number of beneficiaries receiving services. Between 1990 and 1997, the number of Medicare home health users per 1,000 beneficiaries increased from 57 to 109.[5] Associated with the increase in

[4]Duggan v. Bowen, 691 F. Supp. 1487 (D.D.C. 1988).

[5]These numbers reflect Medicare fee-for-service beneficiaries only.

beneficiaries being served over this period was the near doubling of Medicare-certified HHAs to 10,524 by 1997.

Also contributing to the historical rise in spending were a payment system that provided few incentives to control how many visits beneficiaries received and lax Medicare oversight of claims. Between 1990 and 1997, the average number of visits per user climbed from 36 to 73. HHAs could boost revenues by providing more services to more beneficiaries, a strategy that could actually help HHAs avoid being constrained by Medicare's limits on payments per visit.[6] There is evidence that some HHAs provided visits of marginal value. For example, as we noted in a previous report, even when controlling for diagnoses, substantial geographic variation exists in the provision of home health care.[7] In 1996, the average number of visits per user in the West South Central region (Arkansas, Louisiana, Oklahoma, and Texas) was 129, compared with 47 in the Middle Atlantic region (New York, New Jersey, and Pennsylvania). While the precise reasons for this variation are not known, there is no reason to assume that it was warranted by patient care needs. Evidence indicates that at least some of the high use and the large variation in practice represented inappropriate care.[8] Medicare oversight declined at the same time that spending mounted, contributing to the likelihood that inappropriate claims would be paid. The proportion of claims that were reviewed dropped sharply, from about 12 percent in 1989 to 2 percent in 1995, while the volume of claims almost tripled.

To control spending while ensuring the appropriate provision of services, the BBA mandated expeditious implementation of the IPS while the PPS was under development. Prior to BBA, HHAs were paid on the basis of their costs, up to preestablished limits. The limits were set for each type of visit but were applied in the aggregate for each agency; that is, costs above the limit for one type of visit could still be paid if costs were sufficiently below the limit for other types of visits. The IPS lowered the visit payment limits and subjected HHAs to an aggregate Medicare

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[6]Agencies could avoid the payment limits by lowering their per visit costs in two ways: by serving less expensive patients with shorter visits and by providing more visits and thereby spreading fixed costs over more visits.

[7]Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996).

[8]Medicare: Improper Activities by Mid-Delta Home Health (GAO/T-OSI-98-6, Mar. 19, 1998) and Department of Health and Human Services, OIG, Variation Among Home Health Agencies in Medicare Payment for Home Health Services (Washington, D.C.: HHS, July 1995). Our 1997 analysis of a small sample of high-dollar claims found that over 40 percent of these claims should not have been paid by the program. See Medicare: Need to Hold Home Health Agencies More Accountable for Inappropriate Billings (GAO/HEHS-97-108, June 13, 1997).

revenue cap based on a historical per beneficiary amount that factors in both agency-specific and regional average per beneficiary payments. The purpose of the cap is to control the number of services provided to users. The blending of agency-specific and regional amounts accounts for the significant differences in service use across agencies and geographic areas. For new HHAs, without historical cost data, the caps are based solely on the national median. Because per beneficiary limits are tied to fiscal year 1994 payments, the new payment limits will be more stringent for agencies and areas that experienced significant growth in the number of visits per user between 1994 and 1997. Notably, the growth in Louisiana, Oklahoma, and Texas, where 1994 utilization levels were approximately twice the national average, greatly exceeded the average increase nationally. By comparison, utilization levels declined in one-fifth of the states with utilization levels below the national average in 1994, making it easier for HHAs in those states to cope with the cap.

In contrast to the SNF PPS, the IPS had a more immediate effect on the operation of providers because there was no gradual transition to imposition of the revenue cap. The IPS was phased in according to an HHA's cost reporting year–61 percent of agencies came under the IPS by January 1, 1998, and the remainder by September 30, 1998. Moreover, unlike the situation with SNFs, Medicare beneficiaries represent a substantial proportion of the patients served by HHAs. The closure of a significant number of HHAs occurred after the IPS was implemented. Between October 1, 1997, and January 1, 1999, 1,436 Medicare-certified HHAs stopped serving Medicare beneficiaries. However, because of the growth in the industry since 1990, there were still 9,263 Medicare certified HHAs in January 1999–only 500 fewer than in October 1996. (See fig. 3.)

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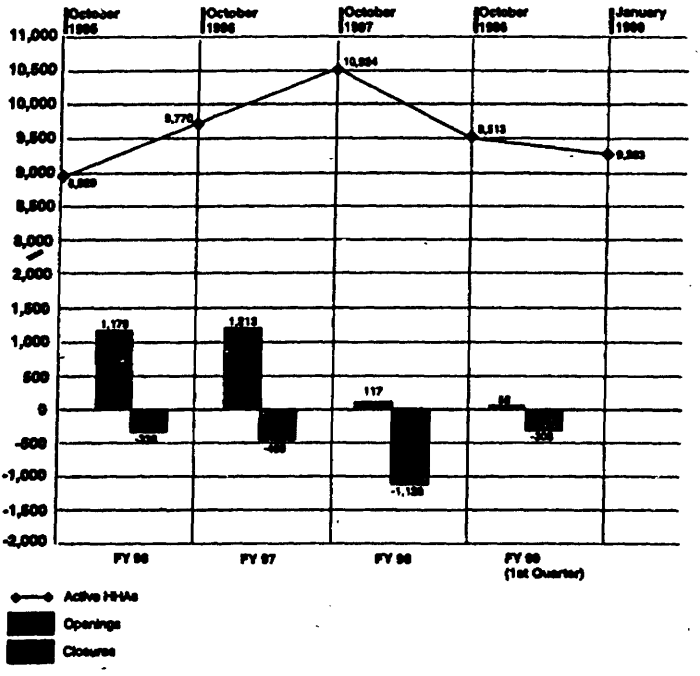
Figure 3: Change in Number of Medicare-Certified HHAs, October 1, 1995, Through January 1, 1999



Forty percent of the closures were concentrated in three states that had experienced considerable growth in the number of HHAs and had utilization rates (visits per user as well as users per thousand fee-for-service beneficiaries) well above the national average (see table 2). Furthermore, the majority of closures occurred in urban areas that still have a large number of HHAs to provide services. The pattern of HHA closures suggests a response to the IPS. The IPS revenue caps would prove particularly stringent for HHAs that provided more visits per user, for smaller agencies, for those with less ability to recruit low-cost patients, and for newer agencies. In fact, HHAs that closed had provided over 40 percent more services per

user than agencies that remained open. Closing HHAs were also about half the size of those that remained open, and they had been losing patients before the implementation of IPS.

Table 2: Decline in HHAs and Changes in Utilization Nationally and in Three High-Use States

	HHA closures as a percentage of active agencies, Oct. 1, 1997	Number of Medicare-certified HHAs, Jan. 1, 1999	People served per 1,000 Medicare fee-for-service enrollees			Visits per user		
			1994	1997	Percentage change	1994	1997	Percentage change
Nationwide	-14.0	9,263	94.2	109.2	15.9	66.0	72.9	10.5
Louisiana	-21.6	407	138.6	157.3	13.5	125.8	161.0	28.0
Oklahoma	-23.2	299	108.9	131.9	21.1	105.7	147.0	39.1
Texas	-20.1	1,580	106.9	133.7	25.1	97.4	141.0	44.8

Despite the widespread attention focused on closures, the critical issue is whether beneficiaries who are eligible to receive services are still able to do so. Utilization rates during the first 3 months of 1998 are consistent with IPS incentives to control costs. Home health utilization in the first quarter of 1998 was lower than during a comparable period in 1996 but was about the same as during a comparable period in 1994--the base year for the IPS. Moreover, the sizeable variation in utilization between counties with high and low use has narrowed. In counties without an HHA, both the proportion of beneficiaries served and the visits per user declined slightly during the first 3 months of 1998, compared with a similar period in 1994, but these counties' levels of utilization remained above the national average. Our February 1999 interviews with officials at HHAs, hospital discharge planners, advocacy groups, and others in 34 primarily rural counties with significant closures indicated that beneficiaries continue to have access to services. Some of the decline in utilization appears to be for beneficiaries who no longer qualify for the home health care benefit. However, these interviews also suggested that as HHAs change their

operations in response to the IPS, beneficiaries who are expected to be costlier than average to treat may have increased difficulty obtaining home health care. The pending implementation of the PPS, which will adjust payments to account for costlier patients, has the potential to ameliorate future access problems.[9]

CONCLUSION

The BBA made necessary and fundamental changes to Medicare's payment methods for SNFs and HHAs to slow spending growth while promoting more appropriate beneficiary care. Further refinements are required to make these systems more effective. However, the intentional design of these systems is to require inefficient providers to adjust their practice patterns to remain viable.

The very boldness of these changes has generated pressure to reverse course. In the current environment, the Congress will face difficult decisions that could pit particular interests against a more global interest in preserving Medicare for the long term. As PPSs are implemented for rehabilitation facilities and hospital outpatient services, and as SNFs continue their transition to full PPS rates, provider complaints about tight payment rates and impaired beneficiary access will continue to be heard. It is important that the implementation of these new payment mechanisms is monitored to ensure that the correct balance between appropriate beneficiary access and holding the line on Medicare spending is being achieved. Our work suggests that it would be premature at this juncture, however, to significantly modify the BBA's provisions without thorough analysis or a fair trial of the provisions over a reasonable period of time.

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Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or other Members of the Committee may have.

GAO CONTACT AND ACKNOWLEDGMENTS

For future contacts regarding this testimony, please call William J. Scanlon at (202) 512-7114. Individuals who made key contributions to this statement include Carol Carter and Walter Ochinko.

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[9]For additional information on the impact of the home health IPS on beneficiary access, see Medicare Home Health Agencies: Closures Continue With Little Evidence Beneficiary Access Is Impaired (GAO/HEHS-99-120, May 26, 1999).

PREPARED STATEMENT OF THOMAS A. SCULLY

Mr. Chairman and Members of the Finance Committee, thank you for inviting the Federation to testify today. The Federation represents almost 1700 privately-owned and managed hospitals nationwide. Within our membership are a large number of specialty hospitals, including rehabilitation facilities, an area which will receive special attention in my testimony.

I will focus briefly on four topics this morning:

1. **The 1997 BBA cut Medicare spending by almost $200 billion over five years — almost $100 billion more than was expected when it passed in October 1997. Medicare had been growing at an average annual inflation rate of 10% in the '90's. The goal of the BBA was to slow that growth to about 5.5% a year. Last year, the first year under the BBA, Medicare hospital spending actually fell, and all Medicare spending increased just 1.5%. For FY '99, Medicare spending will fall by 1.6% and Medicare Part A spending will fall by 5.2%.**

2. **Recent studies have shown that these cuts are having a significant negative impact on hospital margins and hospital operations. Rural hospitals have been impacted most dramatically.**

3. **Priorities for BBA Repair. While many services have been hit hard by the 1997 BBA, the Federation has prioritized three areas where Congress could most effectively address hospital policy and reimbursement problems:**

- ***Fix Unplanned and Unfair Outpatient PPS Cut of 5.7%, or $900 million per year***
- ***Repeal Hospital Transfer Policy***
- ***Restore Excess Cuts in Bad Debt Reimbursement***

4. **Prospective Payment for Rehabilitation Hospitals. HCFA is crafting rehabilitation hospital PPS rules, as directed by the BBA, for release in FY 2000. This system must be a per discharge base system (like DRGs) similar to that in place for acute care hospitals, and not a per diem system (like RUGS) similar to what has been adopted for nursing facilities.**

i. The BBA Far Overshot Its Savings Targets. The Budget Process That Produced This Result Is Fundamentally Flawed

The goals of the 1997 Balanced Budget Act were laudable, and hospitals and the communities they serve are pleased that the federal budget is balanced and that significant surpluses were created. Still, the fact is that Medicare provider payments were far and away the largest contributor to deficit reduction in the 1997 BBA, with $103 billion in net Medicare savings, as it was scored at passage. In real terms, however, the

1997 policies far overshot the mark for Medicare savings in the BBA. Real Medicare savings from the BBA are now likely to exceed $200 billion from FY98-FY02. Unfortunately for health providers, budget reductions are a "one way ratchet". When HCFA and the CBO underestimate the impact of budget reduction policies, the "extra" money that is saved is gone – forever – into the great beyond of the budget surplus.

The 1995 Budget Reconciliation Bill that was vetoed contained a "look back" provision that would have ensured that only the intended level of Medicare spending reductions took place. Under the 1995 provisions, Medicare policies could have been adjusted periodically to ensure that the Medicare program hit the targeted savings in the bill. As we all know, that bill was vetoed. Unfortunately, the 1997 BBA included no such provision. So when the actual savings from the 1997 BBA far exceeded those projected by CBO and HCFA, health care providers had no recourse -- nor did Congress. The money is gone. It certainly helps the surplus. But, it also certainly is unfair to health providers and the seniors they care for.

If we look at FY99, in March, CBO projected that Medicare would spend almost $20 billion less than was expected under the BBA when it passed. Actual spending now appears likely to be over $25 billion less than targets in the BBA. Pre-BBA, Medicare was projected to spend $248.2 billion in FY99. The BBA was expected to reduce that number to $233 billion, but based on actual spending from the Treasury, Medicare spending will actually be about $208 billion for FY99. *This is $25 billion less than anticipated in the legislation just 18 months ago.* (*See Attachment "A"*)

For hospitals, under the BBA, Medicare spending was expected to be held to $107.3 billion for FY99—about a 1.5 growth rate. Reality is that Medicare hospital spending is now expected to be just $101.4 billion, a *2.3% real reduction from FY98*, and over $6 Billion less for FY99 than was projected only 18 months ago. For most hospitals, there is no way to handle *negative* 2.5% spending trends without an impact on patient care. It is simply not possible.

How could this happen? There are many factors, and I would be happy to address the details in the question period. But the vast bulk of these traumatic spending reductions resulted from policy changes in the BBA -- policies whose impact was not fully understood and thus were significantly underestimated at the time the BBA was crafted. Contrary to what others might argue, enhanced fraud and abuse and inflation differences are a very small piece of the $100 billion scoring difference in the last 18 months. This isn't CBO's fault, or HCFA's. They do the best scoring they can, at the time they are asked. It is a fundamental structural flaw in the budget process. CBO is asked to project – or "guesstimate" - the impact of major policy changes in the behavior of health providers over a five-year period -- a multi-billion dollar snap shot in a rapidly changing system. In past Reconciliation Bills in 1987, 1990 and 1993, they had over-estimated the savings impact of many Medicare proposals, and were frustrated when spending did not fall. But in 1997, partly due to that historical experience, they massively underestimated the impact on virtually all providers – hospitals, nursing homes, home health, and Medicare risk contractors. It is a virtually impossible task to project accurately. Still,

sadly, the government's contractors have to try to live with the very unpleasant results of a very inaccurate science. There are better ways – the model in the vetoed 1995 BBA is just one example.

So, what is the impact of the 1997 Medicare BBA policies?

ii. Two major recent studies have shown that there is a significant and growing negative impact on hospitals, and that pain is growing. For rural hospitals the impact is most damaging.

In recent months, two comprehensive studies have been completed analyzing the impact of the 1997 BBA, one by Ernst and Young and HCIA, and another by the Lewin Group, commissioned by the AHA. Guy King, HCFA's former Chief Actuary, now working with Ernst and Young, oversaw the study commissioned by the Federation, "*A Comprehensive Review of Hospital Finances In the Aftermath of the Balanced Budget Act of 1997*". The studies had similar findings, with both finding very negative margin impacts across virtually all care settings, as a result of the BBA.

A summary of the "Key Findings" of the Ernst and Young/HCIA is attached to this testimony. (*See Attachment "B"*) Among the findings:

- Medicare hospital margins have declined to .1% in 1999.
- Medicare outpatient margins are negative 17% now, declining to negative 2.8% by 2002 under the BBA. And this is BEFORE the additional 5.7% unanticipated reduction in the new Outpatient PPS Regulation crafted pursuant to the BBA.
- Total margins for small, rural hospitals will fall from 4.2% in 1998 to negative 5.6% in 2002, largely due to the BBA.

The impact of the BBA has been severe across all sectors of health care, regardless of type of provider or their capital structure. The bond and stock markets have certainly taken note of the impact the Balanced Budget Act is having on health care concerns. Moody's Investors Service, in its February 1999 report, noted the negative credit health of health systems and said that it expects high rating volatility and deteriorating credit to continue, largely due to the BBA. For the first time, Moody's noted significant credit difficulties for Aa-rated hospitals. As credit ratings decline, the cost of capital increases – which puts additional pressure on hospital operating margins. Health care stocks have plummeted over the course of the last 18 months, with many sectors, including hospitals, dropping 40% in value. (*See Attachment "C"*) This, at a time when the rest of the market is reaching new highs. Health care has been the worst sector of the economy for the past two years. Why? The BBA.

Hospitals invest heavily in capital and assets to finance improvements in their infrastructure and technology. The ability to borrow capital to finance equipment purchases to maintain and improve patient care is key to maintaining the health care quality of patients in communities across the nation.

So, if the BBA went too far, what should Congress fix?

iii. **Priorities for BBA Repairs.** The BBA reduced spending by almost $100 Billion more than intended, yet we know Congress will not restore that level of spending. There are easily $25-30 Billion, over 5 years, of legitimate BBA fixes that are needed, but understanding that a package of repairs is more likely to be in the $10-$20 Billion range, we have strictly prioritized our concerns:

a) Outpatient PPS

Outpatient payment policy has been flawed for many years; the chief flaw being that beneficiaries were paying too much for their share of the cost of the services they received in outpatient settings. Over the course of a number of years, HCFA, hospitals and beneficiary groups worked together to fashion a remedy that was based on sound policy that was fair and that involved compromise of all parties. The essence of that policy was included in the 1997 BBA, and was clearly intended to be implemented in a package that was budget neutral. Budget savings totaling $7.2 billion were included as part of the BBA through a number of outpatient related provisions, including the elimination of the so-called "formula-driven overpayment." While these BBA payment reductions clearly have serious financial implications for hospitals, hospitals accepted those cuts in good faith, as a painful but necessary step toward a more rational prospective payment system (PPS) that was budget neutral and included no additional cuts.

The language in both *the House and Senate versions of BBA that were voted on by both chambers and went to Conference were identical versions of the OPD PPS system.* In the final drafting of the Conference language, technical changes were made to the provision. When the bill was signed into law, both HCFA and hospital groups believed the final language had the same budget neutral effect as what was included in the House and Senate bills. It wasn't until August 1998, when HCFA began drafting the implementing rule, that the agency discovered the minor formula change in the Conference Report language governing budget neutrality. **HCFA estimates that its interpretation of that language will cost hospitals an additional $900 million per year or $4.5 billion over five years – a totally unexpected, unfair and massive additional cut.**

Allow me to elaborate. The way the Secretary of HHS was instructed to calculate the total amount of beneficiary co-payments was ambiguous. HCFA, in its interpretation of the statutory language, has proposed in its rule that hospitals, due to the technical change made in the final drafting process, would be expected to shoulder an additional 5.7% cut in their outpatient payments. The 5.7% is an average, across all hospitals; rural hospitals are estimated by HCFA to face an additional 7.4% cut. We believe strongly that HCFA's interpretation is fundamentally inconsistent with Congressional intent. Never was there a discussion among Members, or with HCFA, of the technical change in the language or the intent behind the change. There is no mention in the Conference

Report of any intention to further reduce payments for services in outpatient settings to achieve additional savings. There is no mention anywhere in the legislative record or any analysis of the provision of this additional cut aimed at hospitals. The provision was never reviewed by CBO for scoring purposes. Basically, hospitals have been "sucker-punched" with a new and totally unexpected $900 million per year cut. And this is just the latest estimate of overall impact -- when this was discovered last summer the impact was estimated to be 3.8% or a $450 million cut on hospitals. Earlier this year that figure was revised to 2.8%, then just a few weeks ago that figure was revised upwards to 5.7%. Clearly this uncertainty adds enormously to the angst hospitals already feel from the BBA. But more importantly, Mr. Chairman, how can we be certain that the cuts will not run even higher?

Hospitals and outside legal experts believe that HFCA is not required to follow its current narrow reading of the language of the statute. We believe it has the flexibility to adopt a rule reflecting Congress' clear intent. **Moving to outpatient PPS was intended to be budget neutral policy – and $900 million additional cut to hospitals' bottom lines is not neutral to their budgets!**

Outpatient margins have been estimated to fall to a negative 27.8% by 2002, even without the additional cut. Adding this cut would push hospital reimbursement for outpatient services even further into the red. (*See Attachment "D"*) This is bad for hospitals and worse for patients.

We believe that HCFA has the ability, under the statute, to change its proposed rule and initial interpretation. We hope Congress will clarify its intent to HCFA to restore budget neutrality and fix this clear inequity.

b) Repeal Hospital Transfer Policy

As part of the BBA, Congress enacted what is commonly known as "transfer policy." This policy cuts hospital payments for patients who are discharged to post-acute settings such as rehabilitation centers, nursing homes or to their home when they receive home health care. This policy is ill advised and is fundamentally inconsistent with the essence of a prospective payment system. The foundation of PPS is to reward hospitals for efficient behavior, one indicator of which is shorter hospital stays. Transfer policy undermines the incentive to act efficiently because hospitals suffer a financial penalty for doing so.

Even more important, transfer policy turns its back on advances in patient care. One of the key advances of this decade with regard to patient care is the ability of hospitals to be responsive to each patient's medical needs and treat those needs in the most appropriate care setting. Clearly, it is in patients' interest to move them to less intensive care settings where appropriate.

In addition, transfer policy creates an administrative nightmare for hospitals. They are now required to keep track of what happens after a patient is discharged to another setting. An illustration: A patient is discharged with no plan for further treatment. Several days later the patient's physician decides that they should begin receiving home care, but does not notify the hospital. The hospital is now at financial and legal risk. The original payment must now be adjusted to reflect the per diem methodology rather than payment based on the DRG. This creates a nightmare for hospitals by making them track patients post discharge and requires them to constantly go back and readjust their charges.

Finally, it is unfair to areas of the country that have shorter than average lengths of stay. Even when a patient is transferred for legitimate treatment purposes, these hospitals are penalized with lower reimbursement simply because they have better practice patterns and shorter lengths of stay.

c) Medicare Bad Debt

Under federal law, hospitals, as part of their contract with communities and patients, treat all patients, regardless of their ability to pay. Until the enactment of BBA, hospitals were fully reimbursed for Medicare-based bad debt, once a hospital could show they exercised due diligence to collect the unpaid bill from the patient. BBA cut that reimbursement to 55%.

As you know, there is a hefty $768 deductible charged to Medicare beneficiaries for in-patient hospitalizations as part of the Medicare program. Almost 80% of seniors are covered by Medigap insurance, which helps defray the costs of the deductibles and co-pays. About 10% of seniors are poor enough to qualify for Medicaid, which covers these costs. The remaining 10% of Medicare recipients – the near poor – often cannot and do not pay their Medicare hospital deductible. It is this population that accounts for the bulk of Medicare bad debt. The bottom line is these patients do not have the money to pay, no matter how much time and resources a hospital expends in attempting to collect the money.

This is a government program – hospitals that care for near-poor seniors should not be financially disadvantaged for serving these deserving patients. Full Medicare reimbursement for bad debt is essential to the survival of many hospitals, particularly those with a high percentage of near poor Medicare patients. Without this reimbursement, areas with a high concentration of elderly poor patients, such as many rural areas, could be faced with reduced access to services.

This policy was intended to impact all Part A providers in 1997, but due to a drafting error, it unfairly singled out hospitals. Congress should restore reimbursement for Medicare bad debt, as well as equity in its application to all Part A providers. While there is a limited impact on the federal budget – approximately $100 million per year – this funding is critical to the financial

health of hospitals that provide quality care across this nation to low income seniors.

Prospective Payment System for Rehabilitation Facilities

Some provisions of the BBA have yet to take effect, such as implementation of a prospective payment system (PPS) for rehabilitation facilities, which are currently paid under a cost-based method. The BBA requires the Secretary of Health and Human Services to develop a prospective payment system for rehabilitation hospitals and units by October 1, 2000. The Federation has supported this move to a PPS. However, whether the new PPS is a win for the program, taxpayers and Medicare beneficiaries depends largely upon the choice of payment unit and patient classification system. Congress did not specify a particular approach when it enacted the BBA.

Rehabilitation hospitals and units provide medical care and intensive physical, occupational and speech language pathology services and other rehabilitation therapy services to patients, who because of disease, injury, stroke or similar conditions are physically and cognitively impaired. Because many of these conditions are associated with aging, Medicare beneficiaries account for about 70% of admissions to rehabilitation facilities. As such, it is critical that the Secretary design a PPS that accurately reflects the duration and intensity of services needed by, and provided to these patients. If the PPS is flawed, patient access to quality rehabilitation services will suffer.

To avoid adding rehabilitation services to the list of BBA problems, we support the PPS approach recommended by the Medicare Payment Advisory Commission (MedPAC) in its March 1 report to Congress. The Commission has recommended a per-discharge payment unit that classifies patients based upon functional status, diagnosis and age and resources needed to lead the patient back to optimal functional recovery -- often referred to as functional-related groups, or FRGs. In making this recommendation, the Commission rejected a per-diem or daily payment approach.

We are concerned, however, that the Health Care Financing Administration (HCFA) may be considering a per diem approach that would closely rely on the patient classification system used for skilled nursing facilities, known as resource allocation groups or RUGs. We believe strongly, as does MedPAC, that such an approach is misguided for several reasons. First, it would not adequately account for the range of patients served by rehabilitation providers. Second, it would result in longer lengths of stay, thereby penalizing the most cost-efficient facilities. Last, but not least, it would lead to higher costs, without improving quality of care. A per discharge PPS has worked for acute care hospitals and is far more appropriate for rehabilitation facilities than is a per diem, or RUGs-like system.

Given the important role rehabilitation providers play in meeting the health care needs of our senior citizens, we urge Congress to direct HCFA to develop a per-discharge PPS based on function-related groups. We also believe that the new PPS should not be fully implemented until a final rule has been adopted.

Conclusion

The Federation of American Health Systems and its member hospitals worked closely with Congress to enact legislation to balance the federal budget. Many of the policies were, frankly, hard for hospitals to swallow. Estimates of the impact of legislative provisions contained in this bill were just that, estimates. They have been proven by the government's own spending reports to be woefully inaccurate. Congress voted on $103 billion in payment reductions to the Medicare program; it did not vote on the $220 billion plus in cuts that is the more accurate impact today.

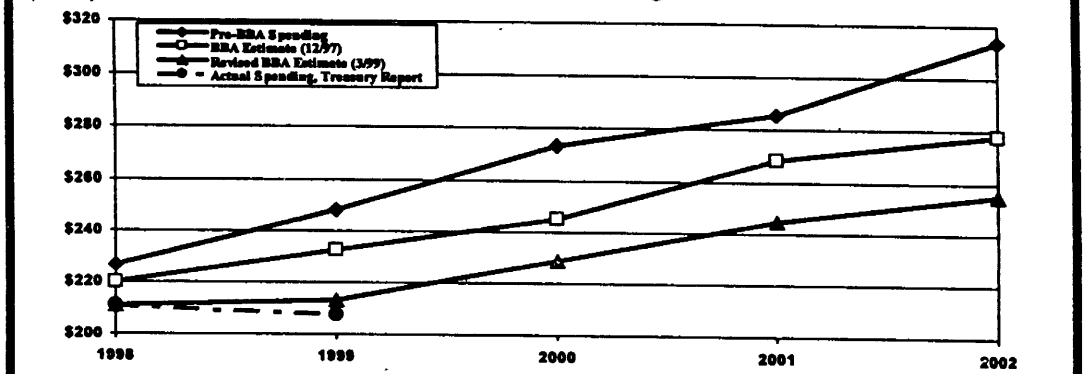
Hospitals across the country are feeling the impact of these cuts. In fact, more than one-third of all hospitals are facing bottom lines in the red due to BBA – a 55% increase. (*See Attachment "E"*) So, clearly, tough choices are being made every day about whether there will be enough capital to buy new technology that is needed to serve patients, whether there needs to be staff layoffs, or whether to cut back on services. A hospital's mission is to serve and to heal patients. It is a fact of life that the bulk of a hospital administrator's time now is spent navigating a myriad of complicated regulations and payment cuts arising from the BBA.

The Federation has prided itself in the past on working with the Finance Committee to craft effective hospital policies and payment reforms. I doubt any Member of the Committee foresaw the full impact of the BBA when it passed in 1997. We would hope to work with you again to identify fair and rational policies that can address these issues, while meeting our shared goal of providing high quality care at a reasonable cost that protects patients and the Trust Funds.

Again, thank you for this opportunity, and I'd be happy to try and answer any questions that the Committee may have for me.

Medicare Spending $91.7 Billion Less Than Projected (FYs 1998-02)

BBA Savings Nearly Double Original Estimate



Projections Pre- and Post-BBA (in billions)	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	Five -Year Difference
Pre-BBA spending estimated	$227.0	$248.2	$273.0	$285.6	$313.7	-
Estimated spending reductions under BBA (12/97)	(6.9)	(15.5)	(27.6)	(17.1)	(35.9)	($103.0)
Estimated spending under BBA (12/97)	220.1	232.7	245.4	268.5	277.8	-
Additional spending reductions per revised estimate	(9.1)	(19.4)	(16.5)	(23.8)	(22.9)	($91.7)
Revised estimated spending under BBA (3/99)	211.0	213.3	228.9	244.7	254.9	-
Actual Spending Treasury * Report	211.0	207.7	-	-	-	-
Real Additional Spending Reduction	0.0	(5.6)	-	-	-	-

*Sources: CBO, "An Analysis of the President's Budgetary Proposals for FY 2000: A Preliminary Report", March 3, 1999; CBO, "Budgetary Implications of the Balanced Budget Act of 1997, "December 1997. *Treasury 3/31/99 Estimates Projected to Entire Year.*

Attachment "B"

REPORT ON HOSPITAL MARGINS FOLLOWING IMPLEMENTATION OF BBA 1997

Last Fall, the Federation of American Health Systems Board of Directors retained Ernst & Young and HCIA to attempt to measure the impact of the BBA on the hospital industry. The analysis used current cost reports and MedPAC's methodology to project the impact of BBA provisions from 1998-2002.

Key Findings and Other Issues

The purpose of this document is to provide a comprehensive, accurate picture of the current and anticipated state of the hospital industry's financial health. Key findings of these analyses are highlighted below.

- ***Total hospital Medicare margins are expected to decline from 4.3 percent in FY 1997 to only 0.1 percent in FY 1999.*** These margins are projected to remain below 3 percent through FY 2002, the duration of the Balanced Budget Act (BBA) payment reduction provisions.

- ***Total hospital margins are projected to decline 48 percent in just five years, from 6.9 percent in FY 1998 to 3.6 percent in FY 2002.*** While total hospital margins for all hospitals would have decreased even if the BBA had not been enacted, these margins are significantly smaller under the BBA and decrease at a much faster rate during the five-year period (see page 13).

- ***Total hospital margins for small, rural hospitals are expected to fall from 4.2 percent in FY 1998 to negative 5.6 percent by FY 2002, a decline of 233 percent.***

- ***Findings on hospital Medicare inpatient margins are consistent with MedPAC.*** While these findings—which revealed that hospital Medicare inpatient margins decreased from 16.9 percent in FY 1997 to 16.5 percent in FY 1998—are consistent with those of the Medicare Payment Advisory Commission (MedPAC), they represent only a portion of the overall fiscal picture for hospitals.

- ***Hospital outpatient margins are already negative 17 percent in FY 1998, and are projected to get substantially worse, dropping to negative 27.8 percent by FY 2002.*** The BBA has significantly reduced outpatient payments, payments that were already inadequate. This analysis modeled the impact of the elimination of the formula-driven overpayment (FDO), but not the impact of the outpatient prospective payment system (PPS). The PPS would reduce margins another 3.8 percent, according to HCFA's impact analysis that was published in a September 1998 proposed rule. As outpatient revenues continue to increase as a portion of total hospital revenues, the impact of these negative margins will be even more injurious to hospitals.

- ***The BBA's transfer payment policy reduces hospital inpatient payments by approximately two and a half times more than original estimates.*** The transfer policy reduced inpatient payments between $500 and $800 million in FY 1998, and by approximately $3 billion between FYs 1998 and 2002. The Congressional Budget Office (CBO) had estimated a $1.3 billion five-year budget impact when the BBA was enacted in 1997.

The magnitude of these reductions in margins and Medicare payments must be considered in light of two other significant outcomes attributable largely to the BBA:

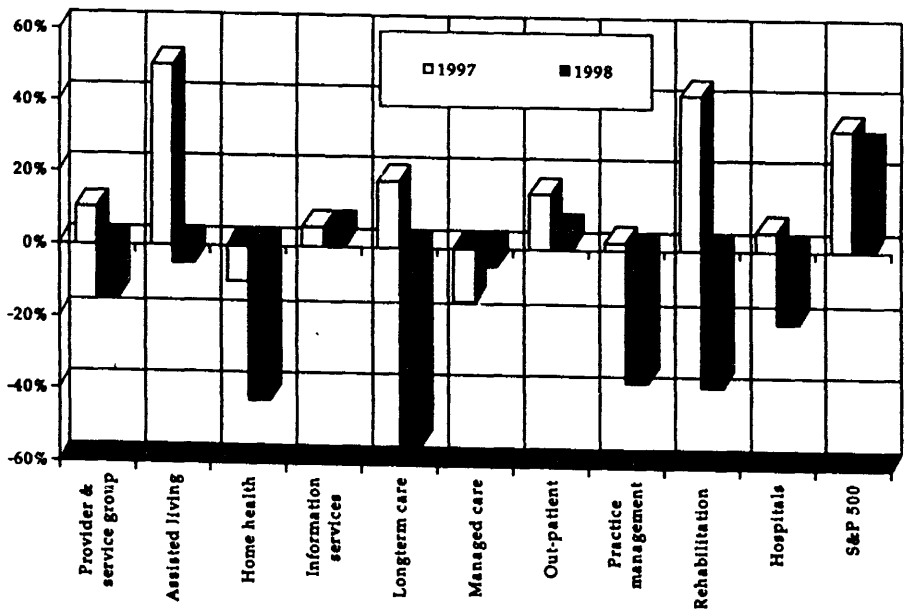
- ***The CBO projects Medicare spending to be $88.5 billion lower than anticipated when the BBA was enacted.*** Recent CBO spending estimates for Medicare project total spending to be $191.5 billion less than original estimates for FYs 1998 through 2002. CBO's estimate of Medicare spending reductions at the time of BBA enactment was $103 billion.

- ***BBA cuts have shaken confidence in the health care industry and have lead to numerous downgrades in bond ratings for community hospitals.*** Many analysts are attributing much of the precipitous drop in health care bond ratings to the impact of the BBA. Lowered bond ratings ultimately impair a hospital's ability to access capital to finance technological and facility improvements which, in turn, negatively affect patient access to, and quality of, care.

Attachment "C"

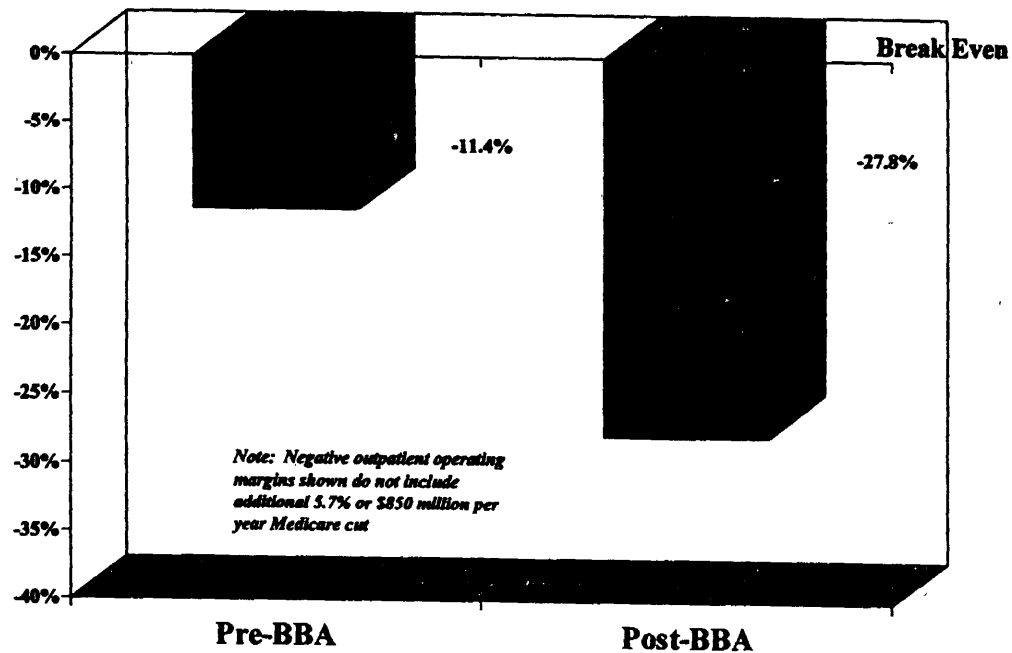
Health Care Stock Performance, 1997 and 1998

Percent stock price from previous year



Attachment "D"

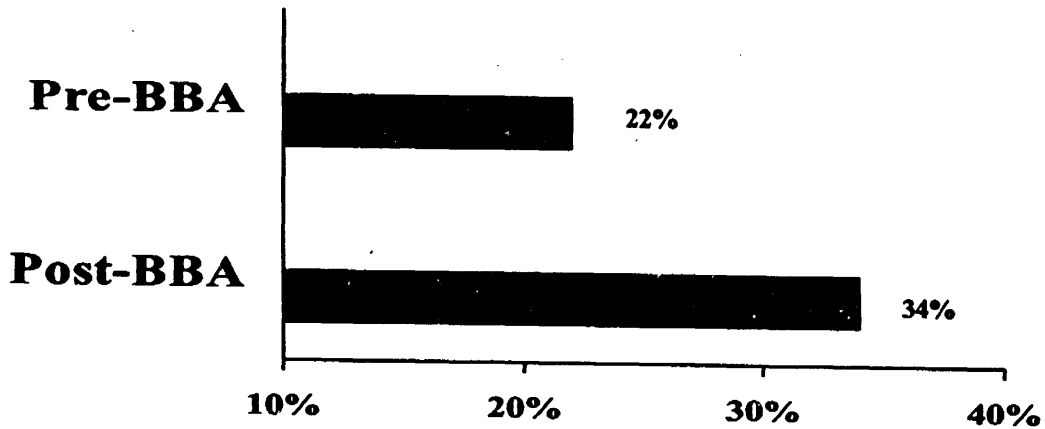
Medicare Outpatient Margins



Attachment "E"

Total Hospitals Operating in the Red

** Post-BBA, there is a 55% increase in hospitals with negative total margins. **



PREPARED STATEMENT OF CHARLES M. SMITH, M.D.

Mr. Chairman, I am Charles M. Smith, M.D., president and CEO of Christiana Care Corporation in Wilmington, DE. I am here today on behalf of the American Hospital Association (AHA) and its nearly 5,000 hospitals and health systems, networks and other providers of care. We appreciate this opportunity to present our views on an issue that is critical to our members and their communities: the need for relief from the unintended consequences of the Balanced Budget Act of 1997.

Christiana Care is a not-for-profit, coordinated health care system that provides health care services to a four-state area. In addition to many other services, Christiana Care includes two teaching hospitals with 1,100 licensed beds and 225 residents and fellows in training; a long-term care facility; a preventive medicine and rehabilitation institute; a home health care company; a primary physician network and a wide variety of other outpatient services including school and senior wellness centers. The Balanced Budget Act of 1997 and the changes it has brought about in Medicare reimbursement affect all of our services.

The Balanced Budget Act was the biggest reform of the Medicare program ever undertaken during the past 30 years. It was a major piece of legislation encompassing approximately 350 changes that have significant implications and consequences for the program, for caregivers, and for the people we serve. Hospitals and health systems are greatly affected by those changes. I urge the committee to seriously evaluate the consequences of the Balanced Budget Act . . . intended or unintended. Such consideration will lead to the conclusion that change is needed as soon as possible.

UNINTENDED CONSEQUENCES

Balancing America's budget shouldn't deprive Americans of the health care they need and deserve. But that's exactly what's happening across the nation, even though two-thirds of the cuts have yet to take effect. Today's hospitals and health systems encompass all elements of health care delivery affected by the Balanced Budget Act: home health, skilled nursing, outpatient and inpatient hospital, and health plans. This makes the act's changes particularly burdensome, and the worst is yet to come, as a new analysis from The Lewin Group, a highly respected health care consulting firm, makes clear.

The Lewin Group was asked by the AHA to forecast the Balanced Budget Act's impact through the year 2002 on payments for hospital services including inpatient, outpatient, hospital-based home health, rehabilitation, long-term care, psychiatric and cancer services. The Lewin Group report shows that the actual cost of the Balanced Budget Act for hospitals will be $71 billion over five years—$18 billion more than was anticipated when the bill passed. Further findings from the analysis:

- For all hospitals, total Medicare margins are projected to be between negative 4.4 percent and negative 7.8 percent in 2002.
- Already in the red when treating Medicare patients, rural hospitals' total Medicare margins may plummet to between negative 7 percent and negative 10.4 percent in 2002 as a result of BBA payment cuts. Urban hospitals' total Medicare margins in three years are predicted to range from negative 3.9 percent to negative 7.3 percent.
- Outpatient service margins also are expected to drop. Medicare outpatient margins . . . already negative in 1999 . . . are estimated to be negative 28.8 percent if costs increase at the historical rate of growth; and negative 20.3 percent if hospital costs increase more slowly.
- In just one year, margins for hospital-based home health services are predicted to drop dramatically from negative 4 percent in year 2000, to negative 11.6 percent margin in 2001. Fifty percent of hospitals now provide home health care.

The new report contributes to the growing evidence that hospitals and their communities are facing hardship. A report released in April by Moody's Investors Services stated that U.S. not-for-profit hospitals' credit deteriorated at a faster clip in the first quarter of 1999 than the entire previous year. Moody's cited the fiscal pressures of the Balanced Budget Act as one of the reasons for the downward slide. And other recent analyses by Ernst & Young and HCIA Inc. and the Association of American Medical Colleges echo that hospital margins and, therefore, their stability, will be greatly eroded.

CHRISTIANA'S STORY

At Christiana Care, the post-hospital care part of the system cannot provide adequate care to home health and nursing patients because of the Balanced Budget Act's reductions in reimbursement for those services. As a result, a genuine "Catch-

22" has been created: Hospitals are unable to discharge Medicare patients when acute care is completed and nursing home placement or home heath support is needed. At the same time these hospitals are being penalized by the system for not discharging these patients. We now have an ever-increasing number of patients in the hospital awaiting placement. Recently, this number reached 80—as opposed to about 25 prior to the Balanced Budget Act.

This creates several significant problems. The most important is that hospitalization of the elderly, when not needed for acute care reasons, is bad patient care. Older people may manifest dramatic physical and mental deterioration during periods of hospitalization, and some may never recover their previous functional state.

It's also a problem for the operation of the hospital. We now have beds filled with patients who do not need to be in the hospital. The fact that these beds cannot be used for the care for which they were intended interrupts the normal flow of patients through the hospital, from more acute to less acute settings, creating what might be termed "medical gridlock."

The financial consequences of all this is an unintended and unnecessary increase in health care costs. Of course, these costs are largely uncompensated and will result in losses to hospitals because Medicare, quite appropriately, pays only for necessary hospitalization.

The medical education programs at Christiana Care are very important for providing medical manpower in our state. We have developed a special program to introduce our medical residents to underserved areas in Delaware, and as many as 45 percent of our graduating primary care residents stay in the state to practice. Without our residency programs, it would probably be impossible—certainly much more expensive—to continue providing the enormous amount of uncompensated care that we provide now to the underprivileged and uninsured. We are the only level one trauma center in the state and without our residents we could not retain that designation and trauma care would be disrupted. As a result, we are very worried about the already implemented, as well as future, BBA reductions in support for medical education and the impact they will have on our community.

Because Christiana also provides so much outpatient care, we also are worried about the changes in the prospective payment system for Medicare outpatient services. Currently, Medicare outpatient payments do not cover our costs, and these changes will make the situation worse. And because we provide so much care to low-income people, we are very concerned about changes in Disproportionate Share Hospital payments.

WHAT CAN BE DONE?

America's hospitals, and the patients and communities they serve, must have relief from these unintended consequences of the Balanced Budget Act. We need both administrative and legislative solutions. Medicare should be treated like Social Security: a portion of the federal budget surplus should be used to address the Balanced Budget Act's unintended consequences . . . because Medicare is Social Security.

Relief from the Balanced Budget Act should include:

- Repeal of the Balanced Budget Act's unreasonable transfer provision, as proposed in H.R. 405 and S. 37, as proposed by Senator Grassley. The transfer provision redefined discharges to post-acute care as transfers for up to 10 types of cases (with authority for the HHS secretary to add more), in effect penalizing hospitals for providing efficient care in the right setting.
- Easing the reductions in the proposed Medicare outpatient prospective payment system (PPS). The new outpatient PPS greatly reduces and redistributes payments for services, and includes a "volume cap" that penalizes hospitals for adopting new technology. It also includes a formula for setting payment rates that, contrary to Congress' intent, cuts payments by an additional 5.7 percent. Our solutions: Establish a transition for implementation of outpatient PPS that ensures that no facility will receive reductions of more than 5 percent per year; repeal the volume cap; and encourage the Health Care Financing Administration (HCFA) to revisit its decision to further reduce outpatient payments by another 5.7 percent, which it has the administrative authority to do.
- Increase the Medicare inpatient hospital service update by 0.5 percent, as recommended by the Medicare Payment Advisory Commission, to reflect the costs hospitals are incurring to prepare for Y2K. This would help offset some of the Balanced Budget Act's cuts, as well as ease the sting of the nearly $8.2 billion hospitals nationwide are expected to spend to make sure the change to the Year 2000 does not affect health care services.

- Relief from reductions for teaching hospitals and academic medical centers. The Balanced Budget Act limits payments for "indirect medical education," causing significant hardship for teaching hospitals and academic medical centers, many of which are the only place for America's urban poor to receive care. AHA thanks Senators Moynihan and Kerrey for introducing S. 1023, which would freeze these payments at current levels and prevent future scheduled cuts.
- Repair the damage the Balanced Budget Act has caused to America's small and rural hospitals. Ensure that a portion of the federal budget surplus is devoted to providing relief to small and rural hospitals through repeal of the transfer provision of the BBA, and prevention of deep losses on the outpatient side.
- Restore adequate reimbursement for skilled nursing facilities (SNF). The new SNF PPS does not adequately account for the high costs of treating medically complex cases. It also penalizes newer skilled nursing facilities, causing many to limit services or shut down completely. In the short term, a pool of funds should be established from which additional payments can be made available to help offset the cost of caring for medically complex SNF patients. In the long run, SNF PPS must be revised.
- Redress for inequities in home health care services. Address both the short-term inequity in the interim payment system, which has severely diminished the availability of these services, and the scheduled 15 percent cut in payments for home health services.
- "Carve out" disproportionate share hospital (DSH) payments. For providers participating in Medicare managed care, Medicare DSH payments are made to Medicare+Choice plans without requiring that the payments be passed on to the providers who actually incurred the costs of caring for large numbers of the poor. AHA thanks Senators Moynihan and Kerrey for introducing S. 1024, which would mandate that these payments be made by HCFA directly to those providers, not to the plans.
- Encourage HCFA to develop a rehabilitation PPS that uses a per-discharge payment method rather than a per-case method. HCFA is contemplating using the SNF PPS per-case model for rehabilitation PPS, but the SNF PPS model may not adequately recognize the unique elements involved in providing rehabilitation care. AHA believes that HCFA should adopt MedPAC's recommendation that the Secretary develop a discharge-based PPS for rehab patients based on the Functional Independence Measure-Function Related Groups.
- Remove barriers to expanded Medicare options through Medicare+Choice.

CONCLUSION

Mr. Chairman, the environment for hospitals and health systems today is filled with uncertainty—financial pressures in the private market, mergers and consolidations, the ebb and flow of managed care, implementation of the Balanced Budget Act, unstable Medicare revenue streams that result, and the specter of even more change on the horizon. For many hospitals, Medicare has been an anchor in choppy waters. It has been a major and relatively stable source of revenue that has allowed hospitals to provide the care their communities need.

The Balanced Budget Act has changed all that. Hospitals today are struggling to make up for the shortfalls caused by the Act. They refuse to compromise the quality of services they provide, but they can't afford to continue providing those services if their costs aren't even covered. As a result, communities are losing access to vital health care services even as Washington debates how to spend a federal budget surplus of billions of dollars.

This is a trend that must be reversed, now. When the government acted to reduce Medicare spending to help balance the budget, no one was certain what effect such enormous reductions would have. Now, the evidence is pouring in from all over the country: the Balanced Budget Act is causing real pain for real people. We look forward to working with you to repair these unintended consequences of the Balanced Budget Act.

PREPARED STATEMENT OF PETER SMITH

Let me start by thanking the Senate Finance Committee for inviting me to testify on "Organizations Advancing Quality in Managed Care". A lot of positive change has occurred in the past few years and we are proud to be a part of the progress being made.

Background and Introduction

Our company, Ralin Medical, Inc. acquired Cardiac Solutions in 1994 and through this division began pioneering the development of disease management. Our program emphasizes the relationship between our nurse specialist, the patient and the patient's referring physician. We identify patients who have a primary diagnosis of congestive heart failure (CHF), coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD) and diabetes. Together these diseases account for about 8% of the population who in turn account for about 40% of all Medicare expenses.

Our disease management system called Multifit™ was developed at Stanford. It is primarily a telephonic program in which our nurse interacts with the patient and the patient's physician to "extend what the physician can do" between office visits to manage pharmaceutical compliance, diet and lifestyle. This is accomplished though contact with the patient and the physician, mostly over the telephone, utilizing various well-tested tools developed and validated by Stanford. We do retain the capability to do home encounters with the patient based on our relationship with over 90 Home Health Agencies sub-contracted nationally.

Our basic philosophy is to educate and motivate patients to be partners in their own disease management. We believe that an ongoing management and surveillance program with the patient is much more effective than the traditional response to acute episodes of care, which are costly and ineffective.

The simple value proposition we offer is that a managed care plan can pay our fees with the result of better patient care, improved medical management, patient and physician satisfaction and enough cost savings to cover our fees and still more.

The financial savings, mostly achieved through reduced hospitalizations, have definitely been achieved with improved clinical results at the same time. In a survey of approximately 5,000 Medicare risk CHF patients over a three-year period, we achieved:

- Reduction of hospital admissions by 62.5% versus historical benchmark
- Reduction of hospital days by 61.8% versus historical benchmark
- Reduction of total medical expenses by 52.0% versus historical benchmark
- Sodium intake decreased by 19.3%
- Number of patients at target dose of medication increased 54.9%
- Number of patients eligible for but not receiving appropriate medications decreased by 30.9%
- Functional status (DASI) increased by 10.1%
- 97% of patients satisfied by the overall quality of care and services provided by the program

Similar results have been achieved in both CAD and COPD. Our outcomes are preliminary in diabetes, but again we expect similar results. We are achieving these outcomes while at the same time assisting plans in achieving their HEDIS, NCQA and QISMC standards.

We are here today representing not only our own organization, but also 30 or more groups like us who have developed programs with managed care in disease management. In fact, a group called the Disease Management Association of America (DMAA) has been formed to help expand this early stage field.

Our customer to this point has been anyone at risk for the health care dollar and who can decide to use a management system such as Multifit™. Managed care organizations fit that description and have aggregated a large number of Medicare-aged patients who are likely to need disease management services.

As a result, since 1994 we have developed over 50 relationships with national, regional and local managed care plans. Our customers have been the early adopters of a significant change in the healthcare delivery system.

Our program, described above, can be formatted in several different ways financially. Most often, we are at risk to improve historical financial results plus clinical, quality of life and patient satisfaction results.

Over the past five years we have developed a strong data collection and outcomes reporting capability to validate our programs to our customers.

Medicare+Choice Risk Adjustment

We are here today to express our basic agreement with the risk adjustment methodology as developed and presented by HCFA. The intention to reimburse more for sicker and costlier patients seems most appropriate. Our concern however is that the proposed approach may have an unintended, negative impact on programs that would both promote better health and reduce costs to the system. The goals of our effort are to describe our concern with one part of the currently proposed methodology and to propose a solution, which we believe, would prevent that consequence from occurring.

The Concern

An unintended consequence likely to result from the proposed risk adjustment methodology is that it would financially penalize Medicare+Choice organizations that have invested in and successfully implemented certain health management programs. Specifically, this would be true for health promotion programs that improve patient quality of life and clinical status while reducing hospitalizations.

This unintended negative impact would manifest itself in two ways. First, plans that have been leaders

and innovators in the development of health promotion programs for the Medicare+Choice population would be penalized during the initial risk adjustment process. They would exhibit a low number of hospitalizations relative to the health status of their patient populations. These plans have invested in focused patient education and behavioral modification programs to improve clinical status and quality of life for their members while at the same time reducing hospitalizations. Under the current methodology, the initial indexing of their populations into PIP-DCG categories would penalize these plans and their health management partners for their existing innovative programs. Second, going forward, plans would have a financial disincentive to developing or maintaining such health-promoting programs. Given that there are costs associated with the development, implementation and maintenance of these programs, Medicare+Choice organizations would be less inclined to bear those costs, knowing that program savings would be offset or even dwarfed by reduced reimbursement. In summary, the unintended consequence of the risk adjustment methodology would be to stifle the development of programs and initiatives which have been shown to be beneficial to patients and to contain medical costs through health promotion, disease prevention, and reduction in hospitalizations.

Numerical Illustration of the Concern

To analyze this issue in greater detail, Ralin Medical commissioned a study, performed by Integrated Healthcare Information Services, Inc. (IHIS). The Team Leader of the project was Daniel Dunn, Ph.D. Dr. Dunn spent 13 years as a health economist at Harvard University where he worked closely with HCFA as the Technical Director of the RBRVS Research Project. In addition, Dr. Dunn spent three years evaluating various health risk assessment methodologies, including the PIP-DCG methodology, and authored a study on the topic for the U.S. Society of Actuaries. Using DxCG, Inc. software for PIP-DCG grouping based on current Medicare methodology, IHIS analyzed claims data of 1,015 Medicare-aged patients. These patients were selected based on two criteria. First, during a designated 12-month period, they experienced a hospitalization for congestive heart failure (CHF) which, under the currently proposed PIP-DCG methodology, would qualify as a CHF admission. Second, throughout the duration of

the subsequent 12-month period, they were enrolled in Ralin's CHF Disease Management Program. The study revealed that during the full year of disease management program enrollment, only 29% of these patients experienced a PIP-DCG-qualifying admission and only 16% of them had a PIP-DCG assignment in the CHF grouping (PIP-DCG 16/CHF) or a higher grouping. In contrast, data provided by Ralin's customers and supported by independent academic studies, indicate that the same population left "unmanaged" would typically exhibit a re-hospitalization rate well above 50%[1]

, most of which would fall into the PIP-DCG 16/CHF or higher PIP-DCG groupings.

Further analysis by Ralin reveals that the medical claims dollars saved by the health plan (net of program administrative costs) via the implementation of a health promotion program for these 1,015 patients would be outweighed by the reduction in premiums received the following year under the currently proposed PIP-DCG grouping methodology. That is, the cost savings created through health promotion would be more than offset by the reduction in risk-adjusted payments that would result from fewer patients being hospitalized. To illustrate this point using the current example, assuming a program impact of a 40% reduction in total medical claims costs[2] *for these 1,015 patients minus the typical program fees, medical claims costs (net of program fees) for this population decline by roughly $3.7 million. Meanwhile, reimbursement the following year under the PIP-DCG model declines, due to the reduced hospitalizations, by roughly $4.1 million. Thus, financially speaking, the payor would have fared better by not investing in the health-promoting program. In other words, the unintended negative impact of the proposed risk adjustment methodology would be a disincentive for payors to invest in programs that have been proven to benefit patients by promoting better health while also reducing hospitalizations.*

It should also be noted that, for the 1,015 patients studied, in addition to the dramatic reductions in hospitalizations cited above, clinical outcomes, functional status, and patient satisfaction indicators all exhibited extremely positive program results, as shown below:

- *Sodium intake for patients decreased by 19.3%.*
- *The number of patients at target doses of medication increased by 54.9%.*
- *The number of patients eligible for but not receiving appropriate medications decreased by 30.9%.*
- *Functional status, as measured by the Duke Activity Status Index (an indicator of patients' quality of life), increased by 10.1% -- particularly impressive, given that CHF is a progressive, degenerative condition.*
- *97% of patients were satisfied by the overall quality of care and services provided through the program.*

These data clearly indicate that such programs serve to benefit patients by promoting better health while also reducing hospitalizations.

In addition to PIP-DCGs, IHIS employed the Hierarchical Condition Categories (HCC) DCG model in order to estimate the relative risk of the same population of 1,015 patients using both inpatient and outpatient data. The goal of doing so was to determine whether HCFA's ultimate evolution to such a model would eliminate the unintended negative consequence related to the current PIP-DCG model. The IHIS study showed that while the health risk estimate for this population did increase using the HCC-DCG model, it only increased by 18%. With this increase, the reduction in HCFA reimbursement versus not implementing the health promotion program becomes roughly $3 million (compared to the $4.1 million under PIP-DCG methodology, as cited above). Ralin's experience with payors indicates that this change would still result in an unintended disincentive for payors to invest in proven health-promoting programs, since the return on the large investment for the program remains quite low.

While we recognize that the changes to risk adjusted payment will occur gradually once the legislation becomes effective (i.e., via the proposed phased-in approach), we are concerned that as the phase-in occurs, the magnitude of the unintended negative consequence described herein increases. While

methodology changes certainly could be made downstream during that phase-in period, we fear that once the program is initially implemented, it will become more difficult to change. The ideal time to try different methodologies, even if on a limited basis, would be now, prior to the phased-in implementation of the new program.

Overview of Proposed Solution

In order to encourage the implementation of favorable health promotion programs within the risk adjustment methodology, HCFA's challenge will be to align incentives accordingly. One possible approach would be for HCFA to identify patients enrolled in such programs and compensate the patients' Medicare+Choice organization for investing in the program. This creates two challenges. First, HCFA would need to define a set of standards to determine what constitutes a HCFA-endorsed health promotion program. Second, HCFA would need to develop the appropriate methodology to determine risk-adjusted payment for patients appropriately enrolled in such programs.[2]

Attachment A

Presentation
to
The Health Care Financing Administration
on
Adjusted Payment for the Medicare+Choice Program

April 28, 1999

Agenda

1. Our Concern

2. Example of Our Concern

3. Proposed Pilot Project

4. Standards For a HCFA Endorsed Health Promotion Program

5. Summary

Our Concern The Issues

1. Plans which have been leaders and innovators in the development of health promotion programs for the Medicare + Choice population would be penalized during the initial risk adjustment process.

2. Going forward, plans would have a financial disincentive to developing or maintaining strong health promotion programs because program savings, net of investment, would be offset by reduced reimbursement.

Offset Discussions

1. Some say that any flaws can be addressed as the program is phased in over a several year period. Our view is the phase-in period is the ideal time to test the results of a pilot program.

2. Some say that once outpatient data is included in the methodology, recognized flaws will be rectified. Our view, supported by our numerical example, is that this additional data does impact the results, but not sufficiently to remedy our basic concerns.

Methodology of Study

1. Study performed by Integrated Healthcare Information Services, Inc. (IHIS). The Team Leader of the project was Daniel Dunn, Ph.D., a person well experienced in general HCFA methodology and risk assessment in particular.

SCENARIO A -- HEALTH PROMOTION PROGRAM (ACTUAL RESULTS)

PIP-DCG	(A) # of Pts (2nd Yr)	Cumulative %	(B) Avg. Age/Sex Base Pmt	(C) PIP-DCG Pmt	(B+C) Total Pmt/Pt	A*(B+C) Total Category Pmt
None	725	71.4%	$3,410.00	$0.00	$3,410.00	$2,472,250.00
8	39	75.3%	$3,410.00	$4,406.00	$7,816.00	$304,824.00
9	27	77.9%	$3,410.00	$5,117.50	$8,527.50	$230,242.50
10	7	78.6%	$3,410.00	$5,829.00	$9,239.00	$64,673.00
11	31	81.7%	$3,410.00	$6,889.50	$10,299.50	$319,284.50
12	15	83.2%	$3,410.00	$7,950.00	$11,360.00	$170,400.00
14	5	83.6%	$3,410.00	$9,946.00	$13,356.00	$66,780.00
16	137	97.1%	$3,410.00	$11,014.50	$14,424.50	$1,976,156.50
18	4	97.5%	$3,410.00	$12,083.00	$15,493.00	$61,972.00
20	14	98.9%	$3,410.00	$16,346.00	$19,756.00	$276,584.00
23	11	100.0%	$3,410.00	$18,950.00	$22,360.00	$245,960.00
	1015			Total PIP-DCG Reimbursement:		$6,189,126.50

SCENARIO A SUMMARY:

CHF Patients:	1,015
Expected CHF Cost/Pt/Yr:	$18,000.00
Total Expected CHF Cost (D):	$18,270,000.00
DM Program % Savings:	40.00%
Gross DM Savings (E):	$7,308,000.00
DM Program Cost/Pt/Yr:	$3,500.00
Gross DM Program Cost (F):	$3,552,500.00
Total Cost (D-E+F):	$14,514,500.00
PIP-DCG Reimb (see above):	$6,189,126.50
Gain/(Loss) on CHF Pts.:	($8,325,373.50)

Methodology/Assumptions:
- Commissioned study via Integrated Healthcare Information Services, who used DxCG software for grouping.
- Analyzed 1,015 CHF DM program patients who had a PIP-DCG-qualifying CHF admission in a one year and for whom claims data spanned through the next year.
- PIP-DCG assignments based on current Medicare methodology; PIP-DCG reimbursement based on 9/8/98 Federal Register document.
- To determine average base payments, used male and female base payment categories with average age of population (73 years old).
- DM program % savings reflects Ralin's actual experience based on over 130,000 months of program experience since 1995.

Quality and Clinical Results of Patients

- Sodium intake decreased by 19.3%
- Number of patients at target doses of medication increased 54.9%
- Number of patients eligible for but not receiving appropriate medications decreased by 30.9%
- Functional status (DASI) increased by 10.1%
- 97% of patients were satisfied by the overall quality of care and services provided through the program.

SCENARIO B -- NO HEALTH PROMOTION PROGRAM

PIP-DCG	(A) # of Pts (2nd Yr)	Cumulative %	(B) Avg. Age/Sex Base Pmt	(C) PIP-DCG Pmt	(B+C) Total Pmt/Pt	A*(B+C) Total Category Pmt
None	354	34.9%	$3,410.00	$0.00	$3,410.00	$1,207,140.00
8	39	38.7%	$3,410.00	$4,406.00	$7,816.00	$304,824.00
9	27	41.4%	$3,410.00	$5,117.50	$8,527.50	$230,242.50
10	7	42.1%	$3,410.00	$5,829.00	$9,239.00	$64,673.00
11	31	45.1%	$3,410.00	$6,889.50	$10,299.50	$319,284.50
12	15	46.6%	$3,410.00	$7,950.00	$11,360.00	$170,400.00
14	5	47.1%	$3,410.00	$9,946.00	$13,356.00	$66,780.00
16	506	97.1%	$3,410.00	$11,014.50	$14,424.50	$7,327,646.00
18	4	97.5%	$3,410.00	$12,083.00	$15,493.00	$61,972.00
20	14	98.9%	$3,410.00	$16,346.00	$19,756.00	$276,584.00
23	11	100.0%	$3,410.00	$18,950.00	$22,360.00	$245,960.00
	1015			Total PIP-DCG Reimbursement:		$10,275,506.00

SCENARIO B SUMMARY:

CHF Patients:	1,015	
Expected CHF Cost/Pt/Yr:	$18,000.00	
Total Expected CHF Cost (D):	$18,270,000.00	
DM Program % Savings:	0.00%	(No DM Program)
Gross DM Savings (E):	$0.00	(No DM Program)
DM Program Cost/Pt/Yr:	$0.00	(No DM Program)
Gross DM Program Cost (F):	$0.00	(No DM Program)
Total Cost (D-E+F):	$18,270,000.00	
PIP-DCG Reimb (see above):	$10,275,506.00	
Gain/(Loss) on CHF Pts.:	($7,994,494.00)	

Methodology/Assumptions:

- Used Integrated Healthcare Information Services study (see Scenario A) as a starting point.
- Searched available literature (see Appendix) to estimate number of PIP-DCG 16/CHF admissions; assumed all other PIP-DCG admissions remained constant.

FINANCIAL COMPARISON OF SCENARIO A VERSUS SCENARIO B

	SCENARIO A (With Program)	SCENARIO B (No Program)
CHF Patients:	1,015	1,015
Expected CHF Cost/Pt/Yr:	$18,000.00	$18,000.00
Total Expected CHF Cost (D):	$18,270,000.00	$18,270,000.00
DM Program % Savings:	40.00%	0.00%
Gross DM Savings (E):	$7,308,000.00	$0.00
DM Program Cost/Pt/Yr:	$3,500.00	$0.00
Gross DM Program Cost (F):	$3,552,500.00	$0.00
Total Cost (D-E+F):	$14,514,500.00	$18,270,000.00
PIP-DCG Reimb (see above):	$6,189,126.50	$10,275,506.00
Gain/(Loss) on CHF Pts.:	($8,325,373.50)	($7,994,494.00)

HEALTH RISK ASSESSMENT IMPACT OF HEALTH PROMOTION PROGRAM

Estimates of Health Risk with Health Promotion Program Using Different Models:

Initial Year	Following Year (with Health Promotion Program)		
PIP-DCG Risk	PIP-DCG Risk	HCC-DCG Risk	Age-Sex Risk
3.31	1.42	1.68	1.061

IMPACT OF OUTPATIENT METHODOLOGY ON FINANCIAL ANALYSIS

	SCENARIO A (With Program)	SCENARIO B (No Program)	SCENARIO C (With Program – HCC-DCG Reimb.)
CHF Patients:	1,015	1,015	1,015
Expected CHF Cost/Pt/Yr:	$18,000.00	$18,000.00	$18,000.00
Total Expected CHF Cost (D):	$18,270,000.00	$18,270,000.00	$18,270,000.00
DM Program % Savings:	40.00%	0.00%	40.00%
Gross DM Savings (E):	$7,308,000.00	$0.00	$7,308,000.00
DM Program Cost/Pt/Yr:	$3,500.00	$0.00	$3,500.00
Gross DM Program Cost (F):	$3,552,500.00	$0.00	$3,552,500.00
Total Cost (D-E+F):	$14,514,500.00	$18,270,000.00	$14,514,500.00
PIP-DCG Reimb (see above):	$6,189,126.50	$10,275,506.00	$7,303,169.27
Gain/(Loss) on CHF Pts.:	($8,325,373.50)	($7,994,494.00)	($7,211,330.73)

Summary Results

- PIP-DCG methodology creates a disincentive for plans to implement health promotion programs.
  - With a health promotion program, costs decrease but so does PIP-DCG reimbursement the following year.
  - Without such a program, both costs and subsequent reimbursement are higher.
- The inclusion of outpatient data does not meaningfully impact the outcome described above.
- HCFA, through its proposed methodology, runs the risk of hindering the development and continuation of the type of health promotion program it intends to encourage.

Proposal to Pilot CHF PIP-DCGS

- Why Pilot CHF and related PIP-DCGs?
  - Piloting one PIP-DCG area to incentivize health promotion programs is possible to do by January of 2000.
  - CHF is the largest DRG in the Medicare system.
  - There is proven evidence in the form of positive outcomes (i.e., quality, clinical and financial) in a Medicare + Choice CHF patient population.

Proposed Pilot Concept

- By January of 2000 HCFA sets quality measurement standards for PIP-DCG 16/CHF (example of standards in the next section).
- HCFA includes PIP-DCG 16/CHF as part of its normal indexing process in preparation for risk stratification implementation in January of 2000.

Proposed Pilot Concept

- HCFA uses the first six months of 2000 to measure health plans against its already developed quality measurement standards.
  - Plans which meet standards keep PIP-DCG 16/CHF payment for previously indexed patients regardless of hospitalization during 2000 or receive modestly reduced PIP-DCG 16/CHF payments to allow HCFA to share in savings.
  - Plans which do not meet standards receive normal treatment for previously indexed PIP-DCG 16/CHF patients as now proposed in risk stratification.

Proposed Pilot Concept

- Going forward beyond 2000 to the next evaluation interval
  - Plans which met standards in 2000 would have to continue to meet standards to retain their reimbursement status on CHF indexed patients or they would drop into normal program status.
  - Plans not meeting standards in 2000 could meet standards in 2001 and retain attractive reimbursements for those patients newly indexed into PIP-DCG 16/CHF.

Proposed Pilot Concept

- HCFA, at its option, could also consider allowing Plans which have historically (prior to 2000) met standards for health promotion to receive some reimbursement benefit in 2000 to avoid otherwise penalizing their prior efforts and investment.
- If the pilot for PIP-DCG 16/CHF is successful, the program could be expanded to other similar PIP-DCGs in 2002, well in advance of complete program phase-in.

Quality Standards

- Philosophy behind the proposed standards
  - Ties reimbursement with quality of outcomes
  - Fits with QISMC
  - Translates QISMC into specifics for CHF program
  - Is auditable
- Quality Improvement System for Managed Care (QISMC)
  - Domain 1: Quality Assessment and Performance Improvement Program
  - Standard 1:3 Performance Improvement Projects
  - Standard 1:4 Attributes of Performance Improvement Projects

Quality Standards

- Translation into specifics
  - Clinical Outcomes
    - % of patients at target dose of medication
    - % of patients eligible but not receiving appropriate medication
    - % decrease of sodium intake
  - Functional Status - Validated Tool Outcomes
    - SF 36/SF 12
    - DASI (Duke Activity Status Index)
  - Financial Outcomes
    - Admission rates
    - Re-admission rates
    - ER admissions
  - Satisfaction Surveys

Quality Standards

- Audit (Hedis Methodology)
  - Define data sources
  - Define numerators and denominators
  - Sample sizes, sampling methodology
  - Time periods for trend analysis
  - Identify standard tools and scoring systems
  - Sustained improvement

Summary

- The overall risk adjustment methodology will improve the Medicare+Choice program. However, there is an unintended consequence which may disincentivize health promotion programs.
- A proposed solution for this concern is a pilot program for PIP-DCG 16/CHF which could later be expanded to other PIP-DCGs.
- Under the proposed pilot, specific quality standards can be used to quantify health plans for enhanced reimbursement. These standards can be developed from current QISMC standards.
- The proposed pilot can be implemented by the start of phase-in (January 2000).

Appendices

Assessment of Relative Health Risk for Cardiac Solutions CHF Patients using the Medicare PIPDCG Risk Assessment Model
Prepared for Cardiac Solutions by Integrated Healthcare Information Services, Inc.
April 6, 1999

Objective

The Balanced Budget Act of 1997 (BBA) introduced a number of changes to how the federal government will pay HMOs for serving Medicare beneficiaries. Currently, Medicare risk contractors are reimbursed based on an adjusted average per capita cost (AAPCC) approach that recognizes a beneficiary's age, sex, institutional and welfare status, and geographic location in setting payments. In the year 2000, the government plans to replace this payment method with a system that also incorporates the clinical diagnoses recorded for enrollees' inpatient stays. This approach, called the "principal inpatient diagnostic cost group" model (PIPDCGs), has been shown to more accurately reflect differences in health risk across Medicare HMOs and between HMO beneficiaries and those enrolled in the fee-for-service sector.

Payment for a beneficiary under the AAPCC method is the product of a county-specific amount called the rate book and the beneficiary's relative health risk based on their demographic characteristics. In the year 2000, the county rate book will continue to be part of the payment formula. However, rather than using an enrollee's demographic health risk to compute payment, health risk will be based on PIPDCGs.

Cardiac Solutions, Inc. (CSI) provides cardiac disease management services to a number of health plans that participate as Medicare risk contractors (Medicare HMOs). A proven outcome of CSI's management approach is a significant decrease in the number of inpatient admissions for congestive heart failure (CHF) patients relative to historical benchmarks for this population. Given PIPDCG's focus on principal inpatient diagnoses for measuring risk, a decrease in the number and severity of inpatient admissions for CSI patients could lead to a decrease in measured risk and a decrease in future Medicare payments to client health plans enrolling these individuals.

The objective of the analysis described here is to simulate the relative health risk for a typical CSI CHF population and to provide empirical evidence related to the issue of the impact of disease management on inpatient utilization and on measured risk. Note that this analysis measures health risk for only the CSI CHF population. A more complete analysis would include unmanaged CHF patients and a comparison of their trends in measured risk with those observed for this study.

Methods

Medicare's PIPDCG model uses a prospective approach to risk assessment – using diagnoses observed for a given year to predict health risk for the following year. The general approach used in this analysis involves the measurement of prospective health risk using the PIPDCG model and data for two consecutive years – the year the patient had an inpatient admission for CHF (resulting in qualification for the CSI CHF program) and the subsequent year. In addition to PIPDCGs, the Hierarchical Condition Categories (HCC) DCG model is also employed. The HCC model uses a more comprehensive approach to risk assessment and both inpatient and outpatient diagnoses – it is likely to provide a more accurate assessment of relative risk. The risk measures produced using these different approaches are compared.

I. Data

- Humana claims data for 1/1/97 through 10/31/98
- CSI data on patient participation in CHF program

II. Patient Selection Criteria

- CSI patients with program enrollment date within the time period11/1/96 through 10/31/97 and discharge date after 10/31/98 and one or more claim lines in the Humana Claims data

III. Assumptions

- Patients had at least one inpatient admission for CHF during the time period 11/1/96 through 10/31/97 (the admit that led to enrollment in the CSI program)
- These CHF admissions had a length of stay >= 2 days (minimum for PIP qualifying)

IV. PIPDCG Risk Group Assignment

- PIPDCG assignments based on current Medicare methodology
- Software marketed by DxCG,Inc. used for grouping
- Grouping based on Humana claims data with dates of service within the time period 11/1/97 though 10/31/98
- All measures of risk are based on prospective models – using diagnoses in a year to predict risk in the following year.

V. Study Periods

Three study periods are defined for the analysis:

- Year 1 – 11/1/96 through 10/31/97 – this is the year the CHF admission is assumed to have occurred (the admission used to qualify the patient for the CSI program)
- Year 2 – 11/1/97 through 10/31/98 – this is the year for which the diagnoses from the Humana claims are used in the PIPDCG model to predict risk for Year 3.

- Year 3 – 11/1/98 through 10/31/99 – this is the year for which risk is predicted based on the Year 2 observed claims and diagnoses. (In this scenario, Year 2 claims would be used to set Year 3 Medicare risk payments PMPM).

(Note: the assumption of a Year 1 admit for CHF can also be used to predict PIPDCG risk for Year 2, as described below.)

Results

- A total of 1,015 patients met the selection criteria for the analysis.
- Of these patients, 400 were found to have one or more inpatient hospital admissions – a total of 818 admissions – during Year 2.
- Of the 818 admissions, 523 qualify as PIPDCG admissions – admissions that increase a patients risk score and payment. Those admissions not qualifying either have a length of stay less than 2 or a PIP diagnosis that does not count toward increased risk and payments.
- Table 1 shows the distribution of PIPDCG assignments for the study patients. As shown, 725 patients had no qualifying PIP admission (71.4%) – either no admission or an admission that does not qualify. Further, 83.6% have a PIPDCG assignment less than 16. (PIPDCG 16 includes CHF inpatient admissions). (Higher PIPDCGs denote greater health risk.)

Table 1. Distribution of PIPDCG Assignments for Year 3 (based on diagnoses from Humana Claim Data for Year 2)

PIPDCG	Number of Patients	Cumulative Percent
No PIPDCG	725	71.4
8	39	75.3
9	27	77.9
10	7	78.6
11	31	81.7
12	15	83.2
14	5	83.6
16	137	97.1
18	4	97.5
20	14	98.9
23	11	100.0
Total	1,015	

- Table 2 shows an overall average risk score for different time periods, using different models and assumptions.

  The first column shows measured PIPDCG risk for 11/1/98 - 10/31/99 (Year 3).
  The second column shows measured HCC risk for 11/1/98 - 10/31/99 (Year 3).
  The third column shows measured Age-Sex risk for 11/1/98 - 10/31/99 (Year 3).
  The third column shows measured PIPDCG risk for 11/1/97 - 10/31/98 (Year 2).

  The first two columns are based on the diagnoses observed in the Humana claims data for Year 2. The third column is an estimate based on the observed age-sex mix and an age-sex risk assessment model similar to the AAPCC. The fourth column is an estimate based on the assumption of a CHF admission for each patient during Year 1. As noted above, a CHF admission will result in each patient being assigned to PIPDCG 16. (These patients could have had an admission assigned to a higher category. However, for these purposes, they are assumed to have had a PIPDCG 16 admission or lower during Year 1).

Table 2. Estimates of Health Risk for CSI CHF Patients using Different Models and Time Periods

PIPDCG Risk Year 3	HCC Risk Year 3	Age-Sex Risk Year 3	PIPDCG Risk Year 2
1.422	1.680	1.061	3.310

Discussion

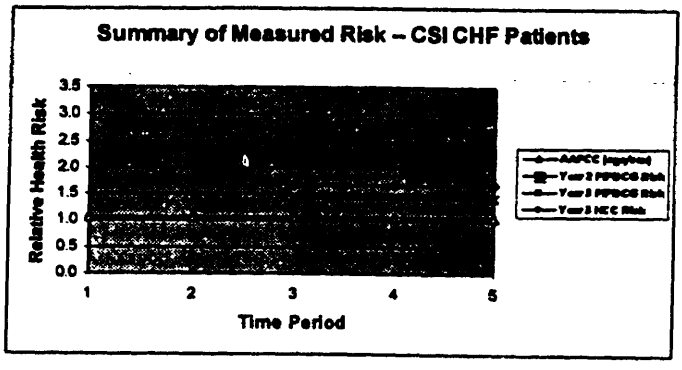
While all patients had at least one admission in Year 1 (resulting in a PIPDCG assignment of 16 or higher for Year 2 risk and payment), a large percentage had either no inpatient admission (60%) or no inpatient admission qualifying for a PIPDCG (71%) in Year 2. Further, 83.6% of the patients had either no qualifying PIPDCG or a PIPDCG assignment of less than 16.

The risk score for Year 2 based on Year 1 diagnoses (at least a CHF admission) was estimated to be 3.310 – risk 330% that of the average Medicare FFS beneficiary. The PIPDCG risk score for Year 3 based on Year 2 diagnoses (from the Humana claims) was 1.422. Using the more comprehensive HCC model, risk is measured as 1.680 for Year 3 based on Year 2 diagnoses. Finally, the age-sex model suggested a relative risk of 1.061 for Year 3.

The results can be interpreted from two different perspectives. First, the introduction of diagnosis-based risk assessment by Medicare will result in an overall increase in payments to health plans that enroll CHF patients. The age-sex model produced a relative risk of 1.061 – 6.1% greater than that for the average FFS Medicare enrollee. The PIPDCG model shows a risk of approximately 3.310 for the year following the CHF admission leading to enrollment in the CSI program and 1.422 for the subsequent year. Using the HCC model, risk is measured as 1.680 for that subsequent year. All of the risk scores using these scenarios greatly exceed the AAPCC-like age-sex model. Medicare payments for patients like those served by CSI will increase significantly with the move from the AAPCC to a diagnosis-based risk assessment approach – PIPDCG or other.

Second, "Does the PIPDCG model provide a fair measure of risk for these patients?" The answer is, "probably not" – particularly for Year 3 and beyond. CSI's disease management approach decreases inpatient hospital admissions and the likelihood of a patient receiving a higher risk PIPDCG. However, the patient still has increased morbidity relative to the general Medicare population and will continue to consume a greater number of healthcare services than the average patient, including patient visits, consultations, prescriptions and the home health visits and phone contact services provided by CSI. A model using only inpatient diagnoses – whose risk weightings are based primarily on healthcare utilization and costs from a largely unmanaged patient population – is likely to underestimate health risk for patients enrolled in CSI's CHF program. This potential bias is supported by the findings from the HCC model, where health risk is measured at 1.680 for CSI patients – 18 percent greater than that based on PIPDCGs.

Figure 1 summarizes the relationships between the risk scores described above. The line labeled "AAPCC" describes relative risk and payments for CSI CHF patients using an age-sex model similar to that used for the AAPCC. The point labeled "Year 2 PIPDCG risk" shows the relative risk for the first full year following the CHF admit that led to CSI program enrollment – risk based on PIPDCGs. The line labeled "Year 3 PIPDCG risk" describes PIPDCG risk for Year 3 (and after). The line labeled "Year 3 HCC risk" describes HCC risk for Year 3 (and after).



A MULTIDISCIPLINARY INTERVENTION TO PREVENT THE READMISSION OF ELDERLY PATIENTS WITH CONGESTIVE HEART FAILURE

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Abstract *Background.* Congestive heart failure is the most common indication for admission to the hospital among older adults. Behavioral factors, such as poor compliance with treatment, frequently contribute to exacerbations of heart failure, a fact suggesting that many admissions could be prevented.

Methods. We conducted a prospective, randomized trial of the effect of a nurse-directed, multidisciplinary intervention on rates of readmission within 90 days of hospital discharge, quality of life, and costs of care for high-risk patients 70 years of age or older who were hospitalized with congestive heart failure. The intervention consisted of comprehensive education of the patient and family, a prescribed diet, social-service consultation and planning for an early discharge, a review of medications, and intensive follow-up.

Results. Survival for 90 days without readmission, the primary outcome measure, was achieved in 91 of the 142 patients in the treatment group, as compared with 75 of the 140 patients in the control group, who received conventional care ($P=0.09$). There were 94 admissions in the control group and 53 in the treatment group (risk ratio, 0.56; $P=0.02$). The number of admissions for heart failure was reduced by 56.2 percent in the treatment group (54, vs. 24 in the control group; $P=0.04$), whereas the number of readmissions for other causes was reduced by 28.5 percent (40 vs. 29, P not significant). In the control group, 23 patients (16.4 percent) had more than one readmission, as compared with 9 patients (6.3 percent) in the treatment group (risk ratio, 0.39; $P=0.01$). In a subgroup of 1 patients, quality-of-life scores at 90 days improved more from base line for patients in the treatment group ($P=0.001$). Because of the reduction in hospital admissions, the overall cost of care was $460 less per patient in the treatment group.

Conclusions. A nurse-directed, multidisciplinary intervention can improve quality of life and reduce hospital use and medical costs for elderly patients with congestive heart failure. (*N Engl J Med* 1995;333:1190-5.)

CONGESTIVE heart failure is the most common indication for hospitalization among adults over 65 years of age,[1] and the rate of admission to treat this condition has increased progressively over the past two decades.[2] Elderly patients with heart failure are also at increased risk for early rehospitalization, with rates of readmission ranging from 29 to 47 percent within three to six months of the initial discharge.[3-5] Moreover, behavioral factors, such as noncompliance with medications and diet, and social factors, such as social isolation, frequently contribute to early readmissions, suggesting that many such readmissions could be prevented.[1,6]

We hypothesized that a multidisciplinary approach to treatment could significantly reduce the rate of readmission for elderly patients at high risk, and we conducted a feasibility study to evaluate this hypothesis.[7] In that study 96 patients 70 years of age or older who were hospitalized with congestive heart failure were randomly assigned to receive either the study treatment or conventional care. During a 90-day period of follow-up, the treatment group had a 27 percent reduction in the readmission rate, but the reduction was not statistically significant.[7] We then conducted a prospective, randomized trial of 282 patients, described in this report, to assess the effect of the intervention on the rate of readmission, quality of life, and the overall cost of medical care.

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METHODS

Patients

All patients 70 years of age or older who were admitted to the medical wards of Jewish Hospital at Washington University Medical Center were screened for congestive heart failure. For a diagnosis of heart failure, either definite radiographic evidence of pulmonary congestion or typical symptoms and signs of heart failure in conjunction with definite clinical improvement in response to diuresis were required. Patients with confirmed heart failure were eligible to participate in the study if they had at least one of the following risk factors for early readmission, as determined in a previous study: prior history of heart failure, four or more hospitalizations for any reason in the preceding five years, or congestive heart failure precipitated by either an acute myocardial infarction or uncontrolled hypertension (systolic blood pressure >200 mm Hg or diastolic blood pressure >105 mm Hg). The criteria for exclusion from the study included residence outside the catchment area of Jewish Hospital Home Care, planned discharge to a long-term-care facility, severe dementia or other serious psychiatric illness, anticipated survival of less than three months, refusal to participate by either the patient or the physician, and logistic or discretionary reasons (including participation in the pilot study[7]). The study was approved by the institutional review board of Jewish Hospital, and all patients provided informed consent.

A total of 1306 patients 70 or more years of age met the criteria for congestive heart failure from July 1990 through June 1994. Among them, 391 (29.9 percent) were excluded because they had no risk factors for early readmission. An additional 633 patients were excluded because they lived outside the catchment area (141 patients), because discharge to a long-term-care facility was planned (116), because they had dementia or psychiatric illness (191 or terminal illness (68), because the patient or the physician decided not to participate (116), or for logistic or discretionary reasons (173), most commonly the inability to complete enrollment before discharge.

Randomization and Study Treatment

The patients underwent blinded randomization with the use of a computer-generated list of random numbers immediately after consenting to participate in the study. Neither the patients nor the members of the study team were aware of the treatment assignment until after randomization.

The study treatment consisted of intensive education about congestive heart failure and its treatment by an experienced cardiovascular research nurse, using a teaching booklet developed by the study investigators for geriatric patients with heart failure; individualized dietary assessment and instruction given by a registered dietitian with reinforcement by the study nurse; consultation with social-service personnel to facilitate discharge planning and care after discharge; an analysis of medications by a geriatric cardiologist who made specific recommendations to eliminate unnecessary medications and simplify the overall regimen; and intensive follow-up after discharge through the hospital's home care services, supplemented by individualized home visits and telephone contact with the members of the study team. The principal goals of follow-up were to reinforce the patient's education, ensure compliance with medications and diet, and identify recurrent symptoms amenable to treatment on an outpatient basis. Additional details about the intervention have been published previously.[7]

Patients assigned to conventional care (the control group) were eligible to receive all standard treatments and services ordered by their primary physicians. In no case was standard or generally accepted therapy withheld.

Data Collection and Follow-up

Detailed data were collected at the time of enrollment, including demographic and psychosocial information; items pertaining to the patient's medical history, physical examination, and laboratory evaluation; results of cardiac tests; and pertinent information pertaining to the hospital course. All patients were followed for 90 days after discharge. For patients rehospitalized during follow-up, data on the cause of readmission, the contributing factors, and information on the hospital course during readmission were obtained. To minimize the burden placed on participating patients, data on quality of life and costs were collected only for subgroups, as described below.

Quality of Life

Quality of life as the patient perceived it was assessed at base line and at three months in 128 patients with the Chronic Heart Failure Questionnaire.[8] This instrument consists of 20 items that the patient was asked to rate on a scale from 1 (lowest) to 7 (highest); there are four subscales: dyspnea (containing 4 items), fatigue (3 items), emotional function (7 items), and environmental mastery (4 items). Previous studies have shown this questionnaire to be responsive to quality-of-life changes in patients with heart failure.[9]

Cost Analysis

Detailed data on all medical costs and costs for care givers were collected prospectively, with cost logs, for 37 patients during the 6-mo period of the study. The logs were checked regularly for accuracy by study nurses. Logs were also maintained by the study personnel to determine the cost of the treatment, exclusive of costs for research and monitoring (i.e., screening, randomization, data collection, and follow-up). An hourly rate of $20 was chosen as the cost of nursing time (including direct contact with the patient, travel, and telephone calls), as well as for time spent by the dietitian, social worker, and home care team. An hourly rate of $6 was chosen as the cost of time spent by unpaid care givers (i.e., spouses, family, and friends). Costs for hospital admissions were based on the allowed reimbursements provided according to standard codes for each diagnosis-related group (DRG). To calculate the overall cost of medical care during the 90-day follow-up period, the mean cost of readmission for all patients in each group was added to the average cost for nonhospital medical services and care givers, and, in the treatment group, for the intervention. All costs were adjusted to 1994 dollars.

Study End Points and Statistical Analysis

All the analyses were conducted according to the intention-to-treat principle, with survival for 90 days without readmission as the primary, prespecified outcome measure. Secondary end points included the number of readmissions for any cause, the number of readmissions for congestive heart failure, the cumulative number of days of hospitalization during follow-up, quality-of-life scores, and the overall cost of medical care.

The two study groups were compared by Student's t-test (two-tailed) for normally distributed continuous variables, by the chi-square test for discrete variables, and by the Wilcoxon rank-sum test for categorial variables and continuous variables not normally distributed. Stepwise proportional-hazards regression was used to identify predictors of readmission within 90 days of discharge from the hospital. A backward, sequential survival analysis was performed with the Cox proportional-hazards model to determine whether the treatment assignment was an independent predictor of readmission after adjustment for other relevant covariates.[10] Kaplan–Meier survival curves were constructed to assess the probability of survival without readmission during the follow-up period. In both the Cox and the Kaplan–Meier analyses, data on patients who died without readmission to the hospital were censored at the time of death. Risk ratios and 95 percent confidence intervals were calculated, when appropriate, to compare outcomes between groups.[11] A P value of less than 0.05 was considered to indicate statistical significance for the major comparisons between groups. The results are expressed as means ±SD unless otherwise specified.

Results

Base-Line Characteristics

The base-line characteristics of the study patients are shown in Table 1. The median age of the patients was 79 years; 63 percent were women, and 45 percent were white (except for two Asians, the remainder were black). The two groups were well balanced with respect to most base-line characteristics, including New York Heart Association functional class and left ventricular ejection fraction. The patients in the treatment group were somewhat older and better educated, however. They also had higher heart rates on the base-line electrocardiogram and were more likely to have undergone previous coronary-artery revascularization. It is important to note, however, that none of those variables had a significant effect on the rate of readmission.

Event-free Survival

As Table 2 shows, 17 patients in the control group (12.1 percent) died during the study period, as compared with 13 patients in the treatment group (9.2 percent). Survival for 90 days without readmission, the primary end point, occurred in 75 patients in the control group (53.6 percent), as compared with 91 patients in the treatment group (64.1 percent), but this difference was not significant (absolute difference, 10.5 percent; 95 percent confidence interval, −0.9 to +21.9 percent; percent difference, 19.6 percent; P = 0.09). When the analysis was restricted to survivors of the initial hospitalization, however, a significant difference in survival for 90 days without readmission was noted (54.3 percent in the control group vs. 66.9 percent in the treatment group; 95 percent confidence interval for the difference, 1.1 to 24.1 percent: P = 0.04).

Readmissions

As Table 2 and Figure 1 show, 59 patients in the control group (42.1 percent) had at least one readmission during follow-up, as compared with 41 patients in the

treatment group (28.9 percent; absolute reduction, 15.2 percent; 95 percent confidence interval, 2.1 to 24.3 percent; P = 0.03). Multiple readmissions were more frequent in the control group (16.4 percent, vs. 6.3 percent in the treatment group; 95 percent confidence interval for the difference, 2.8 to 17.4 percent; P = 0.01), so that the total number of readmissions during follow-up was reduced by 44.4 percent (P = 0.02). Similarly, the total number of days of hospitalization was reduced from 883 in the control group to 356 in the treatment group, for a net reduction in hospital use of 35.7 percent (P = 0.04).

Overall, 78 of the 147 readmissions were for recurrent heart failure (53.1 percent). In the control group, there were 56 readmissions due to heart failure, as compared with only 24 in the treatment group (risk ratio, 0.44; P = 0.04). Readmissions for reasons other than heart failure were also more frequent in the control group (40 vs. 29; risk ratio, 0.71), but this difference was not significant.

Table 1. Base-Line Characteristics of the Study Patients.*

Characteristic	Control Group (N = 149)	Treatment Group (N = 142)	P Value
Age (yr)	76.4±6.1	80.1±5.9	0.02
Female sex	83 (59)	96 (68)	NS
Nonwhite race	82 (59)	74 (52)	NS
Married	46 (33)	53 (37)	NS
Living alone	62 (44)	58 (41)	NS
Education <4th grade	67 (48)	40 (28)	0.03
Hypertension	111 (79)	103 (73)	NS
Diabetes mellitus	41 (29)	39 (27)	NS
Prior congestive heart failure	113 (81)	105 (74)	NS
Prior myocardial infarction	63 (44)	59 (42)	NS
Prior revascularization	18 (13)	38 (27)	0.005
Ischemic cause of heart failure	83 (59)	77 (54)	NS
NYHA class	2.4±1.1	2.4±1.0	NS
Medications taken			
Digoxin	53 (38)	51 (36)	NS
Diuretic	117 (84)	119 (84)	NS
Angiotensin-converting-enzyme inhibitor	89 (64)	77 (54)	NS
Nitrates	100 (71)	90 (63)	NS
Beta-blocker	16 (11)	18 (13)	NS
Calcium antagonist	58 (41)	53 (37)	NS
Activities-of-daily-living score†	5.6±1.1	5.5±1.2	NS
Short Blessed score‡	8.0±7.1	6.8±6.2	NS
Body-mass index§	25.8±6.5	25.4±5.1	NS
Systolic blood pressure (mm Hg)	137±35	139±38	NS
Hemoglobin (g/dl)	11.9±1.9	12.3±1.8	NS
Blood urea nitrogen (mg/dl)	30±19	29±18	NS
Creatinine (mg/dl)	1.8±1.0	1.6±0.8	NS
Sodium (mmol/liter)	139±4	139±3	NS
Albumin (g/dl)	3.7±0.4	3.8±0.4	NS
Cholesterol (mg/dl)	190±55	202±56	NS
Electrocardiographic measures			
Heart rate (per min)	85±19	91±21	0.02
Nonsinus rhythm	35 (25)	44 (31)	NS
Ejection fraction (%)‖	41±13	44±14	NS

*Plus-minus values are means ±SD. Values followed by a number in parentheses are numbers of patients and percentages of the group. NS denotes not significant, and NYHA New York Heart Association. To convert values for urea nitrogen to millimoles per liter, multiply by 0.357; to convert values for creatinine to micromoles per liter, multiply by 88.4; to convert values for cholesterol to millimoles per liter, multiply by 0.02586.

†Scores on a six-point scale.

‡Scores above on the short version of the Blessed Orientation Index, with higher scores indicating more severe cognitive impairment.

§Calculated as the weight of kilograms divided by the square of the height in meters.

‖Data on ejection fraction were available for 122 patients (79 percent).

Table 2. Readmission and Death within 90 Days of Initial Discharge from the Hospital.*

Variable	Control Group (N = 149)	Treatment Group (N = 142)	Difference† (%)	P Value‡
Patients readmitted (no. of times)				
>1	59 (42.1)	41 (28.9)	−31.5	0.03
>2	23 (16.4)	9 (6.3)	−61.4	0.01
No. of readmissions	96	53	−44.4	0.022
For CHF	56	24	−56.5	0.042
Not for CHF	40	29	−28.5	NS
Hospital days				
All	883	556	−35.7	Not applicable
Per patient	6.2±11.4	3.9±10.0	−36.6	0.042
Deaths from any cause	17 (12.1)	13 (9.2)	−24.8	NS
In hospital	2 (1.4)	6 (4.2)	—	NS
After discharge	15 (10.7)	7 (4.9)	—	NS
Survival without readmission	75 (53.6)	91 (64.1)	+19.6	0.09
Death without readmission	6 (4.3)	10 (7.0)	—	NS

*Plus-minus values are means ±SD. Values followed by a number in parentheses are numbers of patients and percentages of the group. CHF denotes congestive heart failure, and NS not significant.

†Percent differences were calculated by dividing the absolute percent difference between groups by the control-group percentage.

‡By the Wilcoxon rank-sum test.

To determine whether assignment to the treatment group was associated with a reduced rate of readmission after adjustment for base-line differences between groups and other prognostic factors, we constructed a Cox proportional-hazards model. As Table 3 shows, the strongest independent predictors of readmission were higher blood urea nitrogen level, higher systolic blood pressure, higher serum sodium level, and presence of diabetes mellitus. After adjustment for these variables as well as for other univariate predictors of readmission, assignment to the control group remained a significant independent predictor of rehospitalization.

Quality of Life

Table 4 shows base-line and three-month scores on the Chronic Heart Failure Questionnaire administered to 126 patients. Although the quality of life improved in both groups, there was significantly more improvement in the treatment group (22.1±20.8 vs. 11.3±16.4, P = 0.001). In addition, quality of life improved consistently on each of the four subscales among the patients receiving the treatment (range, 32 percent to 195 percent). During the 90-day follow-up period, 11 patients were admitted to long-term care facilities (5 in the treatment group and 6 in the control group).

Cost of Care

The average cost of the study intervention was $216 per patient (Table 5). Two thirds of this amount was spent on nursing time, representing an average of 7.2

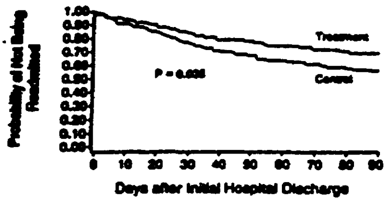

Figure 1. Kaplan–Meier Curves for the Probability of Not Being Readmitted to the Hospital during the 90-Day Period of Follow-up.

Data on patients who died without being readmitted were censored at the time of death.

hours per patient. Other costs for medical care, excluding those for readmissions, were similar between the two study groups. However, care givers spent 33 more minutes per patient per day attending to the patients in the treatment group than to those in the control group, for an estimated incremental cost of $336 per patient. This extra time was anticipated and reflected increased involvement by care givers in the home. The costs of hospital readmissions were higher in the control group by an average of $1,058 per patient ($3,236 vs. $2,178, P = 0.03). As a result, the overall cost of care was higher in the control group by $460, or an average of $153 per patient per month.

Discussion

The Agency for Health Care Policy and Research (AHCPR) recently published guidelines for the evaluation and care of patients with congestive heart failure.[12] These guidelines contain recommendations for patient and family counseling, dietary assessment, nursing and social-service interventions, support groups, and specific measures to improve compliance. These recommendations, though logical, are based principally on expert opinion, with few published data to verify their efficacy.[13] The present study provides strong support for the AHCPR guidelines by demonstrating that a multidisciplinary intervention can significantly reduce the rate of readmission, improve the quality of life, and decrease the overall cost of medical care. The benefit in terms of reducing hospital admissions and improving quality of life was at least as great as that reported with vasodilator therapy, including treatment with angiotensin-converting–enzyme inhibitors.[14-16] Moreover, in contrast to treatment with vasodilators, the benefits of which are associated with incremental increases in cost,[17] the current intervention reduced costs.

Several previous investigators have attempted to reduce readmissions in various patient populations,[18-29] but except for our pilot study,[7] only one trial has specifically been addressed to patients with heart failure.[25] Although the results of these studies were generally favorable, the benefit was slight, perhaps reflecting the nature of the study populations and the interventions used. We focused specifically on elderly patients with heart failure, who are known to be at high risk for early readmission,[3-5] and we developed a multidisciplinary intervention to address previously identified causes of rehospitalization.[5] Although our findings are generally concordant with earlier reports,[18-29] we believe that our approach of targeting a high-risk population and using a more comprehensive intervention resulted in more favorable outcomes.

As expected, the principal effect of the intervention was in reducing the rate of readmission due to recurrent heart failure; this rate declined by 56.2 percent. However, in the treatment group there were also fewer readmissions for other causes. Although this difference was not statistically significant, it suggests that close follow-up may provide additional benefits beyond simply reducing the likelihood of exacerbations of heart failure.

This study has several limitations, the first of which concerns the generalizability of the results. A total of 1306 patients fulfilled the criteria for a diagnosis of congestive heart failure, but only 282 (21.6 percent) were randomized. The distinguishing characteristics of the randomized cohort included advanced age (median, 79 years), a high prevalence of hypertension (73.9 percent), moderate functional impairment, and relatively well preserved left ventricular systolic function. The applicability of our findings to other patients with heart failure requires further study.

A second limitation is that because of the multidisciplinary nature of the intervention, we are unable to say which elements were most important in reducing readmission rates and improving the quality of life. To do so is important from the perspective of cost, since the elimination of any unnecessary features could result in further cost savings. To clarify this issue, additional analyses were performed to assess compliance with medication, evaluate the review of medications, and determine the effects of the intervention on the patients' understanding of heart failure. Good compliance with medication, as assessed by pill counts 30 days after discharge and defined as having been accomplished when 80 percent of pills or more were tak-

Table 3. Independent Predictors of Readmission, According to the Cox Proportional-Hazards Model.

Variable	Rate Ratio*	95% Confidence Interval	P Value
Blood urea nitrogen	1.17	1.08–1.25	0.001
Systolic blood pressure	0.90	0.84–0.96	0.003
Serum sodium	0.94	0.89–0.98	0.007
Diabetes mellitus	1.60	1.05–2.44	0.03
Assignment to the treatment group	0.67	0.45–0.99	0.04

*Rate ratios were based on increments of 1.0 mg per deciliter (0.37 mmol per liter) for blood urea nitrogen, 10 mm Hg for systolic blood pressure, and 1 mmol per liter for serum sodium.

on correctly, was achieved in 82.5 percent of patients in the treatment group as compared with 64.9 percent in the control group ($P = 0.02$). With regard to the number of medications and dosing frequency, the only difference between groups was that the maximal number of daily doses at discharge from the hospital was significantly lower in the treatment group (2.7 ± 1.0, vs. 3.0 ± 0.9 in the control group; $P = 0.01$), suggesting that the intervention had a slight effect in simplifying the medication regimen. Finally, on the basis of the results of an eight-item multiple-choice questionnaire, the patients in the treatment group had a better understanding of heart failure than those in the control group, both at the time of discharge and at the three-month follow-up ($P < 0.001$ for both). These findings suggest that all components of the intervention were beneficial. Given the relatively low cost of the intervention ($72 per patient per month), eliminating any of its components would be unlikely to lower the cost substantially.

A third limitation is the relatively short duration of the follow-up period. We selected a 90-day follow-up interval on the basis of previous studies showing that the period with the highest risk for readmission is the first 30 days after initial discharge and that readmission rates decline substantially after 3 months. Thus, to maximize cost effectiveness, the study was designed for high-risk patients during the high-risk period. Nonetheless, we followed all patients for one year. Readmission rates during the nine months after the discontinuation of the study intervention have been similar in the two groups (135 in the control group vs. 138 in the treatment group), but readmissions for heart failure have been less frequent in the treatment group (80 vs. 57, $P = 0.08$). These data strongly suggest that the intervention did not simply postpone readmissions, but its beneficial effects also appeared to persist for up to one year. Thus, the long-term cost savings with the intervention may be even greater than our data indicate.

Although we believe that the reduced rate of readmission and the improved quality of life in our patients were direct consequences of the study intervention, two alternate hypotheses could explain our findings. First, the patients assigned to the control group may have received substandard care. As we noted in Methods section, the patients in the control group w treated by their private physicians, and no stand: therapy was withheld. When we analyzed the medi tions taken at discharge, there were no differen between the groups in the use of digoxin, diuretics, a giotensin-converting–enzyme inhibitors, or other c: diovascular agents. Thus, differences in outcome ca not be attributed to differences in the medicatic regimen. With regard to the use of other services, di tary consultation was obtained by 49 percent of p: tients in the control group; 46 percent were seen i consultation by social-service personnel; and 39 pe: cent had home care after discharge. These figures like ly reflect current practice patterns for the use of thes services in the United States.

Another alternative explanation for our findings i that the patients in the treatment group may have hac better outcomes simply because of the increased atten tion and care they received. However, we consider it unlikely that the greater attention given to these pa tients accounted for the wide differences in outcomes; instead, the focused nature of the intervention and the fact that it had multiple components provide the most plausible explanations for our findings.

In summary, this study demonstrates that a nurse-directed, multidisciplinary treatment strategy can significantly reduce hospital readmissions and improve the quality of life for elderly patients with heart failure. Widespread use of this intervention in caring for the growing number of elderly patients hospitalized with heart failure could substantially reduce costs for health care.

Table 3. Costs of Care for the Study Patients.

Component of Care	Control Group	Treatment Group	Difference
	$ per patient		
Intervention	Not applicable	216	+216
Care given	828	1,164	+336
Other medical care	1,211	1,257	+46
Readmission	3,236	2,178	−1,058*
All	5,275	4,815	−460

*$P = 0.08$ for the difference between groups.

Table 4. Changes in Quality-of-Life Scores as Determined from the Chronic Heart Failure Questionnaire.*

Domain	Control Group (N = 39)			Treatment Group (N = 61)			Difference	P Value
	Base Line	90 Days	Change	Base Line	90 Days	Change		
	mean ±SD						%	
All four scores	74.4±16.3	86.7±19.8	11.3±16.4	72.1±15.6	94.3±21.3	22.1±20.5	+96	0.001
Dyspnea	8.1±2.7	11.9±10.0	3.8±8.4	9.0±2.9	15.8±12.8	6.8±7.9	+79	0.01
Fatigue	14.1±5.6	16.8±5.5	2.7±6.1	13.9±5.3	18.3±6.3	5.4±5.5	+100	0.01
Emotional function	33.3±8.1	33.2±8.4	1.9±5.3	31.9±8.5	37.4±7.5	5.6±7.1	+195	0.001
Environmental mastery	18.9±4.3	21.7±4.6	2.9±5.0	16.3±5.5	22.7±4.9	6.4±5.3	+72	0.10

*Higher scores on the questionnaire indicate an improvement.

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PREPARED STATEMENT OF MARY SUTHER

Thank you for the opportunity to present testimony today on issues relating to the Medicare home health benefit. My name is Mary Suther. I am the Chairman and CEO of the Visiting Nurse Association (VNA) of Texas. I am also chairman of the Board of Directors of the National Association for Home Care (NAHC).

NAHC is the largest national organization representing home health care providers, hospices, and home care aide organizations. Among NAHC's nearly 6000-member organizations are every type of home care agency, including nonprofit agencies like visiting nurse associations, for-profit chains, hospital-based agencies and free-standing agencies.

NAHC is deeply appreciative of the attention the Chairman and Members of this Committee have shown to the problems created by the home health provisions of the Balanced Budget Act of 1997 (BBA97) and the regulatory burdens imposed by the Health Care Financing Administration (HCFA).

RECENT REPORTS ON HOME HEALTH ACCESS

The Medicare home health benefit has undergone tremendous change as the result of the BBA97 and recent program requirement changes. Home health providers are finding it increasingly difficult to serve the same population of beneficiaries they served even two years ago. Many providers have left the Medicare program, and those remaining have reduced clients, staff, service areas, and made other changes in an effort to remain financially viable. These dramatic changes have compelled providers, beneficiaries, and their advocates to press for relief.

In response, the Congress has sought the input of both the General Accounting Office (GAO) and the Medicare Payment Advisory Commission (MedPAC) to determine the scope of the problem in home care and to make recommendations for needed changes. In recent weeks both of these advisory bodies to the Congress have reported on their findings.

While, in general, both of these studies convey the sense that whatever problems exist in home care are not of crisis proportions, we would urge that members of the Committee take a closer look at their findings. Both GAO and MedPAC found that beneficiaries are losing access to home care services. Both have indicated that the number of visits per patient, the number of admissions, and the number of agencies participating in Medicare have gone down significantly. Both reports confirm that the beneficiaries who are most costly to treat are at risk for losing access to care.

Perhaps of greatest importance for you as policy makers to consider is that the home health utilization findings of GAO and MedPAC are based, for the most part, on data from the first quarter of calendar year 1998. During this period of time many agencies had not yet transitioned to the interim payment system (IPS). Additionally, agencies that were on IPS had not yet received notices of their per beneficiary limits. Yet the data indicate that the home health program had already gone back to 1994 utilization levels. Given there is no indication that the deceleration in home health utilization is "leveling off," the current situation is much more severe.

We believe that the GAO and MedPAC findings must be trended forward in order to get an accurate picture of the devastation that is occurring to the home health benefit and in the home care field.

The home care community has experienced the same difficulty that GAO and MedPAC have had in attempting to precisely quantify the impact of BBA97 on beneficiaries and providers and isolate that from other programmatic changes. However, we've received reports from home care providers, beneficiaries, and from media throughout the nation that have showcased individual cases where access to care has become a serious problem. Real people who are in need of and eligible for home health services are going without care. We have attached some examples of these reports to our testimony.

We understand the need for Congress to make prudent decisions with respect to changes in the Medicare program. We also believe that the highest priority must be to target resources to ensure that beneficiary access is protected, and that the vital home health infrastructure be stabilized so that it is positioned to respond to future needs of the disabled and elderly.

We believe that the concerns expressed in the GAO and MedPAC reports closely mirror our own and those of our member agencies. For this reason, we have put a high priority on legislative relief for the home health program that would:

1. Target specific resources through some type of outlier provision to high-cost, heavy needs patients to ensure that eligible beneficiaries maintain access to needed home health services;
2. Eliminate the 15% additional cut scheduled for October 1, 2000; and

3. Provide relief from financially disabling overpayments in order to preserve the home health infrastructure so that it may help address future care needs.

These proposals, which will be discussed in depth later in our testimony, are in keeping with the concerns that the GAO and MedPAC have outlined and that led members of this Committee and others in the House and Senate to reexamine the home health program changes in the first place. We are grateful for your leadership, and look forward to working with you in these and other important areas.

REDUCTION IN MEDICARE HOME HEALTH EXPENDITURES PROJECTED TO BE NEARLY THREE TIMES GREATER THAN EXPECTED UNDER THE BBA

BBA97 was expected to reduce Medicare home health spending by $16.1 billion over five years. Although home care represents only 9% of Medicare, it was slated for about 14% of the reductions in Medicare spending. The 1999 Congressional Budget Office (CBO) analysis of anticipated Medicare program expenditures showed a dramatic, unintended reduction of the Medicare home health program.

At the time of BBA97's enactment, CBO reported that the effect of BBA97 would be to reduce home health care expenditures by $16.1 billion between fiscal years 1998 and 2002. CBO's revised analysis now projects those reductions to exceed $47 billion—nearly three times the anticipated budgetary impact.

When Congress passed BBA97, Members believed they were voting for a modest reduction in the rate of growth of home care, not slashing the benefit itself. Over the last two years, more than 2,000 home health agencies (HHA) across the country have been forced to close, and hundreds of thousands of Medicare beneficiaries are no longer receiving home health services. The changes enacted by Congress in 1997 have had a serious, unintended result of severely reducing access to the Medicare home health benefit.

CBO projected that home health expenditures in 1998 would be $20 billion, and in fact those expenditures ended up at less than $15 billion. Congress now has the hard evidence necessary to take action to put an end to the dismantling of the home health benefit.

INTERIM PAYMENT SYSTEM

The most devastating change for HHAs under BBA97 has been the enactment and implementation of IPS. The severe payment reductions under IPS coupled with other HCFA initiatives have had severe repercussions for home health providers and beneficiaries alike. Thousands of agencies have gone out of business, jeopardizing access to needed home care services. Agencies who have survived have, in many cases, been forced to refuse to take on patients with more intensive care needs, lest they risk financial ruin. Despite some measure of relief in the last Congressional session, severe problems remain, which must be dealt with in this Congress to ensure the continued viability of the home care program.

1. Medically complex patients

A 1998 study conducted by The Lewin Group entitled "Implications of the Medicare Home Health Interim Payment System (IPS) of the 1997 Balanced Budget Act" and a 1998 study by the Center for Health Policy Research of the George Washington University entitled "Medicare Home Health Services: An Analysis of the Implications of the Balanced Budget Act of 1997 for Access and Quality" both found that IPS curtails access to covered services for the sickest, most frail Medicare patients. Under IPS, HHAs have strong financial disincentives to care for patients with more intensive care needs because taking on these patients could threaten the financial stability of the agency.

HCFA has taken the position that there is no statutory authorization for exceptions to the annual aggregate per beneficiary limit. Since the base year for the per beneficiary limits is fiscal year 1994, agencies are using data from 1993 as their base year. Many agencies have experienced significant changes in case mix and services provided since that base year. Currently, no adequate case mix adjuster exists which reflects the characteristics of patients served that influence cost. IPS uses agency-specific data in establishing the per beneficiary limits as a proxy for case mix under the theory that an agency's case mix does not vary significantly from one year to the next. The validity of this assumption is severely tested when utilizing base year data that is four to five years old.

Technological advances in recent years have vastly expanded the scope of services that can be provided to Medicare beneficiaries in their homes. Services such as parenteral and enteral nutrition, chemotherapy and care of ventilator/trach-dependent patients, which used to be provided only on an inpatient basis, can now be provided in the home, thus reducing the need for more costly hospitalization. These services

are costly for the home health agency to provide, however. These services often require nursing staff who have had additional training in administration of drugs and procedures, as well as patient monitoring. In addition, such services require prolonged visits in the patients' homes, as well as high standby costs, extensive case management, transition discharge planning and other activities that add further to the cost per visit.

A type of outlier provision is needed for purposes of recognition of the higher cost of serving certain patients who qualify for Medicare home health services.

2. Per beneficiary limits

CBO, in estimating savings that would result from implementation of IPS, used an unprecedented 2/3 behavioral offset. What this means is that CBO directed Congress to cut $48 billion to yield $16 billion in savings over five years. To yield $48 billion in savings, Congress was forced to go all the way back to FY94 data for the base year in determining per beneficiary limits. It is now painfully clear, given recent CBO data, that this was completely unnecessary. But this mistake has had devastating consequences. The per beneficiary limits, based on 1993-94 data, clearly do not reflect changes that have occurred in the population served by home care or the types of services agencies are providing today. Further, IPS fails to distinguish between efficient cost-effective HHAs and providers that have high visit utilization and per-visit costs. In some circumstances, the use of a per beneficiary limit based upon agency-specific data perpetuates Medicare expenditures for overutilization. The lack of an effective case mix adjustor which distinguishes patients based upon needs and service costs prevents IPS from properly setting reimbursement limits. As a result, historically efficient HHAs may have lower payment limits than historically high cost providers. Agencies who serve a greater number of medically-complex patients may have limits insufficient to care for those patients, despite higher per beneficiary limits.

3. Per visit limits

BBA97 reduced the per visit cost limits from 112% of the mean to 105% of the median per visit costs by freestanding agencies. As a result, agencies have been forced to dramatically reduce the costs of delivering home health services. In many cases, agencies are reducing expenditures by reducing the number of visits they provide. However, as the number of services provided in a visit increases, costs per visit go up. Given the reduction in the per visit limits under BBA, many providers, in an attempt to stay within the per beneficiary limit, are being caught by the per visit limit.

Under the 1998 Omnibus Consolidated and Emergency Supplemental Appropriations Act (OCESAA), the per visit limits were raised from 105% to 106% of the median. This 1% increase was insufficient to help HHAs who are operating under cost limits that have been reduced from 14-22% under BBA97. The current cost limits are inadequate to cover the costs of providing care and to account for the increased administrative costs of participation in the Medicare program.

Reduced per visit cost limits jeopardize patients' access to necessary home health services. Under IPS, many HHAs have been forced to be more selective about the patients they accept, especially with respect to patients in rural or inner-city areas and those who have special needs and require more intensive care. Especially vulnerable have been individuals who need therapy services to restore their ability to care for themselves and inner-city residents for whom caregivers may require security escorts and language translators. Agencies in rural areas have been particularly hard hit by reductions. Their costs tend to exceed national averages because of longer travel times between visits and higher wages resulting from the lingering personnel shortages in rural areas.

4. Overpayments

BBA97 did not require HCFA to publish information on calculating the per visit limits until January 1, 1998, even though the limits went into effect beginning October 1, 1997. Likewise, HCFA was not required to publish information related to calculation of agencies' annual aggregate per beneficiary limit until April 1, 1998, despite an October 1, 1997, start date. More than a year after IPS began, many agencies had not yet received notice from their FIs providing the visit and per beneficiary limits under which they were expected to operate. Some agencies were operating for more than a year under IPS before they received information regarding their limits.

In other cases, where agency limits were provided, the FIs' calculations of agencies' limits were wrong due to the use of faulty data. Additionally, most of the FIs never modified agencies' payments to reflect the IPS reductions; rather, they contin-

ued to pay agencies according to the previous year's levels, resulting in significant overpayments to many HHAs across the country.

The BBA97 home health reductions were so deep and occurred so quickly that many agencies were not aware of the full impact the cuts would have on their reimbursements, particularly since most agencies did not even know their reimbursement limits until months after care was delivered. More importantly, most agencies continued full access to care within the scope of the Medicare benefit rather than terminate care to patients.

FIs have been issuing notices of overpayments to agencies and demanding repayment. The IPS reductions make it near impossible for agencies to provide high quality, appropriate care to Medicare beneficiaries and to comply with repayment requests. These overpayments are not the result of abuse or inefficiency. Rather, most overpayments have occurred because HHAs continued to serve high-cost patients within the scope of Medicare coverage and the payments have already been used to provide legitimate needed care to eligible beneficiaries. Without some relief from these overpayments, it can be expected that agency closures, and the attendant access problems, will accelerate.

5. Mandatory 15% reduction in home health limits

Under the BBA97, expenditures under a prospective payment system (PPS) were to be equal to an amount that would be reimbursed if the cost limits and per beneficiary limits were reduced 15%. Even if PPS was not ready to be implemented on October 1, 1999, the Health and Human Services Secretary was required to reduce the cost limits and per beneficiary limits in effect on September 30, 1999, by 15%. The OCESAA delayed the 15% reduction for all HHAs until October 1, 2000.

IPS already significantly reduces the reimbursement rates for providers. On average, agencies are receiving 31% less in reimbursement under IPS than they did previously. HCFA has projected that nearly all HHAs under IPS will receive reimbursements that are lower than their actual costs of providing care. Given CBO's estimates of outlay reductions far in excess of those anticipated (nearly $48 billion as opposed to the expected $16 billion), further cuts to home health of 15% would be devastating to providers, severely jeopardize the ability of beneficiaries to access care, and restrict the level of care beneficiaries could receive.

6. Proration

BBA97 stipulates that the per beneficiary limit will be prorated among agencies when a patient receives services from more than one agency. This provision is unnecessary and too complicated for routine administration of the payment system.

The per beneficiary limit is calculated from the 1994 fiscal year where patients were also served by more than one agency. Therefore, the per beneficiary limits already account for patients being served by more than one agency and prorating of fees is unnecessary. However, it is recognized that one method of circumventing the per beneficiary limits would be to transfer patients to another agency. HCFA should have a mechanism to deal with these situations if they arise.

The tracking required to comply with this provision would be problematic for both providers and HCFA. HHAs do not have access to the information that would allow them to sufficiently track beneficiaries' use of other home health services and do not have control over where patients receive services before and after the home care they provide. Prorating becomes even more complicated given that agencies have different limits and fiscal years over which those limits are applied. Further, proration of the limits would interfere with a patient's right of choice of an HHA and potential access to care. A patient previously served by another provider may bring high-cost care needs and a reduced payment limit, thereby discouraging the patient's admission.

7. Periodic interim payments (PIP)

Medicare allows for periodic interim payments (PIP) for many Medicare providers in order to maintain a steady cash flow for services rendered on behalf of Medicare beneficiaries. PIP payments to HHAs are based on volume experience which is adjusted on a quarterly basis.

BBA97 eliminated PIP for HHAs effective for cost reporting periods beginning on or after October 1, 1999, a date intended to coincide with implementation of PPS for home health. OCESAA extended PIP to fiscal year 2001, eliminating it for portions of cost reporting periods occurring on or after October 1, 2000.

Under IPS, maintaining PIP is more important than ever in allowing agencies to serve Medicare beneficiaries effectively. The cash flow generated by PIP is critical to the financial viability of small HHAs that do not have large cash reserves to support delayed payments from HCFA. Congress should maintain PIP or, at a minimum, extend it at least one year beyond implementation of PPS.

VENIPUNCTURE

Effective February 5, 1998 a provision included in the BBA removed blood drawing (venipuncture) as a qualifying service for the Medicare home health benefit. Before this date, if a beneficiary needed venipuncture and met all other home health criteria, he or she could receive venipuncture from a home health nurse along with other Medicare-covered home health services, including home health aide services, ordered by his or her physician. Under the new policy, if venipuncture is the sole skilled service needed, Medicare will only cover venipuncture provided by lab technicians under Part B, and homebound beneficiaries in need of blood monitoring will lose eligibility for home health services.

Beneficiaries who qualified for home health services based on venipuncture are some of the oldest and most disabled Medicare beneficiaries, many with multiple diagnoses including diabetes, heart disease, stroke and clinical depression. Many homebound individuals with chronic conditions and complex medication regimens no longer receive nurse assessments for purposes of preventing acute episodes and hospitalizations. The home health aide services that were sometimes provided by the agencies in conjunction with blood monitoring made it possible for beneficiaries to remain in stable condition and at home. Without such services, many of these individuals are admitted to long-term care facilities. NAHC has received hundreds of phone calls and letters from consumers, physicians, providers, and other organizations raising concerns about the severe impact on patients resulting from the removal of venipuncture as a qualifying service under the Medicare program.

15 MINUTE INCREMENT REPORTING

BBA 97 required that claims for home health services on or after July 1, 1999, must contain a code that identifies the length of time for each service visit, measured in 15-minute increments. HCFA issued instructions to the FIs on February 18, 1999, directing them to initiate necessary steps to implement this new billing requirement for all HHAs participating in the Medicare/Medicaid programs (Transmittal No. A-99).

This new administrative burden imposes a complex time-keeping requirement for agencies to stop the in-home clock when an interruption in active treatment occurs. The HCFA transmittal defines the "time of service visit" to begin at the beneficiary's place of residence, when delivery of services has actively begun. Agencies must count the number of 15-minute intervals, but cannot report services lasting less than 8 minutes.

Since the time counted must be actual treatment time, providers are expected to discount time spent on non-treatment related interruptions during the in-home visit. For example, if a beneficiary interrupts a treatment to talk on the telephone for other than a minimal amount of time (less than 3 minutes), then the time the beneficiary spends on the telephone and not engaged in therapy does not count in the amount of service time.

In-home time represents only a portion of the total time invested by an agency in caring for a patient. Numerous activities required by the Medicare Conditions of Participation and needed to ensure effective patient care are often times performed outside the home, including communication with physicians and family members, coordination of services with other home health personnel and community agencies, care planning, and clinical documentation. In order for home care treatment time to be meaningfully quantified, visit time must be better defined and recognized as only part of the resource cost involved in providing home care services.

Neither Congress nor HCFA has indicated how this information will be used. Its value is questionable in light of the ongoing move from a per-visit reimbursement system to a prospectively set per-episode of payments that are not tied to number of visits or visit length. In light of the substantial financial and administrative strains already being experience by agencies, we urge you to revisit this requirement.

CONCLUSION

Thank you again, Mr. Chairman, for the opportunity to present our views. You and the Committee have our thanks for bringing home health issues to this level of consideration. We look forward to working closely with you to resolve these issues.

Attachments.

HEADLINES

AFTERNOON NEWS UPDATES
Weekdays by 3 p.m.

Monday, April 26, 1999

Medicare's drive to cut costs forces many companies to go belly up

Home health care companies die en masse

Economic survival is the theme at the Virginia Association for Home Care's annual conference, which begins today at the Hotel Roanoke and Conference Center.

By SANDRA BROWN KELLY
THE ROANOKE TIMES

Interim Home Health of Roanoke Valley this month became one of the latest casualties of a financial tidal wave in the home health care industry that was one consequence of the drive to balance the federal budget.

The 18-year-old company had recently cut its full-time employees from 44 to 22. Now, it has filed a Chapter 11 petition for debt reorganization in U.S. Bankruptcy Court.

In the Galax-Hillsville area, Deerfield Home Health Care in Mouth of Wilson and Tri-County Home Health in Hillsville are completely bankrupt.

This trend is why survival is the theme of the agenda for the Virginia Association for Home Care's annual conference, which begins today at the Hotel Roanoke and Conference Center, said Bobbye Terry, director of legislative affairs.

The conference program includes speakers on the financial effect of Medicare changes, ways agencies can be more efficient, and how they can retain staff during a period of turmoil.

A temporary capped payment plan Medicare set up for home health agencies has driven more than 1,000 of them into bankruptcy or out of business since last October, according to data collected from 23 states by the National Association for Home Care. When all states report in, the association expects the number of agencies lost to reach 2,000, about 20 percent of the U.S. total.

"The home health industry has been under the gun for a year and a half," Terry said.

Most of what has happened can be traced to the Balanced Budget Act of 1997, which included a dictum that Medicare trim home health payments by about $16 billion over four years. (Medicare is a federal program that pays for some health care services for people older than 65 or disabled.) To do this, the Health Care Financing Administration (HCFA), which runs Medicare, had to figure out a new way of reimbursing for home health services. In the meanwhile, it placed home health agencies on a temporary payment system based on the agencies' 1994 expenses. In April 1998, HCFA gave each agency an annual cap per patient and made it retroactive to 1996.

If a company was really efficient in 1994 or provided less expensive services, it got a lower per-patient cap than another company that might have been less efficient or was delivering more complicated services. Because of these caps, which in this area average about $3,000, agencies must have the right mix of patients to stay in business. The cap amount gets paid whether a patient is seen twice overall or twice a day, so the ideal is to have lots of patients who get well within a few visits to offset the cost of caring for patients with more intensive and long-term needs.

The cap amount is not guaranteed income. Medicare might decide after an audit that a company's expenses don't warrant that level of reimbursement.

Services provided by home health agencies vary greatly by agency. Most employ a combination of registered and licensed nurses and home health aides. Others also have therapists on staff. The services are intended to be short term and designed to help a patient go home from the hospital as soon as possible and become self-sufficient. An agency might offer therapy to a patient who has had a knee replacement, care for wounds, or provide a companion for someone who temporarily cannot be alone.

Housecall Home Healthcare in Salem, one of the area's largest agencies, offered a broad range of services, including physical therapy, and had a lot of patients in 1994, so its per-beneficiary cap is higher than some other agencies' cap, administrator Joe Hearst said.

Hearst said he expects Housecall to grow larger at the same time "the cap is wiping out small agencies."

"I heard a consultant say that at least 4,000 agencies are out of business and don't know it because they haven't yet gotten their bills for overpayments," Hearst said. "We're going to be one of the survivors."

"It's a bad time to be in home health, though," he said.

Donna Peery of Galax knows that for sure. She and her husband, Tom Peery, recently filed Chapter 7 debt liquidation for Tri-County Home Health, which they had operated since 1994.

"We couldn't provide the quality of care with a per-patient beneficiary limit below $2,800," Donna Peery said. "It was all well and good if somebody had surgery and just needed a couple of days of dressing changes. We had patients who needed dressings changed twice a day and patients needing daily insulin injections."

When the Peerys officially closed Feb. 12, they faced an $87,000 bill from Medicare for overpayments. Both are nurses. He now works for a hospice, and she draws unemployment.

In addition to the pressure put on agencies, Peery anticipates that patients who need longer-term visits will eventually be shunned by agencies.

"Home health care got to be more than what it started out to be, and people have become dependent on it," she said.

Kimberly Wilson, a former Tri-County Home Health employee who opened Southwest Virginia Home Health Care Inc. in Galax in July 1997, doesn't know if she can stay in business.

"I've yet to take an income home," Wilson said. She owes money back to Medicare, maybe as much as $25,000, which she hopes to be allowed to pay over time.

Wilson says the government has been too strict on what it will pay for. For example, since February 1998, it has refused to pay for a home health worker to draw blood samples for a patient taking the blood thinner Coumadin, although too much of the drug can cause dangerous bleeding.

Her home area has a number of widows who don't drive who need the Coumadin blood checks, she said.

When Medicare eliminated payments for blood withdrawals, called venipuncture, many agencies lost large numbers of patients. The home health service run by the Roanoke Health Department lost 50 percent of its patients, said Linda Hudgins, director of the program.

Some of the patients were kept on through the health department's free services, she said.

The annual payment cap pressures the health department's program just as much as it hits the private companies, said Hudgins, who considers some of Medicare's expectations unrealistic.

For example, she said, Medicare expects a home health worker to wean away a patient who needs dressings on a wound changed by teaching family members or the patient to change the dressings. Her agency has a patient who has a back wound that the patient can't reach, and no family members are available to provide the care.

"We will lose money on that patient," Hudgins said.

The cost pressures on home health are driving health departments' home health services out of the business, too, she said. Thirty health departments in the state used to provide the services, but only nine do now, she said.

Home health has had fraud and abuse in it, Hudgins said, but she argues that home care also has been instrumental in keeping people in their home and out of nursing homes, which cost the government more than home health visits.

Leland Sigmon, who owns the Interim franchise in Roanoke, said he expects to pay his bills and stay in business, but said he needed the protection of the courts while he revamps. His company operated at a loss in 1998 for the first time since it opened, Sigmon said.

In addition, he just paid $33,000 back to Medicare for overpayments in 1996, and he expects he will owe more to the government once his books are audited for 1997 and 1998. Because of the complexity of the Medicare reimbursement system, it's not unusual for home health agencies to owe money back after an audit. But the repayment coupled with a drop in reimbursement amounts proved to be too much, Sigmon said.

"The unknown is what's difficult to deal with," Sigmon said.

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200 protest cuts that threaten home care

■ Elderly Rhode Islanders, visiting nurse groups, home health aides and politicians rally against Medicare cuts that have forced some agencies to close.

By JONATHAN SALTZMAN
Journal State House Bureau

WOONSOCKET -- As Roland Trudel lay dying of brain cancer five years ago, his wife of 48 years made him a promise: She would strive to keep him out of a nursing home so he could die at home.

To help make good on her pledge, Alice Trudel turned to the Visiting Nurse Service of Greater Woonsocket. The agency sent a nurse or nursing assistant to the couple's house daily to bathe Roland Trudel, give him medication and ease his pain.

When the 75-year-old retired Texas Instruments manufacturing worker died in late 1994, he was home, in his living room, surrounded by cherished photographs of their three children, four grandchildren and one great-grandchild.

"It would have broken my heart if I had to break my promise," said Alice Trudel, 77. "But if they didn't come, I would have had to put him in a nursing home."

Yesterday, Trudel joined more than 200 elderly Rhode Islanders, home health workers, civic leaders and politicians at a spirited rally to protest federal cutbacks in Medicare reimbursements that threaten home care agencies.

The cuts, which are squeezing agencies across the country, led to the recent closing of two in Rhode Island that provided home health aides.

Meanwhile, visiting nurse associations throughout the state are laying off scores of workers, or considering merging or reorganizing in the face of enormous losses.

One of the hardest hit agencies has been the Visiting Nurse Service of Greater Woonsocket. An agency official said it has lost 130 workers through layoffs or attrition in the past year.

"This is something that's very real, very now, and directly hurting people," said former Lt. Gov. Roger N. Begin, a Woonsocket native who hosted the event in a packed dining room of the Woonsocket Senior Citizens Center.

Elected officials at the rally, all of them Democrats, traced the problems to the 1997 federal Balanced Budget Act passed by Congress and signed by President Clinton. The act reduced the growth of Medicare, the health insurance program for the elderly, but had what detractors describe as disastrous consequences on home health care.

It led to enormous cutbacks in reimbursements to visiting-nurse agencies, reductions in the number of visits that Medicare would finance and the amount it would pay for each visit.

The new formula for reimbursement was based on past spending, and in the Northeast -- where costs have typically been low -- agencies were hard hit. Some closed; all had to cut back sharply.

Patients who could no longer get care through Medicare turned to the state. Some were eligible through the Medicaid program for the poor; others qualified for a state program that subsidizes home care for people whose incomes are just above the cutoff for Medicaid.

But the network of 35 home health agencies in the state was already struggling with a shortage of qualified home health aides.

These employees have less training and earn less than visiting nurses. In Rhode Island, they are particularly low-paid. Home health agencies get a base rate of $10.94 an hour for an aide's services compared with $19.60 in Massachusetts and $20.22 in Connecticut. After paying for costs such as overhead and worker's compensation insurance, the agencies typically have $6 to $7 an hour left to pay their workers.

The low pay and tight labor market have left many agencies strapped for workers. When a small health agency in Providence, Advanced Home Care, closed recently, its owner cited an inability to find qualified employees.

Rep. Patrick J. Kennedy, one of the key speakers at the senior citizens center, said that when he voted against the Balanced Budget Act, critics called him a big spender.

But, he said, he knew the measure was "penny-wise and pound-foolish." Cuts in home health care have forced elderly Rhode Islanders to go to hospitals or nursing homes, he said, usually paid for by the state at many times the cost of home care.

Apart from the burden on taxpayers, he said, the cuts have taken an intangible toll on patients who would rather stay home, and families who would prefer to have them there.

Kennedy said he understands that desire from his own experience. His grandmother, Rose Fitzgerald Kennedy, was the "real glue" in his family, he said, and he was grateful she could live out her final days at home. She died in 1995 at the age of 104.

Sen. Jack Reed, another speaker, said the Balanced Budget Act may have been well intended, but "solvency is no justification for running a program that's insufficient."

He and Kennedy vowed to lobby Congress to increase the Medicare payments to home health agencies.

The issue is heading for debate at the State House as well.

Republican Governor Almond, who did not attend the rally, said in a recent statement that the Balanced Budget Act was "landmark legislation" that stoked the economy. But he conceded that it had "unintended consequences" on health care programs such as home health care.

He has earmarked $350,000 in the state budget that begins July 1 for home health care. He has promised to add $1.65 million, assuming May estimates of state revenue remain optimistic. The nearly $2 million would enable the state to increase hourly reimbursements of home health aides by $2.50, according to the Almond administration.

But Lt. Gov. Charles J. Fogarty, a Democrat and vocal proponent of improving the long-term-care system, said that's not enough.

He has asked two Democratic legislators in the General Assembly to introduce bills that would increase state aid by $3.6 million. That would enable the state to raise the reimbursement rate to $16 an hour.

"It's really economically foolish for us to underfund home health care because the direct result will be people going to more expensive care in institutions," Fogarty said.

By increasing the reimbursement rate, he said, the state will be able to expand the pool of home health workers before the situation becomes dire.

"As agencies are reducing services and some are closing their doors," he said, "it's becoming more and more apparent that this is not a problem -- it's a crisis, and we have to deal with it."

Add Your two cents' on this topic

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The Salt Lake Tribune

Utah Has Lost About Half of Home Health Agencies Due to Cuts

BY NORMA WAGNER
THE SALT LAKE TRIBUNE

Utah has lost about half of its home health-care agencies in the past two years because of benefit cuts in the Medicare program.

"We had over 112 at one point and our latest count is around 55 [agencies]," said Allan Elkins, who oversees inspections and certifications for agencies that care for Medicare and Medicaid patients.

Small agencies were forced out of the business as were some larger ones in rural Utah and along the Wasatch Front.

The Columbia hospital chain divested its home health services across the nation, including seven agencies in Utah. Intermountain Health Care (IHC) no longer houses its home health-care services in some of its rural hospitals.

"We've had to reduce overhead, administrative services, brick and mortar," said Boyd Woolsey, spokesman for IHC home health services. "But we're still offering the services to the patients in those areas."

"And we've had small ones close who had so few clients it was no longer [financially] beneficial to stay in the program," said Royal Simpson, manager of the state Health Department's hospital and ambulatory-care survey section.

Elkins, also of the Utah Department of Health, said the drop "is amazing to us. We're hoping there's adequate agencies left out there to meet the consumers' needs."

The Salt Lake Tribune

Sunday, April 4, 1999

Lawmakers Scrambling to Fix Medicare

Spending cuts have severe impact on home health-care industry

BY LARRY WHEELER
GANNETT NEWS SERVICE

WASHINGTON -- A budget-balancing law Congress approved in 1997 was supposed to slow federal spending on Medicare home health services. Instead, it resulted in the largest benefit cut in Medicare history and lawmakers are scrambling to fix the problem.

More than 1,400 Medicare home health providers have closed since the Health Care Financing Administration, the agency that administers the Medicare program, began implementing a new payment system last year, agency records show.

The nation's largest home health industry trade association estimated the cuts have left 700,000 Medicare beneficiaries without home health-care services, but some experts challenge that estimate because of weaknesses in Medicare data.

What is not debatable is that mounting anecdotal evidence points toward an extensive impact.

In Florida, where the state has a well-developed safety net for retirees, state agencies are seeing significant increases in demand for homebound personal-care services, an increase they attribute directly to Medicare benefit cuts.

And an Illinois visiting nurse agency recently decided to discharge 25 patients whose care was so costly the agency said it faced certain bankruptcy if it continued to care for the patients.

Similar stories can be found across the country.

The Congressional Budget Office, which predicted cost-cutting measures would reduce Medicare home health spending by $16 billion, now estimates the cuts will exceed $47 billion over a five-year period.

Last year, Medicare spent $14.9 billion to provide home health services to more than 3 million elderly and disabled patients, the first time in the history of the Medicare program that spending declined from the previous year.

"This is clearly the largest cutback that we have seen," said Barbara Markham Smith, senior researcher at George Washington University Center for Health Policy Research. "The nature of this particular cutback is pretty much unprecedented."

President Clinton announced Tuesday that the latest Medicare trustees report extended the projected solvency of the Medicare trust fund from 2008 to 2015. The extra seven years were due in part to savings generated by cutting the home health benefit.

Home health industry officials, patient advocates and some lawmakers believe the new payment system and other cost-cutting measures have been a disaster both for elderly patients and the small businesses that send nurses and aides to care for the homebound Medicare beneficiaries.

Medicare managers and government auditors say they have detected no adverse impact on the Medicare population.

The cost-cutting measures, which include increased audits and more stringent screening of providers, are difficult but necessary reforms, said Robert Berenson, director of Medicare's Center for Health Plans and Providers.

"We are looking very carefully at whether beneficiaries are losing access to needed services," Berenson said. "As of now, we don't have any information that beneficiaries who need home health care are not receiving it."

Despite the alarming number of agency closures since 1997, there still are more than 9,000 active Medicare home health providers nationwide, which Berenson said appears to be an adequate number.

Next year, the interim payment system will be replaced with a prospective payment system designed to repay home health agencies based on the nature of a patient's illness rather than based on historic spending patterns in a particular county.

"The prospective payment system will be better for everyone," Berenson said. "Patients who have more health-care needs will get substantially more payment."

But the law Congress passed requiring the prospective payment system also dictates that home health spending will decline another 15 percent in addition to the cuts already under way.

Senators and House members aren't waiting for official confirmation for a problem they already

know exists.

"A lot of people are trying to deny nothing bad is happening," said Sen. Russ Feingold, D-Wis. "But the reality is we have lost a lot of agencies crucial to providing home care for older people and those with disabilities."

Feingold successfully amended the recently passed Senate budget resolution with language that calls on the Senate to alter the new payment system and other changes that have had a "negative impact" on Medicare home health delivery.

A similar amendment was included in the House budget resolution.

With 55 of his state's 150 Medicare home health agencies out of business, an alarmed Sen. Jeff Bingaman, D-N.M., summoned Health and Human Services Secretary Donna Shalala to his office.

Following the meeting, Shalala dispatched a special team to New Mexico to investigate. Since then, the investigation has grown to include other states, but the group has not reported its findings, Bingaman said.

"We were getting lots of complaints from providers essentially advising us they were having to fire their employees, go out of business and terminate their services," Bingaman said. "After you hear that from several sources, you begin to think this is a problem worthy of attention."

At least four government and academic studies are under way in an attempt to measure the impact of the Medicare home health reforms.

Home health-industry representatives are cautiously optimistic that senators and House members will be able to repair some of the damage.

"We recognize the world of the budget is such that monies aren't readily available to bring about significant fixes," Dombi said. "At the same time, our cautious optimism is triggered by the many visits our industry members have had with their members of Congress where the member says, `We know we didn't fix all the problems and we have to revisit it.' "

By April M. Washington

Balanced Budget Act a bitter pill for some

GRAND PRAIRIE - Janis Fisher awoke from emergency surgery in an Oak Cliff hospital 35 years ago paralyzed from the waist down. The Grand Prairie resident broke her back in three places when she flew out of the back seat of a 1956 Ford convertible and smacked into a utility pole on Santa Fe Road in Duncanville. She was 16 years old, in the prime of her young life.

The nephew of her stepfather drank one too many beers before picking up Mrs. Fisher from her best friend's house. On the way home, he sped around a sharp corner and lost control of the car. She barely knew the boy.

Since the accident, the 52-year-old Mrs. Fisher estimates she has been operated on more than 20 times. Her greatest fear is being forced out of her modest duplex built in the 1940s.

"I just want to remain in my own environment - just me and my cats," said the wheelchair-bound Mrs. Fisher. "Just thinking about being in a nursing home scares me out of my mind."

Medicare decided Mrs. Fisher's home health care wasn't a medical necessity earlier this month and cut the benefit, moving her one step closer to the nursing home she dreads.

She's not alone. Thousands of chronically ill and elderly patients are losing some or all of the home-health-care services once covered by Medicare.

Last summer, Congress passed legislation as a part of the broad-sweeping 1997 Balanced Budget Act that limits the amount of payments home-health agencies can receive for taking care of homebound patients.

Lawmakers took action to curtail exploding home-health-care costs and rampant fraud, waste and abuse.

Once a small component of Medicare, spending for home health care soared in the last decade, said U.S. Rep. Joe Barton, a Republican whose District 6 includes parts of Arlington.

The costs to care for homebound patients quadrupled, from about $3 million in 1990 to $17 billion in 1996, said Mr. Barton, who supported the new guidelines.

For that reason, Congress imposed a cap on the amount of funds Medicare reimburses home-health-care agencies per year for the care they provide to people like Mrs. Fisher.

Under the old guidelines, health care providers had no incentive to streamline their costs, said Mr. Barton, chairman of a congressional oversight subcommittee conducting Medicare hearings around the country.

As a result, many bilked the Medicare system for services not covered by the law, he said.

"While you had a lot of good health care providers, you also had a number, if not fraudulent, that were wasteful in spending taxpayers' dollars," Mr. Barton said. "The system started out as a less expensive way to let people out of the hospital to receive short-term medical care in their homes.

"Then people started going into the home supposedly to treat medical conditions. Instead, they were cooking, cleaning and giving patients baths and charging Medicare.

"That's what's going to come to an end. The people who really need home health care are going to get home health care."

Mrs. Fisher received notification about the elimination of her home health care benefits April 1.

No joke

"I thought it was an April Fools' Day joke," she said. "I really rely on the care the nurses give me.

"I'm afraid they (lawmakers) didn't understand how much damage the changes were going to have on a lot of people like me who live alone and have no family close enough to take care of them."

Poor blood circulation forced doctors to amputate Mrs. Fisher's right leg in 1975.

Just last year, a nurse who visits her home once a week treated Mrs. Fisher for eight kidney infections and taught the woman how to care for sores that develop from sitting for extended periods.

She has grown to depend on the care she receives from Arlington-based Cuidado Casero Home Health Care Services.

"I get so sick sometimes that I can't even get out of bed to dress myself, to get on a bus, or call a taxi to get to the doctor," Mrs. Fisher said.

Complaints from distraught beneficiaries like Ms. Fisher have flowed into the congressional offices of Mr. Barton and Democratic U.S. Rep. Martin Frost, D-Dallas, the other congressman who represents parts of Arlington and Grand Prairie.

Like Mr. Barton, Mr. Frost voted for the far-reaching health care changes. But unlike Mr. Barton, he has since had a change of heart.

He now wonders whether Congress acted too hastily.

"We were trying to bring the deficit down," said Mr. Frost, who recently co-sponsored legislation that would delay the new payment system until Congress can reassess its effect.

"The home-health-care provision needs to be looked at again and changed. People ought to be able get as much help as possible.

"There were some concerns about fraud, and I think Congress overreacted in trying to address that."

First-hand experience

The 20-year incumbent said he began realizing the severity of the cost-cutting changes after his mother fell and broke her hip about two months ago.

Mr. Frost has had to make several trips to San Antonio to look after his 79-year-old mother's medical needs.

"I've been down there quite a bit," he said. "She's had to pay quite a bit out of her pocket for some of her home health care.

"It's so much, she can't afford to pay as much as she needs. This is an issue that's hit close to home."

U.S. District 24 GOP challenger Shawn Terry assailed Mr. Frost for supporting a bill he argues unfairly cuts the medical care of constituents like Mrs. Fisher.

"Mrs. Fisher is a classic example of someone who doesn't need to live in a nursing home, but under the current system might be forced into one," said the Dallas management consultant, who met the Grand Prairie resident after accompanying a nurse to her home last month.

"Frost voted for a bad bill that doesn't take into account the fact that people have different medical needs and requirements. I think home health care can save this country money. It can avoid unnecessary hospitalization that some find troublesome and expensive.

"We can't have a blanket, one-size-fits-all approach to health care. We have to strike a balance."

A day before Medicare terminated Mrs. Fisher's benefit, Cuidado Casero Home Health Care Services owner Carmen Santiago learned her agency would be limited to a maximum of $3,310 per year to care for minor to critically ill patients.

That's a drop in the bucket compared to the average $8,100 the Health Care Financing Administration paid agencies annually per patient, according to the Texas Association for Home Health Care. The health care administration oversees Medicare.

Business groups protest

Mrs. Santiago, who estimates Medicare payments represent about 95 percent of her company's income, said "that's what it costs us to take care of really sick patients in one week.

"We take care of patients that are totally bedridden, blinded by diabetes, paralyzed. They take a lot of care," she said. "A nurse has to go out twice a week to care for them.

"The $3,310, that won't cover the gas or supplies."

Mrs. Santiago and the state's home health care association insists the new payment cap penalizes reputable agencies, forcing some out of business and their chronically ill patients into nursing homes.

For now, Mrs. Santiago's multimillion-dollar agency is able to survive the cutbacks. Some longtime friends with other agencies

aren't so lucky, she said.

"It's sad to watch people you've worked with for years, knowing they have families to support and take care of go by the wayside because of all these horrible changes," Mrs. Santiago said.

The Texas Association for Home Care and Rockwall Home Health, Inc., filed a lawsuit last month seeking an injunction to prevent the U.S. Department of Health and Human Services from implementing the new payment caps.

The class-action lawsuit, filed in the U.S. Northern District Court in Dallas, contends the new limits inadequately cover the cost of caring for homebound patients, particularly those like Mrs. Fisher with multiple medical needs.

The association, which represents more than 1,200 home-health-care agencies throughout the state, also charges that more than half of the 3,000 such businesses in Texas will go bankrupt if the changes are allowed to stand.

'Devastation' assailed

"Realistically, these cuts are so severe that Texas home-health agencies cannot continue to care for most of their higher-cost patients," said Sara Speights, director of government affairs for Texas Association for Home Care. "They are really underestimating the devastation it caused to some human beings.

"They have blown a lot of isolated cases of fraud out of proportion and created a whole new system that verges on the insane."

Cuidado Casero representatives have trekked to Washington, D.C., in recent months, attending a series of hearings and forums to implore lawmakers to revise the changes.

"They've done this to balance the budget," said Gloria Carrillo, Cuidado Casero's director of human resources. "But they've balanced the budget on the backs of the elderly and the chronically ill."

U.S. Rep. Greg Ganske, R-Iowa, a member of Mr. Barton's oversight committee, accused home-health-care providers of exaggerating the threat of reduced services.

"Faced with new policies to eliminate fraud, some home care agencies have tried to frighten their patients into becoming advocates against the reforms," said Dr. Ganske, who operated a private medical practice before he was elected to Congress in 1994.

"The service will still be there, but will cost a lot less. And it won't be an opportunity to exploit the program for unnecessary services."

Mrs. Santiago said lawmakers like Dr. Ganske just don't get it.

"They only see the outside. They don't know what we go through to make sure our patients are taken care of, whether it's paying for a patient's prescription, gas bills or toys for their kids out of our own pockets."

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Medicare cutbacks strand housebound poor, elderly

By EVE ROSE
Daily News reporter

Karen Jones has been going to Emitt Soldin's home for two years to sample his blood and make sure the steroids he takes have not caused him to bleed internally.

Soldin's arthritis has left his hands and feet deformed, making it painful for the 74-year-old Anchorage man to walk the few feet from his bedroom to the kitchen.

Last week, Jones showed up at Soldin's home the same as always. The only difference this time was that she was not getting paid.

Jones is one of an unknown number of nurses, aides and other health care workers across the city who are continuing to provide their services for free out of fear their elderly and disabled patients who receive care at home will get sicker or even die if they do not.

They say major cuts in federal funding have forced them to make the difficult choice of leaving patients to fend for themselves or continuing to care for them without pay.

In the last two months, three Anchorage firms providing home health care for the poor and elderly have shut down, one has changed hands and the four remaining have had to cut back on the amount of care they provide to Medicare patients, according to home health care industry officials.

Many in the industry fear that in the long term, the cuts could severely limit the poor's access to home health care — long praised for improving the quality of life of the old and disabled by enabling them to be at home instead of housed in institutions.

The cuts and other changes that took effect in October are

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CARE: Medicare cuts back

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the result of the 1997 Balanced Budget Act in which Congress slashed billions from Medicare funding in an attempt to hold down federal spending on the service, which had skyrocketed in the past seven years, said Pam Negri, a health insurance specialist for Medicare in Seattle.

Home health care visits — in which nurses and others do everything from administer chemotherapy to change bandages on foot ulcers — can cost $150 to $200 per visit.

The old system, which allowed almost unlimited visits, gave agencies little incentive to cut costs and opened the door to widespread fraud, Negri said. The new rules put a cap on the number of some visits and eliminate some services.

While many in the local health care industry believe there was fraud in the Lower 48, they do not think it extended to Alaska.

"One bad apple tends to make everyone look bad," said Roxanne Thygeson, director of clinical services for Geneva Woods Home Health.

With agencies shutting the doors, hundreds of Anchorage patients are scrambling to find care. The four remaining agencies in Anchorage are picking up many of the patients and say they can handle more.

In some cases, however, patients are no longer covered under the new rules. For example, the federal program no longer covers the cost of taking blood tests in a person's home. If the patient can get to a lab or doctor's office, Medicare will cover the service, but for some that is impossible or risky.

For Soldin, a former Bush pilot who can no longer walk down the stairs of his home, the trip would be extremely painful and dangerous to his health, Jones said. Soldin could pay the $150 per visit cost himself, but Jones feared it would be too hard on him financially, which is why she continues to provide the service for free.

Some health care workers said they feared for some patients who are simply falling through the cracks — people who can't make it to the doctor's office for blood work, can't afford to pay the cost of someone coming to their home or simply won't make the trip.

"There are a lot of old, stoic pioneers out there who aren't going to go to the doctor's office or the hospital to get their blood checked, but they would take the care from someone coming to their home," said Cindi Swarts, administrator of Alascare, who shut down her Medicare home-health arm this week because of the cuts.

Meanwhile, agencies that are still open are struggling to survive with less funding from the government.

Pacific Home Health has had to lay off a few administrative workers and cut nurses' benefits, said Margo LaChapelle, the agency's administrator. "We are committed to maintaining the quality of care as best we possibly can," she said.

But some in the industry fear the cuts will end up putting pressure on agencies to cut back on the number of visits, pushing people back into hospitals for longer stays or into nursing homes.

"The government is going to see that it has come full circle and won't have saved any money in the process," LaChapelle said.

Kathy Lum, director of Providence Alaska Medical Center's home health care operation, the largest in the city, hopes the government will see how shortsighted some of the changes are and the "pendulum will swing back again."

Ron Cowan, a supervisor with the state's health facilities and licensing bureau, said his agency has not received any complaints from patients, but he has heard from area health care providers about their concerns.

"If it's having this kind of ripple effect, I would hope the federal government would change the policy. I can't believe we would cut off our nose to spite our face," he said.

Meanwhile, people like Dania Fischbach plan to spend their own money to fill the gap.

Fischbach, an owner of Professional Infusion Pharmacy, was so concerned about a few of her patients she's decided to pay for them to continue to receive care from their nurses. They could have gone to another provider, but it would be too traumatic for them, she said.

"Right now, I can't go tell that little old man that he's not going to see his nurse anymore. Morally, I can't do that."

□ Reporter Eve Rose can be reached at erose@adn.com.

Funding cuts leave home care facilities in poor health

By CHUCK ERVIN World Capitol Bureau
11/18/98

OKLAHOMA CITY -- More than 100 home health-care agencies in Oklahoma have gone out of business in the past year because of cuts in federal funding, and state senators expressed concern Tuesday that people could be forced into nursing homes because of that.

The number of private agencies providing health-care services to homebound patients has fallen from a peak of 531 in July 1997 to the current level of 428.

Nearly half of the agencies that closed were in metropolitan areas.

The largest number of closures were in Oklahoma County, with 32. Tulsa County is second with eight, and Cleveland County is third with seven.

Gary Glover, a state Health Department official, said home health care still is available in all 77 counties.

"If the closures continue, it could [illegible] a problem," he said.

Despite assurances from Glover that most of those clients served by agencies that have gone out of business are receiving similar services from other agencies, several senators expressed concern that many people have fallen through the cracks.

"I suspect many have been cut off and don't know what to do about it," said Sen. Gene Stipe, D-McAlester, the chairman of a special committee studying the problem.

Glover said the problem was an outgrowth of the federal Balanced Budget Act of 1997. He said funding declined from an average of $7,000 per beneficiary to $2,600 after the legislation took effect.

"They don't know anything about the Balanced Budget Act," Stipe said of people wanting home care. "They just know they need care, and they aren't getting it."

He said home health care allows many Oklahomans to remain at home at a relatively low cost rather than have to go to more expensive nursing home care.

Glover concurred, but he said there has been some abuse, in which services have been provided to patients who are not truly homebound.

Glover said the federal government is scheduled to start a new payment system next year, which may improve the situation.

Chuck Ervin can be reached at (405) 528-2465.

Tulsa World

Vermont Business Magazine

06/01/1998

Main Topics: IPS; Medicare; Vermont; agencies; health care

By Anonymous

Home health care: The interim payment system

The treatment was a success, but the patient died. That sums up the state of affairs for Vermont's 13 non-profit Medicare certified home health agencies. Because of recent federal government mandates, they are beginning a battle for economic survival that will be played out in the homes of frail, elderly and disabled Vermonters as well as in the courts. The agencies are trying to preserve home health care benefits for Medicare recipients in the face of some of the most severe budget cuts to hit the program. Most home care industry insiders not only see the cuts as Draconian but also ill conceived and unconstitutional.

In order to understand the complexity of the problem one needs to look at the recent history of the Medicare home health benefit.

Over the past few years greater numbers of Medicare beneficiaries have been receiving home health care provided by nurses, therapists, social workers and home health aides. It is care that has helped people remain at home without the need for more costly institutional care.

This is a national trend that is reflected in Vermont statistics. In 1990, 7,100 Medicare patients were served by Vermont home health agencies. That number nearly doubled to 13,463 in 1997. While Vermont's overall numbers are not high, what is impressive is the fact that over this period of time Vermont's average cost per visit has been the lowest in the nation at $42-$45.

During this period of rapid growth in the utilization of the Medicare home health benefit, the Health Care Financing Administration (HCFA), the agency that runs Medicare, helped to create the Operation Restore Trust (ORT) program. ORT has been a federal initiative executed by the Office of the Inspector General (OIG) to weed out wasteful, fraudulent and abusive over-utilization of the Medicare home health benefit.

The reasoning behind the creation of ORT was the assumption that the Medicare home health program must have a lot of fraud and abuse in it if it is growing at such a rapid rate. Home health providers are quick to point out that the program has grown so rapidly because people are living longer and they are deciding that they prefer to receive health care in their homes when possible.

As the ORT initiative proceeded, fraud and abuse was found in states such as Tennessee, Texas and Florida. Not a single a case of fraud and abuse was found in Vermont.

Whenever the ORT inspectors found fraud and abuse it made headlines, and the public as well as federal legislators started to see the Medicare home health benefit as something rife with fraud and in need of change. So it was logical that when the Balanced Budget Act (BBA) was passed in the summer of 1997 it included a change in the Medicare home health benefit payment system.

Prior to the BBA, home health agencies were reimbursed by Medicare based on their actual cost per visit; a cost-based reimbursement system. During the years of a cost based system, non-profit Visiting Nurse Associations (VNAs) still struggled for economic survival, but they were able to recapture the cost of doing business.

Unscrupulous agencies inflated their cost per visit and made more visits than honest agencies and they were able to rake in millions of dollars in the process. There was minimal oversight of this system in the early 1990's prior to ORT.

The BBA of 1997 changed the payment system to one which imposes a yearly payment cap on agencies. That cap was determined by looking at agency costs across the nation during 1993 and 1994, when most of the fraud and abuse was going unchecked.

This means that an agency in Tennessee that may have been operating inefficiently and possibly unscrupulously in 1993 will be rewarded for its fiscal irresponsibility while agencies in Vermont that were keeping their costs the lowest in the US will be punished.

This new payment system is called the Interim Payment System (IPS). It is supposed to be in effect for two years and is projected to save the Medicare program $3.1 billion dollars, according to Congressional Budget Office (CBO) estimates. IPS was put in place without any public hearings and implemented in record time for any government program.

Medicare and the US home health industry have been working on a plan to implement a Prospective Payment System (PPS) similar to the Diagnosis Related Group (DRG) system put in place in hospitals in 1983. All parties have agreed that as long as a PPS system reimbursement is fair, that they can live with it. The IPS came as a surprise and a shock to many in the home health industry looking forward to a PPS.

As home health agencies in Vermont look at their reimbursement under IPS they are realizing they have been discriminated against for keeping their per visit costs low for so many years. Under IPS, the average statewide Medicare reimbursement limit for Vermont will be based on 1993 or 1994 figures, setting it at $2,696 a year. Tennessee's average will be based on $6,500 per person. That means that patients in Tennessee will have more of their visits paid for than patients in Vermont even though benefits for all Medicare beneficiaries are identical under Medicare regulations.

Vermont agencies will have to keep track of each patient's account in terms of how close they come to meeting or exceeding the yearly cap. The reality in Vermont and across the nation is that the health care needs of people at home are more intense and complex than they have ever been. Patients continue to be discharged from hospitals sicker and quicker. In addition, Vermont has cut back on the number of nursing home beds in

an effort to funnel more care into people's homes under Act 160.

Home care patients tend to have periods of intense illness that repeat cyclically over the course of years. One visit a week in July may meet a patient's needs, but when bouts of worsening heart failure or progressive chronic lung disease occur in January, it may take two, three or mo visits a week to keep that patient at home and in a near functional state. A typical home care patient such as this could run up a yearly visit cos of over $6,000, meaning the home health agency would have to absorb a loss in excess of $3,000.

Under IPS, every time a Vermont home health agency sees a patient with complex needs, usually at a greater cost than the Medicare reimbursement, they put their financial future on the line. It is expected that Vermont's home health agencies will lose $5.1 million dollars a year under IPS.

The comments of Peter Cobb, executive director of the Vermont Assembly of Home Health Agencies, reflect the statewide frustration over IP

"This (IPS) is crazy. Vermont has had the lowest costs in the nation for years and we get rewarded with the lowest payments. The cap is highl discriminatory against the people served by low cost, not for profit home health agencies," Cobb said.

Commenting recently on IPS, Vermont Governor Howard Dean said, "I can understand why the federal government wants more efficiency an I support that, but to attack the states that are doing a good job with the same vigor which you're attacking the states that are doing a bad job is mindless nonsense."

Dean has called IPS an atrocity and said that he would be sending a letter to Washington asking that Vermont be granted a waiver of exemption from IPS. Department of Social Welfare Commissioner Jane Kitchel echoed the governor's sentiments and urged that Vermont's Washington delegation support legislation to correct the IPS.

Betsy Davis, CEO of the Visiting Nurse Alliance of Vermont/New Hampshire, has emphasized that the overall mission of her organization will not change despite the fiscal uncertainties that lie ahead. She emphasized that agencies such as hers will, "need to look to the community for more support, not only funding but volunteer help such as providing support services for patients."

She does admit however that in the longer term, if there are no changes, home health agencies may have to say to hospitals that, "We cannot take care of your sickest patients." That means that all of the health care providers in the state will be affected by IPS, and Davis believes they will all work together to find common solutions to problems they are facing.

The current IPS problem in Vermont has a uniquely regional twist in the sense that there are two roads diverging and the home health agencies in the state will most likely travel one of them. It will not be a matter of choice, but something that will be dictated by circumstance.

One road will take two years to travel. It will be the worst case situation in which the IPS stays in place for the mandated two years while home health agencies struggle for survival. Some agencies will survive and some will not. Many lives of frail, elderly and disabled people will be adversely affected.

The other road is shorter and offers more hope. The Vermont Assembly of Home Health Agencies has filed papers in the US District Court in Burlington seeking an injunction to the IPS in Vermont, based on the belief that IPS violates the Fifth Amendment of the United States Constitution that protects people from arbitrary, irrational and discriminatory action by the federal government. The motion for preliminary injunction also addresses issu es of lack of due process, the rewarding of fraud and abuse and the assurance that, "no good deed shall go unpunished."

The court date has been set for June 1.

The shorter road also has a detour that could solve the IPS problem without the need for a court injunction. There are bills in Congress, one the so-called Collins Bill, that if passed would change the IPS inequities by using a combined national and regional blend formula to determine reimbursement to home health agencies.

The short-term treatment prescribed by Medicare to preserve its budget is the Interim Payment System. It will save money, but will Vermont's 13 non-profit Medicare certified home health agencies survive the treatment? These agencies will be forced to react to the changing political climate and hope that communities rally to their support to preserve an essential service for Vermonters ****** Copyright Lake Iroquois Publishing, Inc. d/b/a Vermont Business Magazine Jun 01, 1998

_____via IntelliX_____

-END-

Home health-care firms struggling after cuts in Medicare

By Phil Galewitz
Palm Beach Post Staff Writer

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The federal government's cuts in Medicare payments to home health-care businesses this year has caused 10 percent of the businesses in Florida to stop operating and has forced others to lay off workers and reconsider how they can afford to treat patients needing long-term care.

Forty-five of Florida's 450 Medicare home health-care businesses have given up their Medicare licenses since January, according to the state Agency for Health Care Administration. In Palm Beach County and on the Treasure Coast, two companies have closed some of their offices and laid off employees.

Nationwide, about 800 of the nearly 10,000 Medicare-certified home-health agencies have closed, according to the National Association for Home Care, a Washington, D.C. trade group.

Until now, the home-health industry has soared in the 1990s, with hospitals having the financial incentive to get patients out quicker and home-care businesses having better technology to make it easier to provide care at home. Home health care means medical services delivered at a person's home; it does not include home assistance such as delivering meals or helping the ill or elderly bathe.

The costs of home health care have grown, too. Medicare this year will spend about $20 billion on home health care - seven times what it spent in 1990.

After years of hearing from government investigators about how much money Medicare squandered from unnecessary care, Congress last year finally did something about it.

Rather than continuing to pay home-health businesses a fee of $63-$88 per visit to a patient, Congress placed limits on how much Medicare would pay businesses annually for each patient. In Florida, the average cap is about $3,100 a patient. The range is from $2,000 to $5,000 per patient.

The home-health industry says the government went too far. Industry officials say not only will the changes force many companies to leave the Medicare program, but it will leave many chronically ill patients without care.

Fort Pierce-based RN Home Health last month closed its Medicare offices in Boca Raton and West Palm Beach. It maintains offices in Martin, St. Lucie and Okeechobee counties.

Redi-Nurse, a West Palm Beach-based chain of home-health agencies, closed its Medicare office in northern Indian River County. It still operates from Boca Raton to Vero Beach.

Redi-Nurse also laid off 33 of its 136 staff members this year to prepare for the cuts, said controller Kenneth Healy. "I've been in this business for 24 years, and this is the worst I've ever seen it," he said.

The National Association for Home Care estimates the Medicare changes resulted in businesses getting an average of 31 percent less for each patient.

Industry analysts also complain that rates are inconsistent, varying from company to company because the rate each company is paid now is based in part on its average charges in 1994. The companies that charged Medicare more in 1994 are receiving more today, analysts say. They say such a system rewards inefficiency and penalizes agencies that worked to keep costs down.

The companies hurt the most by the change are small, not-for-profit home-health chains, such as the Visiting Nurse Association of Florida, which covers the Treasure Coast. Such companies generally rely on Medicare for much of their business, and the only business they do is home health care. Other business such as hospitals have other lines of business to subsidize their home health-care operations.

The VNA this year reduced its administrative staff by 10 percent. It also switched most of its nurses from full-time employees to per diem, which meant they lost benefits such as health insurance from the VNA.

"The system Medicare has now does not make any sense," said Bob Quinn, director of operations of the VNA. "Why would you want to drive the most economical people out of business?"

A spokesman for the Health Care Financing Administration, which oversees Medicare, said the industry should have known the changes were coming. He said the new payment system is a result of Congress trying to rein in runaway home-health spending.

Anne Menard, manager of the home health-care unit at the Florida Agency for Health Care Administration, said her agency has received more than 70 complaints this year from patients worried they may lose their home health care. When a Medicare home-health company leaves the business it is supposed to make arrangements for its patients, but there are no guarantees.

"I worry there are very sick patients falling through the cracks," Menard said. *The number for the AHCA is 888-419-3456.*

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The Register-Herald, Beckley, West Virginia
June 25, 1998

Group keeps abreast of spiral effects

Some state residents already affected by congressional cuts

By Mannix Porterfield
REGISTER-HERALD REPORTER

Like a mighty steamer sinking in the ocean, the balanced budget movement is leaving many homebound patients to fend for themselves with neither life preserver nor lifeboat to reach an island of safety.

Already in West Virginia, since Congress began curtailing home health services, some 3,000 lost benefits when the venipuncture program was altered.

And that, one official warns, could be only the tip of the iceberg.

The venipuncture program now only covers blood work if another primary service is performed in the home, such as dressing a wound or working with a catheter.

From her Beckley office, Violet Burdette is monitoring the spiraling effects of the rollbacks in her role as president of the West Virginia Council of Home Health Agencies.

Burdette's group is seeking to enlist the help of West Virginia's congressional delegation. The council is attempting to learn effects of the cuts and invites agencies and patients alike to call Burdette at 252-2146, or the state headquarters in Morgantown at 1-800-210-4663. Such data will help arm the council in taking its case to Congress.

The group represents about 60 of the 113 providers in this state. Cuts in Medicare forced two out of business this year, and Burdette fears others may follow.

State lawmakers sought to soften the blow in the venipuncture program by covering the service via Medicaid.

"So they're paying a nominal amount for people to be able to continue to receive services in their home under Medicaid," Burdette said. "But if they have Medicare, they won't cover it. Only through Medicaid."

Burdette sees two other major setbacks to home health providers.

One is a requirement for $50,000 surety bonds to participate in Medicare and Medicaid.

"Home health agencies don't have a lot of physical assets," Burdette said. "They provide services, so you'll see them rent spaces. They don't own buildings.

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HEALTH

CONTINUED FROM 1A

"It wasn't the intent of Congress for everyone to have to have bonds, actually," she said. "It was the intent that new providers or providers that had problems with fraud and abuse, and other issues, would be required to have bonds.

"When the regulation was written by Medicare, it included everybody."

The other setback, which will have the greatest impact, is in the payment system, she said.

"Medicare has decided that the payment structure for home health is wrong, and that's probably true, because it's cost-based reimbursed," Burdette said.

"There was not a lot of incentive for providers to keep down costs as long as they kept them down to a certain degree. So now, they're going back and saying, 'We shouldn't have reimbursed like that.' And they're going to a perspective payment system ..."

This means payment is based on the types of patients' needs.

"They're going to pay home health providers based on what their costs were in 1993 or 1994," Burdette said. "They're not taking into consideration that the patients' needs have changed, or they're sick, or any of those kinds of things.

"That's the one that's starting to really harm providers at this point."

If an agency handled 1,000 patients five years ago for a combined $200,000, it would be allowed $2,000 for each under the new system.

"That's an aggregate," she said. "If it cost you $1,000 for one patient, and $5,000 for another patient, they'd still pay you just the $2,000. That's an aggregate. They don't pay you the $1,000 and the $5,000."

Ripples are evident within the public health sector, as well. Witness the demise of the West Virginia Family Home Health Agencies, with 16 units that operate such agencies.

"They're disbanding," Burdette said. "They're eliminating that group. One is going to try to make it on their own. They can't make it under this new payment system as a unit."

Elimination of the venipuncture service alone translates into a $4.9 million less this year for the public agencies, she said.

"Now, with this additional cut, based on this new reimbursement system, many of those agencies may go out of business," Burdette said.

"This state, I think, has some concerns that other states don't even have because we don't have backup systems. If we don't have home health, where is the service going to be provided? There is just not a backup to that.

"A lot of people are starting to recognize that this system is probably not working. That's the whole crux of the problem. Instead of just saying the government can't afford to meet all of your needs, so we're going to cut this benefit, they disguised that cut in terms of provider payment."

Albert "Mac" Tieche, former administrator at Beckley Hospital, sees a disturbing old trend manifesting itself.

"They're doing the same thing to home health care agencies that they did to hospitals 20 years ago," he said.

"They start off and say, 'All right, we're going to do cost-based reimbursement. Everybody have a good time.' Then they turn around and say, 'We're going to go to perspective payments.' "

In the switch to perspective payments, based on a state or national average, the government claimed cheaters would get hurt and responsible providers would be helped, Tieche said.

The idea was to keep more efficient providers in the market to absorb the service of less efficient ones.

"So you were efficient and you get penalized for it," Tieche said. "The inefficient ones get rewarded for that because they had built-in gaps there.

"They can back up three or four years. They can cut enough costs to survive until the next round and figure out another way to get by. It's a terrible way to do things. And they continue to do it."

Tieche scorned such tactics as "an election-year bonanza" when voters are dished out something that appears "really big and really great."

"And then we go privately and quietly ream people or create victims that are silent victims, that are not voting victims," Tieche said.

"These are minority people that get home health. And the workers. They don't have a big lobby like the teachers or the veterans."

In 10 states to date, 350 agencies have thrown in the towel, Burdette said.

"This is one of the cases where they have kind of thrown out the baby with the bath water," she said.

"They recognized home health was the fastest growing industry in the health care industry. Well, it should have been. We were putting people out of hospitals and we were pushing them into the home environment, which is more cost effective."

Val Halamandaris, president of the National Association for Home Care, recently pointed out that 1995 marked the first time in the nation's history that more people died of chronic illness than acute illness.

"By definition," he said, "this means a greater need for home care services."

Echoing this sentiment, Burdette said many West Virginians face years of chronic illness with black lung and heart diseases. Many enrolled in home health care are seeing a decline in services.

"You're going to start seeing patients who need a lot of care having difficulty finding home health agencies that will be willing to take them at the beginning of their care," she said.

Many of the 3,000 eliminated from home health care in February wound up in nursing homes, meaning that Medicaid is picking up much of the tab.

"Unfortunately, when it comes to reimbursement, there's a lot of it that makes no sense," Burdette said.

Burdette produced a Medicare statistic showing 93 percent of home health care providers will get reimbursed below costs.

"If you're running a business and 93 percent of the businesses are getting less than the costs, who's going to be left to provide the services?" she asked.

"This is truly the first time I believe we're in danger of losing an entire service, an entire part of the continuing care."

CAPITAL DISTRICT
BUSINESS REVIEW

December 21, 1998

Health Matters

Business of health care is a human and humanitarian endeavor

John W. Rodat

Just by looking at the header of this section--"Strategies"--you can tell that this column is mostly about the business and organizational aspects of health care.

This is, after all, the Business Review. But as we enter the holiday season, it's worth reminding ourselves how the health care "business" is not just commerce. So here are a couple of stories. As usual, some names have been changed.

Health care professionals

Joe Doolittle tells a story of four nurses in the continuing-care department of a health maintenance organization receiving a bouquet of roses from a 61-year-old patient. The patient had died two weeks earlier.

But the card was addressed to each of them, signed in the patient's own hand and read, "Thank you for all that you did for me."

These nurses will tell you that they didn't do all that much for her. Well, yes, they had known her since her initial diagnosis two years prior, and had been with her through her surgery and chemotherapy. Since the patient lived alone, they had made sure there were rides for her, and people to be there with her.

As time passed, they saw a lot of her at home and in and out of the hospital. Despite the fact that these nurses didn't think they had done much, the patient obviously thought differently; they had done a lot for her. She'd planned ahead to say thank you to people who had become an important part of her life.

For these professionals, it may have seemed all in a day's work. But to the patient, it was far from routine. It was valuable enough to be recognized at the end.

Health care organizations

Jane is a 47-year-old grandmother. Because her daughter has a drug problem, Jane has taken in her grandchild, who is about 8 years old. Painfully, this is a pretty common story these days.

What makes Jane's story even more wrenching is that she herself has multiple sclerosis.

Each day, staff from a visiting nurse organization help Jane get up and into her wheelchair, take her medications and take care of her catheter. Under new federal rules, this agency's payments for Jane's care are based on an average number of

visits far below what's required for Jane's care and far below what's necessary for her to live independently.

This agency is going to lose money on Jane, and it had resigned itself to that fact.

However, when Jane was hospitalized a few months ago, she was discharged from the agency's care. Of course, when Jane was ready to leave the hospital, she wanted to return home. Under both federal and state rules, nothing required the agency to take her back. It did anyway.

Knowing it was going to lose money (and probably a lot), this agency promised to continue the services that allow Jane to continue living at home and caring for her grandchild. Absent those services, Jane likely would have spent the rest of her life in a nursing home, and her grandchild would have spent the rest of his youth in foster care.

A neighbor

Pat was in her late 20s when she died of cancer. After 15 months of trying just about everything, her physicians finally told her there was nothing left they could do, and she went home.

Her last few weeks were just what you would expect: painful for her and her family. Pat lived in a rural community with no hospice. She had gotten extraordinary hospital care during her illness (despite being uninsured), but during her last few weeks, the organizational supports pretty much disappeared.

Mary was a nurse who lived down the road. She knew Pat, but really only enough to say hello when they passed on the road. When Pat went home for the last time, Mary simply arrived, having heard about Pat's plight.

During those last weeks, Mary went to see Pat every morning before she went to work, every afternoon after she returned, and every night before bed. She often left work during her lunch hour to drop by.

Mary was the one who gave Pat her pain medication, who called the doctor when it was time to increase the dosage, and who remained a steady presence during those last weeks. She never asked for anything.

After Pat's death, her family offered to pay Mary, but she shrugged it off. "Yes, it's my profession, but I'm a neighbor," she said. "My profession simply enables me to do things that I couldn't otherwise."

Every day, thousands of professionals, family members, friends, neighbors, volunteers and just folks share in the joys of a healthy newborn and the relief of a recovery from illness or injury. Every day, these same folks struggle with the issues that arise in the most intimate, vulnerable and painful moments of our lives.

At the end of the year, it's worth remembering them and reminding ourselves that every day, they do it with skill, energy, generosity and grace.

So in this month's column, we'll ignore business strategy, the economics of health insurance, government regulation and whatever the latest aggravation is. Instead, we'll salute and thank all of those folks and remind ourselves that the real core of the health care enterprise is both human and humanitarian.

Rodat is president of Signalhealth, a Delmar firm that specializes in health care strategies and analysis. He can be reached at 439-5743, or by e-mail at jwr@signalhealth.com.

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ISSUES THAT LIMIT ACCESS FOR BENEFICIARIES

Prior to the passage of the BBA, 13 counties in Texas had no Medicare home health agency parent or branch office located there. As of April 1999, 40 counties had no Medicare home health agency parent or branch office, and another 40 counties have only one parent or branch office left. These counties are located primarily in North and West Texas. Two of the counties with no parent or branch office are more than 4,500 square miles in size and share a border with a county that also does not have a parent or branch office.

In response to reduced reimbursement under the BBA, rural agencies who used to provide therapy services to homebound patients no longer do so. In many rural counties there is no other source of therapy.

A small hospital-based agency in Ochiltree County, the sole agency in the county, is surrounded by counties with no other Medicare home health agency parents or branches. Due to staff cutbacks, the agency does not have the nursing staff to accept patients who require daily skilled nursing or who live more than 60 miles from the agency office. There are no other agencies these patients can turn to for services.

A patient who is hospitalized in El Paso but needs home care upon discharge to Van Horn, Texas (Culberson County) is unable to find a Medicare-certified agency located close enough to serve him. There had been one Medicare-certified branch office in Culberson County at one time. But it has closed, and the county is more than 3,800 square miles in size.

No. of Medicare-Certified Agencies in Texas by County as of 4/2/98 (Source: Texas Dept. of Health data)

COUNTY	CURRENT PARENTS	CURRENT BRANCHES	CHANGE IN PARENTS SINCE 8BA	CHANGE IN BRANCHES SINCE 8BA	# OF MEDICARE ELIGIBLES	SQ. MI
Anderson	4	2	-3	1	7,968	1,070.9
Andrews	1	0	0	-2	1,624	1,500.7
Angelina	6	2	-2	-5	12,325	801.6
Aransas	1	2	0	-1	3,969	252.0
Archer	2	1	2	-1	1,107	909.8
Armstrong	1	0	0	0	384	913.7
Atascosa	1	0	-1	-1	4,218	1,232.2
Austin	1	1	0	-3	3,969	662.7
Bailey	1	0	0	-1	1,142	826.7
Bandera	0	0	-2	-1	2,865	791.8
Bastrop	3	3	-1	1	6,537	888.5
Baylor	2	0	-1	0	1,134	870.6
Bee	1	3	0	-3	3,503	880.2
Bell	14	4	-6	-2	22,008	1,056.0
Bexar	102	18	-37	-25	162,812	1,246.9
Blanco	0	0	0	-1	3,617	711.3
Borden	0	0	0	0	53	899.9
Bosque	2	0	1	0	3,739	989.3
Bowie	10	5	0	-2	14,178	887.9
Brazoria	7	3	-2	0	23,256	1,386.9
Brazos	6	1	-3	-2	10,961	585.6
Brewster	1	0	0	0	1,379	6,183.0
Briscoe	0	0	0	0	419	900.3
Brooks	1	1	-2	-4	1,376	943.3
Brown	6	2	0	-2	7,108	946.0
Burleson	0	0	0	0	2,913	666.6
Burnet	1	3	0	-4	4,906	999.3
Caldwell	0	2	-1	-1	4,207	546.8
Calhoun	1	0	0	-1	2,952	512.4
Callahan	1	0	1	-2	2,336	898.7
Cameron	32	8	-10	-13	36,249	906.6
Camp	1	0	0	0	2,310	197.5
Carson	0	0	-1	0	1,030	923.2
Cass	6	2	-3	-1	8,177	937.5
Castro	1	0	0	0	1,037	899.4
Chambers	3	1	1	-1	2,072	599.4
Cherokee	3	1	-4	-5	8,916	1,052.3
Childress	1	0	0	-1	1,298	710.4
Clay	1	0	0	-2	1,507	1,097.9
Cochran	1	0	0	0	822	775.2
Coke	0	0	0	-1	908	898.9
Coleman	3	2	0	-1	2,464	1,272.9
Collin	14	5	6	-3	22,750	847.7
Collingsworth	2	0	-1	0	741	918.8
Colorado	3	0	0	0	3,900	963.0
Comal	0	0	-2	-3	12,263	561.5
Comanche	2	2	0	-3	2,867	937.8
Concho	1	0	0	-1	993	991.5

No. of Medicare-Certified Agencies in Texas by County as of 4/2/99 (Source: Texas Dept. of Health data)

COUNTY	CURRENT PARENTS	CURRENT BRANCHES	CHANGE IN PARENTS SINCE BBA	CHANGE IN BRANCHES SINCE BBA	# OF MEDICARE BENES	SQ. MI.
Cooke	2	3	-2	-3	5,531	873.8
Coryell	1	1	0	-2	4,809	1,051.9
Cottle	0	0	-1	0	521	901.2
Crane	1	0	0	-1	503	785.6
Crockett	0	0	0	-1	572	2,807.6
Crosby	1	1	0	0	1,196	898.8
Culberson	0	0	0	-1	340	3,812.7
Dallam	2	0	1	-2	1,275	1,504.8
Dallas	228	16	-69	-26	206,977	878.9
Dawson	1	0	-2	0	2,410	902.1
Deaf Smith	2	1	0	0	2,439	1,497.4
Delta	1	0	0	0	1,017	277.2
Denton	7	2	-4	-3	20,722	888.5
Dewitt	1	2	0	-1	3,638	909.3
Dickens	0	1	0	0	634	904.3
Dimmit	1	1	0	-3	1,535	1,331.0
Donley	0	0	0	-2	883	929.8
Duval	5	0	-2	-5	2,078	1,792.9
Eastland	3	4	-1	-2	4,431	926.1
Ector	3	2	-7	-6	15,362	901.1
Edwards	0	0	0	-2	2,157	2,119.9
Ellis	5	3	-1	-2	11,868	940.0
El Paso	26	3	-2	-6	73,643	1,013.1
Erath	3	5	1	-5	4,920	1,086.4
Falls	2	1	1	-1	3,130	769.1
Fannin	2	2	0	0	5,991	891.8
Fayette	2	1	0	-2	5,154	950.1
Fisher	1	0	0	0	971	901.2
Floyd	0	1	-1	0	1,323	992.3
Foard	0	0	-1	0	413	706.7
Fort Bend	5	2	-7	-2	17,172	875.0
Franklin	1	1	-1	1	1,388	285.7
Freestone	0	1	0	-2	2,908	886.3
Frio	2	3	0	0	1,758	1,133.1
Gaines	2	0	1	0	1,519	1,502.4
Galveston	12	8	-2	-8	31,187	398.7
Garza	0	1	0	0	783	895.6
Gillespie	3	0	1	-1	4,907	1,061.2
Glasscock	0	0	0	0	95	900.8
Goliad	0	2	0	-1	1,126	853.6
Gonzales	1	0	-1	-1	3,492	1,067.9
Gray	6	0	-1	-1	4,569	928.3
Grayson	11	4	-2	-5	18,743	933.7
Gregg	16	7	-4	-3	19,361	274.1
Grimes	3	0	1	-2	3,183	793.8
Guadalupe	5	1	-2	-3	9,930	711.2
Hale	3	0	-1	-1	5,436	1,004.7
Hall	1	0	0	0	804	903.1
Hamilton	1	3	-1	-2	1,756	836.8

No. of Medicare-Certified Agencies in Texas by County as of 4/2/99 (Source: Texas Dept. of Health data)

COUNTY	CURRENT PARENTS	CURRENT BRANCHES	CHANGE IN PARENTS SINCE BBA	CHANGE IN BRANCHES SINCE BBA	# OF MEDICARE BENES	SQ. MI.
Hansford	2	0	0	-2	877	919 9
Hardeman	2	0	0	0	1,086	695.4
Hardin	7	0	-2	-1	6,709	894.4
Harris	263	30	-56	-28	279,109	1,729 0
Harrison	5	4	-5	-2	8,353	899.9
Hartley	0	0	0	0	199	1 462.4
Haskell	2	3	1	2	1,614	903.0
Hays	8	4	1	1	7,883	677.9
Hemphill	1	0	0	0	477	909 7
Henderson	8	4	0	-1	9,855	874.4
Hidalgo	61	9	-27	-21	53,164	1,568.1
Hill	3	1	2	-6	6,149	962.4
Hockley	3	1	0	-2	3,058	908 3
Hood	4	2	-2	-3	7,792	421 6
Hopkins	2	1	-1	-3	5,377	784 8
Houston	4	1	0	-3	4,899	1,231 0
Howard	3	4	1	-2	5,500	902 9
Hudspeth	0	0	0	0	332	4,571 3
Hunt	4	4	1	-5	10,975	841.2
Hutchinson	2	3	0	-3	4,297	887 4
Irion	0	0	0	0	286	1,051 6
Jack	1	1	0	-1	1,303	917.4
Jackson	1	1	0	1	2,401	829.5
Jasper	7	4	-2	11	5,872	937.5
Jeff Davis	0	0	0	-1	367	2,264.6
Jefferson	39	8	-20	-7	39,348	903.8
Jim Hogg	1	2	0	-3	822	1,136 2
Jim Wells	10	1	-2	-6	8,002	864.7
Johnson	8	2	2	-5	15,073	729.4
Jones	3	2	0	-1	2,979	931.1
Karnes	1	1	0	-1	2,563	750.3
Kaufman	11	8	-3	-14	12,868	786.1
Kendall	1	0	-1	0	3,982	662.6
Kenedy	0	0	0	0	48	1 458.9
Kent	0	0	0	0	219	902 4
Kerr	3	1	-1	-4	11,393	1,106 3
Kimble	1	1	0	0	886	1,250.8
King	0	0	0	0	35	912 3
Kinney	0	0	0	0	747	1,363.5
Kleberg	4	4	-1	-1	3,615	871 1
Knox	3	1	1	0	1,007	864.2
Lamar	12	3	-1	-1	8,537	917 1
Lamb	1	1	-1	-2	2,760	1,016.3
Lampasas	2	0	2	-6	2,713	712.1
La Salle	0	1	0	-1	778	1,486.0
Lavaca	2	1	-2	-4	5,044	970.0
Lee	1	1	0	-1	2,130	626.6
Leon	0	2	0	-2	3,788	1,072 1
Liberty	9	4	0	-9	9,128	1,156.8

No. of Medicare-Certified Agencies in Texas by County as of 4/2/99 (Source: Texas Dept. of Health data)

COUNTY	CURRENT PARENTS	CURRENT BRANCHES	CHANGE IN PARENTS SINCE BBA	CHANGE IN BRANCHES SINCE BBA	# OF MEDICARE BENES	SQ. MI.
Limestone	2	1	-2	-2	4,346	908.9
Lipscomb	0	0	-1	-1	829	932.2
Live Oak	0	1	0	-1	1,362	1,036.4
Llano	1	2	0	0	4,533	934.9
Loving	0	0	0	0	20	673.1
Lubbock	19	6	-25	-7	29,629	899.6
Lynn	1	0	0	0	1,019	991.9
McCulloch	3	1	-1	0	1,904	1,068.4
McLennan	8	3	1	-5	30,889	1,041.8
McMullen	0	0	0	0	130	1,113.1
Madison	1	1	0	0	1,777	468.7
Marion	1	2	0	-1	1,840	381.2
Martin	1	0	0	-1	832	914.9
Mason	1	0	0	0	918	932.1
Matagorda	1	2	0	-3	5,200	1,114.5
Maverick	4	3	0	-3	5,705	1,280.2
Medina	3	1	3	-6	4,567	1,327.9
Menard	0	2	0	0	589	902.0
Midland	7	1	-4	-7	13,736	900.3
Milam	1	2	0	0	4,975	1,016.8
Mills	0	2	0	0	1,211	748.2
Mitchell	1	0	0	-1	1,702	910.1
Montague	2	2	0	-1	4,278	930.7
Montgomery	6	2	2	-3	26,160	1,044.3
Moore	1	1	0	0	2,156	899.7
Morris	0	3	0	-1	2,872	254.3
Motley	0	0	0	0	353	989.4
Nacogdoches	4	2	0	-2	8,299	946.8
Navarro	4	3	-1	-1	7,606	1,071.2
Newton	1	0	0	0	2,179	932.8
Nolan	1	2	-1	0	3,118	912.1
Nueces	47	1	-15	-16	39,479	836.8
Ochiltree	1	0	0	-1	1,131	917.8
Oldham	0	0	0	0	348	1,500.7
Orange	6	1	-4	-5	12,486	356.4
Palo Pinto	1	3	0	-2	4,662	953.0
Panola	2	2	0	0	3,730	801.0
Parker	2	4	-2	-1	9,378	903.8
Parmer	1	0	0	0	1,307	881.7
Pecos	2	1	-4	0	1,850	4,764.0
Polk	1	4	-1	-4	11,960	1,057.4
Potter	10	6	-3	-3	22,814	909.4
Presidio	0	0	0	0	1,284	3,855.8
Rains	0	0	0	-1	1,339	232.1
Randall	0	0	-1	-1	4,845	914.5
Reagan	2	0	0	0	362	1,175.4
Real	3	0	0	0	736	700.0
Red River	2	0	0	-4	3,202	1,050.2
Reeves	2	0	-1	0	1,993	2,636.1

No. of Medicare-Certified Agencies in Texas by County as of 4/2/99 (Source: Texas Dept. of Health data)

COUNTY	CURRENT PARENTS	CURRENT BRANCHES	CHANGE IN PARENTS SINCE BBA	CHANGE IN BRANCHES SINCE BBA	# OF MEDICARE BENES	SQ. MI.
Refugio	0	1	0	-1	1,604	770 3
Roberts	0	0	-1	0	133	924 1
Robertson	1	0	0	0	2,088	854.6
Rockwall	1	3	-2	2	3,425	128.8
Runnels	2	1	-2	-1	2,545	1,054 5
Rusk	3	2	0	-1	6,997	923 6
Sabine	2	2	-1	0	3,330	480 3
San Augustine	1	0	-1	0	1,974	527.9
San Jacinto	0	0	0	-1	2,884	570 7
San Patricio	4	2	-3	-3	8,883	691.8
San Saba	2	2	-1	0	1,243	1,134.5
Schleicher	1	0	-1	0	486	1,310 7
Scurry	1	1	0	-1	2,886	902.6
Shackelford	0	0	0	-1	841	914 0
Shelby	2	1	1	-2	4,705	794.2
Sherman	0	0	0	0	438	923.1
Smith	12	7	-5	-5	27,136	928.5
Somervell	0	0	-1	-1	822	187.2
Starr	3	1	-2	-4	4,958	1,223.1
Stephens	1	1	0	-1	1,815	894 7
Sterling	0	0	0	0	178	923.4
Stonewall	0	0	0	-1	445	918 7
Sutton	0	1	0	-1	542	1 453.9
Swisher	1	0	0	0	1,885	900.5
Tarrant	72	15	-30	-10	132,497	863.5
Taylor	12	2	-2	-5	18,341	915 7
Terrell	0	0	0	0	229	2,357.9
Terry	1	0	0	0	2,072	888 9
Throckmorton	1	0	1	-1	401	912.4
Titus	5	0	-1	-6	3,887	410 8
Tom Green	8	4	3	-4	16,066	1 522.2
Travis	20	6	-7	-14	61,514	988 4
Trinity	0	2	-1	0	3,196	692.9
Tyler	3	1	-1	0	3,912	923.0
Upshur	1	1	0	-2	5,987	587.7
Upton	2	0	-1	0	528	1,241.8
Uvalde	2	2	0	-1	3,629	1,556.6
Val Verde	3	3	0	-6	3,670	3,170.7
Van Zandt	6	5	1	-2	8,302	848.6
Victoria	6	3	2	-4	11,418	882 6
Walker	4	0	2	-3	5,784	787.5
Waller	2	3	0	1	2,986	513.6
Ward	1	1	0	-1	1,803	835.6
Washington	2	1	1	-2	5,844	608.3
Webb	18	3	-1	-13	16,475	3,367 0
Wharton	3	2	1	-3	6,406	1,090 2
Wheeler	2	1	-2	-1	1,291	914 3
Wichita	12	5	-7	0	19,597	627.7
Wilbarger	2	1	0	0	2,816	971.1

No. of Medicare-Certified Agencies in Texas by County as of 4/2/99 (Source: Texas Dept. of Health data)

COUNTY	CURRENT PARENTS	CURRENT BRANCHES	CHANGE IN PARENTS SINCE BBA	CHANGE IN BRANCHES SINCE BBA	# OF MEDICARE BENES	SQ. MI.
Willacy	1	3	-1	-1	2,636	998.7
Williamson	6	1	-1	-5	17,156	1,124.4
Wilson	2	1	1	0	3,536	807.2
Winkler	1	1	0	-2	1,151	841.1
Wise	2	1	1	-5	5,330	904.7
Wood	1	2	0	-6	8,111	680.3
Yoakum	0	1	1	-1	958	799.8
Young	3	1	1	-1	3,904	922.4
Zapata	0	1	0	-4	1,423	998.8
Zavala	1	0	0	0	1,631	1,298.8
TOTAL	1519	434	-414	-574		

Note: Change in agencies since passage of BBA are net losses since August 1997.

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June 7, 1999

FAX 214-689-0010

Ms. Emily Tripp
Ft. Worth, Texas

Re: Home Health Care & Home Health Visits

Dear Ms. Tripp:

As you know, you were once Director of Nurses at White River Medical Center here in Batesville, Arkansas. Recently in a discussion with you, I explained to you that it is not uncommon for some home health patients to no longer receive care. The driving factor seems to be fear on behalf of the home health agencies from HCFA. Generally these are patients who are home bound with medical problems, but not with problems that require daily care; they are patients who have poor family support, and these patients are frail, but mobile within the home environment. Certainly, they cannot ambulate any distance outside their home, nor are they competent enough to drive vehicles. Many of them also have eye and ear sensory deficits.

Generally speaking, when I ask home health agencies why they will no longer see these type patients, I receive the following response: "We are fearful that HCFA will punish us, and/or brand us as criminals for making unnecessary visits." Generally speaking, my concern is that many times their family support is not the best in the world, and for the most part these patients - for all practical purposes - are being abandoned.

I hope this information is of some value to you, and if the good people in Washington ever needed specifics, I would be happy to provide more pointed information.

Sincerely yours,

Dennis O. Davidson, M.D.

Dennis O. Davidson, M.D.

DOD:rem

Diplomate, American Board of Family Physicians
Fellow, American Academy of Family Physicians

PREPARED STATEMENT OF PAUL N. VAN DE WATER

Mr. Chairman and Members of the Committee, I am pleased to represent the Congressional Budget Office (CBO) at this hearing on the fee-for-service portion of the Medicare program. After many years of rapid increases, the growth of Medicare spending has slowed sharply in the past two years. My statement discusses the reasons for that slowdown and presents CBO's assessment of future trends. I will make three main points:

- The greater-than-expected slowdown in the growth of Medicare spending stems mainly from successful efforts to combat fraud and from delays in payments to health care providers.
- With one exception, CBO's estimates of the effects of the Medicare provisions of the Balanced Budget Act (BBA) of 1997 still appear reasonable. CBO did not anticipate how home health agencies would implement the interim payment system for home health services, however, and may therefore have underestimated its savings.
- The factors that are holding down the growth of Medicare spending will be played out in the next few years, and more rapid growth will then resume.

TRENDS IN MEDICARE SPENDING

Between 1980 and 1997, Medicare spending increased at an average rate of 11 percent a year and expanded from 5 percent to 12 percent of the federal budget. Total outlays for Medicare rose by only 1.5 percent in 1998, however, and may decline in 1999. Part of that slowdown was anticipated; the Balanced Budget Act lowered the projected growth of Medicare spending by an estimated 4 percentage points in 1998. The BBA reduced payment rates for many services and restrained the update factors for payments through 2002. Both fee-for-service providers and Medicare+Choice plans are experiencing lower increases in payments as a result.

But the actual rate of spending growth is considerably slower than the BBA provisions alone were expected to produce. Other factors appear to have contributed to the sudden flattening of Medicare expenditures, including greater compliance with Medicare payment rules and a longer time for processing claims.

Widely publicized efforts to clamp down on fraud and abuse in the program have resulted in greater compliance by providers with Medicare's payment rules. Those efforts include more rigorous screening of claims by Medicare contractors and tougher enforcement of Medicare laws by the Departments of Justice and Health and Human Services. Through investigations and lawsuits, those agencies have pursued a wide range of providers—including hospitals, teaching physicians, home health agencies, clinical laboratories, and providers of durable medical equipment—as well as Medicare contractors themselves. Although the total reduction in spending growth attributable to the improved compliance cannot be quantified, CBO estimates that one response alone to recent enforcement efforts—less aggressive billing by hospitals—lowered growth in Medicare spending by 0.75 percentage points in 1998.

The average time for processing Medicare claims rose dramatically in 1998. Expanded compliance activities, combined with major efforts to prepare computer systems for 2000, contributed to longer payment lags, which can have a substantial effect on Medicare outlays. An increase of one week, for example, in the average time for processing claims reduces Medicare outlays for the fiscal year by 2.3 percent. But that reduction is only temporary because the delay merely moves outlays into the next fiscal year. CBO expects that improved compliance with payment rules and longer

claims-processing times will have little or no effect on the rate of growth of Medicare spending in the longer run. Our projections assume that payment lags will begin to return to more typical levels late in 2000, with a catch-up in spending and a resumption of normal spending growth in 2001 and 2002 (see Table 1). Most of the projected increase over the next few years reflects rising expenditures per enrollee. The leading edge of the postwar baby boom will not reach age 65 until after 2010.

TABLE 1. MEDICARE OUTLAYS (By selected fiscal year)

	1990	1998	1999	2004	2009
		In Billions of Dollars			
Gross Mandatory Outlays					
Benefits	107	210	212	298	443
Mandatory administration and grants[a]	b	1	1	1	1
Total	107	211	213	300	444
Premiums	-12	-21	-21	-34	-53
Mandatory Outlays Net of Premiums	96	190	192	266	391
Discretionary Outlays for Administration	2	3	3	4	4
All Medicare Outlays Net of Premiums	98	193	195	269	396
		Average Annual Growth Rate from Previous Year Shown (Percent)			
Gross Mandatory Outlays		8.8	1.1	7.1	8.2
Premiums		7.5	3.4	9.7	9.3
Mandatory Outlays Net of Premiums		9.0	0.8	6.7	8.0
Discretionary Outlays for Administration		1.5	7.4	4.7	4.0
All Medicare Outlays Net of Premiums		8.8	0.9	6.7	8.0

SOURCE: Congressional Budget Office.

a. Mandatory outlays for administration support peer review organizations, certain activities against fraud and abuse, and grants to states for premium assistance.

b. Less than $500 million.

Projections of Spending and Enrollment in Medicare+Choice

Payments for Medicare+Choice plans in CBO's baseline soar from $37 billion in 1999 to $141 billion in 2009 as enrollment in those plans continues to expand. The spending increase also reflects the expected growth in expenditures per enrollee. CBO projects that risk-based plans will account for 16 percent of Medicare enrollees in 1999, 22 percent in 2004, and 31 percent in 2009, assuming that the second phase of risk adjustment is implemented on a budget-neutral basis.

Projections of Spending and Enrollment in the Medicare Fee-for-Service Program

CBO projects that spending in Medicare's fee-for-service program will increase from $175 billion in 1999 to $302 billion in 2009 (see Table 2). That growth will occur despite shrinkage in fee-for-service enrollment, which will decline by 1.5 million over the next decade, and cuts in the growth of payment rates for many services.

Spending growth for different services will vary considerably over the same period. The extent of the recent slowdown in spending has also varied by type of service, although spending for all services has been affected by the 1.9 percent drop in fee-for-service enrollment that occurred in 1998 and the further 0.8 percent decline expected in 1999.

TABLE 2. OUTLAYS FOR MEDICARE BENEFITS, BY SECTOR (By fiscal year)

Sector	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
In Billions of Dollars												
Medicare+Choice[a]	32	37	41	49	48	60	70	88	88	108	124	141
Fee-for-Service												
Skilled nursing facilities	13	13	13	14	14	15	16	17	18	19	21	22
Home health	15	15	17	16	17	18	20	21	23	24	26	28
Hospice	2	2	2	2	3	3	3	3	3	3	4	4
Hospital inpatient[b]	87	86	91	95	99	104	108	112	117	123	129	135
Physicians' services	32	32	33	34	35	36	37	38	39	40	41	43
Outpatient facilities	17	16	17	18	20	21	23	25	26	28	30	33
Other professional and outpatient ancillary services	12	12	14	15	17	20	22	25	28	31	34	38
Subtotal	178	175	186	194	205	217	228	241	255	269	285	302
Total	210	212	228	243	253	277	298	328	343	378	409	443
Annual Growth Rate (Percent)												
Medicare+Choice[a]	26.3	14.0	11.7	18.0	-1.3	25.0	16.7	24.7	0.8	22.8	14.6	13.4
Fee-for-Service												
Skilled nursing facilities	8.9	-3.8	1.7	5.3	5.1	6.4	6.0	6.4	6.5	6.4	6.4	6.4
Home health	-14.9	0.8	10.3	-5.8	10.1	6.6	7.2	7.9	7.8	7.4	6.8	6.6
Hospice	1.0	2.5	8.6	6.3	4.6	5.7	5.3	5.7	5.8	5.7	5.8	5.8
Hospital inpatient[b]	-2.5	-1.5	5.7	4.7	4.5	4.7	3.9	4.1	4.5	4.6	4.9	4.8
Physicians' services	3.0	0.6	4.2	2.3	2.4	3.4	2.6	2.8	3.0	3.0	3.3	3.5
Outpatient facilities	-5.5	-6.6	8.4	8.5	7.1	7.7	7.2	7.4	7.3	7.3	7.6	7.9
Other professional and outpatient ancillary services	0.7	0.6	14.0	13.0	12.5	13.2	12.3	12.3	12.1	11.0	10.7	10.2
All Fee-for-Service	-2.1	-1.4	6.4	4.4	5.5	5.8	5.2	5.5	5.8	5.8	5.9	5.9
All Medicare Benefits	1.4	1.0	7.3	6.8	4.1	9.5	7.7	10.0	4.4	10.1	8.4	8.2

SOURCE: Congressional Budget Office.

a. Includes spending for health maintenance organizations paid on a cost basis, certain demonstrations, and health care prepayment plans, which are paid on a cost basis for Part B services.

b. Includes subsidies for medical education that are paid to hospitals that treat patients enrolled in Medicare+Choice plans.

Postacute Care Services. Growth in payments for skilled nursing facility (SNF) and home health services—the fastest-growing areas of fee-for-service spending in Medicare during the decade preceding passage of the Balanced Budget Act—slowed significantly in 1998. The most dramatic change was in spending for home health care, which actually fell by 14.9 percent in 1998. SNF expenditures, by contrast, continued to rise but at less than half the rate of growth in 1997C8.9 percent compared with 21.1 percent. The slowdown in spending reflects the implementation of new prospective payment systems and increases in the time for processing claims.

The transition to prospective payment systems is expected to hold down the average annual rate of growth in these categories of spending through 2001. Spending is then projected to increase through 2009 at an average annual rate of 6.2 percent for SNF services and 7.5 percent for home health services.

Inpatient Hospital Services. Medicare payments for inpatient hospital services fell 2.5 percent in 1998, to $87 billion. The factors contributing to that drop include a decline in the volume of services provided (reflecting the drop in fee-for-service enrollment) and several provisions in the BBA that froze payment rates for most operating costs, reduced capital-related payment rates by 17.8 percent, and cut subsidies for medical education. In addition, the case-mix index—a measure of the relative costliness of the cases treated in hospitals paid under the prospective payment system—fell 0.5 percent in 1998. Much of that unprecedented drop in the index is probably attributable to widespread adoption by hospitals of less aggressive billing practices following antifraud initiatives that focused on those practices.

For most hospitals, the BBA limits cumulative increases in payment rates for operating costs to about 6 percentage points below inflation over the 1999-2002 period.

CBO projects that the limit on rate increases, in combination with declining fee-for-service enrollment, will result in a 1.5 percent drop in payments for hospital inpatient services in 1999. Those payments are projected to begin rising in 2000, with annual growth rates averaging 4.5 percent from 2000 through 2009.

Physicians' Services. Medicare payments for physicians' services rose 3.0 percent in 1998, to $32 billion. Payments are projected to remain flat in 1999 and to grow at an average annual rate of 2.8 percent over the next decade, reaching $43 billion in 2009. That growth rate is a result of payment formulas enacted in the BBA that tie the growth of per-enrollee expenditures for physicians' services to the growth of gross domestic product per capita. Those formulas generate annual rate changes that oscillate widely around a smooth trend. CBO projects stable growth rates, however, because the timing of those oscillations is impossible to predict.

Outpatient Services. Payments to outpatient facilities—such as hospital outpatient departments, dialysis facilities, and rural health clinics—fell by 5.5 percent in 1998 and are projected to decline another 6.6 percent in 1999. Those reductions result largely from lower payment rates accompanying the transition to a prospective payment system for hospital outpatient services. Outpatient payments are projected to rebound in 2000 and grow at annual rates of 7 percent or more for the rest of the decade.

Spending for outpatient therapy services and other outpatient ancillary services—including pharmaceuticals, durable medical equipment, and chiropractic care—rose only 0.7 percent in 1998 as a result of reductions in payment rates and a cap on payments for therapy services performed outside hospitals. Projected payments for nonphysician professional services and outpatient ancillary services will grow only slightly in 1999 before taking off again in 2000. Annual spending growth is expected to average 11.3 percent from 1999 through 2009.

EFFECTS OF THE BALANCED BUDGET ACT

In January 1997, CBO projected that net mandatory outlays for Medicare would grow from $189 billion in 1997 to $288 billion in 2002. That January 1997 baseline was the basis for CBO's estimate of the savings from the BBA. CBO estimated that the BBA would reduce net mandatory spending for Medicare by $6 billion in 1998, $41 billion in 2002, and $112 billion over the 1998-2002 period. As a result, in its August 1997 analysis of the BBA, CBO projected that net mandatory outlays for Medicare would grow to $247 billion in 2002, rather than the $288 billion projected the previous January (see Table 3).

CBO's current baseline, prepared in March 1999, projects that net mandatory Medicare spending will grow from $192 billion in 1999 to $227 billion in 2002. Those figures are $18 billion and $20 billion, respectively, below the levels projected in August 1997.

TABLE 3. COMPARISON OF AUGUST 1997 AND MARCH 1999 PROJECTIONS OF NET MANDATORY OUTLAYS FOR MEDICARE (By fiscal year, in billions of dollars)

	1997	1998	1999	2000	2001	2002
January 1997 Projection	189	206	226	250	261	288
Minus Effects of Balanced Budget Act	0	-6	-16	-29	-20	-41
August 1997 Projection	189	200	210	220	241	247
March 1999 Projection	187	190	192	206	219	227
March 1999 Projection Minus August 1997 Projection	-1	-9	-18	-15	-22	-20

SOURCE: Congressional Budget Office.

NOTE: Numbers may not add up to totals because of rounding.

Why the Projections Have Changed

Each year CBO updates its budget projections to account for legislative changes, updated economic assumptions, and other new information. Since the enactment of

the BBA, the only noticeable legislative effect on Medicare spending has been the modification of home health payment rates included in last year's omnibus appropriation bill (Public Law 105-277). CBO estimated that legislation will increase Medicare outlays by $2 billion in 2000 and reduce them by $1 billion in 2001. CBO's current projections of inflation rates are slightly lower than they were in January 1997. Those lower inflation rates account for about $3 billion of the annual differences between the August 1997 and March 1999 projections.

Most of the difference between the two sets of projections is attributable to new information—most notably the unanticipated slowing of spending growth in 1997 and 1998 resulting from improved compliance with Medicare payment rules. In essence, the 1997 projections were too high because CBO did not anticipate the full effects of Operation Restore Trust—Medicare's program to combat fraud. CBO also did not foresee the increasing lag in 1998 and 1999 between when services are furnished and when payment is made and implementation of adjustments to payments to Medicare+Choice plans on the basis of risk in a manner that will reduce spending.

CBO has not revised its estimates of the effect of the BBA on Medicare spending. With one possible exception, CBO believes that its estimates of the Balanced Budget Act were reasonable.

Spending for Home Health Services

The one policy for which CBO may have significantly underestimated savings is the interim payment system for home health agencies. CBO's current projection of outlays for home health services is much lower than projected in August 1997. Those lower projections are largely attributable to new information about the effects of Operation Restore Trust and other antifraud initiatives and to increases in the lag between when services are furnished and when payment is made; they do not fully incorporate our revised assessment of the effects of the interim payment system.

Lower payments for home health services also explain most of the shortfall in Medicare spending so far this year. Some of the drop in home health spending stems from longer payment lags resulting from a new method of processing claims known as sequential billing, in which a claim is paid only if all prior claims have been processed. Medicare will suspend that billing process in July, which should increase spending during the last quarter of the fiscal year. In addition, the use of home health services seems to have dropped substantially, probably as a result of both antifraud activities and an unexpectedly cautious response by home health agencies to the per-beneficiary limit under the interim payment system. That limit applies to aggregate payments: payments for individual beneficiaries may exceed the limit as long as the average payment for all beneficiaries served by an agency does not exceed the per-beneficiary limit. Some agencies, however, apparently believe that the limit applies to each beneficiary and are cutting off services to patients who have reached the per-beneficiary limit. Thus, the average payment per beneficiary is well below the allowable amount.

CONCLUSION

CBO is currently updating its projections of Medicare spending and will release them on July 1, as called for in the budget resolution. Because the rate of Medicare spending through May of this year has been lower than CBO estimated in March (and about 22 percent below the rate for the first eight months of last year), the July projections of Medicare spending in 1999 and 2000 will probably be several billion dollars lower than the March estimates.

Medicare will replace the interim payment system for home health services with a prospective payment system in 2001. Because that system will remove much of the uncertainty about payments that has contributed to the current apparent drop in utilization, spending for home health services could rebound in 2001 and subsequent years. Therefore, CBO does not now anticipate significantly revising its projections of spending on home health services—or other categories of services—beyond 2000. CBO expects that total Medicare spending will resume growing at an average rate of 7 percent to 8 percent a year in the decade after 2000.

PREPARED STATEMENT OF GAIL R. WILENSKY, PH.D.

[MARCH 17, 1999]

Good morning Chairman Roth, Senator Moynihan, and members of the Committee. I am Gail Wilensky, Chair of the Medicare Payment Advisory Commission

(MedPAC, or the Commission). I am pleased to be here this morning to discuss the provisions of the Balanced Budget Act (BBA) of 1997 that affect the Medicare program and how they are being implemented. My testimony will draw heavily on MedPAC's Report to the Congress on Medicare Payment Policy, which was released March 1.

Broadly speaking, the Commission's recommendations address four topics: adequacy of payment updates, equity of payments, technical and regulatory components of new payment mechanisms, and other payment-related issues concerning coverage and beneficiary cost sharing.

For certain services whose payment updates are set in law by the BBA—such as those provided by Medicare+Choice plans, inpatient hospitals under the prospective payment system (PPS), and physicians—MedPAC's recommendations address whether the statutory updates are appropriate. In general, the Commission finds the updates to be appropriate and does not recommend changes to the law. In the case of payment for physicians' services, however, the Commission has developed several recommendations.

For example, the sustainable growth rate mechanism should account for changes in medical technology and changes in the characteristics of beneficiaries enrolled in traditional Medicare, such as their distribution across age groups.

MedPAC's recommendations also address the issue of payment equity. The Commission supports the introduction of a new risk adjustment system for the Medicare+Choice program to make payments that better reflect enrollees' health status. We also recommend changing payment methods for hospital outpatient and physicians' services to account for cost differences that reflect differences in patients' health status.

For services that the BBA directed to be paid under new payment systems, MedPAC addresses recommendations to the Secretary of the Department of Health and Human Services (the Secretary) and to the Congress, as appropriate. We recommend technical changes in regulations that would make payments more equitable within provider groups and more consistent across types of providers. For example, the Commission supports the Secretary's efforts to develop a case-mix adjustment system for skilled nursing facilities that would better account for use of services other than rehabilitation therapy. The Commission also supports developing a common unit of payment—a facility discharge where possible—across providers of post-acute care.

With respect to other issues, MedPAC's key recommendations concern services provided in outpatient hospital departments and by home health agencies. For the former, MedPAC recommends accelerating the so-called coinsurance buydown provided for in the BBA. For the latter, we recommend further clarification in statute eligibility guidelines for receiving home health services.

THE BALANCED BUDGET ACT OF 1997 AND THE MEDICARE PROGRAM

The Balanced Budget Act made wide-reaching changes to the Medicare program. It established the Medicare+Choice program, which allows new types of private health plans to offer options for Medicare beneficiaries, and changed how Medicare pays private health plans to slow the rate of growth of spending and make payments more equitable among providers and across geographic areas. In the traditional Medicare program, the BBA changed payment updates and methods for services provided by acute care hospitals and physicians. It also directed the Secretary to establish new prospective payment systems for skilled nursing facilities, home health agencies, rehabilitation hospitals, and hospital outpatient departments.

MedPAC is monitoring the implementation of BBA policies closely and evaluating them on the principle that Medicare's payment policies should ensure beneficiaries have access to necessary medical care in an appropriate setting. At the same time, the program should not spend more than is required to achieve that goal. This principle implies that payment rates must be consistent with the costs of efficiently providing the necessary level of care, while not interfering with clinical decisions as to the amount of care or the setting in which it is provided.

CREATION OF THE MEDICARE+CHOICE PROGRAM

The BBA abolished the so-called section 1876 risk contracting program, which had allowed Medicare beneficiaries to enroll in health maintenance organizations (HMOs). In its place, the Act established a new program called Medicare+Choice, which permits many new types of private health plans to participate in Medicare, including preferred provider organizations (PPOs), HMOs with a point-of-service option, provider-sponsored organizations (PSOs), private fee-for-service plans, and high-deductible plans offered in conjunction with a medical savings account.

The BBA also changed how private health plans are paid. Under the old risk contracting program, Medicare set payments for managed care enrollees in each county at 95 percent of what the program would have paid had those enrollees remained in the traditional fee-for-service program. The BBA broke the direct link between the level of county fee-for-service spending and Medicare managed care payments. Under the new system, Medicare+Choice plans are paid the higher of a floor rate, a 2 percent increase from the prior year's rate, or a blend of local and national payment rates (but only if a so-called budget neutrality condition is met). The BBA also directed the Secretary to implement a new system of risk adjustment based on the health status of plans' enrollees, effective for payments in 2000.

One of the major objectives of the BBA was to make a wider variety of private health care coverage options available to Medicare beneficiaries by expanding the types of private health plans eligible to participate in Medicare. However, changes in how payment rates are determined, the establishment of new regulations to implement the program, and concurrent trends in the health insurance environment resulted in few new available options and, in fact, a sizable portion of former risk plans declined to participate in Medicare+Choice.

It is too soon to tell whether the recent departures from Medicare stem from systematic problems with the level or distribution of payment. Accordingly, the Congress should not modify payment rates at this time. MedPAC will continue to monitor this situation during the next year. In the meantime, the Health Care Financing Administration (HCFA) should continue to work with the relevant parties to identify changes in regulations or other policies that would reduce the burden of compliance without compromising the objectives of the program. Two specific changes recommended by MedPAC include postponing the date by which Medicare+Choice organizations must file their premium and benefit proposals and allowing organizations to vary their benefit packages by county within their service areas.

The Commission supports the Secretary's plan to phase in, beginning in 2000, an interim risk adjustment mechanism for Medicare+Choice payments. In this mechanism, differences in expected costliness among enrollees will be based on health status, as measured by diagnoses from hospital stays in the previous year, prior entitlement to Medicare benefits based on disability, and eligibility for Medicaid benefits during the previous year. As quickly as feasible, however, the risk adjustment mechanism should be refined to incorporate diagnosis data from all sites of care. These changes should improve the correlation between payments to Medicare+Choice organizations and the expected service use of their enrollees.

PROVISIONS AFFECTING PAYMENTS TO HOSPITALS

For inpatient services provided in acute care hospitals under the PPS, no update was made to payments in fiscal 1998, and the BBA limited updates for 1999 through 2002 to the growth in the hospital market basket less a specified factor. For rehabilitation, long-term, and psychiatric hospitals—whose payments had been made on the basis of costs subject to facility-specific limits—the BBA instituted new national cost limits and established more stringent limits for new facilities.

Hospitals covered by the acute care prospective payment system. Based on our ongoing analysis of the factors that determine year-to-year changes in hospital costs, we believe the operating update for fiscal year 2000 that was enacted in the BBA—1.8 percentage points less than the increase in HCFA's hospital operating market basket index—will provide reasonable payment rates. If the current market basket forecast holds, the update would be 0.7 percent.

MedPAC's analysis shows that hospitals have responded to a more competitive market by improving their productivity and shifting services to other sites of care. These two responses have resulted in a substantially lower rate of inpatient cost growth and sharply higher Medicare inpatient margins. Although both Medicare and the industry benefit from productivity improvements, the site-of-care substitution has increased Medicare's payments. When post-acute care replaces the latter days of inpatient stays, Medicare picks up an additional payment obligation while its per-case payment for hospital care is unchanged.

MedPAC believes that a downward adjustment to payments is warranted to account for site-of-care substitution. Part of this adjustment was reflected in the update recommendation we made last year for fiscal 1999, and in our predecessor commission's recommendation for fiscal 1998. But we currently believe that an additional adjustment of between 3 and 6 percentage points should be made. To avoid too great a single-year impact, the adjustment should be spread over three years.

At the same time, however, several factors point toward the need for caution in specifying future updates. First, the expanded transfer policy included in the BBA

should be considered part of Medicare's response to site-of-care substitution, and its effects are not yet known. Second, evidence is emerging that the decade-long trend of cases shifting towards higher-weighted diagnosis-related groups, which automatically increases PPS payments, is subsiding. Third, we question whether the unusually low rate of hospital cost inflation in recent years can be sustained without adverse effects on quality of care. The year 2000 computer problem will also put upward pressure on hospital costs. And finally, several provisions of the BBA will reduce Medicare's payments for other hospital services, and the overall impact of the BBA on hospitals is not yet evident.

The BBA also phased in a 5 percent reduction in Medicare's extra payments to hospitals that care for a disproportionate share of low-income patients, increasing the importance of allocating these payments appropriately. Currently, disproportionate share payments are made through a complex formula that determines a percentage add-on to each hospital's PPS payments based on its location, size, certain other characteristics, and a measure of care to low-income people. The measure of care to low-income people, however, excludes uncompensated care and local indigent care programs, which represent a large share of the burden faced by many hospitals that treat low-income patients. Moreover, under the current formula, rural and small urban hospitals that treat a disproportionate share of low-income patients receive a much smaller adjustment (if any) than large urban hospitals with the same share. Our technical recommendations are intended to eliminate these flaws.

Facilities exempt from the acute care prospective payment system. Certain types of hospitals and distinct units of hospitals are exempt from the acute care PPS. These so-called PPS-exempt facilities are a diverse group that share a common Medicare payment method established by the Tax Equity and Fiscal Responsibility Act of 1982. They include rehabilitation, long-term, psychiatric, children's, and cancer hospitals, and rehabilitation and psychiatric units in acute care hospitals. Each of these facilities is paid an amount based on its own costs in the payment year relative to a per-case target that depends on its costs in a base year, updated to the payment year.

MedPAC's analysis of the factors that determine year-to-year cost increases for PPS-exempt facilities indicates that the update factor applied to the per-case targets in fiscal year 2000 should be increased by 0.4 percentage point more than in the formula prescribed in the BBA. The BBA also established a category-specific cap on the per-case targets for rehabilitation and psychiatric facilities and long-term hospitals but did not provide that these nationwide caps be adjusted for differences in input prices across areas. We recommend correcting that technical oversight.

The BBA required that Medicare implement a new payment system for rehabilitation facilities and that the Secretary develop a proposal for long-term hospitals. It did not mention psychiatric facilities, however. MedPAC encourages additional research in case-mix classification for payments to psychiatric facilities, with an eye toward developing a PPS for them in the future.

PROVISIONS AFFECTING PAYMENTS TO PHYSICIANS

The BBA mandated a number of changes in the Medicare Fee Schedule for physicians. To update payment rates for physicians' services, a sustainable growth rate system was established to replace volume performance standards. To make the fee schedule fully resource based, HCFA recently began to phase in a new methodology for the practice expense component (which it intends to refine as it is used) and is developing revisions to the professional liability component.

MedPAC recommends several modifications to the sustainable growth rate system (SGR). These include revising the SGR to include measures of changes in demographic and other characteristics of Medicare fee-for-service enrollees, to reflect cost increases due to desirable improvements in medical capabilities and scientific technology, and to correct for inaccuracies in estimates used in SGR system calculations. We also call for a reduction in time lags between the periods on which the various components of the SGR are based and the earlier availability of estimated updates for each upcoming year.

With respect to HCFA's implementation of resource-based practice expense payments, MedPAC agrees that, for some services, it is appropriate to pay a lower practice expense amount when physicians perform the service in facilities other than their offices. MedPAC recommends, however, that a service-by-service approach be used to decide which services are subject to this site-of-service differential, rather than applying the same decision to entire groups of services. Services generally recognized as inappropriate to perform in a physician's office should be paid at the lower facility practice expense level. In refining practice expense payments, participants with a wide variety of relevant expertise should be included in the process.

To make the professional liability component of the fee schedule resource based, payments should reflect the risk of a professional liability claim in providing each service.

ESTABLISHING NEW PROSPECTIVE PAYMENT SYSTEMS IN THE FEE-FOR-SERVICE PROGRAM

The BBA established new prospective payment systems for post-acute care providers—skilled nursing facilities, home health agencies, and rehabilitation hospitals—and for services provided in hospital outpatient departments. Payments to these providers had previously been made on the basis of facilities' costs—and also charges in the case of hospital outpatient departments—subject to certain limits. Under the new prospective payment systems, fixed predetermined payments will be made for a specified set of services.

For skilled nursing facilities, a three-year phase-in of the PPS began in July 1998. Implementation of the PPS for home health agencies, originally scheduled for October 1999, was delayed for one year by the Omnibus Consolidated Emergency Supplemental Appropriations Act of 1998. The PPS for rehabilitation hospitals is scheduled to be implemented in October 2000. The prospective payment systems for hospital outpatient departments was originally scheduled to be implemented in January 1999 but has been delayed.

The new prospective payment systems will reduce uncertainty for both providers and policymakers and will encourage providers to deliver care efficiently. Prospective payments will also allow policymakers to compare rates across settings more directly, which will make it easier to set payment rates that vary according to the services provided and not simply their location. Policymakers will need to monitor the quality of and access to care to ensure that providers do not react to the new systems by stinting on care, rather than improving efficiency.

Developing new payment systems for post-acute care providers. The BBA mandated substantial changes in Medicare payment policy for providers of post-acute care. To guide the development of consistent payment policies across post-acute care settings, MedPAC recommends that common data elements be collected to help identify and quantify the overlap of patients treated and services provided. Further, it is important to put in place quality monitoring systems in each setting to ensure that adequate care is provided in the appropriate site. We also support research and demonstrations to assess the potential of alternative classification systems for use across settings to make payments for like services more comparable.

The Commission has several recommendations intended to improve the PPS for skilled nursing facilities. More work is needed to refine the classification system used in the PPS for skilled nursing facilities, particularly in its ability to predict the costs of nontherapy ancillary services. Alternative ways of grouping rehabilitation services provided in SNFs may also be called for to reduce reliance on measurements of rehabilitation time. A method for updating the relative weights that determine how much facilities are paid for each type of patient is crucial as the system and the types of services provided change over time. In general, as better data become available with the new system, distortions in the base payment rates due to imperfections in the initial data and measures used should be detected and corrected. To avoid future problems, facilities must be accountable for accurately assessing patients' needs and reporting the data used to determine payment for each case. Finally, payments should be adjusted for geographic differences in labor prices using wage data from SNFs, rather than hospitals, to make them more equitable among providers.

The BBA put in place an interim payment system (IPS) to govern payments to home health agencies until a prospective payment system was developed. The IPS was the subject of a great deal of controversy in the year following its enactment. This controversy stemmed, in part, from the use of payment policy as a vehicle for curbing the rapidly rising cost of a benefit that was poorly defined. Although the debate appears to have subsided, at least temporarily, with recent changes to the IPS, MedPAC believes that more fundamental changes are necessary even as a new payment system is being developed. We urge the Congress, in consultation with the Secretary, to enact clearer eligibility and coverage guidelines for Medicare home health services. To better understand the content of home health visits, agencies' bills should describe the specific services provided. Moreover, we recommend that an independent assessment of need be conducted for Medicare beneficiaries who receive extensive home health care to ensure that care is appropriately coordinated and suits the needs of the patient. Finally, modest beneficiary cost sharing should be introduced for home health services; copayments should be subject to an annual limit, and low-income beneficiaries should be exempt from this requirement.

As systems for rehabilitation facilities are developed, a number of crucial decisions must be made. Among them is the unit of payment. MedPAC recommends that a per-discharge mechanism be adopted for rehabilitation services. A system currently exists that with some modifications could serve as a basis for such an approach. We also recommend that, in choosing a patient classification methodology for a long-term hospital PPS, HCFA consider not only per diem but also existing and potential per-discharge approaches.

Modifying payment for services provided in ambulatory care facilities. Spending for facility-based ambulatory care services has grown substantially since the early 1980s, in part because a combination of financial incentives and technological advances encouraged shifting of services that once were provided exclusively in the inpatient setting to hospital outpatient departments (OPDs), ambulatory surgical centers (ASCs), and physicians' offices. Medicare pays for many of these services differently according to where they are provided.

As required by the BBA, the Secretary has proposed a new payment system for hospital outpatient services. MedPAC recommends these changes be closely monitored to ensure that beneficiary access to appropriate care is not compromised in the face of substantial reductions in payments to hospital OPDs. In addition, payments should reflect the higher costs of treating certain types of patients. In the absence of adequate patient-level indicators, facility-level adjustments may be required for the time being. We are also concerned that loosening guidelines for determining whether a procedure is eligible for coverage in an ASC may lead to inappropriate changes in the pattern of service provision across ambulatory settings.

Although the BBA provided for a gradual reduction in the amount of beneficiary coinsurance for services provided in hospital outpatient departments, it will be years before that amount is reduced to a level comparable with that for similar Medicare-covered services furnished in ASCs or physicians' offices. MedPAC recommends accelerating the reduction in the outpatient coinsurance, to be funded by increased program spending rather than by further reductions in hospital payments.

The Commission makes several recommendations that apply to payment for ambulatory care in general. Consistent with the way that Medicare pays for physicians' services, the unit of payment should be the individual service—that is, the primary service and the ancillary supplies and services integral to it—rather than a larger bundle of services. Accordingly, the relative cost of the individual service should determine payment, rather than costs for groups of services taken together. When payment rates are set, the pattern of services and costs across ambulatory settings should be taken into account. Moreover, a single update mechanism that links updates to spending growth across all ambulatory care settings should be applied to the payment rates for each type of provider.

IMPROVING THE QUALITY OF DIALYSIS SERVICES

The BBA required the Secretary to develop and implement methods to measure and report the quality of dialysis services. MedPAC is studying the quality of care provided to beneficiaries with renal failure and will comment on this topic in its June Report to the Congress. In March, the Commission recommended updating the composite rate for outpatient dialysis services. The dialysis industry has been profitable, and firms continue to enter the market despite the lack of a significant update in the composite rate since it was established in 1983. The Commission's analysis indicates, however, that costs have been approaching payments in recent years. We are concerned that further increases in dialysis costs relative to the payment rate may cause quality to deteriorate.

CONCLUSION

In just over a decade, the first members of the baby-boom generation will become eligible for Medicare, and policymakers have appropriately focused significant attention on how to address Medicare's future fiscal pressures. But Medicare also faces challenges in the short run as HCFA continues to implement the BBA, developments unfold in the market for health care, and new technologies and treatments emerge.

These short-run challenges are inevitable because Medicare is an extraordinarily large and complex program. The program has almost 40 million beneficiaries, and it makes payments to hundreds of thousands of providers who deliver tens of thousands of different kinds of health care services and supplies. Medicare's payment policies both influence and are influenced by the larger health system and market for health services in which the program operates. Therefore, Medicare's payment policies must continue evolving to ensure that beneficiaries have access to high quality, medically necessary care across the country.

To assist the Congress and HCFA in meeting this objective, MedPAC will continue to monitor Medicare beneficiaries' access to health care and will examine what can be done to improve quality in both Medicare+Choice and in the traditional fee-for-service program. The Commission will track developments as the Medicare+Choice program matures and will look at the availability of plans, the impact of risk adjustment, and other payment policies. MedPAC will continue to analyze fee-for-service payment policies in a broad context that takes into account the implications of providing health care services in an increasing variety of settings. This work will look at what constitutes an appropriate unit of payment and how payments are currently updated using different methods. Finally, the Commission will continue to study the delivery of services in the broader health care market to determine whether strategies that have evolved in private markets can be used to improve Medicare policy.

RESPONSE TO QUESTIONS FROM CHAIRMAN ROTH FOR GAIL WILENSKY:

1. [regarding MedPAC's recommendation on outpatient cost-sharing]

In MedPAC's March 1999 *Report to the Congress: Medicare Payment Policy*, the Commission did not make a specific recommendation with respect to the time frame that would be appropriate for reducing beneficiaries' coinsurance for outpatient services.

Under the provisions of the Balanced Budget Act of 1997, prospective rates will be set for services provided in hospital outpatient departments. For each rate, beneficiaries' and Medicare's payment shares will be calculated as a flat dollar amount. For services where beneficiaries' share is greater than 20 percent of the rate, the beneficiary coinsurance amount will be held constant as a dollar amount. As rates are updated each year, all of the increase in payments will be program spending, because the beneficiary coinsurance amount is held constant. This process will continue until the beneficiary coinsurance for a service equals 20 percent of the payment rate for that service. At that point, the coinsurance dollar amount will be unfrozen, and will increase concomitantly with payment rates.

The appropriate time frame for the reduction in beneficiary coinsurance depends entirely on how much additional money policymakers determine the Medicare program can afford to spend. If the beneficiary coinsurance were set at 20 percent of the total payment to hospitals upon implementation of the prospective payment system, program payments for outpatient services would have to increase by about three-fifths (from 50 percent of spending to 80 percent of the rate for those service), or almost $6 billion per year.

2. [regarding MedPAC's recommendation on coverage guidelines for home health]

Medicare spending for home health services in recent years has been fueled by an increase in the number of beneficiaries receiving care and growth in the number of visits per user. (Costs per visit, however, have been relatively stable.) Medicare's current eligibility guidelines, however, are vaguely defined and once eligible for the benefit, individuals may receive any number of services. Further, eligibility and coverage guidelines are not applied uniformly across home health providers because determinations are made largely by Medicare's fiscal intermediaries.

MedPAC has not considered specific guidelines, but has recommended that the Congress work with the Secretary of Health and Human Services to define the services covered by the home health benefit better and to make the criteria for determining eligibility more clear. We would be happy to work with the Committee in exploring different options.

On the subject of cost-sharing, MedPAC has recommended for the past two years that the Congress require modest beneficiary cost-sharing for home health services, subject to an annual limit. While the Commission did not specify an amount, we have discussed a per-visit copayment of $5 for the first 60 visits. Under an episode-based system, this amount might need to be adjusted to fit the unit of payment under that system.

PREPARED STATEMENT OF GAIL R. WILENSKI, PH.D.

[JUNE 10, 1999]

Good morning Chairman Roth, Senator Moynihan, members of the Committee. I am Gall Wilensky, chair of the Medicare Payment Advisory Commission (MedPAC), and I am pleased to be here to discuss the implications of the Balanced Budget Act (BBA) of 1997 for beneficiaries and providers in Medicare's traditional fee-for-service program.

My testimony today focuses on what we know about the effects of payment changes for five types of services-inpatient hospital, outpatient hospital, skilled nursing, home health, and physician-that have been the subject of much discussion this spring. It draws on MedPAC's March report to the Congress, which presented the Commission's recommendations on Medicare payment policy, and our June report, issued last week, which discusses our recommendations on a range of issues in Medicare, including quality of care and access to care.

A greater than expected slowdown in Medicare spending began in fiscal year 1998 and has continued this year. Unfortunately, we cannot draw definitive conclusions about what in Medicare's fee-for-service sector is generating this slowdown. Data for the BBA period are extremely limited, and we cannot easily isolate the effects of the BBA from other changes. Hospitals, for example, have argued that the changes in Medicare payments stemming from the BBA are reducing their margins and impinging on their ability to provide quality care. But the most recent complete information we have for the Medicare program is from fiscal year 1997, the year before the BBA took effect. For home health services, we have seen lower than expected outlays, closures of home health agencies, and declines in the use of services. But our interpretation of these findings is clouded by other policy changes, notably efforts by the Health Care Financing Administration (HCFA) to cut down fraud and abuse in the home care industry.

The BBA had an ambitious objective for Medicare's fee-for-service program: modernizing payment systems and slowing the growth in spending while preserving Medicare beneficiaries' access to high-quality health care. To expect legislation as sweeping as the BBA to achieve this objective flawlessly is unrealistic and, as I discuss, in a number of instances targeted changes in statute or in regulation could improve Medicare's payments and access to care for beneficiaries. But providers' complaints notwithstanding, we have no evidence that wholesale changes in the BBA are either necessary or desirable.

PROVISIONS OF THE BALANCED BUDGET ACT AFFECTING FEE-FOR-SERVICE PROVIDERS

The BBA enacted the most far-reaching changes to the Medicare program since its inception. In Medicare's fee-for-service sector, it made changes to a number of payment mechanisms for inpatient hospital services. The law established, or directed to be established, new prospective payment systems for services provided by hospital outpatient departments, skilled nursing facilities, home health agencies, and rehabilitation hospitals and units. It introduced a new mechanism for updating fees for physician services. Finally, it reduced payment updates or otherwise slowed the growth in payments to virtually all fee-for-service providers.

The changes enacted in the BBA and implemented by the Health Care Financing Administration reduced Medicare spending relative to what it would have been otherwise and, not surprisingly, have generated concerns among providers about their effects. These concerns arise from perceptions that the effects have been more harsh than what the Congress intended, or that the effects, while intended, have nonetheless imposed burdens on providers, and that there are specific problems with how HCFA has implemented the law.

Providers' concerns are clearly relevant to any assessment of the BBA. But at the same time, we must remember that the primary objective of the Medicare program is to maintain access to high-quality care for beneficiaries. Assessing the implications of the BBA should therefore focus on whether access to or quality of care has been hampered and, if so, what can be done about it.

In evaluating the impact of the BBA, two issues seem especially important. One is whether the case-mix adjustments used in the new payment systems adequately reflect predictable differences in patient care costs that result from differences in patients' health status. This issue is important because inadequate case-mix adjustments create financial incentives for providers to deny access to care or undertreat identifiable groups of patients.

A second critical issue is how payment policies for different services may interact to affect providers' incentives to furnish efficient, high-quality care. Some providers, such as many hospitals, furnish most types of services. Consequently, they must

consider and respond to the combined effects of policy changes that have altered payments for virtually every service they provide.

INPATIENT HOSPITAL SERVICES

The BBA changed payments for inpatient hospital services in a number of ways. For hospitals under Medicare's prospective payment system (PPS), the law provided for no update to operating payments in fiscal year (FY) 1998 and limited updates in FY 1999 through FY 2002. It phased in reductions in the percase adjustments for the indirect costs of medical education and for hospitals serving a disproportionate share of low-income patients. And it instituted a new transfer policy for 10 high-volume diagnosis related groups (DRGs), reducing the payment rates when hospitals discharge patients in these DRGs to post-acute care facilities following unusually short stays.

In formulating its recommendations for the FY 2000 update, MedPAC noted that hospitals have responded to an increasingly competitive market by improving their productivity and shifting services to other sites of care. These two responses generated substantially lower rates of growth in inpatient costs-with costs per case actually falling every year between 1994 and 1997—and sharply higher Medicare inpatient margins. Hospitals' average Medicare inpatient margin in 1997—17.1 percent-was the highest it had been since the inception of the PPS.

At the same time, MedPAC recognized several factors pointing to the need for caution in specifying future updates, including emerging evidence that the decade-long trend in rising case mix complexity, which automatically increases PPS payments, may be subsiding. We also questioned whether the unusually low rate of hospital cost inflation observed in recent years can be sustained without adverse effects on quality of care. With these factors in mind, we concluded that the operating update for FY 2000 enacted in BBA—1.8 percentage points less than the increase in HCFA's operating market basket index-will provide reasonable rates. (Under current forecasts, that would be an update of 0.9 percent.) MedPAC's recommendation took into account part, but not all, of the cumulative reduction in costs per case due to shifts in the site of care.

Since MedPAC made its recommendation in March, the hospital industry has issued several reports projecting, the impact of the BBA on hospital revenues and margins. These reports contain new projections but no new data. In response to congressional requests, MedPAC staff have analyzed these studies and found that all of them project a more adverse impact of the BBA than we believe to be the case. Some present a particularly inaccurate picture of the impact in FY 1998 by assuming a rate of increase in costs that substantially exceeds what we already know has occurred. Data from the American Hospital Association's National Hospital Panel Survey suggest that when complete Medicare cost report data become available, we will again see a decline in Medicare cost per discharge for FY 1998, the fifth year in succession.

Although we believe that these reports overstate to some degree the impact the BBA will have on hospital margins, the overall direction of that impact is correct. The law has thus reversed a six-year trend of Medicare payments rising more rapidly than the costs of treating Medicare payments. But changes in total margins also reflect developments in the private sector, where HMOs and other payers have continued to exert strong downward pressure on hospital revenue flows. As Medicare tightened its payment policies in 1998, the combined pressure on revenues has caused the financial distress that hospitals are currently experiencing.

Projections of margins also need to be interpreted with caution. Because hospitals will respond to financial pressures, MedPAC views projected margins only as a gauge of the pressure that Medicare payment policies will impose on hospitals but not as a prediction of what will occur. Evaluating whether those responses affect quality and access to care will be just as important as measuring financial performance. MedPAC has seen no evidence that the changes to date have affected either quality or access in the inpatient sector, but we will continue to monitor developments.

OUTPATIENT HOSPITAL SERVICES

In addition to changes in payments for inpatient services, the BBA also enacted major changes in Medicare's payments for services provided in hospital outpatient departments. It eliminated the so-called formula-driven overpayment under which Medicare's payments did not correctly take into account the effect of beneficiaries' cost sharing and extended the reduction in payments for services paid on a cost-related basis. The law also directed the Secretary to establish a prospective payment

system for services that previously had been paid under a blend of fees and cost-based reimbursement.

In contrast to the payment changes for inpatient services, hospitals have not yet felt the full impact of the BBA provisions affecting outpatient services. MedPAC estimates that elimination of the formula-driven overpayment, which took effect in FY 1998, reduced payments by about 8 percent. However, the PPS that was to have gone into effect in January 1999 will not be put in place before next spring. HCFA originally estimated that the PPS would reduce payments by 3.8 percent; the agency recently revised its estimate to 5.7 percent.

MedPAC's principal concern with the PPS proposed by HCFA is that it is too aggregated. In basing payments on groups of services instead of individual services, the system is likely to overpay for some services and underpay for others. This could lead to access problems for beneficiaries needing services whose payments fall short of costs. In our March report, MedPAC recommended that the PPS be based on the costs of individual services.

Implementing the outpatient PPS will reduce payments for virtually all hospitals but could have much larger effects on specific types of hospitals. For example, based on HCFA's original estimates, small rural hospitals would see a 10 percent decline in payments, and payments to cancer hospitals would drop almost 30 percent. Given the magnitude of these changes, MedPAC recommends that the Secretary closely monitor the use of hospital outpatient services to ensure that beneficiaries' access to appropriate care is not compromised. Consideration should also be given to phasing in the new payment system to help us detect any problems before they become severe.

SERVICES IN SKILLED NURSING FACILITIES

The BBA enacted a prospective payment system for services provided in skilled nursing facilities (SNFs). These services had previously been paid on the basis of costs, subject to certain limits. Under the new system, patients in SNFs will be classified under the Resource Utilization Group system, version III (RUG-III), which groups patients by their clinical characteristics for determining per them payments. Payments are intended to cover the routine, ancillary, and capital costs incurred in treating a SNF patient, including most items and services for which payment was previously made under Part B of Medicare. The PPS is being phased in over a three-year period; during the phase-in, payments are based on a blend of federal rates and facility-specific rates.

Industry representatives and others have asserted that the SNF PPS does not adequately account for the costs of high-acuity patients, which may impair access for these people. The RUG-III classification system is based on the time providers spend furnishing nursing and therapy services. But SNF patients can vary significantly in their use of ancillary services and supplies, such as respiratory therapy, lab tests, imaging services, drugs and biologicals, and transportation. Variation in the use of these services is reflected in the RUG-III system only to the extent that their use is correlated with the use of nursing and therapy services.

Although anecdotal, early evidence indicates that some Medicare patients are in fact having difficulty accessing care in SNFs. The problem is not the PPS by itself, but the mismatch between payments and costs for patients who require relatively high levels of nontherapy ancillary services and supplies. Accordingly, the Commission recommended in our March report that the Secretary continue to refine the classification system to improve its ability to predict the use of nontherapy services and supplies. An improved classification system would match payments more closely to beneficiaries' needs for services and help to avoid access problems among medically complex patients.

HOME HEALTH SERVICES

Before the BBA, home health agencies were paid on the basis of costs, subject to limits based on per-visit costs. The BBA directed the Secretary to implement a prospective payment system effective October 1999 and established an interim payment system (IPS) to control the growth in spending until the PPS was implemented. The IPS reduced limits based on costs per visit and added an average per-beneficiary cost limit based on a blend of agency-specific costs and average per-patient costs for agencies in the region. Home health agencies are now paid the lower of their actual costs, the aggregate per-beneficiary limit, and the aggregate per-visit limit.

Following a decade of extremely rapid growth, outlays for home health services actually fell in 1998, the first year of the IPS. The home health industry contends that the IPS has been responsible for large numbers of agency closures and that it has adversely affected care. Beneficiary advocates have echoed these sentiments.

In response to such concerns, the Congress last fall directed MedPAC to examine the impact of the EPS on access to home health services. Our analysis is contained in our June 1999 report.

MedPAC found that fewer Medicare beneficiaries are receiving home health care than in the recent past, the number of visits per user has decreased, and the number of agencies has declined. Based on a survey of home health agencies conducted for MedPAC by Abt Associates, Inc., we found that some agencies report they no longer accept, or are likely to discharge earlier, certain types of patients because of the payment changes. We also convened a panel of experts familiar with beneficiaries' problems accessing home health services. The panel indicated that some beneficiaries are having more difficulty obtaining services to which they believe they are entitled under Medicare's home health benefit.

These findings are consistent with the claim that the IPS has hampered access, but they do not tell the whole story. First, numerous concurrent policy changes have contributed to the changes we observed. These policies include efforts by HCFA to reduce fraud and abuse by stepping up oversight of home health care providers, imposing a four-month moratorium on the certification of new agencies in early 1998, and adopting a new bill-processing policy. Concurrent policy changes also include enactment by Congress of a much stricter per-beneficiary limit for new home agencies. The new limit has probably reduced entry into the home health care market significantly.

Changes in the use of home health services may also reflect confusion about the EPS on the part of home care providers. Anecdotal evidence suggests that some home health agencies have interpreted the per beneficiary limits to apply to specific Medicare beneficiaries, not to the agency's average cost per beneficiary as intended by the BBA. Thus, some agencies may be failing to recognize that costs for beneficiaries who use a large number of visits can be balanced against the costs of short-stay users.

Finally, it is impossible to determine whether the changes in use of home health services that have been observed during the past two years are appropriate. It is difficult in part because Medicare's standards for eligibility for and coverage of home health services are too loosely defined. MedPAC recommends in our June report that the Secretary should speed the development of regulations that would outline home health care coverage and eligibility criteria based on the clinical characteristics of beneficiaries and that she should recommend to the Congress the legislation needed to accomplish the implementation of those regulations.

MedPAC is also concerned that the timetable for implementing prospective payment for home health services is very tight. Accordingly, we recommend in our June report that Congress explore the feasibility of establishing a process for agencies to exclude a small share of their patients—say 2 percent—from the aggregate beneficiary limits. Under our recommendation, Medicare would reimburse care for excluded patients based on the lesser of actual costs or the aggregrate per-visit limits. MedPAC believes that such a policy should be in a budget-neutral manner.

PHYSICIANS' SERVICES

The BBA replaced the volume performance standard system that had been used to update physicians' fees with a new sustainable growth rate (SGR) system. Under the SGR, the annual update each year depends on how Medicare's cumulative actual fee-for-service spending from 1997 to the update year compares with cumulative allowed spending for the same period. Cumulative allowed spending reflects actual and projected fees for physicians' services, anticipated Part B fee-for-service enrollment, projected real gross domestic product per capita, and changes arising from laws and regulations other than the SGR system.

Two technical aspects of the SGR system have come under criticism: the Secretary's lack of authority to correct for projection errors and the potential for oscillations in fee updates. MedPAC concurs with these criticisms and recommended in its March report that Congress enact legislation to address them.

Because the SGR is cumulative, uncorrected projection errors affect all subsequent updates. This happened in 1999, when an unexpected slowdown in Medicare+Choice enrollment growth led to a smaller than projected decline in Part B fee-for-service enrollment. To address this problem, MedPAC recommended in its March report that the Congress require the Secretary to correct estimates used in SGR system calculations every year.

The potential for oscillation in fee updates arises from problems with the data and methods used to calculate the updates. These problems are likely to lead to extreme positive and negative updates. MedPAC recommends legislation to correct these problems and modulate swings in updates.

COMMUNICATIONS

STATEMENT OF THE AMERICAN ASSOCIATION OF HOMES AND SERVICES FOR THE AGING (AAHSA)

The American Association of Homes and Services for the Aging (AAHSA) is pleased to present written testimony to the Senate Finance Committee on the impact of the 1997 Balanced Budget Act on long-term care providers. As members of Congress are realizing, deep cuts in Medicare funding for skilled nursing facilities have had unintended consequences that are severely affecting vulnerable Americans residing in our nation's skilled nursing facilities. We welcome the opportunity to provide input and comments to the Committee about how we can better serve the aging population.

AAHSA is a national non-profit organization representing more than 5,300 not-for-profit nursing homes, continuing care retirement communities, assisted living and senior housing facilities, and community service organizations. More than half of AAHSA's members are religiously sponsored and all have a mission to provide quality care to those in need. Every day AAHSA members serve one million older persons across the country.

The Balanced Budget Act of 1997 was intended to rein in the growth of Medicare expenditures on post-acute care by encouraging providers to become more efficient. However, the ways in which the new payment systems have been implemented have had unintended consequences for Medicare beneficiaries receiving care from skilled nursing facilities and home health agencies.

SKILLED NURSING FACILITIES

In 1997, the Balanced Budget Act was expected to save $9.5 billion over five years from Medicare funding of skilled nursing facilities by changing the payment system from a cost-based reimbursement to a prospective payment system that reimburses for care based on residents' needs. This new system reduced Medicare spending on skilled nursing facilities by 17 percent. The prospective payment system for skilled nursing facilities provided payment rates for the average cost of providing care to patients based on defined Resource Utilization Groups (RUG-IIIs). The system that went into effect July 1, 1998 is being phased into national rates over four years. Under prospective payment system rates, skilled nursing facilities are reimbursed for the bundle of all Medicare Part A and Part B services provided to residents covered under a Part A stay. This forces the skilled nursing facility to act as a prudent buyer of services and to provide cost effective care. The efficiency encouraged by the prospective payment system was expected to account for the 17 percent reduction in funds.

In developing the prospective payment rates for the RUG classifications, non-therapy ancillary services such as prescription drugs, ventilator care, wound care and prosthetics represented approximately 43 percent of the nursing component. Whereas the nursing component costs were developed with staffing time measurements within the RUG-III classification system, non-therapy ancillary costs were lumped into the RUG-IIIs without regard to the type, amount, and cost of the services required and provided to patients within each grouping. HFCA has a contract for research to modify the RUG-III classification of non-therapy ancillary costs. However, the research is not expected to be completed until early 2000 for changes to be in effect by October 2000.

AAHSA does not oppose the prospective payment system, because we recognize the need to control the growth of Medicare costs. However, the RUG-III payment rates that HCFA developed do not accurately reflect some important costs involved in providing essential care to nursing facility residents. At the time the Balanced Budget Act was considered, Congress recognized that payment rates must be suffi-

cient to meet the needs of nursing facility residents with complex conditions. The conference report on the Balanced Budget Act stated, "It is the intent of the Conferees that the Secretary develop case mix adjusters that reflect the needs of such patients," (House Report 105-217, page 758). The RUG-III payment rates that are now in effect do not meet this criterion for residents with complex needs.

As not-for-profit providers, AAHSA members are driven primarily by the goal of fulfilling their mission of providing high-quality medical care to their residents. Furthermore, nursing facilities, unlike all other health care providers, are subject to federal quality standards under the Omnibus Budget Reconciliation Act of 1987, which requires skilled nursing facilities to maintain every resident at his or her highest practicable level of functioning. This requirement limits the degree to which skilled nursing facilities can achieve efficiencies by cutting back on care.

Many AAHSA members now are in a difficult position. On the one hand, their mission and legal obligation is to provide as much care as is necessary to achieve and maintain a resident's highest level of functioning. On the other hand, there is a large discrepancy between the per diem rates that Medicare pays and the actual cost of caring for someone with very complex needs. While AAHSA members do not have to show a profit, there is a limit to the amount of losses that they can absorb. Although the prospective payment system has been in effect for less than a year, we are hearing increasingly from skilled nursing facilities that have had to dip into endowments or step up charitable fundraising in order to subsidize the care of Medicare residents with complex needs. These funding sources generally have been reserved for other needy residents who have exhausted their personal financial resources, and to supplement reimbursements under the Medicaid program, which also does not pay its fair share of the cost of care. Having to use charitable funds to supplement inadequate Medicare reimbursement puts a severe strain on nursing facilities' ability to serve all of their residents.

Because of the flaws in the way the RUGs categories were designed, Medicare spending on skilled nursing care is falling below the levels that facilities can absorb by becoming more efficient. In fact, it appears that the way in which the prospective payment system has been implemented will cut the growth of Medicare spending far more than the $9.5 billion that originally was projected. Although the numbers are still being reviewed as to whether more money than expected have been removed from skilled nursing facility services, the fact remains that vulnerable residents in need of quality skilled care in nursing facilities are being hurt by the unintended consequences of the budget cuts.

In addition to lower funding than is needed to provide quality care, the distribution of funds is also inequitable. The prospective payment system's payment rates according to RUG-III are averages. Individual residents of a skilled nursing facility rarely consume the average cost of nursing, therapy and non-therapy ancillary services. Some require less, others slightly more, which averages out. However, a few residents require substantially more care and services, and thus significantly higher costs, than ever expected for the average resident. Most of the excessive costs are for non-therapy ancillary services. Examples of medically complex patients requiring extraordinarily expensive non-therapy ancillary costs include the following:

- In Michigan, a skilled nursing facility provided over $80,000 in intravenous medications to a resident with cancer who was in the facility for 27 days. Of that amount, Medicare paid less than $10,000.
- A skilled nursing facility that treats residents with AIDS provides each of them with an extensive battery of medications whose daily cost exceeds $450; whereas the Medicare payment is less than $200 per day for each resident.
- A skilled nursing facility in rural Wisconsin had to close down its ventilator care unit because Medicare reimbursement fell to half of the actual cost of providing the services. The facility could not refuse to provide the care just to Medicare patients, since that would have constituted illegal discrimination under federal law, so the facility was forced to stop providing ventilator care to anyone. This facility had been the only provider of ventilator care in a large geographic area that covered several counties and portions of three states. As a result, many patients who were ready to leave hospitals in the vicinity but who needed ventilator care had to remain in the hospital because they had no other access to the care they needed.
- After providing wound care at a cost of over $200 a day for a resident who had had an amputation, a skilled nursing facility provided him with a prosthetic device costing over $5,000 so that he could maintain the greatest degree of independence possible. Medicare reimbursed his care at less than $200 per day.

As indicated by these examples, patients needing expensive non-therapy ancillary services may have difficulty finding access to a skilled nursing facility with specialty

services because most facilities cannot absorb the large losses that the new reimbursement system imposes.

Recommendation: AAHSA strongly encourages Congress to restore some of the funds cut from Medicare funding for skilled nursing facilities and to ensure that restored funds are allocated to payment for medically complex cases.

The non-therapy ancillary problem is two-fold: the RUG III rates need a temporary adjustment for the next year until HCFA's current research is completed and the agency is able to make a permanent revision in the rates to make a more appropriate allowance for non-therapy ancillary costs. Whatever changes are made in the RUG III rates, however, there are likely to be a small number of patients whose care is extraordinarily costly, beyond the ability of a skilled nursing facility to average out. For the long term, an outlier provision should be added to the prospective payment system, similar to provisions that have been included in the Medicare payment system for hospitals, to allow for additional payments to a skilled nursing facility once a patient's costs rise beyond a certain threshold.

Skilled nursing facilities—therapy caps

Effective January 1, 1999, the Balanced Budget Act limits Medicare beneficiaries to an annual beneficiary cap of $1,500 for physical therapy which include speech-language pathology and a separate $1,500 cap for occupational therapy. The only exception is unlimited rehabilitation services from an hospital outpatient facility.

Beneficiaries living in the community have the option of switching from an independent therapist to a hospital outpatient facility. Although the beneficiary is able to circumvent the therapy cap, changing therapists does not provide continuity of care which is essential to sustain improvements from therapy. Residents of a skilled nursing facility are not allowed to receive therapy in any other setting or by another provider other than the skilled nursing facility. The therapy cap is a restriction based on where the Medicare beneficiary resides and receives rehabilitation services, and it therefore discriminates against residents of skilled nursing facilities.

Medicare beneficiaries in skilled nursing facilities require rehabilitative services to restore and maintain functioning that might enable a return to the community or enhanced quality of life. Residents of a skilled nursing facility are limited as to where they may receive therapy by the very nature that they required placement in a skilled nursing facility. The Part B therapy caps place unfair and unrealistic limitations on services available to these Medicare beneficiaries. Furthermore, as noted above, skilled nursing facilities have a legal obligation under federal law to provide residents with as much therapy as they need in order to regain and maintain their highest practicable level of functioning.

Once again, the therapy caps are having unintended consequences for Medicare beneficiaries. While the nursing facility must offer therapy services that exceed the cap if the therapy is still medically necessary, the resident can be required to pay out-of-pocket for these services, since they are not covered by Medicare. This poses a serious problem for most nursing home residents who have extremely limited incomes. Almost six months into 1999, some residents of AAHSA facilities already have reached the cap on their therapies. Other residents who anticipate that they may reach the cap are refusing therapy, fearing that they may need it more later in the year.

Recommendation: AAHSA strongly urges Congress to pass S. 472 and H.R. 1837, legislation to ease the therapy caps for Medicare beneficiaries who encounter multiple episodes or who have multiple conditions requiring physical, speech, or occupational therapy.

Home health reimbursement

The combined effects of the Balanced Budget Act of 1997, Operation Restore Trust, and the Omnibus Reconciliation and Appropriations Act of 1998 have left Medicare-certified home health services in turmoil. Reimbursement levels were severely cut by the interim payment system; numerous federal agencies are strongly scrutinizing the industry for fraud; and adjustments made last year to the interim payment system provide little relief to home health agencies, especially those that care for the sickest beneficiaries.

The home health interim payment system that was included in the 1997 Balanced Budget Act significantly lowered the reimbursement level for home health agencies for cost reporting periods beginning on or after October 1, 1997. At the time of its passage, Congress and the Administration calculated that the interim payment system would cut $16 billion in home health expenditures over a five year time period. This past March, the Congressional Budget Office (CBO) determined that the savings will approximate $79.1 billion over five years. It therefore appears that home health savings over the 5year period will far exceed the $16 billion target.

Reimbursement was cut so low by the interim payment system that small, rural and/or traditionally cost-efficient agencies (those already providing the fewest visits and services that were medically necessary) are being forced out of business. Furthermore, many agencies' ability to care for sicker patients in need of complex services or multiple visits have been severely restricted. Adjustments made to the interim payment system in 1998 were too late to prevent the demise of approximately 14 percent (1,261) of the nation's home health agencies, as recently reported by the GAO (GAO/HEHS-99-120). More will fail this year without additional relief.

While AAHSA appreciates the finding of the aforementioned GAO report, *Medicare Home Health Agencies: Closures Continue, With Little Evidence Beneficiary Access Is Impaired:* "home health agency closures due to implementation of the interim payment system are consistent with interim payment system incentives to control utilization," AAHSA remains concerned that the data analyzed for the study does not reflect the current status of home health access. Unfortunately, this study used beneficiary utilization data from the first quarter of 1998 and compared it to similar data in 1994 and 1996. While this was the best available data at the time, we urge Congress to request further study as more reliable, up-to-date data becomes available. We also must recommend that Congress continue to hear from beneficiaries and their caregivers as to how all of these changes are affecting their access to home health services, keeping in mind that consumers may have a limited understanding of the Medicare home health benefit's eligibility and coverage guidelines.

AAHSA members surveyed earlier this spring reported various effects of the implementation of the Balanced Budget Act across the continuum of care. Our members who provide home health services are experiencing declines in admissions either because hospitals with captive home health agencies are not referring patients to other home health agencies, or due to fears associated with inappropriate referrals from doctors, an outgrowth of the intensified scrutiny from Operation Restore Trust. Consequently, AAHSA home health members report decreases in their home health reimbursements under the interim payment system ranging from 10 to 33 percent.

The home health interim payment system must be adjusted so that the medically complex, sickest beneficiaries do not lose access to care. At the same time, HCFA must work with home health providers to assure that the development of a permanent home health prospective payment system is fair to all stakeholders including the beneficiaries and the federal budget. We must assure quick implementation of a new home health prospective payment system that does not penalize cost-efficient home health agencies or that creates competitive disparities among agencies.

While the interim payment system is in effect, Congress must amend it to assure access to beneficiaries and to provide relief to home health providers. AAHSA urges Congress to: 1) adjust the per-visit and per-beneficiary cost limits up to reasonable levels; 2) eliminate the additional 15% total spending reduction that is supposed to be implemented in October 2000; 3) include an outlier provision to reflect the extraordinary needs of high utilization/medically complex patients; and 4) assure that periodic interim payments are extended at a minimum through the first year of implementation of the home health prospective payment system to ensure adequate cash flow for agencies.

CONCLUSION

In the long run, the new Medicare prospective payment systems for skilled nursing facilities and home health providers will help to slow the growth of Medicare spending by making post-acute care more efficient. The ways in which these systems have initially been implemented, however, have resulted in larger spending reductions than Congress intended and in sizable discrepancies between Medicare reimbursement rates and the actual cost of providing care. These discrepancies pose serious difficulties for not-for-profit skilled nursing facilities and home health agencies that already have been providing high quality care in an efficient manner. Not-for-profits cannot provide services indefinitely when the reimbursement they receive falls far short of the actual cost of providing the care and results in significant financial losses to the provider. Medicare beneficiaries with complex needs already are having some difficulty in accessing care; these access problems are likely to worsen if changes are not made in the reimbursement rates. Some funding must be restored to Medicare post-acute care, and adjustments in the prospective payment rates must be made in order to ensure the continued availability of post-acute care not only to Medicare beneficiaries, but to the wider community as well.

STATEMENT OF THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

The American Occupational Therapy Association, representing 60, 000 practitioners and students nationwide, applauds the Finance Committee's attention to the Medicare fee-for-service program as shown by the holding of today's hearing.

"The Medicare fee-for-service program is what most beneficiaries depend on for their care and the recent changes to key programs such as skilled nursing, home health and outpatient rehabilitation. AOTA supports the Finance Committee's review of fee for service and the impact the BBA changes and other issues are having on beneficiaries.

Occupational therapy is a health and rehabilitative service that uses activity, or "occupation," to enable individuals with illnesses, injuries or disabilities to overcome the effects of those conditions and lead full lives. In Medicare, occupational therapy is covered under hospital, skilled nursing care, home health, hospice and as an outpatient service.

AOTA is concerned about two major issues in the BBA that are having a significant impact on members and the patients they serve:

THE PROSPECTIVE PAYMENT SYSTEM FOR MEDICARE PART A SKILLED NURSING FACILITY SERVICES

The Balanced Budget Act of 1997 mandated a change in the payment under Medicare Part A for services in skilled nursing facilities (SNFs) from a cost-based system (with routine limits) to a fully prospective system (PPS) is causing tremendous upheaval in the occupational therapy profession. Practitioners are experiencing changes in their employment status, in their economic status, challenges to their professional standards and ethics, and, most importantly, limitations in their ability to provide adequate, appropriate, and required services to Medicare beneficiaries in these settings. The reductions in staff have gone as high as a 30% percent reduction in therapy workforce in some companies; in addition, remaining caregivers are no longer continuously involved in the SNFs and therefore less involved in patient observation and care. Rather, staff are being moved to "on call" service, limiting continuity of care and, in many cases, relegating the provision of care to unqualified, inadequately supervised personnel.

In addition, some facilities or companies are changing treatment protocols, reducing the time a trained therapist spends with a patient. Therapists' ethics may be compromised by requirements to move patient care to aides or other unqualified personnel without appropriate supervision.

Ethical concerns are also being raised in relation to assessments of patient need that do not allow for adequate time or diminish patient access to therapy because of financial concerns.

For the PPS, the Health Care Financing Administration (HCFA) is using the framework developed under a demonstration effort over the past several years. In this system, patients are classified into a payment category for a daily rate. The category is called the "Resource Utilization Group," or RUG. A patient's health and functional status are reviewed using a "Resident Assessment Instrument" that identifies a patient's needs for nursing, pharmaceuticals, physical/occupational/speech-language therapy, and other services. Patients' needs then translate into a daily rate that is adjusted as a patient's needs change. This process applies for the 100 days of SNF stay covered under Medicare Part A.

Because payment for all services is included in the daily rate, facilities are required to manage more intensively to provide and pay for services in order to assure both appropriate care and efficient use of resources. If the patient classification and the management of resources is not done carefully and correctly, the patient may be vulnerable to less than adequate care or the facility may be liable for costs that are not covered by the daily rate.

Options for Change

AOTA supports the changes in the BBA to move to a prospective system in SNFs but patients may be in jeopardy during this implementation period of a brand new system and oversight by HCFA and Congress appears to be lax.

Thousands upon thousands of layoffs of therapy staff are being caused by the industry's reaction to the PPS. AOTA believes that these reductions in staff and provision of therapy are disproportionate to the reductions in payment that the facilities are experiencing under the PPS and to the slight reductions in SNF census that HCFA is reporting

AOTA is concerned that HCFA is not adequately or effectively monitoring the implementation of this massive change. HCFA has provided no guidance to fiscal intermediaries about medical review or quality assurance criteria to assure patients are

receiving the care that nursing facilities are being paid for. AOTA urges that efforts be undertaken to assure that nursing homes are not minimizing care, either intentionally, because of inadequate payment levels or because of confusing direction from HCFA and its agents.

For instance, rules for using qualified professionals to provide therapy services are being skirted. Standards of supervision of aides and assistants, though covered by law in most states and reaffirmed in Medicare regulation, are a particular area of concern. If standards of care, including use of qualified personnel, are not upheld, patients will suffer loss of function and reduced health status. Thus the purposes of the Medicare program will not be achieved.

The cuts to the SNF program appear to be far greater than anticipated in the BBA estimates. AOTA urges that additional resources be returned to the SNF program to assure that quality care, such as that required by the OBRA nursing home protections, is provided to these vulnerable citizens.

AOTA also believes legislation should be considered to address the limited amount allowed in the daily rates for high cost items such as chemotherapy drugs and prosthetics.

Because therapists are spending less time with patients because of cutbacks in hours and are being asked to adhere only minimally to appropriate practice standards, AOTA is concerned that there will be increases in health and other problems in nursing facilities. Congress should undertake a monitoring effort to monitor increases in problems such as pneumonia or bedsores because of lack of activity, increases in use of medications to control behavior, and impact on appropriate staffing levels for other services such as nursing.

THE $1500 CAPS ON MEDICARE PART B OUTPATIENT REHABILITATION

The Balanced Budget Act of 1997 imposed a payment limitation on outpatient rehabilitation services under Medicare Part B. The limit affects providers including private practitioners, clinics, rehabilitation agencies, skilled nursing facilities and home health agencies (for services for non-homebound individuals). The limit established is $1500 for occupational therapy and a combined cap of $1500 for physical therapy and speech-language-hearing services. Implementation in 1999 is incomplete; the Health Care Financing Administration (HCFA) has determined that the cap will apply per provider as there is no way at this time to track individual beneficiary use.

This cap will be imposed without regard to patient need for continued therapy and without regard to whether the patient has more than one episode of need for therapy during a year

In addition, this provision puts the government squarely between the patient and his or her medical caregiver. Such interference in medical decision making is inappropriate for the Medicare program and potentially harmful to beneficiaries.

Legislative Proposals: AOTA supports legislation to address the cap:

Rep. Jo Ann Emerson (MO) introduced H.R. 1385, the Reinstatement of the Medicare Rehabilitation Benefit Act of 1999" which repeals the cap entirely.

Sen. Charles Grassley (R-IA) and Sen. Harry Reid (D-NV) introduced S. 472, the "Medicare Rehabilitation Benefit Improvement Act of 1999." The bill creates exemptions for:

- Individuals who have more than one incident or diagnosis of need for therapy during a calendar year;
- Individuals who have one or more diagnoses of illness, injury or disability which intensify their need for therapy in a calendar year;
- Individuals who would be hospitalized if they did not receive therapy beyond the limit;
- Other individuals that the Department of Health and Human Services designates (such as those with severe stroke, Parkinson's disease, burns, or multiple sclerosis, etc.)

Reps. Jim McCrery (LA), Richard Burr (NC), Frank Pallone (NJ), and Ben Cardin (MD) introduced a similar bill in the House, H.R. 1837, the "Medicare Rehabilitation Benefit Improvement Act" of 1999.

Rep. Pete Stark (CA) introduced H.R. 1736, the "Medicare Rehabilitation Benefit Equity Act" which provides for exemptions and establishes an alternative system by a date certain (2002).

STATEMENT OF THE AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION (AMRPA)

[SUBMITTED BY DENNIS O'MALLEY, CHAIRMAN, AMRPA, AND PRESIDENT, CRAIG HOSPITAL, ENGLEWOOD, COLORADO]

The American Medical Rehabilitation Providers Association (AMRPA) is pleased to submit testimony today on the Balanced Budget Act's (BBA) requirements relating to the development of a prospective payment system (PPS) for rehabilitation providers. AMRPA is a membership organization representing 360 freestanding rehabilitation hospitals and units. This is about 33% of such facilities recognized by the Medicare program.

I. BACKGROUND

Rehabilitation hospitals and units provide medical care and various therapies to patients who, because of disease, injury, stroke or similar incidents, have impairments of their abilities to function, either physically or cognitively. Our goal is to help them regain the maximum level of functional capability and to return to their homes and independent living patterns. More than 80% of patients admitted to rehabilitation hospitals and units return to their homes, in spite of the fact that many have experienced severe disabilities. Because many of the conditions producing the need for rehabilitation are associated with aging, a significantly high percentage of patients in rehabilitation hospitals and units are covered by the Medicare program. In 1997 over 70% of admissions to such facilities were patients covered by fee-for-service Medicare. Accordingly, the policies of the Medicare program largely determine the availability and quality of rehabilitation services. And there is little room for error.

Our association and its predecessor strongly supported the idea of a rehabilitation prospective payment system (RPPS) to replace the flawed and inequitable system of TEFRA limits which have distorted care for Medicare beneficiaries for over 15 years. We were very pleased when an RPPS was included in the BBA of 1997.

The BBA is completely adequate to support a rational, patient-oriented PPS. However, we believe that amendment of the law is needed to ensure adoption of a rehabilitation PPS without negative consequences, particularly for Medicare patients.

II. MEDPAC PROPOSAL

This matter was addressed in depth in the March 1, 1999 Report on the Medicare program submitted to Congress and the Administration by the Medicare Payment Advisory Commission (MedPAC). We support MedPAC's recommendations regarding a PPS for rehabilitation and related matters, which parallel our views of how to proceed on a PPS, and we urge that Congress ensure that the Department adopt this approach. MedPAC recommends that the payment unit for an RPPS be per-episode and that patient classifications and payment weights be based on function related groups (FRGs) in recommendation 5J (attached for reference). MedPAC also found that there are serious flaws in the PPS being used for skilled nursing facilities (SNFs) (based on Resource Utilization Groups or RUGs) in recommendation 5C, 5D, 5E, 5F, and 5G (attached for reference), and counsels against using such a system for rehabilitation. We strongly commend these observations to this committee.

III. THE PPS SYSTEM RECOMMENDED BY MEDPAC IS COMPLETELY SOUND AND SHOULD BE USED FOR AN RPPS

We believe the most efficient way to use the funds allotted under the BBA to benefit Medicare patients is to adopt an episode-based payment system designed for HCFA by the RAND Corporation, as recommended by MedPAC. The system is based on a patient classification system developed by researchers at the University of Pennsylvania. In its work for HCFA, RAND both evaluated this classification system and built upon it. The result is a well-developed system based on data from a large number of rehabilitation hospitals and units. We believe it accurately measures patients' needs for treatment and will fairly match Medicare payments to the relative needs for rehabilitation services—two critical steps HCFA's approach will not accomplish.

The system designed by RAND parallels the structure of the PPS used for general hospital care. Payment would be per-discharge and case mix groups would be determined by a combination of diagnosis, age, and functional abilities of the patient. These factors are the basis for a patient classification system know as FRGs.

The BBA requires that the Secretary set rates in the rehabilitation PPS to reduce total expenditures for inpatient rehabilitation services by 2% from what they would

have been in the absence of a PPS. Any such calculation is subject to misjudgments about volume of services, but a per-episode payment system is much more predictable than a per-diem system. The former is subject to changes in total patient volume. The latter is subject to this factor and the number of days of care provided on average, resulting in the increased expenditures noted above.

The system designed by RAND is a per-episode system. In its work for HCFA, RAND used 1994 data for over 90,000 Medicare patients. HCFA and RAND now have comparable data from 1997 for over 200,000 patients, and will soon have similar data for 1998. Further, patient classification and weights under the FRG system can be easily updated before the implementation date of October 1, 2000. Such data is available annually permitting regular review of payment classifications and weights.

Finally, adoption of the FRG system would allow assessment of the impact of the PPS on patient care and outcomes. There is data on outcomes—the functional improvement of patients—going back a decade or more. These data can be used to examine patient outcomes before and after introduction of a PPS. In fact, the payment system could even reward the achievement of superior results for patients. None of this is possible with RUGs, which throws out the window all of this historic data and starts over.

IV. CONCERNS ABOUT ALTERNATIVE APPROACH

AMRPA hopes the Department will implement the MedPAC recommendations. However, the Department's approach may not be fully clear until it publishes its methodology, which is not expected until December 1999. AMRPA has a number of concerns about potential adoption of a per-diem payment system based on a method of patient classification developed for assessing chronic care patients in nursing homes. It is called Resource Utilization Groups (RUGs). HCFA currently has a contract and RUGs are to be developed for rehabilitation using a one-time sample of staff time based on the treatment of some 4,000 Medicare patients. HCFA reportedly is planning to spend $1.7 million to do staff time measurement studies on only 4,000 patients and only five days of care to each patient. This is less than ° of 1% of the patients treated annually in rehabilitation hospitals and units. The 20,000 days to be studied amount to substantially less than 1% of the total days of service provided to Medicare patients annually.

HCFA says that it will call the groups developed from the study Rehab Resource Group version 2000 (R2G2). We are concerned that this very small sample will not capture data on many types of rehabilitation patients and, therefore, will produce patient categories that lump together patients with dissimilar needs. If used for PPS reimbursement purposes, the result would be to overpay for some types of patients and underpay for others.

Of equal significance, the RUGs scheme is designed to be used to measure services to chronic patients whose treatment needs are relatively static. It is not oriented to a dynamic treatment environment where the goal is restoring the patient's ability to function independently. Nor is it geared to assess the intensity of largely medical services—such as drugs, medical supplies and diagnostic services—which constitute a significant portion of treatment and cost in rehabilitation hospitals and units. While the STM study proposed may gather data on some of these sources, it will be highly limited and such data already exists.

It is impossible to predict which types of patients will be victimized by this process because the small sample to be used by HCFA makes this largely a matter of chance. Further, staff time measurements do not assess services the cost of which are not driven by staff time, such as drugs, medical supplies and diagnostic-radiology. The SNF PPS provides an average allowance for such costs (and which MedPAC also recommends be changed). Doing so in a rehab PPS will seriously distort payments, since such costs vary widely among rehab patients and on average account for 43% of ancillary costs. MedPAC's recent report examines many of the failings of the RUGs system, both as applied to skilled nursing facilities and, potentially, to rehabilitation providers.

Staff time measurement studies are expensive. Apart from the question of whether the methodology is sound, this means that samples will always be very small and sampling infrequent. Errors in case classifications and payment rates will not be quickly or easily corrected. Because Medicare patients constitute such large portions of the patient populations in rehabilitation facilities, treatment will inevitably follow the government's judgments of relative levels of services, producing problems of access and quality for many patients. Because we cannot know in advance the errors that will inevitably result from using a small sample, it can not be forecast which types of payment will be disadvantaged, only that some will be.

There is another problem with the RUGs methodology. In formulating payment rates, determination of the basic payment rate is critical. This involves determining the distribution of Medicare cases among whatever patient classifications are adopted. This cannot be done accurately if groups derived from the RUGs methodology are used as the basis for a rehab PPS, because the information needed to classify patients will not exist. RUGs are based on a data collection system not now in use in rehabilitation facilities, the MDS 2.0. HCFA is proposing a new data collection instrument in the rehab field, the Minimum Data Set—Post Acute Care (MDS-PAC). However, HCFA will have such data only on its very small sample. So, the distribution of cases among whatever categories are constructed will be largely guesswork. A 4,000 case sample can not be projected to the universe and there will be no other way to determine case distribution accurately. Accordingly, payment rates will be set based on a guess as to the distribution of cases. This means that payment rates will be either too high or too low.

A. Why is the RUGs approach for rehabilitation bad for Medicare patients?

RUGs is a per-diem system. If payment rates are too low because HCFA guesses wrong on the distribution of cases, then the overall quality of care will suffer. If payment rates are too low for some types of patients, either because the limited sample used is not representative, the patient categories are too broad (for the same reason) or some types of patients are not assessed at all, providers will be financially unable to provide the intensity of therapies and medical care needed by patients. The effects will be to reduce the quality of services to patients and over time to restrict access to care for patients for which payment is chronically deficient.

One of the great defects of the TEFRA system is that the system strongly encouraged providers to treat patients with lesser medical complications and functional impairments, and imposed a financial penalty for taking more disabled and medically complex patients. A primary goal of a PPS should be to match payment rates with varying treatment requirements so that there is no financial incentive to treat one type of patient over another.

Our fundamental argument with the alternative approach is that it will not accomplish this goal and would inevitably discriminate against some types of patients. This should not be allowed to happen.

B. Why is the RUGs approach bad for the Medicare Program?

The BBA requires that a PPS be developed with rates that will result in a 2% reduction in outlays from what would have been spent in the absence of a PPS. We do not quarrel with that requirement. We are not seeking additional funding. Based on data for FY 1997 it appears that this provision of the BBA will produce a budget for rehab PPS of about $4.4 billion. The issue is how to most effectively use this amount of money to obtain the best possible rehabilitation services for the approximately 325,000 Medicare patients admitted to rehabilitation hospitals each year.

Rehabilitation providers have been under a sort of per-episode payment system, namely, TEFRA limits, for 16 years. Such limits have encouraged reductions in lengths of stay. Average Medicare length of stay in rehabilitation hospitals and units has declined from about 22.6 days in 1988 to just over 16 days in 1997. A per-diem system would provide a huge incentive to reverse this trend. Based on 1997 data, a one-day increase in the average Medicare length of stay would, under a per-diem system, result in increased Medicare spending of about $240 million.

Rehabilitation is a process, and the determination as to when a patient is ready for discharge involves a number of variables, including the patient's physical and cognitive progress, his or her medical condition, the level of support in the home and the patient's attitude. These and other social and clinical factors are weighed by the attending physician and other members of a rehabilitation team in determining when discharge is appropriate. For over 15 years Medicare, through the TEFRA system, has encouraged shorter lengths of stay. A per-diem system would reverse course by providing payment for each additional day of service.

If a per-diem system would produce much higher Medicare outlays, why are we, as a representative of providers, advising you against it? The reason is because the BBA presumes that a rehab PPS will produce cost savings for the Hospital Insurance Trust Fund. Sharply higher payments under a per-diem PPS (due to longer lengths of stay) could only be offset through reductions in per-diem rates. The result would be a downward spiral where less service per day results in slower progress and longer stays. A per-episode payment system would be far more stable and predictable. Such a system would allow clinicians to determine the tradeoffs between length of stay and intensity of service per day within an overall payment per-episode, while also producing budgetary stability.

C. Why Are RUGs Bad For Providers of Services and Patients?

Rehabilitation facilities exist to meet the needs of their patients. A payment system that discriminates against certain types of patients poses a serious problem to ethical people in the business of providing good services and outcomes. Financial reality means that they can not treat large numbers of patients for whom the payment is inadequate. Matching services to an inadequate daily payment and keeping patients longer is a very poor substitute for providing the optimum level of services and the earliest possible discharge. Providers want to be able to deliver the care that is in keeping with maximum progress for patients. They do not want to try to operate under a system that will chronically frustrate achieving that goal. For all the above reasons, AMRPA urges the Department to adopt and implement the MedPAC recommendation for a discharged based rehabilitation prospective payment system, based on FIM-FRG.

V. CONCLUSION

AMRPA believes the future of rehabilitation access is at stake in the design and implementation of the rehab PPS. We, like MedPAC, think that the means are at hand to produce a sound, stable system that will provide open access to all types of patients and high quality of services to them. However, we urge the Committee to take limited legislative action.

To direct that HCFA adopt the RAND system as the basis for a rehabilitation PPS would require only two changes in the language of the BBA pertinent to this matter. First, the payment unit for a rehab PPS should be a discharge. Second, the factors used by the RAND patient classification system—impairment, age, co-morbidities, and functional capabilities of the patient—should be made mandatory and referenced explicitly.

Therefore, we recommend the Committee amend the BBA to direct the Secretary to develop a rehab PPS based on a per-discharge payment unit utilizing the function related groups and the other adjustments MedPAC recommends.

We thank the Committee for this opportunity to submit testimony. AMRPA looks forward to working with Congress and the Department as we face the future.

MARCH 1999

REPORT TO THE CONGRESS:

Medicare Payment Policy

MEDPAC Medicare Payment Advisory Commission

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RECOMMENDATIONS

The Secretary should:

5A Collect a core set of patient assessment information across all post-acute settings.

5B Establish quality monitoring systems for post-acute care as prospective payment systems are implemented.

5C Conduct a demonstration to assess the potential of the Functional Independence Measure–Function Related Groups classification system to predict the resource use of intensive rehabilitation patients in skilled nursing facilities.

5D Continue to refine the classification system used in the skilled nursing facility prospective payment system to improve its ability to predict the resources associated with nontherapy ancillary services.

5E Explore the potential for revising the rehabilitation groups of the classification system used in the skilled nursing facility prospective payment system to reduce reliance on measurements of rehabilitation time.

5F Develop a method for updating payment weights in the skilled nursing facility prospective payment system as soon as possible.

5G Identify any distortions in the base payment rates of the skilled nursing facility prospective payment system and explore options for correcting them as better data become available.

5H Develop ways to ensure skilled nursing facilities' accountability for accurately assessing patient needs and classifying them for payment purposes.

5I Develop a wage index based on skilled nursing facility wage data and use it to adjust payments for those facilities' services.

5J Develop a discharge-based prospective payment system for rehabilitation facility patients based on the Functional Independence Measure–Function Related Groups classification system. Policies to address transfers and short-stay outliers would be necessary components of such a system.

5L Require home health agencies to use consistent, service-specific codes on all patient bills for services provided during home health visits.

5O Evaluate all relevant case-mix and prospective payment methodologies for their utility in developing a prospective payment system for long-term hospitals.

The Congress should:

5K Establish in law clear eligibility and coverage guidelines for home health services.

5M Require independent assessments of need for beneficiaries receiving extensive home health services to ensure the appropriateness of such care. Beneficiaries receiving 60 or more home health visits should qualify for assessments. Assessors should confer with prescribing physicians to modify care plans are needed.

5N Require modest beneficiary cost-sharing for home health services, subject to an annual limit. Low-income beneficiaries should be exempt from cost-sharing.

STATEMENT OF THE CONSUMERS UNION

[SUBMITTED BY GAIL SHEARER, DIRECTOR, HEALTH POLICY ANALYSIS, WASHINGTON OFFICE]

INTRODUCTION

Consumers Union[1] has serious reservations about the premium support model and its ability achieve substantial cost savings and improve the ability of Medicare to meet beneficiaries' needs. Three areas of concern are described immediately below. Consumers Union's Medicare Reform Checklist follows, with brief comments on the extent to which the Breaux-Thomas proposal addresses our concerns.

INHERENT PROBLEM WITH THE "CHOICE" MODEL

Proponents of the premium support concept rarely (if ever) acknowledge that the traditional fee-for-service model of Medicare provides beneficiaries with more freedom of choice of doctor than any Medicare Health Maintenance Organization or Provider Sponsored Organization ever will. "Choice of health plan" is assumed to be a good thing, by supporters of the premium support model. We are concerned because along with "choice of health plan" come many things that are not good. Of course for many beneficiaries, the immediate result of choice is confusion, especially for those who are visually or cognitively impaired. Another major concern is that when benefits vary (and they would vary considerably under the Breaux-Thomas plan), beneficiaries' health status and needs will influence the selection they make. People at highest risk of needing prescription drugs are likely to seek a plan with this coverage. People at high risk are likely to seek lower deductible plans. The phenomenon of "adverse selection," in which benefits offered affect consumers attracted greatly complicates the design of this important program.

COVERAGE FOR PRESCRIPTION DRUGS AND A CAP ON OUT-OF-POCKET COSTS

The best way to avoid the problem of adverse selection, while assuring that everyone's needs are met, is to have a standard, comprehensive benefit package. Two of the early proponents of a carefully designed premium support model identified the need for a comprehensive, standard benefit package as a core ingredient.[2] A modernized Medicare benefits package—one that might well eliminate the need for medigap coverage—would include prescription drugs and a cap on out-of-pocket expenditures.

REDUCING THE RANKS OF THE UNINSURED

Congress has adopted an "incremental" strategy of health care reform, yet to date the nation seems to be moving further and further from health care coverage for all Americans.[3] Medicare reform at its best should move the nation in the direction of greater health care coverage. It could do this by creating new buy-in options (carefully designed to minimize adverse selection) for people aged 55 to 64, who are not yet eligible for Medicare coverage. It would be a serious mistake if Medicare "reform" increased the number of uninsured Americans by raising the age of eligibility for Medicare to 67, as considered by the Bipartisan Medicare Commission. Many 65 and 66 year-olds have existing health conditions. Many are forced out of the work force, often before they wish to retire. It is unfair to cast them into the ranks of the uninsured just when they are unable to afford to pay the full premium for health care coverage (even if they are lucky enough to find an insurer willing to cover them.)

For Medicare reform to work, it is crucial that Congress make it clear that any insurance companies and health plans wishing to participate must play by a fair set of rules and be accountable to the interest of the public. Medicare has succeeded for over 30 years in large part because of very low administrative costs. Congress should not discard Medicare's achievements without assuring that Medicare in the future will be able to achieve low administrative costs while meeting the needs of its beneficiaries. It is unclear to us that the expected efficiency gains will be sufficient to cover new private sector administrative costs, marketing costs, and profits. If they do not, we could find that the country faces even larger fiscal challenges in the future—at a time when even more special interests have a vested stake in the "reform" efforts. It is clear that a strong federal regulatory role will be needed to hold private health plans accountable.

MEDICARE REFORM CHECKLIST AND THE BREAUX-THOMAS PROPOSAL

The checklist below is a list of questions that are key to whether or not Medicare reform proposals advance the interests of consumers and the extent to which the Breaux-Thomas proposal addresses each particular concern.

1. Does the reform proposal provide relief for people in need of prescription drugs, including caps on out-of-pocket prescription drug costs?

The failure of Medicare to cover prescription drugs has been one of its most serious weaknesses. Medicare should be reformed so that prescription drugs are in reach of all Medicare beneficiaries. Co-payments should not be so high as to present financial barriers, and coverage should be deep, and should not be limited to first-dollar coverage (e.g., with a $500 cap on prescription drug benefits). The erosion of employer-based coverage for retirees, limited benefits available through medigap (in part because of adverse selection inherent in a voluntary benefit structure) argue for a universal (non means-tested, not voluntary) prescription drug benefit.

The Breaux-Thomas proposal does not at this point include a universal prescription drug benefits for Medicare beneficiaries. Senator Breaux has indicated an interest in including "some kind of subsidy for all beneficiaries," but has not put forth a universal proposal. He has expressed concern[4] about displacing coverage that exists today. However, it is very important to keep in mind that today's coverage for prescription drugs is inadequate. Employer-provided prescription drug coverage for retirees is decreasing. Medigap coverage is inadequate. Because prescription drug coverage in medigap is voluntary, adverse selection leads the people most likely to need it to buy plans with prescription drug coverage. The limits on coverage is very low, and the premiums very high. Clearly, a voluntary benefit, with "first dollar" (vs. catastrophic) coverage is simply not going to meet the needs of Medicare beneficiaries. Requiring medigap policies to cover prescription drugs is not the answer; doing so will drive up premiums and create an even larger population of seniors with Medicare coverage only (without medigap or Medicaid protection). Furthermore, the non-catastrophic coverage (like that available in certain medigap policies today) is inadequate.

2. Does the reform proposal cap beneficiaries' out-of-pocket costs, providing relief for those with the highest health care costs, i.e., the sickest?

Another serious benefit deficiency of Medicare is its failure to limit beneficiaries' out-of-pocket costs after maximums are reached. While medigap and Medicaid cover gaps for many, millions of moderate income Americans are at risk of devastating out-of-p ocket costs. A restructuring of benefits could provide stop-loss protection while eliminating the need for medigap coverage for some.

The Breaux-Thomas proposal does not assure that beneficiaries' out-of-pocket costs are capped though it is possible that some plans will offer such caps. Many seniors' out-of-pocket costs could increase since traditional Medicare benefits (with limits on cost-sharing) as defined in law today would not be guaranteed.

3. Does the reform proposal establish a framework (even if not fully funded at first) for addressing the growing problem of long-term care?

Nursing home care and home care for the disabled are extremely expensive and can quickly wipe out families' savings and create financial catastrophe for families. Private long-term care insurance will not be a practical solution for most families, who sim ply can not afford it. Recognition of the growing long-term care problem is the first step in addressing this problem, which will only grow worse over time as the population ages.

The Breaux-Thomas proposal does not establish a framework for meeting growing long-term care costs.

4. Does the reform proposal establish a framework, a beginning, for addressing the insurance needs of people who are 55-64, before they are eligible for Medicare, and begin to reduce the ranks of uninsured Americans?

Many people have existing health conditions by the time they reach 55, or develop them by the time they reach eligibility for Medicare at age 65. Ideally, Medicare coverage will be phased in to protect people in this age group (and even younger). If the age of eligibility for Medicare were increased, there would be growth in the number of uninsured Americans, as well as a missed opportunity for expanding insurance coverage for the near elderly.

Not only does the Breaux-Thomas proposal not establish a framework for addressing the insurance needs of people who are 55 to 64, but (as considered by the Commission) it would have increased the age of eligibility from 65 to 67, without providing a health insurance plan for people 55 to 67. Millions of people in this age brack-

et are likely to remain uninsured. Millions of people aged 65 and 66 could become uninsured. Since employed people (and spouses) 65 and 66 are now covered first by employer plans, savings (for the employed part of this age group) for the Medicare budget would be extremely modest. We are pleased that Senator Breaux and Congressman Thomas have withdrawn this provision of their initial premium support proposal.

5. Does the reform proposal put marketplace competition to work on behalf of consumers, or is marketplace competition likely to bolster profits of companies that don't best serve consumers' needs (e.g., by denying needed care, or avoiding enrolling the sickest consumers)?

Marketplace competition usually offers consumers substantial benefits such as increased choices, lower prices, and higher quality. This can only happen in the health care system if private companies are required to play by the rules established and enforced by the government. Unfortunately, when it comes to health insurance, often competition is among insurance companies who compete for the healthiest consumers and work hard to either deny coverage to the highest risks or charge them high premiums.

It is unclear to what degree market competition will benefit beneficiaries under the Breaux-Thomas proposal, and the proposal contains risks of destructive competition. Since there is not a standard benefit package, HMO's and insurance companies can compete by paring back benefits that may not be very visible. They will compete by seeking good health risks and rely on being a step ahead of the Medicare Board in assessing risks (and undermining risk adjustment). While the proposal includes subsidies that are adjusted by risk (helping to assure that the sickest will be able to get coverage), there are many questions about the authority of the Medicare Board, the benefit structures that will be offered, guarantees for the sickest, how the most vulnerable seniors (who are unable because of infirmity to comparison shop) will fare. It is unclear whether the benefits of market competition will be offset (or more than offset) by the administrative costs, marketing costs and profits that will eat into any savings. (Traditional Medicare has been able to achieve 2 to 3% administrative costs, much lower than that of private companies). To what extent will the "reformed" Medicare program be accountable to the public vs. the interests of the HMOs and insurance plans?

6. Does the proposal target relief to moderate income individuals and families—those whose income is too high to qualify for Medicaid yet too low to be able to afford medigap coverage?

It is these families that need the most help. They need protection against catastrophic costs. They need comprehensive prescription drug coverage. They need assistance with the high cost of long-term care.

The details provided so far do not allow firm conclusions about the impact of the Breaux-Thomas premium support plan on low-income and moderate income consumers. One of the examples used in the early discussions suggests that low income consumers might have to pay 10 percent of their premiums. Many low-income consumers face no premiums under today's Medicare system. It is possible that the burden on low-income beneficiaries could increase under the Breaux-Thomas reform plan.

7. Does the reform proposal tap financing sources that appropriately seek revenues from those people who are able to pay?

Medicare as a social insurance program—a universal program that pools risks broadly—can be preserved while at the same time charging more to those high income beneficiaries who can afford to pay more. (The overwhelming majority of Medicare beneficiaries have moderate incomes, so there is a limit to how much money can be raised from the well-off beneficiaries). It is fair to ask higher income individuals and families to pay more, but this added contribution should not be so onerous as to discourage participation in Medicare.

The Breaux-Thomas reform proposal calls on high-income consumers to pay higher premiums than lower income consumers do. Consumers Union supports higher premiums for higher income consumers. Senator Breaux suggests that higher income beneficiaries (with income at least five times the poverty level) should pay 25 percent of the average total Part A and Part B Medicare cost, and this seems a reasonable target. (Subsidies for low-income beneficiaries should continue to come from general Medicare revenues, which include a contribution from high-income Medicare beneficiaries.)

8. Does the reform proposal assure that Medicare is universal (for the covered age group) to help achieve the highest quality and highest level of political support?

The success of Medicare to date stems largely from the fact that it has been universal. Payments have been sufficient to encourage broad participation by providers. Quality of care has been high. If provider payments were cut too severely, participation and quality would erode. The well-to-do would have a strong incentive to drop out of Medicare. The political support for a program for all seniors and disabled would erode.

The Breaux-Thomas proposal preserves Medicare as a universal system for the covered group.

9. Does the reform proposal spread risks broadly?

Broad spreading of risks, coupled with universal participation, is the key to keeping average costs down. If the private sector were allowed to select the healthy, without a reduction in their payments, the solvency of the Medicare program would be severely threatened.

The ability of the Breaux-Thomas proposal to spread risks broadly is not entirely clear. To its credit, it calls for risk adjustment. It is not clear that the government will have the ability to do this accurately in the time frame needed to implement this proposal. There is a serious risk (depending for example on design details and accountability of the Medicare Board to the public) that HMOs and insurance plans will select lower risk beneficiaries (as Medicare HMOs have done) and that risk adjustment will not be adequate to compensate for this.

10. Does the reform proposal assure that beneficiaries have the freedom to choose their own doctor?

Freedom of choice of doctor allows consumers to exert some control over their health care destiny. This freedom is very important to many consumers, and has been one of the cornerstones of the Medicare program. Many consumers wish to maintain this freedom, even if it means higher costs for them.

Uncertainties of design and implementation of the Breaux-Thomas proposal make it impossible to predict whether beneficiaries will enjoy they level of freedom of choice of doctor that they now have under traditional Medicare. It is possible that traditional Medicare will be out of reach for many beneficiaries. The plan calls for choice for low-income consumers, but there are many uncertainties about how this will translate into choice of provider and choice of plan for beneficiaries.

ENDNOTES

[1] Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide consumers with information, education and counsel about good, services, health, and personal finance; and to initiate and cooperate with individual and group efforts to maintain and enhance the quality of life for consumers. Consumers Union's income is solely derived from the sale of Consumer Reports, its other publications and from noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, Consumer Reports with approximately 4.5 million paid circulation, regularly, carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

[2] Henry J. Aaron and Robert D. Reischauer, "The Medicare Reform Debate: What Is the Next Step?" Health Affairs, Winter 1995.

[3] For a discussion of principles that Consumers Union believes should be incorporated in incremental reform, see Blueprint for Fair Share Health Care: Incremental Steps Toward Universal Coverage, Consumers Union, May 24, 1999.

[4] See Testimony before the Senate Finance Committee, "Using the FEHBP Model to Reform Medicare," Senator John Breaux, May 26, 1999.

A COMPREHENSIVE REVIEW OF HOSPITAL FINANCES

IN THE AFTERMATH OF THE

BALANCED BUDGET ACT OF 1997

March 1999

ERNST & YOUNG LLP

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Table of Contents

Key Findings and Other Issues

The purpose of this document is to provide a comprehensive, accurate picture of the current and anticipated state of the hospital industry's financial health. Key findings of these analyses are highlighted below.

- ***Total hospital Medicare margins are expected to decline from 4.3 percent in FY 1997 to only 0.1 percent in FY 1999.*** These margins are projected to remain below 3 percent through FY 2002, the duration of the Balanced Budget Act (BBA) payment reduction provisions (see page 12).

- ***Total hospital margins are projected to decline 48 percent in just five years, from 6.9 percent in FY 1998 to 3.6 percent in FY 2002.*** While total hospital margins for all hospitals would have decreased even if the BBA had not been enacted, these margins are significantly smaller under the BBA and decrease at a much faster rate during the five-year period (see page 13).

- ***Total hospital margins for small, rural hospitals are expected to fall from 4.2 percent in FY 1998 to negative 5.6 percent by FY 2002, a decline of 233 percent*** (see page 14).

- ***Findings on hospital Medicare inpatient margins are consistent with MedPAC.*** While these findings—which revealed that hospital Medicare inpatient margins decreased from 16.9 percent in FY 1997 to 16.5 percent in FY 1998—are consistent with those of the Medicare Payment Advisory Commission (MedPAC), they represent only a portion of the overall fiscal picture for hospitals (see page 11).

- ***Hospital outpatient margins are already negative 17 percent in FY 1998, and are projected to get substantially worse, dropping to negative 27.8 percent by FY 2002.*** The BBA has significantly reduced outpatient payments, payments that were already inadequate. This analysis modeled the impact of the elimination of the formula-driven overpayment (FDO), but not the impact of the outpatient prospective payment system (PPS). The PPS would reduce margins another 3.8 percent, according to HCFA's impact analysis that was published in a September 1998 proposed rule. As outpatient revenues continue to increase as a portion of total hospital revenues, the impact of these negative margins will be even more injurious to hospitals (see page 15).

- ***The BBA's transfer payment policy reduces hospital inpatient payments by approximately two and a half times more than original estimates.*** The transfer policy reduced inpatient payments between $500 and $800 million in FY 1998, and by approximately $3 billion between FYs 1998 and 2002. The Congressional Budget Office (CBO) had estimated a $1.3 billion five-year budget impact when the BBA was enacted in 1997 (see page 16).

The magnitude of these reductions in margins and Medicare payments must be considered in light of two other significant outcomes attributable largely to the BBA:

- ***The CBO projects Medicare spending will be $191.5 billion lower than was anticipated when the BBA was enacted.*** Recent CBO spending estimates for Medicare project total spending to be $191.5 billion less than pre-BBA estimates for FYs 1998 through 2002. CBO's estimate of Medicare spending reductions at the time of BBA enactment was $103 billion (see page 6).

- ***BBA cuts have shaken confidence in the health care industry and have led to numerous downgrades in bond ratings for community hospitals.*** Many analysts are attributing much of the precipitous drop in health care bond ratings to the impact of the BBA. Lowered bond ratings ultimately impair a hospital's ability to access capital to finance technological and facility improvements which, in turn, negatively affect patient access to, and quality of, care (see page 19).

Introduction

There is a perception among some federal policymakers that the financial health of the nation's hospitals is strong. But how much of this is myth and how much is reality? The perception appears to be perpetuated mostly by the "inpatient Medicare margin" figure issued each year by MedPAC, a nonpartisan body that advises the Congress on Medicare payment policies. In the absence of any other credible and accepted measures, MedPAC's inpatient margin figure has become the dominant, if not exclusive, financial benchmark that Congress relies on when making payment policy decisions that affect hospitals.

In recent years, hospital Medicare inpatient margins have been reported to be strong. However, robust Medicare inpatient margins do not equate to strong overall financial health. In fact, other indicators of financial health, such as bond ratings, are declining, signaling a weakening of the industry's financial status.

This study was designed to assess the financial status of the hospital industry, taking into account the various environmental changes that are affecting hospital revenues. These changes include revenue streams that are eroding as managed care penetration increases, private payor revenue growth rates that are diminishing, and hospital revenues that are increasingly derived from other service lines. These expanded service lines—specifically outpatient and post acute care services—are experiencing large negative margins. In addition, the full impact of the BBA payment reductions has not yet been realized by providers.

The purpose of this work is to supplement the efforts of Congress, MedPAC, and others attempting to assess the financial status of hospitals. The various analyses serve to produce a complete and current picture of the industry's financial health and Medicare's contribution to hospitals' financial status by:

1. Projecting hospital Medicare inpatient margins using more current cost report data;

2. Projecting total Medicare margins, including margins for all service lines—e.g., outpatient, skilled nursing facility (SNF), and home health agency (HHA)—not just inpatient acute care; and

3. Assessing the impact of the BBA on total hospital margins through modeling of actual hospital cost report data.

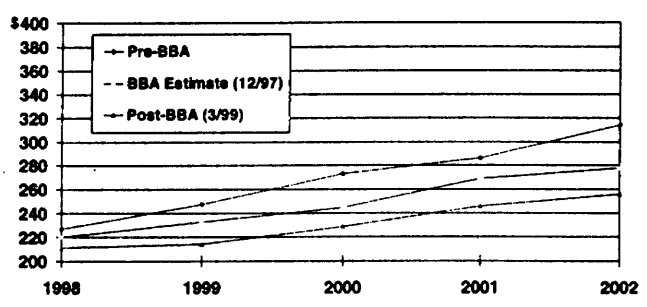
Congressional decisions that could ultimately determine the financial fate of community hospitals across the country should be made with a thorough understanding of hospitals' financial health.

A Snapshot of Today's Hospital Operating Environment: Impact of the BBA

The Medicare program is the largest public payor of health care services. According to Health Care Financing Administration (HCFA) projections, in 1998 the program spent $231.1 billion on health care for its 38.4 million enrollees. Of that, HCFA projects that $128.5 billion was spent on hospital care, $12.7 billion on SNF care, and another $13.8 billion on home health care.[1]

Provisions that reduced Medicare reimbursement for hospitals and other health care providers were a major part of the BBA. According to CBO scoring, at the time of its passage the BBA was projected to reduce Medicare spending by $103 billion through FY 2002; this included reductions in hospital payments which were then projected to save over $44 billion between FYs 1998 and 2002. However, the CBO's latest projections indicate that Medicare spending will be far below its original estimates. The CBO now projects that Medicare spending will be $191.5 billion lower than was anticipated when the BBA was enacted (see Figure 1 and Table 1)[2].

Figure 1. **Medicare Spending $88.5 Billion Less Than Projected (FYs 1998-02)**



Source: CBO, "An Analysis of the President's Budgetary Proposals for FY 2000," March 3, 1999; CBO, "Budgetary Implications of the BBA of 1997," December 1997.

Table 1. **Medicare Spending Projections Pre- and Post-BBA (in billions)**

	FY1998	FY1999	FY2000	FY2001	FY2002	Five-Year Difference
Pre-BBA spending	$227.0	$248.2	$273.0	$285.6	$313.7	--
Estimated spending reductions under BBA (12/97)	(6.9)	(15.5)	(27.6)	(17.1)	(35.9)	($103.0)
Estimated spending under BBA (12/97)	220.1	232.7	245.4	268.5	277.8	--
Revised estimated spending under BBA (3/99)	211.0	214.0	229.0	246.0	256.0	--
Additional spending reductions per revised estimate	(9.1)	(18.7)	(16.4)	(22.5)	(21.8)	(88.5)

Source: CBO, "An Analysis of the President's Budgetary Proposals for FY 2000: A Preliminary Report," March 3, 1999; CBO, "Budgetary Implications of the Balanced Budget Act of 1997," December 1997.

While MedPAC projects strong hospital inpatient margins for FYs 1997 through 1999, the true financial impact of the BBA on hospital Medicare margins will not be known until cost reports from FYs 1998—2002 are filed, audited, and analyzed. As reductions in Medicare payments take effect as a result of the BBA (see Table 2 for the estimated impacts of key provisions), margins are expected to fall, and more importantly, the percentage of facilities that lose money under the hospital PPS is also likely to increase.

In addition, for the growing number of hospitals that have developed integrated delivery systems that include post acute care services, the magnitude of the BBA's impact will be even greater. Many of the provisions in the BBA were designed to dramatically reduce Medicare payments to post acute care providers, specifically SNFs, HHAs, and rehabilitation and psychiatric units. At passage, the BBA was projected to reduce payments to these providers by nearly $30 billion over a five-year period (see Table 2). These payment reductions will be accomplished through: implementation of an interim payment system (IPS) for home care, which began in October 1997, and eventual implementation of a new PPS for HHAs; a new PPS for SNFs, which is being phased in over four years; and changes to the payment methodology for PPS-exempt services, including rehabilitation and psychiatric units.

Table 2. **Estimated Budgetary Effects of Key BBA Provisions (in billions of dollars)**

Provision	FY '98	FY '99	FY '00	FY '01	FY '02	FYs '98-'02
PPS Hospitals	$(1.3)	$(2.4)	$(3.6)	$(4.5)	$(5.3)	$(17.1)
Update Factor	(0.8)	(1.1)	(1.1)	(1.1)	(1.2)	(5.3)
Capital Payments	a	(0.1)	(0.1)	(0.2)	(0.2)	(0.6)
DSH Payments	0	(0.1)	(0.1)	(0.5)	(0.5)	(1.3)
Transfer Cases						
PPS-Exempt Hospitals	(0.3)	(0.6)	(0.7)	(0.8)	(0.9)	(3.5)
Operating Payments	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.5)
Capital Payments						
Post Acute Care	(0.1)	(1.3)	(2.1)	(2.7)	(3.3)	(9.5)
PPS for SNFs	(1.1)	(2.0)	(4.1)	(4.2)	(4.7)	(16.2)
Home Health PPS						

a Less than $50 million
Source: CBO, "Budgetary Implications of the Balanced Budget Act of 1997," December 1997.

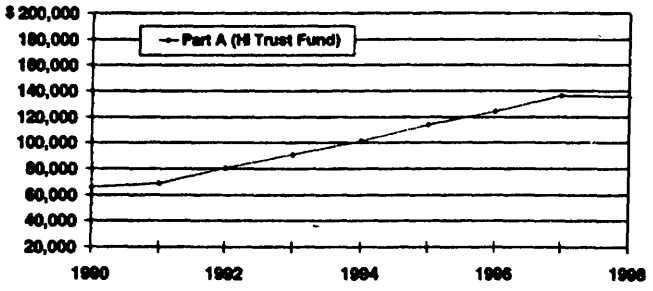
Another change the BBA imposed on hospitals is the expanded Medicare definition of a hospital transfer. The BBA expanded the definition so that acute care hospitals that discharge Medicare beneficiaries classified in one of 10 specified diagnosis-related groups (DRGs) are now paid primarily based on length of stay and no longer automatically receive the full DRG rate. Patients in these 10 DRGs tended to have a disproportionate use of post acute care services.

The CBO's original projections for the financial impact of the transfer payment policy on hospitals was a reduction in Medicare payments of $1.3 billion between FYs 1998 and 2002. Our projections estimate Medicare payment reductions of at least $3 billion between FYs 1998 and 2002 (this topic is discussed in more detail on page 16).

In response to these measures and others designed to reduce provider reimbursement, hospitals and health systems have taken aggressive steps to reduce their costs. Cost saving activities include: outsourcing many non-clinical support services such as housekeeping, food services, and groundskeeping; improving clinical efficiencies by adopting treatment protocols; redesigning work processes for more efficient use of staff resources; and adopting drug formularies. After nearly a decade of growth rates above six percent, for the past three years (1995–1997) hospitals have had little or no growth in total expenses per adjusted admission. In 1997, hospitals held these costs to a 0.6 percent increase.[3]

In addition, for the first time in history, Medicare Part A spending on hospitals actually went down, by 0.06 percent (see Figure 2 and Table 3) in FY 1998.

Figure 2. **Medicare Part A Spending First Reduction in Program History (FY 1998)**



Source: Administration's Proposed Budget of the United States Government, Fiscal Year 2000, January 1999.

Table 3. **Medicare Part A Spending on Hospitals (Fiscal Years)**

Part A	1990	1991	1992	1993	1994	1995	1996	1997	1998
Spending (millions)	$65,912	68,705	80,787	90,730	101,535	113,583	124,009	136,175	135,406
Change (percent)		4.2%	17.5	12.3	11.8	10.8	9.1	9.8	(0.06)

Source: Administration's Proposed Budget of the United States Government, Fiscal Year 2000, Table 11.3, Historical Tables, January 1999.

Once initial cost efficiencies have been achieved, however, hospitals may not be able to absorb additional cost cutting because of other cost pressures that they will be facing, including expenses associated with becoming Year 2000 compliant, rising pharmaceutical prices, and new technology. Furthermore, since labor costs account for more than half of hospital expenses, the slightest change in labor costs will have enormous implications. As the full impact of the BBA starts to take effect, many hospitals are already reporting large operating losses; in response, many hospitals are reluctantly taking aggressive and swift action by closing services, laying off staff, and cutting or freezing employee wages. These actions ultimately affect patient access to services, especially in rural areas, and could diminish the quality of care provided.

Current Picture of Hospitals' Financial Health Inadequate

MedPAC recently projected that Medicare hospital inpatient margins reached 16.1 percent in 1997, the highest level since the inception of the hospital PPS in 1984. According to MedPAC, the inpatient margin outlook for FYs 1998 and 1999, when the impact of the payment cuts enacted in the BBA begin to take effect, will remain strong at 15.9 percent and 15.7 percent, respectively. While the Medicare inpatient margin is an important indicator of hospitals' financial health, it does not adequately represent the overall financial picture, for a number of reasons. Key among them:

Hospitals are not simply stand-alone providers of inpatient acute care services. Today, most hospitals are integrated systems of care; these systems include, at a minimum, outpatient services, and may also include post acute care services. Thus, looking at strictly the hospital inpatient Medicare margin distorts the representation of the overall financial health of hospitals. Margins that compare revenues and expenses of all hospital services for Medicare and all payors (i.e., total Medicare and total hospital margins) present a more complete picture of hospital finances for consideration in a federal policymaking context.

Data used do not reflect the impact of the BBA. Data from the 1996 and partial-year 1997 cost reports used by MedPAC do not reflect the impact of the payment reductions mandated by the BBA, which only began to take effect in October 1997. In fact, only about 10 percent of the expected impact of BBA changes will show up in FY 1998 cost reports; most BBA changes were "backloaded" and payment reductions will grow through the year 2002 (see Table 2).

Not all BBA provisions were included in the calculations. While MedPAC made its best effort to model the payment policies contained in the BBA (e.g., reductions in the annual Medicare inflation update), it did not attempt to model other key policies such as the transfer provision, which is projected to reduce hospital revenue much more than the CBO's initial estimate.

Results of Analyses: Overall Financial Health of Hospitals Is Eroding

The primary differences in this study when compared to MedPAC's methodology include: (1) FY 1998 data were used, when appropriate, so that at least part of the BBA impact on margins would be reflected in the results; (2) total hospital margins were determined based on all lines of business (e.g., outpatient, SNF, HHA); and (3) the impact of many more of the BBA provisions were included in the analyses (e.g., outpatient PPS, transfer payment, SNF PPS, and HHA IPS/PPS).

The results of the analyses discussed in this section all indicate that hospitals' financial health is indeed deteriorating. In particular, the research found that all Medicare margins (i.e., inpatient, total, and outpatient) are decreasing and that Medicare payments are dropping precipitously.

Hospital Inpatient Margins Declining: Results of Replicating MedPAC's Methodology With Newer Data

MedPAC (and its predecessor, the Prospective Payment Assessment Commission—ProPAC) has been projecting hospital Medicare inpatient margins under the hospital PPS for more than a decade. Rather than create a new methodology for this analysis, MedPAC's methodology was obtained and utilized. While MedPAC used data from FY 1996 and partial-year FY 1997 cost reports for its projections, cost report data from a sample of hospitals for FY 1997 and partial-year FY 1998 were used in this analysis. Hospital Medicare inpatient margins were projected using the more recent data so that some of the BBA impact would be reflected in the results. Since the purpose of this analysis was solely to replicate MedPAC's methodology using more recent data to compare results, no projections were made regarding the inpatient margins for FYs 1999—2002. (See Appendix A for a description of the methodology, database, and hospital sample used in this analysis.)

These results project that hospital inpatient Medicare margins will decline between FYs 1997 and 1998. The inpatient Medicare margin was determined to be 16.9 percent in FY 1997 and 16.5 percent in FY 1998[1]. The study's margins appear to corroborate MedPAC's inpatient margin projections for FYs 1997 and 1998.

Inpatient margins that were increasing pre-BBA may have been illusory

One factor that may have contributed to the illusion of increasing inpatient margins pre-BBA is the effect expanded service lines have had on the allocation of fixed costs. As pointed out earlier, many hospitals have diversified into other service lines, including

[1]These results are based on a reweighting of the sample to reflect national norms. Using raw data, the overall Medicare inpatient margin dropped from 17.9 percent to 17.6 percent between FYs 1997 and 1998.

outpatient, and possibly SNF and/or home health services. These additional services cause fixed costs to be spread over not only inpatient care, but the other service lines as well. Spreading them over all service lines results in what looks like, on paper, a financial benefit to the inpatient margin. Stated another way, with revenue held constant, a hospital's inpatient margin seems to improve simply because a smaller amount of fixed costs are allocated to inpatient services.

Total Hospital Medicare Margins Become Virtually Nonexistent Under BBA: Results of Analysis of BBA Impact on Total Medicare Margins

This analysis was designed to determine the total hospital Medicare margins, not just inpatient Medicare margins, when the impact of the BBA is accounted for. MedPAC has provided Congress with projections of hospital inpatient Medicare margins that reflect some portion of the impact of some of the BBA's provisions, and has also provided historical data on total hospital Medicare margins. However, no projections of total hospital Medicare margins that reflect the full impact of the BBA provisions have been developed for use by policymakers.

This analysis focused on projecting total hospital Medicare margins using FY 1996 as the base year; cost-to-payment ratios for FY 1996 were the most recent available from MedPAC. The projections used assumptions developed by HCFA's Office of the Actuary (OACT). (Appendix B provides a complete discussion of the methodology and data used for this analysis.) It was important to look at the impact of the BBA on total hospital Medicare margins for two reasons: (1) the BBA significantly reduced Medicare payments for hospitals and other health care providers, and (2) many hospitals now operate as integrated health systems with distinct components whose financial health are interdependent and contribute to the overall system's financial status.

Table 4 below displays the Medicare hospital-based margins resulting from the payment (Table B-1) and cost projections (Table B-2) in Appendix B. The projections show that Medicare hospital-based payment margins increased from 2.3 percent in FY 1996 to 4.3 percent in FY 1997 (the year before the BBA had an impact), and then they begin to decrease as the BBA takes effect. Payment margins fall to 1.7 percent in FY 1998 and then become negligible, reaching a low of 0.1 percent in FY 1999; in FY 2000 they begin to slowly rise, from 1.0 percent to 2.6 percent in FY 2002. OACT's baseline projections assumed current law with no further reductions in payments to hospitals. Margin rises in the outyears are attributable, in part, to a less severe reduction in the PPS update factor (which sunsets in FY 2002) and to other OACT assumptions, such as coding increases.

Table 4. **Medicare Hospital-Based Costs, Revenues, and Margins (billions)***

	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002
Hospital-based Costs ($)	$107.3	$110.1	$111.6	$113.2	$111.5	$114.3	$119.2
Hospital-based Payments ($)	109.8	115.1	113.6	113.3	112.6	115.6	122.4
Medicare Payment Margins ($)	2.6	5.0	2.0	0.1	1.1	1.3	3.1
Medicare Payment Margins (%)	2.3	4.3	1.7	0.1	1.0	1.1	2.6

*Assumes cost increases of market basket (MB) minus 1%
Source: Ernst & Young analysis using OACT and MedPAC data, 1999.

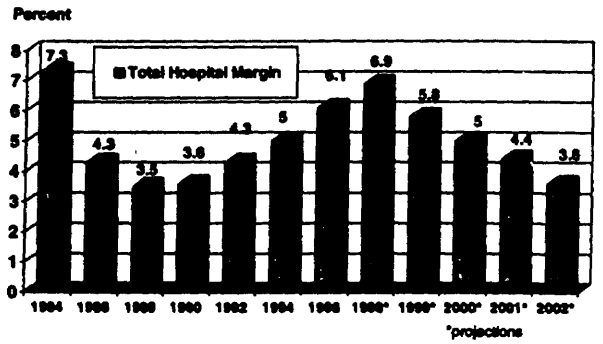
Total Hospital Margins Significantly Smaller Under BBA: Results of Using Current Data to Project BBA Impact

This analysis was designed to model the impact of the BBA on Medicare revenues and total hospital margins using the data available from a sample of FY 1997 hospital cost reports. FY 1997 data were used to ensure that the baseline data would not reflect any impact of the BBA. (See Appendix C for a description of the methodology and data used for this analysis.)

- **Impact on Total Hospital Margins**

This analysis included the impact of the outpatient PPS and transfer payment provisions on total hospital margins. Historically, total hospital margins were at their highest in 1984 at 7.3 percent, and had been rapidly declining when they bottomed out at 3.5 percent in 1988. However, since 1989, total hospital margins have slowly been on the rise, reaching an estimated 6.4 percent in 1997 (see Figure 3).

Figure 3. **Total Hospital Margins (Actual and Projected)**



Sources: MedPAC, Report to the Congress, March 1999, Figure 3-4, p. 55 (historical margins for FYs 1984-1996); Ernst & Young analysis, projections for FYs 1998-2002.

The results of this analysis (summarized in Table 5) indicate that while total margins for all hospitals would have decreased even if the BBA had not been enacted, total hospital margins are significantly smaller under the BBA and decrease at a much faster rate between FYs 1998 and 2002. Pre-BBA total hospital margins are projected to drop from 8.2 percent in FY 1998 to 7.7 percent in FY 2002. Post-BBA, however, total margins are projected to be 6.9 percent in FY 1998 and by FY 2002 decline to 3.6 percent, a decrease of 48 percent. The projected total hospital margin of 3.6 percent in FY 2002 nears the all-time low of 3.5 percent in 1988.

While total hospital margins would have decreased even without the BBA, they are significantly smaller under BBA and experience a 48 percent drop during the five-year period, nearing the all-time low.

When stratified by bed size, the results indicate that the total margins for small hospitals with 99 beds or less, which are predominantly rural, are hardest hit by changes under the BBA. Their margins significantly decrease from 4.2 percent in FY 1998 to negative 5.6 percent in FY 2002, a decrease of 233 percent.

Table 5. **Total Hospital Margins (With Expenses Increasing at MB -1%)**

	FY'98	FY'99	FY'00	FY'01	FY'02
All Hospitals					
Pre-BBA	8.2%	8.2%	8.1%	8.0%	7.7%
Post-BBA	6.9	5.8	5.0	4.4	3.6
Bed Size					
Pre-BBA					
0-99	5.1%	4.8%	2.9%	0.7%	(2.0)%
100-199	9.4	9.4	8.3	7.2	6.0
200-299	11.1	11.2	11.3	11.5	11.6
300-499	7.4	7.5	7.6	7.7	7.9
500+	7.6	7.6	7.7	7.8	7.8
Post-BBA					
0-99	4.2%	2.5%	0.2%	(2.4)%	(5.6)%
100-199	8.5	7.2	5.6	4.1	2.4
200-299	10.2	9.0	8.7	8.4	8.1
300-499	6.5	5.4	5.0	4.6	4.3
500+	6.9	6.0	5.6	5.2	4.9

Source: Ernst & Young analysis, 1999.

Finally, the study examined how many hospitals would experience a negative total hospital margin (with expenses increasing at MB -1 percent) under the BBA. Before the BBA, 22 percent of hospitals (75 hospitals) in the sample had negative total hospital margins; after the BBA (between FYs 1998 and 2000), 34 percent of hospitals (116 hospitals) are projected to have negative margins—a 55 percent increase in the number of hospitals with negative margins.

Hospitals with less than 100 beds are hardest hit by the BBA: their margins significantly decrease from positive 4.2 percent in FY 1998 to negative 5.6 percent in FY 2002, a drop of 233 percent.

- **Impact on Outpatient Margins**

These results indicate that, even without the BBA, all hospitals were already losing money on the provision of outpatient services. However, after implementation of the BBA, the negative outpatient margins are projected to get substantially worse (see Table 6). Pre-BBA, in FY 1998, margins were anticipated to be negative 11.4 percent, declining to negative 18.7 percent in FY 2002. However, post-BBA, the outpatient margins are projected to become even worse, starting at negative 17 percent in FY 1998 and dropping precipitously to negative 27.8 percent in FY 2002. It should be noted that this portion of the analysis only included the impact of the elimination of the outpatient FDO, and does not account for the impact of the outpatient PPS, which HCFA has estimated will result in an additional 3.8 percent reduction in payments.[4]

As hospital outpatient revenue continues to grow as a share of total hospital revenues (outpatient revenues increased from 14 percent of hospital revenues in 1984 to 32 percent in 1997), losses like these will dramatically affect the overall financial health of hospitals.

***Table 6.* Medicare Outpatient Profit Margins (Expenses Increasing at MB –1%)**

	FY '98	FY '99	FY '00	FY '01	FY '02
All Hospitals					
Pre-BBA	(11.4)%	(13.0)%	(14.7)%	(16.6)%	(18.7)%
Post-BBA	(17.0)	(21.7)	(23.5)	(25.6)	(27.8)

Source: Ernst & Young analysis, 1999.

• Impact on Medicare Payments

The results of this analysis projected that enactment of the BBA will significantly reduce Medicare payments each year between FYs 1998 and 2002 (the analysis excluded the impact of outpatient PPS, discussed above, and the transfer payment methodology changes, which are discussed in a subsequent section). In FY 1998, Medicare payments to all hospitals are projected to decrease by 3.0 percent as compared to baseline[ii] (see Table 7); by FY 2002, there will be an estimated 11.1 percent reduction in payments. (See Appendix C, Table C-2, for estimated line-item impacts for select years.)

***Table 7.* Reduction in Medicare Payments (compared to FY 1997 baseline)**

All Hospitals	FY'98	FY'99	FY'00	FY'01	FY'02
Percent Reduction	(3.0)%	(6.8)%	(8.5)%	(9.9)%	(11.1)%

Source: Ernst & Young analysis, 1999.

• Impact of the Transfer Payment Policy

The transfer provision is a costly one for hospitals and health systems. In the past, Medicare considered patients to be discharged from an acute care hospital when they were sent to a rehabilitation hospital/unit, SNF, or home to receive care from a HHA. For a discharge, acute care hospitals are paid the full Medicare DRG rate, regardless of the patient's length of stay.

Since October 1, 1998, "qualified discharges"—those involving one of 10 specified DRGs (i.e., 14, 113, 209, 210, 211, 236, 263, 264, 429, and 483)—to a post acute care provider (i.e., PPS-exempt hospital/distinct part unit, SNF, or HHA within three days of discharge from the hospital) are treated as transfer cases. In these cases, the hospital forfeits part of the DRG payment if a patient's stay is shorter than the average length of stay for that condition. For DRGs 209, 210, and 211, HCFA pays transferring hospitals 50 percent of the DRG payment for the first day of stay plus 50 percent of the amount

[ii] Baseline is defined, for purposes of this analysis, as payments per a given year had BBA not been enacted.

which would be paid under the per diem methodology. The transfer policy does not affect the post acute care provider's payment.

Payments for cases with shorter than average stays (and, in general, corresponding lower costs) help defray the costs of caring for patients with longer-than-average stays (and corresponding higher costs). This rule of averaging is one of the fundamental principles upon which the PPS is built. However, under the new transfer definition, Medicare pays less for the shorter stays but does not increase payments for longer-stay patients.

This analysis used FY 1997 data for 5,244 hospitals obtained from HCFA's MedPAR file. Because of the way HCFA classifies its discharge codes, two analyses were conducted to ensure that all discharges to providers affected by this provision were appropriately captured. The first analysis determined the revenue impact taking into account only transfers to SNFs and HHAs, while the second analysis determined the revenue impact of transfers involving SNFs, HHAs, and HCFA's "other" category (which includes inpatient rehabilitation and psychiatric facilities, and other types of providers).

Results of the first analysis projected a 0.6 percent reduction in Medicare revenues for transfers to SNFs and HHAs (see Table 8a). Results of the second analysis involving all "other" providers projected a 0.98 percent reduction in Medicare revenues (see Table 8b).

Table 8a. **Projected One-Year Impact of Transfers to SNFs and HHAs Only**

DRG	Count	Reimbursement Decrease	
		Dollars	Percent
14	130,270	$ 58,767,780	0.07%
113	22,155	61,252,217	0.07
209	168,053	102,597,363	0.13
210	82,541	51,329,014	0.06
211	13,492	4,143,542	0.01
236	24,762	6,711,007	0.01
263	14,119	28,520,376	0.03
264	1,376	1,097,673	0.00
429	28,623	8,734,058	0.01
483	11,468	171,565,098	0.21
Total	496,859	$494,718,128	0.60%

Table 8b. **Projected One-Year Impact of Transfers to SNFs, HHAs, and All Other Providers**

DRG	Count	Reimbursement Decrease	
		Dollars	Percent
14	196,022	$ 93,170,862	0.11%
113	32,479	87,075,276	0.11
209	253,212	173,061,444	0.21
210	113,904	70,583,500	0.09
211	19,070	5,923,960	0.01
236	31,504	9,310,939	0.01
263	16,532	33,371,045	0.04
264	1,560	1,213,653	0.00
429	43,877	12,979,059	0.02
483	20,082	313,976,518	0.38
Total	730,242	$800,686,256	0.98%

Source: HCIA analysis, 1999.

Therefore, the projected impact likely falls somewhere in between 0.6 and 0.98 percent, since HCFA's "other" category may include providers not affected by the transfer provision. This would result in an estimated reduction in Medicare revenues of between $494.7 million and $800.7 million in one year due to this policy change, and at least a $3 billion impact over five years—much greater than the $1.3 billion reduction predicted by the CBO.

The transfer payment policy is projected to have a much greater impact than the CBO's estimates, reducing Medicare payments by at least $3 billion between FYs 1998 and 2002.

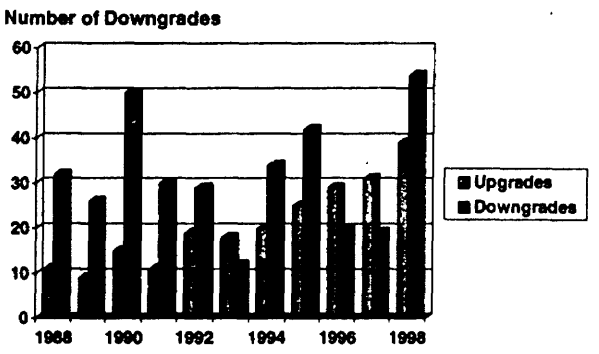
Other Factors to Consider

Financial Markets Losing Confidence in Health Care Industry Due to BBA Impact

Bond ratings have value as one barometer of fiscal viability. Judging an organization's financial viability is a complex task and no single factor is applicable to every hospital in the country. Hospitals are assuming greater levels of risk; pressures from managed care and private-sector purchasers have increased economic risk for providers. Pressures from managed care have also increased competition in many markets. In response, the financial markets have required increasingly stronger performance levels for organizations to be deemed credit-worthy.

Moody's Investors Service has noted in a February 1999 report that the BBA has negatively affected the credit health of not-for-profit hospitals and health systems in 1998, and that it expects that the sector's high ratings volatility and deteriorating credit quality will continue throughout 1999 and beyond. In fact, 1998 was the first year that Moody's noted significant credit difficulties for the best-performing hospitals (i.e., Aa-rated hospitals). The number of overall downgrades surged in 1998 (see Figure 4) as the impact of the BBA began to take effect, and the outlook for the hospital sector was lowered for 1999, with analysts expecting further credit deterioration.

Figure 4. **More Bond Rating Downgrades**



Source: Moody's Investors Service, "U.S. Not-for-Profit Healthcare: Ratings Volatility Ahead for 1999 and Beyond," February 1999.

According to Moody's, over the past several years, exceptional returns from the stock market and a strong economy have protected not-for-profit hospital financial profiles from further downgrades. However, Moody's does not foresee that current investment

returns will be sustained in the future. A possible market decline will have a more pronounced impact on hospital financial performance, and will have a detrimental impact on not-for-profit hospitals, which will have lower returns on their investments in equity markets.[5] As credit ratings decline, the cost of capital increases—a spiral affect that will put additional pressure on hospital operating margins.

If hospitals cannot absorb additional cuts in Medicare reimbursement or continue to cut costs, this will further erode already declining bond ratings and, as a result, impede their ability to access capital. This domino effect would be especially damaging to the health care community, since hospitals are highly invested in capital and assets. If hospitals cannot finance improvements in their infrastructure and technology, this will clearly have a detrimental impact on their ability to provide quality patient care and may force them to limit availability or altogether close some crucial services. Thus, it is imperative that hospitals maintain higher margins than other sectors so that they are able to access financing.

Bond ratings have dropped precipitously, in large part due to the impact of the BBA on hospitals and health systems. A ratings drop increases the cost of capital, which exacerbates the BBA's impact.

Conclusion

The results of these analyses demonstrate that overall hospital financial performance is eroding as a direct result of the BBA provisions. The research indicates that, as a result of the BBA, Medicare inpatient margins are declining, and all other hospital margins considered by this study (i.e., total Medicare, total hospital, and outpatient) are expected to experience significant declines during FYs 1998—2002, with some margins even becoming extremely negative. Given these poor margins, it is unlikely that most hospitals will be able to reasonably absorb additional Medicare cuts or extensions of key BBA payment reduction provisions.

In addition to the payment reductions that are occurring as a result of the BBA, the Administration has proposed additional measures to reduce Medicare payments to providers in FY 2000. Included in that package is a proposal to freeze Medicare hospital inpatient payment rates, which would cut $650 million in FY 2000 and $3.9 billion over the course of five years. If Congress follows through on the President's proposal to freeze the hospital update, it would be the second time in the past three years that hospitals have experienced no annual increase in their Medicare inpatient payments. There is also discussion about extending the BBA provisions for an additional two years.

Hospital and health systems also face increased pressures as a result of managed care growth and capitation, Year 2000 compliance issues, and increased competition. The convergence of all of these pressures and others has resulted in many hospitals experiencing weakened financial and credit health in 1998, which makes them less attractive to potential lenders.

Serious consideration needs to be given to all of the factors that impact upon the industry's operating environment and fiscal status. In fact, before making any further payment policy decisions affecting acute care hospitals, Congress should assess the impact of the myriad of changes enacted in the last two years under the BBA and consider other important indicators of hospitals' financial health in addition to Medicare inpatient margins.

Decisions that affect the financial health of the nation's hospitals directly and indirectly impact the health of the communities they serve. If hospitals cannot maintain fiscal soundness under the BBA, their ability to access the capital they need to make improvements to infrastructure and technology will be severely impeded.

Appendix A
Hospital Medicare Inpatient Margin Analysis

The Methodology

This analysis was a collaborative effort between Ernst & Young and HCIA.[iii] Data from FY 1997 and partial-year FY 1998 cost reports of 487 geographically-dispersed hospitals were used in this analysis; MedPAC's analysis used FY 1996 and partial-year FY 1997 cost reports.

Based on the methodology provided by MedPAC, a template was developed which allowed for the replication of MedPAC's analytic technique using more recent data (provided by HCIA) than were available through the HCFA's Public Use Files (PUFs). (PUFs are downloadable files available on HCFA's Web site that contain various types of information and data on providers that are paid by Medicare.) Some files also include data used to develop provider payment rates and cost limits.

Provider Database Description

HCIA's hospital database contains more than 800 data elements for over 6,000 U.S. hospitals. Virtually every general acute care hospital with 25 or more beds in service is included in the database, as well as all hospitals with bonds rated by Standard & Poor. The primary source of these data is the Medicare cost reports filed by the general acute care hospitals in the U.S. that participate in the Medicare program. Required by HCFA to participate in Medicare, hospitals must complete one each year. The cost report information promotes comparability and consistency among hospitals in reporting. In addition to including balance sheet and income statement information, the Medicare cost report contains detailed data on staffing, facility characteristics, hospital utilization, patient mix, overhead structure, detailed cost and charge data, production costs, and pricing strategies.

As allowed by the Freedom of Information Act (FOIA), HCIA obtains copies of these cost reports. Selected data elements are extracted from the cost report and entered into the database. The data are then checked for accuracy and consistency before being made available for general use. The cost report data are from unaudited hospital submissions, some of which are incomplete. Hospitals that are members of multi-hospital systems may provide individual-level cost and charge data but report financial and balance sheet data for the combined multi-hospital group rather than the individual hospital. HCIA further enhances the comprehensiveness of the cost report database by adding its own information on hospital location, system affiliation, teaching status, case mix, bond rating, and market-area demographics.

[iii] Pace Management Services, Salt Lake City, Utah, provided assistance with this analysis.

The Sample

The sampling strategy bypassed the traditional flow of data, whereby the hospital submits data to its intermediary, which then submits it to HCFA. Instead, HCIA obtained electronic cost reports (ECRs) directly from the intermediaries and obtained sets of ECRs directly from some proprietary hospitals on an "as filed" basis. As a result, the raw data sample was somewhat over-weighted with investor-owned hospitals. However, the data were reweighted to reflect the national distribution of hospitals so that these results accurately depicted what was happening to hospital Medicare inpatient margins.

It was impossible, under the circumstances, to fully replicate whatever editing and quality assurance testing is done to the data by the intermediaries and HCFA. HCIA, however, conducted its own quality assurance testing and is not aware of any reason to believe that the data are biased. In addition, based on discussions with MedPAC staff there is no reason to believe that using as-filed or ECRs obtained from the intermediary should cause systematic bias.

The sample used in this analysis consisted of 487 hospitals. A total of 675 hospital data records were provided by HCIA, however, nearly 200 of the records were eliminated if the hospitals fell into any of the following categories:

- PPS-exempt
- No Medicare cases
- No case mix
- Data were missing that were needed to compute PPS operating, Medicare inpatient, and total margins (for FYs 1997 and 1998)

To replicate the "peer grouping" (i.e., bed size, urban/rural, etc.) used by MedPAC, at MedPAC's advice, the 487 hospital HCIA sample was compared with the contents of the PPS payment impact file available on HCFA's Web site—a file containing descriptive data on 5,070 hospitals. As shown in Table A-1, the sample of 487 hospitals represents less than 10 percent of the hospitals contained in the HCFA file. In terms of peer groups based on bed ranges, the sample matches the national distribution almost exactly. The HCIA data are less representative when split by region. The sample under-represents the East North Central, the Middle Atlantic, and New England, while over-weighting the East South Central and Mountain regions.

The sample is about five percentage points more rural (and five points less urban) than the nation. Because of the cost reports obtained, proprietary hospitals represented 24 percent of the sample versus 14 percent nationally. However, there was no significant difference in our results when the data were reweighted to reflect national norms.

Table A-1. **Hospital Distributions (Aggregate and Peer Groups)**

Hospital Categories	HCFA Web Site		HCIA Sample	
	National Count	Percent of Total	Sample Count	Percent of Total
All Hospitals	*5,070*	*100%*	*497*	*100%*
Bed Size				
0-99	2,525	50%	246	51%
100-199	1,270	25	125	26
200-299	639	13	62	13
300-499	481	9	43	9
500+	155	3	11	2
Region				
East North Central	761	15%	38	8%
East South Central	432	9	74	15
Middle Atlantic	504	10	7	1
Mountain	353	7	55	11
New England	206	4	4	1
Pacific	609	12	64	13
South Atlantic	751	15	74	15
West North Central	699	14	87	18
West South Central	702	14	81	17
Puerto Rico	53	1	3	1
Urban/Rural				
Rural	2,852	56%	248	61%
Urban	2,218	44	239	39
Ownership				
Proprietary	710*	14%	119	24%
Voluntary	2,991*	59	227	47
Government	1,369*	27	141	29
Teaching Status				
Major	295	6%	18	4%
Other	476	9	35	7
Non-teaching	4,299	85	434	89

*These data were not available on the HCFA Web site. Based on *Federal Register* data in the July 31, 1998 edition (Table 4, pp. 41116-17), these numbers were determined based on percentages provided in that table of the *Federal Register*.

Appendix B
Analysis of Total Hospital Medicare Margins

The Methodology

This analysis used data available from the government rather than hospital cost report data. To project total hospital Medicare margins, projected hospital Medicare costs and projected hospital Medicare payments are compared. In order to ensure that these projections are objective and credible, the hospital Medicare payments projected by HCFA's OACT were used.

Since hospital Medicare cost data were not available, in the interest of time, these numbers were derived using MedPAC's hospital payment-to-cost ratio for FY 1996. The volume increases and increases in the hospital input price index (also referred to as the market basket, or MB) which were assumed by OACT in making the payment projections were used to project total hospital Medicare costs.

Hospital Medicare unit costs are projected to increase at MB –1% (the same rate of increase used by MedPAC in its analyses) using the same input price indices and volume increases as those underlying the OACT projections. Thus, OACT assumptions for price and volume growth were used for the projections of both hospital costs and hospital Medicare payments.

Because hospital medical costs for the base year were derived using MedPAC's payment-to-cost ratio, FY 1996 was used as the base year, the same (and most current) base year as that used by MedPAC. Hospital medical costs were derived using MedPAC's most recent estimate of the Medicare hospital payment-to-cost ratio for 1996 of 102.4 percent.[6] This payment-to-cost ratio was derived by MedPAC using inpatient and outpatient data only. A small inconsistency results from assuming this same figure applies to all hospital-based revenues, including SNF and HHA. However, since SNF and HHA payments account for a small portion of hospital payments, the resulting error is small, and should result in an overstatement of total hospital Medicare margins. Since Medicare payments were $109.8 billion, costs were estimated at $107.3 billion and the total hospital Medicare margin at 2.3 percent in FY 1996.

Table B-1 displays projections of hospital-based Medicare payments, including payments to hospitals for inpatient, outpatient, SNF, and HHA services. The figures in the table were all derived from projections developed by OACT. Since OACT does not project hospital-based SNF and HHA payments separately from all SNF and HHA payments, these figures were derived by applying percentages published by MedPAC.[7]

Table B-2 displays the increases in volume, input price indices, and total cost increases for each of the four components of Medicare hospital costs projected. This analysis assumed cost increases to be one percent less than the input price index to replicate MedPAC's use of MB –1 percent.

MedPAC's use of MB –1 percent reflects the Commission's assumption that improvements in hospital productivity could result in actual unit cost increases being one percentage point lower than the increase in the input price index. However, based on the history of hospital cost increases published in MedPAC's Data Book, it is questionable whether productivity gains of that magnitude can continue to be achieved by hospitals during the next few years. Typically, productivity gains do not occur at a steady rate, but occur in surges followed by periods of retrenchment. The historical data provided by MedPAC indicates that hospitals reduced Medicare inpatient PPS operating costs per case continuously from 1993 to 1997, and have actually reduced nominal cost per case by nearly 3.5 percent. This translates into a real reduction of nearly 13 percent during the same period of time. This period of intense productivity growth makes it that much more difficult for hospitals to achieve productivity gains in the near future.

***Table B-1.* Hospital-Based Medicare Payments**

Fiscal Year	Inpatient	Outpatient	SNF	HHA	Total Hospital-Based Revenues
1997	88,956	17,174	2,267	6,692	115,089
1999	85,918	18,169	2,608	6,651	113,346
2001	85,284	20,941	2,543	6,795	115,563

Source: E&Y analysis of OACT, 1999 projections; MedPAC, July 1998.

Table B-2. **Volume, Input Price Indices, and Cost Increases**

	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Inpatient										
Admissions Increase	1.019	0.998	0.980	0.957	0.999	1.017	1.010	1.010	1.012	1.014
Input Price Index Increase	1.020	1.028	1.027	1.025	1.026	1.028	1.027	1.028	1.029	1.030
Total Cost Increase	1.039	1.026	1.006	0.981	1.025	1.046	1.038	1.038	1.041	1.045
Outpatient										
Volume Increase	1.063	0.988	1.029	1.027	1.052	1.052	1.051	1.049	1.048	1.046
Input Price Index Increase	1.020	1.028	1.027	1.025	1.026	1.028	1.027	1.028	1.029	1.030
Weighted Cost Increase	1.084	1.016	1.057	1.053	1.079	1.081	1.079	1.078	1.078	1.077
SNF										
Days Increase	1.006	1.046	1.100	0.961	0.995	1.013	1.002	1.002	1.004	1.006
Input Price Index Increase	1.024	1.028	1.030	1.030	1.028	1.029	1.029	1.029	1.030	1.030
Total Cost Increase	1.030	1.076	1.133	0.989	1.023	1.042	1.031	1.031	1.034	1.036
HHA										
Visits Increase	0.856	0.958	1.098	0.980	1.002	1.047	1.030	1.026	1.016	1.023
Input Price Index Increase	1.028	1.030	1.032	1.030	1.030	1.030	1.030	1.031	1.031	1.032
Total Cost Increase	0.880	0.987	1.134	1.032	1.032	1.078	1.031	1.058	1.048	1.056
Weighted Avg. Increase	**1.036**	**1.024**	**1.025**	**0.995**	**1.035**	**1.054**	**1.046**	**1.046**	**1.048**	**1.051**

Source: E&Y analysis of OACT, 1999 projections.

Appendix C
Analysis of Total Hospital Margins

The Methodology

Ideally, specific analyses would have been performed for all program areas affected by the BBA. In a best-case scenario, this analysis would have included data from Medicare cost reports, specific patient claims data, and the minimum data set (MDS) for SNFs. However, for a variety of reasons, some or all of these data elements were not available. In addition, for several of the BBA provisions, the actual payment methodologies have not yet been developed and/or finalized (e.g., PPSs for home health, rehabilitation facilities, and outpatient services).

Therefore, in the interest of reasonableness and timeliness, the approach adopted allowed for the measurement of the most significant payment changes using a variety of methodologies, data sources, and tools. For example, for those program areas which are specifically driven by cost report data, filed cost reports were used in the analysis. For those program elements for which specific claims data were necessary, either independent analyses were performed using claims data (i.e., transfer payment policy change) or the results of externally prepared analyses were used (i.e., CBO projections were used to estimate the SNF PPS impact: HCFA estimates were to used to project the impact of the outpatient PPS).

In addition, there were several program elements that could not be measured for this study, given time, data, and methodology constraints. The following matrix summarizes which reimbursement components were utilized in which type of analysis.

Analyses Performed to Determine Impact of BBA Provisions

Component	Cost Report Data Used	Independent Analysis Performed	BBA Impact Not Measured
Inpatient PPS	X		
Disproportionate Share	X		
Inpatient Capital	X		
PPS-exempt Hospitals	X		
Outpatient (FDO)	X		
Indirect Medical Education	X		
Bad Debts	X		
Home Health[a]	X		
Hospital Outpatient PPS[b]		X	
Transfer Payment Policy[c]		X	
SNF PPS[d]		X	
SNF Consolidated Billing			X
Rehabilitation Hospital PPS			X
TEFRA Provider Exemption Elimination			X
TEFRA Rebase Option			X
Voluntary FTE Reduction Program			X
Systemwide Aggregation of FTEs			X

[a] The 15 percent mandatory reduction was applied to home health Medicare payments as the estimated impact of the HHA PPS, beginning with FY 2001.
[b] A 3.8 percent reduction was applied, based on HCFA's estimate in its proposed rule published in the 9/8/98 *Federal Register*.
[c] Impact of the transfer payment policy change was determined by an HCIA analysis.
[d] Since data was not available regarding the SNF PPS, the CBO's scored percentage reduction in SNF Medicare payments was used to estimate the BBA impact.

Using the BBA legislation and regulations, a spreadsheet was developed to model the impact of BBA provisions (based on available cost report data) on total hospital margins and on Medicare payments for FYs 1998—2002. Using this information and impact projection information obtained from external sources (e.g., CBO, HCFA), the impact on total hospital margins and Medicare payments were determined for the five-year period.

The base year used was FY 1997 and the analysis determined both the pre- and post-BBA total hospital margins and Medicare payments. In addition, it was assumed that expenses would increase at MB –1 percent, since that is the assumption used by MedPAC.[8] The FY 1997 cost reports of 340 hospitals were used to determine a baseline just prior to the period when the BBA would have an impact on cost report data.

The Sample

The sample consisted of 340 hospitals (see Table C-1), which is a subset of the 487 hospitals used in the MedPAC analysis simulation. Of the 340 hospitals, 170 (50 percent) are voluntary, 83 (24 percent) proprietary, and 87 (26 percent) government-owned. According to HCFA's hospital distribution by ownership (as published in the July 31, 1998 *Federal Register*, pp.41116-17, Table 4), this sample has about 10 percent more proprietary hospitals than it should have and nine percent fewer voluntary providers. When compared to national norms, hospitals in the Mid-Atlantic and East North Central regions are under-represented in this sample and hospitals in the East South Central region are over-weighted. When the data were reweighted to reflect the national distribution of hospitals, there were no discernible differences in the results.

***Table C-1.* Summary of Sample Data Distribution for BBA Analysis**

Hospital Categories	Sample Hospitals		HCFA Web Site	
	Number	Percent of Total	Number	Percent of Total
All Hospitals	*340*	*100%*	*5,070*	*100%*
Bed Size				
0-99	130	38%	2,525	50%
100-199	85	25	1,270	25
200-299	52	15	639	13
300-499	49	14	481	9
500+	24	7	155	3
Region				
East North Central	24	7%	761	15%
East South Central	55	16	432	9
Middle Atlantic	12	4	504	10
Mountain	37	11	353	7
New England	2	1	206	4
Pacific	54	16	609	12
South Atlantic	53	16	751	15
West North Central	48	14	699	14
West South Central	55	16	702	14
Puerto Rico	0	0	53	1
Urban/Rural				
Rural	126	37%	2,852	56%
Urban	214	63	2,218	44
Teaching Status				
Major	38	11%	295	6%
Other	55	16	476	9
Non-Teaching	247	73	4,299	85
Ownership				
Voluntary	170	50%	2,991	59%
Proprietary	83	24	710	14
Government	87	26	1,369	27

Numbers may not add to 100 percent due to rounding.

Table C-2. **Estimated BBA Line Item Medicare Payment Reductions for Sample Hospitals, Individual Year Impacts—Select Years**

BBA Provision	Pre-BBA Medicare Payments (millions)	FY 1998 Post-BBA Medicare Payments (Millions)	FY 1998 Dollar Impact (Millions)	Line-Item Percent Reduction*	Reductions as Percent of Total Payment**
PPS Part A	$5,808.2	$5,701.7	$(106.5)	(1.83)%	(1.20)%
DSH	501.0	497.5	(3.5)	(0.70)	(0.04)
Medical Education	605.7	568.6	(37.1)	(6.13)	(0.41)
Inpatient Capital	672.2	612.3	(59.9)	(8.91)	(0.66)
Bad Debt	171.0	168.2	(2.8)	(1.64)	(0.03)
Outpatient - FDO	242.6	184.6	(57.9)	(23.87)	(0.64)
PPS Exempt-Psych	173.5	171.0	(2.5)	(1.44)	(0.03)
PPS Exempt-Rehab	221.7	218.4	(3.3)	(1.49)	(0.04)
Home Health PPS	454.7	454.7	0.0	0.00	0.00
SNF PPS	279.5	279.5	0.0	0.00	0.00
Totals	$9,117.0	$8,843.5	$(273.5)	(3.00)%	(3.00)%

BBA Provision	Pre-BBA Medicare Payments (Millions)	FY 2000 Post-BBA Medicare Payments (Millions)	FY 2000 Dollar Impact (Millions)	Line-Item Percent Reduction*	Reductions as Percent of Total Payment**
PPS Part A	$6,111.3	$5,769.1	$(342.2)	(5.60)%	(3.60)%
DSH	537.8	493.2	(44.6)	(8.29)	(0.47)
Medical Education	638.4	511.1	(127.4)	(19.96)	(1.34)
Inpatient Capital	672.2	586.0	(86.2)	(12.82)	(0.91)
Bad Debt	171.0	102.0	(68.9)	(40.29)	(0.73)
Outpatient - FDO	242.6	156.2	(86.4)	(35.61)	(0.91)
PPS Exempt-Psych	175.3	161.9	(13.5)	(7.70)	(0.14)
PPS Exempt-Rehab	223.0	212.0	(11.0)	(4.93)	(0.12)
Home Health PPS	466.8	446.3	(20.5)	(4.39)	(0.22)
SNF PPS	279.5	274.1	(5.4)	(1.93)	(0.06)
Totals	$9,504.8	$8,699.7	$(805.0)	(8.50)%	(8.50)%

Table C-2. **Estimated BBA Line Item Medicare Payment Reductions for Sample Hospitals, Individual Year Impacts—Select Years (continued)**

BBA Provision	Pre-BBA Medicare Payments (Millions)	FY 2002 Post-BBA Medicare Payments (Millions)	FY 2002 Dollar Impact (Millions)	Line-item Percent Reduction*	Reducti as Perce Tota Payme
PPS Part A	$6,446.3	$5,943.3	$(503.1)	(7.80)%	(5.08)
DSH	566.6	497.7	(69.0)	(12.18)	(0.70
Medical Education	672.9	480.6	(192.3)	(28.58)	(1.94
Inpatient Capital	672.2	586.0	(86.2)	(12.82)	(0.87
Bad Debt	171.0	94.0	(76.9)	(44.97)	(0.78
Outpatient - FDO	242.6	156.2	(86.3)	(35.57)	(0.87
PPS Exempt-Psych	177.0	163.7	(13.3)	(7.51)	(0.13
PPS Exempt-Rehab	224.3	212.5	(11.8)	(5.26)	(0.12
Home Health PPS	471.4	419.9	(51.6)	(10.95)	(0.52
SNF PPS	279.5	271.5	(7.9)	(2.83)	(0.08)
Totals	$9,910.7	$8,813.0	$(1,097.5)	(11.07)%	(11.07

* The "Line-item Percent Reduction" column represents the percent reduction in line-item Medicare payments. It is calculated by dividing the Dollar Impact by the line-item Pre-BBA Medicare Payment.

**The "Reduction as Percent of Total Payment" column represents the percent each line-item contributes to the total reduction in Medicare payments. It is calculated by dividing the Dollar Impact column by the Total Pre-BBA Medicare Payments amount.

Source: Ernst & Young analysis, 1999.

Appendix D
Glossary of Acronyms

BBA	Balanced Budget Act of 1997
CBO	Congressional Budget Office
DRG	Diagnostic-related group
DSH	Disproportionate share
ECR	Electronic cost report
FDO	Formula-driven overpayment
FOIA	Freedom of Information Act
FTE	Full-time equivalent
FY	Fiscal year
HCFA	Health Care Financing Administration
HHA	Home health agency
IPS	Interim payment system
MB	Market basket
MDS	Minimum Data Set
MedPAC	Medicare Payment Advisory Commission
OACT	Office of the Actuary
OBRA	Omnibus Budget Reconciliation Act
OMB	Office of Management and Budget
PPS	Prospective Payment System
ProPAC	Prospective Payment Assessment Commission
PUF	Public Use File
S&P	Standard & Poor
SNF	Skilled nursing facility
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982

[1] HCFA Web site, www.hcfa.gov, 1999.
[2] CBO, "An Analysis of the President's Budgetary Proposals for Fiscal Year 2000: A Preliminary Report," March 2, 1999 and "Budgetary Implications of the Balanced Budget Act of 1997," December 1997.
[3] AHA Web site, www.aha.org, 1999.
[4] Federal Register, September 8, 1998, p. 47601.
[5] Moody's Investors Service, "U.S. Not-for-Profit Healthcare: Ratings Volatility Ahead for 1999 and Beyond," February 1999.
[6] MedPAC, *Health Care Spending and the Medicare Program: A Data Book, July 1998* (Chart 3-25).
[7] MedPAC, *Health Care Spending and the Medicare Program: A Data Book, July 1998* (Charts 4-4 and 4-13 for SNFs and HHAs, respectively).
[8] MedPAC, *Report to the Congress: Medicare Payment Policy, Volume II: Analytical Papers*, March 1998, page 35 (Figure II-3-5).

Firm Profiles

Ernst & Young, LLP is one of the nation's leading professional accounting, tax, and consulting firms. The professionals in Ernst & Young's large health care consulting practice work with many of the top provider, payor, and life sciences companies worldwide to design and deliver enterprise-wide business solutions and create a stronger competitive edge. The firm's other business offerings include strategic services, operations improvement, finance, accounting, tax consulting, real estate consulting, and technology design and implementation.

HCIA, Inc. maintains the health care industry's largest health care data warehouse. It collects data from a variety of industry sources that include hospitals, managed care and insurance companies, federal and state governments, clinics, physicians' offices, and patients. By combining leading industry databases, methodologies, and analytic services, HCIA creates information assets that help customers manage health care costs and improve patient care. Serving a client base of more than 7,000 customers, HCIA provides decision support systems to more than 1,500 hospitals, as well as many of the largest U.S. health insurance companies, managed care organizations, and pharmaceutical manufacturers. HCIA also supports the efforts of research organizations and government agencies, and has formed proprietary relationships with more than 20 hospital associations nationwide.

HEALTH INDUSTRY DISTRIBUTORS ASSOCIATION
Serving Medical Products Distributors & Home Care Companies Since 1902

Statement for the Record of the Finance Committee
United States Senate

Submitted by: Health Industry Distributors Association
Balanced Budget Act Implementation
March 17, 1999

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The following statement is submitted to the Senate Finance Committee behalf of the Health Industry Distributors Association (HIDA). HIDA is the national trade association of home care companies and medical products distribution firms. Created in 1902, HIDA represents more than 700 companies with approximately 2000 locations nationwide. HIDA Members provide value-added services to patients in their homes as well as virtually every hospital, physician office, and nursing home in the country. HIDA is pleased to be able to provide the Committee with our evaluation of the Health Care Financing Administration's (HCFA's) implementation of the Balanced Budget Act of 1997 (P.L. 105-33).

Home medical equipment (HME) providers are an integral component of the home healthcare delivery chain. HME providers supply medically necessary equipment and related services that help beneficiaries meet their therapeutic goals. Pursuant to the physician's prescription, HME providers deliver medical equipment to a consumer's home, set it up, maintain it, educate and train the consumer and caregiver in its use, provide access to trained therapists, monitor patient compliance with a treatment regimen, and assemble and submit the considerable paperwork needed for third party reimbursement. HME providers also coordinate with physicians and other home care providers (such as home health agencies and family caregivers) as the consumer improves and his/her needs evolve. Specialized home infusion providers manage complex intravenous services, including chemotherapy, in the home.

These providers and the beneficiaries that they serve are at a great risk for negative consequences resulting from HCFA's implementation of Balanced Budget Act (BBA). Although a large number of provisions in the BBA have the potential to impact HME providers, our testimony will focus just two issues – HCFA's implementation of an expanded inherent reasonableness authority and the competitive bidding demonstration program.

Inherent Reasonableness

HIDA is concerned that HCFA's implementation of the expanded inherent reasonableness (IR) authority granted in the BBA has violated a number laws that govern the promulgation of regulations, superceded Congressional intent, and will ultimately threaten beneficiary access to quality medical equipment services.

In 1985 HCFA was granted the authority to alter Medicare reimbursements for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) through the "inherent reasonableness" (IR) authority. This authority allowed HCFA to adjust reimbursements for individual items and services if the payments are found to be grossly deficient or excessive. Under this original authority, HCFA had to take certain logical steps to make adjustments to the fee schedule. Specifically, HCFA had to (1) consult the communities that would be impacted by this change, (2) publish the proposed new reimbursement limit in the *Federal Register*, (3) allow 60 days for public comment, and (4) publish a final rule in the *Federal Register*. This process was used successfully by HCFA in 1995 to reduce the national fee schedule reimbursement for blood glucose monitors.

The BBA provision (Section 4316) granted HCFA a greatly expanded authority to adjust DMEPOS reimbursements by as much as 15 percent each year without industry consultation, publication in the *Federal Register*, or public comment. On January 7, 1998, HCFA issued an interim final rule implementing this authority, declaring that the protection of the Medicare Trust Fund necessitated a waiver of the public notice and comment period mandated by the Administrative Procedures Act (APA), and the Social Security Act (SSA). In addition, HCFA failed to conduct and report a small business impact statement as required by the Regulatory Flexibility Act (RFA). Interestingly, HCFA stated that the RFA analysis was not needed because the rule did not constitute a "significant change," while simultaneously maintaining that the need to enact the rule constituted an "emergency" worthy of bypassing the notice and comment periods necessitated by the APA and the SSA

On April 9, 1998, HCFA delegated the IR authority to the four Durable Medical Equipment Regional Carriers (DMERCs). The DMERC's were quick to announced payment reductions. In their respective September 1998 Supplier Bulletins, the four DMERCs proposed IR reductions between 0.5% to 35.7% for the same eight product codes; an apparent violation of the 15% threshold established in the BBA. As you are aware, the BBA outlined specific notice and comment guidelines for HCFA to follow for payment adjustments over 15%. HIDA suggests that by including the legislative language addressing the process for implementing adjustments greater than 15%, Congress was expressing its intent for HCFA to follow this process.

HIDA is also concerned that the data used by the regional carriers to support these reductions reveal serious weaknesses in Medicare's data collection processes. The DMERC Pricing Units contacted specific providers in 16 States to obtain *retail* pricing data. The DMERCs then arbitrarily selected the median of a varying number of observations for each code as a value, which represents a "fair and equitable payment amount" and proposed payment reductions to the median for each and every payment above the median. HIDA maintains that this process contained a number of important weaknesses, such as the following:

- The DMERCs relied on pricing from retail pharmacies, which do not accurately represent the costs incurred by a supplier in furnishing these items to Medicare beneficiaries. HCFA has

- determined that HME suppliers incur at least 15 percent higher costs in order to comply with the administrative burdens imposed by the Medicare program. These costs were not recognized in the retail pricing data accumulated by the DMERCs.

- The items surveyed by the DMERCs simply are not the same items for which Medicare allowables are derived. For example, for items such as enteral nutrition and blood glucose test strips, HIDA's review of the survey data reveals that the DMERCs relied upon pricing for products that are not covered by Medicare or rarely used by beneficiaries. Several of the observations reported to the DMERCs for test strips are for low-end brands of such poor quality that physicians do not prescribe them.

- HIDA's review of the data obtained by DMERC Pricing Units for blood glucose test strips and lancets reveal a selection of localities heavily skewed away from large urban areas, as well as fundamental flaws in the questions posed by DMERC representatives. HIDA has contacted numerous participants in the survey, whose responses reveal that the pricing obtained by the DMERCs were not representative of the actual prices charged to beneficiaries.

HIDA fears that similar flaws will be repeated in further IR determinations, unless Medicare is required to use a rational, apparent and statistically valid data collection process.

As Section 4316 of the BBA provides HCFA with vast authority to modify the statute-based Medicare Part B payment system, and these modifications could have a significant impact on HME providers and beneficiaries alike, it is imperative that HCFA comply fully with the important procedural requirements enacted by Congress. HIDA urges this Committee to require HCFA to re-issue the regulations enacting the IR authority in order to allow the agency to come into full compliance with the requirements of the APA, the SSA, and the RFA. HCFA did not analyze the impacts that this regulation would have on small entities and failed to contact the affected industries that could have supplied the agency with this information. HIDA urges this Committee to require HCFA to use statistically valid, appropriate data collection techniques when promulgating future IR determinations of less than 15%.

Competitive Bidding

HIDA is concerned about the Health Care Financing Administration's implementation of a competitive bidding demonstration program for HME and supplies authorized by the BBA (Section 4319). It is important to remember that although the term "competitive bidding" may sound attractive, this program will actually stifle the existing free market competition that encourages the provision of high quality medical services to Medicare beneficiaries. HCFA is currently implementing this demonstration in Polk County, Florida, where competitive bidding will enacted in the fall of this year. Once this demonstration program is under way, only a very limited number of HME providers in this county will be reimbursed by Medicare for home oxygen services, hospital beds, wound care supplies, enteral nutrition, and incontinence supplies. The fact that the vast majority of providers will be excluded from providing these services will create monopolistic forces that will eliminate the existing market competition. In addition, by radically reducing the number of providers of HME services, consumer access may be threatened and beneficiaries in the demonstration areas will lose the important right to choose their own healthcare provider.

HIDA is particularly concerned that HCFA's current competitive bidding plan threatens access to important health services. Home medical equipment (HME) such as oxygen equipment cannot be drop-shipped to patients because the therapeutic support services offered by HME providers are crucial to positive health outcomes. History shows that once an artificially low bid is awarded and the winning bidder faces budget pressures, the first thing the provider eliminates are these therapeutic services (e.g., preventative maintenance, patient education, 24-hour on call service, the professional care of respiratory therapists, and the furnishing of supplies). Once these services are eliminated, the beneficiary is much more likely to experience health problems. Importantly, beneficiaries in the demonstration area will be have extremely limited options if they are unhappy with the HME services provided by the selected bidder.

As this demonstration program has the potential to directly impact the healthcare services of thousands of Medicare beneficiaries, it is urgently important for HCFA to conduct a well-reasoned, responsive program. We urge the Committee to review the design of the HME competitive bidding demonstration. If the Committee determines that the current design fails to protect the wellfare of beneficiaries in the demonstration area, the demonstration should be halted.

Conclusion

HIDA appreciates the opportunity to provide the Committee with our views on HCFA's implementation of the BBA. We hope that you will take this opportunity to review the irregularities of HCFA's implementation of IR. We urge the Committee to exercise its oversight function to require the Administration to use a rational, legal, and valid process. In addition, we hope the Committee will investigate the possibility negative consequences of the competitive bidding demonstration in Polk County, Florida.

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The Honorable William V. Roth, Jr., Chair
United States Senate Committee on Finance
215 Dirksen Senate Office Building
Washington, D.C.

Re: Finance Committee Hearing June 10, 1999
Impact of Balanced Budget Act of 1997 Provisions on Medicare Fee-for-Service

Dear Senator Roth:

I am a physical therapist with over two decades experience, including extensive experience with Medicare A and B, Medicare assigned managed care plans and Long Term Care. I also am an attorney and a mediator. I fully understand the need to balance our country's budget, the difficulty of changing fiscal impact legislation such as the Balanced Budget Act of 1997, the concerns regarding Medicare fraud, and the impact of the BBA on reimbursement for rehabilitation services pursuant to Medicare A and B.

However, the Medicare A and B payment structure for rehabilitation services for physical, occupational and speech therapy, so adversely has been affected, that the projected fiscal savings is illusory. In fact, the impact of the present provisions in the BBA will cost not only the federal government, but each of the fifty states far more than any anticipated savings, due to the increased Medicaid costs incurred for seniors forced prematurely into long term care.

I.

Seniors will NOT and presently are NOT receiving adequate rehabilitation pursuant to Medicare A to allow them to achieve their pre-injury/pre-hospitalization level of independent functioning and enable them to return to living in their own homes, apartments, assistive living, and other living situations as was the case prior to these BBA reimbursement changes.

Medicare guidelines always have stated quite clearly that a rehabilitation provider can not and may not rehabilitate a senior to a "higher" level of function than that of his/her pre-hospitalization status. For example, the long term rehabilitation goal for a senior that was walking independently without an assistive device and living in his/her own home prior to falling and breaking a hip would be to be able to return him/her to that SAME level of independence. Whereas, for a senior with a fractured hip that was

already living in a long term care facility, wheelchair dependent but transferring independently to his/her bed, the long term rehabilitation goal for this person would not be to get him/her walking independently, even if she/he had the potential to achieve this goal.

Frequently, rehabilitation takes a significant amount of time for seniors as there are many uncontrollable variables which occur. These include, in the example of a hip fracture patient: adverse effects of general anesthetic; the type of hip repair surgery and its effect on weight bearing status; muscular strength and ability to use assistive device; medical complications; and prior level of functioning.

Under the previous Medicare A guidelines, seniors received days 1-20 of skilled services for rehabilitation or sub-acute rehabilitation at 100% reimbursement without a co-pay, which 20 days frequently were adequate for them to return to their previous living situations. If not, then they, their families or their supplemental insurance policies covered the co-payment amount for days 21 to 100, that were required. During their rehabilitation, seniors had to show progress towards their short term and long term therapy goals, or they would have to be taken off rehabilitation, as they would lose their eligibility for services.

Now, however, because of the extremely low reimbursement for Medicare A rehab services based upon PPS for seniors at nursing homes, not only are they not receiving the rehabilitation services that are indicated, they are receiving totally inadequate services for their medical conditions, which frequently are administered to them in a "group" therapy setting, with little one-on-one therapy even provided. Additionally, now, instead of receiving therapy from a physical therapist, seniors are receiving therapy from physical therapy assistants or on the job trained therapy aides, both of whom are less expensive employees. The current reimbursement rate is so low, that it doesn't even come close to covering the rate of pay for skilled nursing care, let alone skilled rehabilitation services in long term care facilities.

Ultimately, because seniors are receiving inadequate physical therapy to rehabilitate them back to their pre-hospitalization level of function, they are and will have to be placed permanently in long term care facilities. If, at that time, they immediately are not eligible for Medicaid, they will spend down their assets until they are eligible for payment of their long term care under Medicaid. The fiscal impact and purported savings for Medicare A and B rehabilitation services truly is a "dollar foolish and penny wise" scenario. As seniors also can not be covered by any other health care insurance, presently, they are being unfairly taken advantage of by the effects of the reimbursement provisions of the BBA legislation.

II.

The Senate's concerns with decreasing Medicare fraud caused by excessive charges for physical, occupational and speech therapy, best can be addressed as follows:

1) Increase the funding for more investigators of Medicare fraud. A complaint was filed by a physical and occupational therapist against a nursing home in Aurora, Colorado, owned by a large national company. The complaint claimed excessive rehab charges and poor nursing care. This was investigated almost a year later due to lack of investigator staff. By that time, this nursing home had conducted its own internal audit, discovered its rehab program manager intentionally had increased the Medicare charges for rehab services submitted by her therapists and the nursing home had reimbursed Medicare, thus avoiding any significant penalty.

2) Develop a three tiered reimbursement plan for Medicare A rehabilitation services which reflects greater payment for rehab services provided by therapists, and progressively less for assistants and aides. A tiered payment system would decrease significantly the use of less highly trained workers being utilized for rehab, its financial incentive and improve patient care.

3) Require Medicare assigned managed care plans to reimburse nursing homes at the same rate as that gotten directly from Medicare for a senior, in order to decrease the financial incentive of purposely over billing Medicare patients to make up for the significantly lower reimbursement received from a managed care company. A rehab manager at a nursing home in Denver owned by a large national company, required her therapists to increase their charges on Medicare patients to cover for lower reimbursement from Medicare assigned managed care plans.

4) Consult with experienced therapists "in the field" to explore options on how best to make viable Medicare policy changes in order to address the concerns of patient care, fraud and fiscal savings.

Addressing these concerns will not only assure the return of adequate and professional rehabilitation pursuant to Medicare A for all seniors, but will restore the rehabilitation profession for all physical, occupational and speech therapists nationwide who presently are unemployed due to BBA reimbursement effects. Thank you in advance for your consideration.

Very truly your,

Michele M. Lawonn

Michele M. Lawonn, JD, PT

(NASL.tst)

NATIONAL ASSOCIATION FOR THE SUPPORT OF LONG TERM C.

Statement of Jack J. Pivar, President
National Association for the Support of
Long Term Care

Medicare Fee-For-Service Program
Impact of the BBA '97 Provisions

Submitted for the Record to
United States Senate
Committee on Finance

Hearing Date June 10, 1999

HEADQUARTERS
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Chairman Roth:

On behalf of the National Association for the Support of Long Term Care (NASL), I am pleased to submit the following written testimony to you and members of the Senate Finance Committee. This testimony is provided in response to the hearing held by your Committee on June 10, 1999 to examine the impact of the Balanced Budget Act of 1997 upon the Medicare Fee-for-Service program.

NASL represents over 150 companies involved in the provision of services, products and supplies to the long term care industry and is the only organization at the national level concentrating its concerns and endeavors exclusively on legislative and regulatory matters affecting the ancillary service and product supply components to long term care facilities. NASL has worked closely with Congress and the Health Care Financing Administration (HCFA) as many of the provisions included in the Balanced Budget Act (BBA) were developed. Our members have a particular interest in the impact of the skilled nursing facility prospective payment system (SNF PPS) provisions, as well as the non-physician Part B issues.

We appreciate not only the opportunity to comment, but also your continuing efforts to monitor the impact of the comprehensive BBA, particularly upon beneficiaries' access to quality services. We, like you, agree that our nation's seniors deserve a Medicare program that meets their health needs.

The passage of the BBA marked the most drastic changes to the Medicare program since its inception in 1965. While the goals may have been laudable, too many changes were made too fast with too little understanding as to how the changes would impact each other. The inevitable operational defects in this vastly complex law, have been exacerbated by HCFA's inability to competently administer or implement the changes. This, in turn, has put beneficiary services at risk and the post-acute health care sector on the verge of economic collapse. Closing options and the resulting service disruption for beneficiaries across the spectrum of health care settings, has begun to translate into real problems of access and quality of care.

I. Immediate Concerns:

We are particularly concerned about the severe impact two specific provisions of the BBA are having upon beneficiaries. **We appeal to the Committee to ensure beneficiaries' continued access to quality care by:**

(1) Mandating an interim solution to the flawed skilled nursing facility (SNF) prospective payment system (PPS) that restores Medicare funding to levels of reimbursement the provision of non-therapy ancillary services provided under the SNF PPS;

(2) passing the "Medicare Rehabilitation Benefits Improvement Act of 1999," (S. 472) which would exempt certain beneficiaries from the arbitrary $1,500 cap placed upon outpatient rehabilitation services.

The problems associated with these provisions are real. Early research findings show the Resource Utilization Group III (RUG III) system used for the skilled nursing facility prospective payment system (SNF PPS) fails to adequately account for the costs of certain non-therapy ancillary services. These non-therapy ancillary services include prescription drugs, respiratory therapy, laboratory, radiology, ultrasound, enteral and parenteral feeding, and the provision of certain complex medical equipment which is used in the treatment of pressure ulcers. Without the implementation of an interim solution and the restoration of Medicare funds to the Program, elderly Medicare beneficiaries will be denied access to these services.

Mr. Chairman, sixty-six of your Senate colleagues signed their names to a letter to Donna Shalala, Secretary, U.S. Department of Health and Human Services expressing their deep concerns about the "growing crisis in the nursing home industry" and urging the Secretary use her authority to "ensure the transition to the new prospective payment system does not harm beneficiaries with unneccessary reductions in payment rates that go beyond" what was anticipated.

As you heard during the June 10 hearing, the American Health Care Association (AHCA) recently commissioned Muse & Associates, leading health care analysts, to examine the findings of an AHCA membership survey. The survey was intended to assess changes in such things as admission, length of stay, average Medicare payment and occupancy since the implementation of the BBA. According to the report, "*A Survey of Changes in Skilled Nursing Facilities Medicare Patterns Since the Implementation of the Prospective Payment System*," payments to SNFs decreased between the first quarter of 1998 and the first quarter of 1999 by an average of $50 per day. The report also documented significant declines in the length of stay for Medicare patients (15%) and a large drop in Medicare patient days (10.5%).

NASL strongly supports the efforts already underway to *immediately* address the problems related to the flawed SNF PPS. Essential to a remedy is an acknowledgment that the system has been under-funded and the services used by beneficiaries, particularly those with high-acuity needs, have been under-recognized. Another aspect crucial to a solution, is a reassessment of the Health Care Financing Administration's (HCFA) use of an early 1990's industry snapshot to set the base of all rates. The current demographics of the health care system are significantly different and this exacerbates the funding shortfall.

Congress must also act quickly to ensure our nation's Medicare beneficiaries continue to have access to medically necessary therapy services. This can be done by supporting the "Medicare Rehabilitation Benefit Improvement Act of 1999," (S. 472 / H.R.1837). The

BBA imposed an annual coverage limit of $1,500 upon rehabilitative services provided to beneficiaries outside of hospital settings. The Medicare program, pursuant to this provision, therefore no longer provides reimbursement for the rehabilitative services received by beneficiaries when the financial limitations, or caps, have been exceeded. The provision has been interpreted as establishing two $1,500 caps – one for occupational therapy and another for physical therapy and speech-language pathology services combined.

Data show that in the first three months following the enactment of the provision, beneficiaries negatively impacted by the therapy cap continued to escalate at an alarming rate.[1] An extrapolation of this data projects as many as 13% of Medicare beneficiaries receiving rehabilitative therapy services will exceed the cap. One of the Committee's witnesses, and Chair of the congressionally-created Medicare Payment Advisory Commission, Gail Wilensky, has called the caps "totally arbitrary and capricious."[2] The same Commission estimates 1 in 7 Medicare beneficiaries who seek rehabilitation therapy, or about 200,000 people, will exceed one of the caps this year.[3]

The continued provision of medically necessary services in a hospital outpatient department, which is not subject to the limitations, may be difficult, if not impossible, for nursing home residents or beneficiaries living in rural areas. Many beneficiaries may therefore decide to forgo or limit medically necessary services rather than pay for the services out of pocket. The arbitrary limitations may also result in inappropriate placements for some beneficiaries or an increase in the cost of care.

Legislation has been introduced in both the Senate (S. 472) and the House (H.R. 1837) to help ensure the most vulnerable of our nation's population - those with high acuity conditions - have access to rehabilitation therapy services. The "Medicare Rehabilitation Benefit Improvement Act of 1999" is a common sense targeted approach which would exempt from the financial limitations those beneficiaries meeting certain criteria. Specifically, in order to be exempted from the limitations, a Medicare beneficiary would need to meet one of the following requirements: (1) be subsequently diagnosed with an illness, injury, or disability that requires the additional provision of medically necessary services in the same year; (2) have an additional diagnosis or incident that exacerbates the individual's condition, thereby requiring the provision of additional services; (3) the individual will require hospitalization if the individual does not receive the services; or (4) meet other criteria determined by the Secretary.

NASL continues to oppose as bad health care policy, the implementation of any type of arbitrary financial limitations on medically necessary services. We believe beneficiary needs should dictate the provision of services. NASL urges your support of the "Medicare Rehabilitation Benefit Improvement Act of 1999," S. 472/H.R.

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[1] Analysis prepared by NovaCare Regulatory Affairs office, March 1999, based on January – March 1999 Medicare claims.
[2] "Medicare Caps on Therapies Spark Protest," *Wall Street Journal*, April 26, 1999.
[3] "Medicare Cutbacks Prove Painful to Some, " *Washington Post*, May 10, 1999.

1837 and your assistance in ensuring these beneficiary protections are enacted into law.

II. BBA Implementation Concerns:

These immediate concerns cannot be viewed in a vacuum. Essential to the discussion of the impact of the BBA, is an analysis of the Act's implementation which necessarily includes an examination of the following issues:

(A.) Beneficiary services are being put at risk or disadvantaged by HCFA's computer systems problems.

(B.) Clinical standards and program safeguards are being undermined by the inability of HCFA and its contractors to meet minimum performance standards.

(C.) HCFA's administrative problems should not supersede the need to address real policy issues.

Each issue is discussed in greater detail below.

I. Beneficiary services should not be put at risk or disadvantaged by HCFA's computer systems problems.

We are deeply concerned that HCFA has begun to cite Y2K issues as the primary reason for not moving forward on needed policy changes.

- The skilled nursing facility prospective payment system must be finalized. SNF PPS, perhaps the biggest change to the industry since the beginning of the Medicare program, is currently being implemented pursuant to an interim final rule. HCFA now projects the final rule will be released in July. Initially it was to be released in May. By definition, an interim final rule lacks the level of certainty needed by providers who are in the process of making costly changes to their own systems. By the time the final rule is released, providers will have worked under an interim rule for almost a year.

- Non-therapy ancillary services must be appropriately funded. As discussed above, early research findings show the Resource Utilization Group III (RUG III) system under the skilled nursing facility prospective payment system (SNF PPS) fails to adequately account for the costs of certain non-therapy ancillary services. Nevertheless, potential, interim solutions continue to be rejected or limited by HCFA's Y2K computer compliance problems. Policy decisions directly affecting beneficiaries' needs are being dictated by the status of HCFA's "mission critical systems."

- Due to computer systems problems, HCFA has also been unable to fully implement the $1,500 on outpatient rehabilitation therapy services which has exacerbated the already inequitable impact of these financial limitations. The way HCFA has implemented the policy significantly impacts skilled nursing facility outpatient and rehabilitation facility patients, many of whom may exceed the cap. Nursing homes are put at risk to provide services without assurances such services will be reimbursed

B. Clinical standards and program safeguards should not be undermined by the inability of HCFA and its contractors to meet minimum performance standards.

We are concerned that the integrity of the Medicare program is being compromised by management challenges within HCFA and its contractors. HCFA's lack of oversight of its contractors, combined with inadequate training, has resulted in inconsistent and incorrect implementation instructions.

Criticisms have been leveled against HCFA, particularly by the Small Business Administration (SBA) for the agency's apparent disregard of the requirements under both the Administrative Procedures Act and the Regulatory Flexibility Act in their promulgation of regulations pursuant to the Balanced Budget Act of 1997.

Informal directives in the form of program transmittals and HCFA web site guidances are being used as pseudo rulemaking vehicles. Many of these directives have been inconsistent or contrary to the language of the interim final rule. Systems crucial to the SNF PPS transition, including the Arkansas Shared System, continued to remain inoperable seven months after the effective date of SNF PPS.

The following are just a few illustrative examples of management performance problems which have threatened to undermine services being provided under the Medicare program:

- In January, fiscal intermediaries under the Arkansas Shared System notified facilities they would be unable to pay claims pursuant to the physician fee schedule until "approximately" April. According to the notice, Medicare claims would be temporarily paid under cost reimbursement methodology which were likely to result in overpayments. These overpayments were in turn likely to result in a future recovery of payments. In addition, the contractor predicts the coinsurance amounts calculated during the interim period will also be invalid.

- In a recent transmittal, HCFA instructed their contractors, as of April 5, 1999, to "return as unprocessable" all claims submitted by providers that are not Y2K compliant. At this time, a standard UB92 form capable of accepting that much data still does not exist.

- A provider's claims for outpatient services were recently rejected due to the inclusion of discipline specific modifiers on the claim. The provider was instructed by the fiscal intermediary to resubmit the claims – this time, without the modifiers. A week later the claims were again rejected for not including discipline specific modifiers.

- A provider contacted their fiscal intermediary in an effort to obtain a copy of the physician fee schedules, and was told they would need to submit a Freedom of Information Act request to obtain the information.

C. HCFA's administrative problems have superseded the need to address real policy issues.

HCFA's "short term" management challenges, while administrative in nature, can and do have a direct and immediate impact upon policy and the quality of services provided to beneficiaries. The debate regarding HCFA's administrative performance, should not be allowed to eclipse the need to address the real policy issues that continue to exist.

In addition to the problems associated with the flawed SNF PPS and the $1,500 therapy cap addressed above, we see the need for the following policy issues to be addressed:

1. HCFA needs to establish an appropriate site of service differential for non-physician services shifted to fee schedules by the Balanced Budget Act of 1997. Establishing a site of service differential for services performed at a SNF or similar facility is needed to reflect the fact that different providers have different cost structures and that different costs arise in connection with the performance of similar services.

2. Congress must reconsider the consolidated billing provisions of the BBA and better define core beneficiary services for nursing home residents in order to prevent further harm to beneficiaries. The demands placed upon skilled nursing facilities by Part A consolidated billing requirements, coupled with a lack of clear direction from HCFA as to the what constitutes core beneficiary services, and wholly inadequate reimbursement levels, have led to a back up of high acuity patients in hospitals. To allow core beneficiary services to remain undefined, and to fully implement the consolidated billing provisions of the BBA for Part B and for home health agencies, would be to put quality beneficiary services are even greater risk.

Part B consolidated billing should be re-considered in light of the administrative failings already exhibited by HCFA and its contractors. The current arrangements for the provision of, and billing for, these important ancillary services function

smoothly and assure beneficiary access. There is little to be gained and potentially much to be lost from a major change like consolidated billing.

3. Congress should enact legislation to give HCFA the authority to pay mobile diagnostic testing companies a transportation rate, when it is economically advantageous to bring the services to the patient. The Secretary of Health and Human Services failed to comply with a BBA mandate to make a recommendation on the continuation of EKG transportation to Congress by July 1, 1998. Congress would be able to use the recommendation to extend or allow the expiration of the EKG transportation provision in the BBA. Failing to receive a recommendation from HCFA, Congress allowed the EKG transportation provision to expire.

The General Accounting Office reported that Medicare would save approximately $10 million per year by continuing to reimburse for EKG transportation if nursing home patients would continue to receive EKG's at their bedside rather than be transported via ambulance to a hospital or clinic. In December 1998, the Office of the Inspector General (OIG), reported that approximately $150 million per year was for ambulance services which were used, in part, to transport nursing home patients to diagnostic tests. There is overwhelming evidence that without a transportation component to the diagnostic testing services, patients and nursing homes have limited choices but to send the patient via ambulance to the hospital or clinic at a great expense to Medicare.

Conclusion

The unintended consequences of the BBA are being exacerbated by severe implementation problems which continue to plague the Program, particularly within the skilled nursing facility prospective payment system. Computer systems capabilities are dictating decisions being made regarding beneficiaries' access to services. Policy decisions which should be made in accordance with the Administrative Procedures Act, are being implemented by informal notices. Providers are struggling to comply with rules that seem to change daily, only to find out the claims systems are not capable of processing the claims. HCFA and its contractors must be required to meet the same standards to which providers continue to be held.

Mr. Chairman, NASL appreciates the opportunity to provide this testimony and asks that it be made a part of the June 10, 1999 record. We welcome the chance to work with you and your fellow Committee members in trying to ensure the nation's Medicare beneficiaries continue to have access to quality services.

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