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PRESIDENT'S FISCAL YEAR 1998 BUDGET PROPOSAL FOR MEDICARE, MEDICAID, AND WELFARE

HEARINGS

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FIFTH CONGRESS

FIRST SESSION

WITH VIEWS FROM

CONGRESSIONAL ADVISORY COMMISSIONS; CONGRESSIONAL BUDGET OFFICE; AND THE GENERAL ACCOUNTING OFFICE

FEBRUARY 13 AND 27; MARCH 4 AND 5, 1997

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PRESIDENT'S FISCAL YEAR 1998 BUDGET PROPOSALS FOR MEDICARE, MEDICAID, AND WELFARE

THURSDAY, FEBRUARY 13, 1997

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

The hearing was convened, pursuant to notice, at 1:10 p.m., in room SD–215, Dirksen Senate Office Building, Hon. William V. Roth, Jr. (chairman of the committee) presiding.

Also present: Senators Chafee, Grassley, Gramm, Jeffords, Moynihan, Baucus, Rockefeller, Conrad, Graham, Moseley-Braun, 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 come to order. Secretary Shalala, it is certainly a pleasure to welcome you to the hearing this afternoon. As head of the Department of Health and Human Services, the Secretary, of course, will address the President's budget proposals as they relate to Medicare, Medicaid, and welfare.

Let me begin by saying that, as chairman of this committee, it is both my hope and intention to work with a spirit of conciliation to address the serious problems that threaten these programs.

The outlook for the Medicare trust fund remains quite bleak. The most recent estimates by the Congressional Budget Office still projects the Medicare HI trust fund to go bankrupt in 2001.

If we do nothing, the deficit of the trust fund is projected to be over one-half trillion dollars just 10 years from now. This is before the baby boomers begin to retire in 2010.

Frankly, I am encouraged that President Clinton has moved in our direction by his call for $100 billion in reduced spending growth in Medicare over the next 5 years. I am encouraged that he has also demonstrated a willingness to adopt certain proposals the Republicans advocated the last time we engaged in the Medicare debate.

I must admit, however, that I was somewhat concerned when the President, in the State of the Union Address last week, devoted only one sentence to discussing his plans for Medicare, and half of that sentence was devoted to expanding the program.

The President states that his plan extends the life of the Medicare trust fund until 2007. However, in order to achieve this, the President's budget resorts to a budgetary sleight of hand.

The challenge before us is not to simply extend the life of the trust fund for some arbitrary period of time, rather it is to secure the viability of this program for future generations.

I believe we cannot begin to make the changes necessary to preserve Medicare unless we are honest with the American people about the seriousness of this problem and the options available to address it.

For this reason, I will be introducing legislation today, with Senator Moynihan, to establish a commission charged with making recommendations on Medicare's future financial integrity. I invite members of this committee to join us in co-sponsoring this legislation.

Concerning Medicaid, the President proposes to reduce spending by $22 billion. Although we may disagree on how to achieve additional savings in the Medicaid program, I am pleased the administration recognizes that there is still room to find savings.

The experience of the past few years demonstrates that Medicaid spending can be controlled. Between 1990 and 1995, the annual rate of growth of spending was nearly 17 percent. Last year, it was just over 3 percent. Much of the credit goes to the States.

At the same time, 45 States have expanded coverage to pregnant women and children beyond at least one of the Federal requirements, through exercising optional coverage, waivers, or State-funded programs. I am pleased the President's budget reflects that experience and proposes to give the States even greater flexibility in managing the massive programs.

The reduction in the baseline is, indeed, good news, but we must not be complacent. The same demographics driving Medicare costs will hit Medicaid as well. In the area of welfare reform, I believe it is safe to say that I do not anticipate the same level of legislative activity as we have experienced for the past 2 years.

The sweeping welfare law enacted last year included SSI, child support enforcement, child care, and food stamps, as well as creating the new Temporary Assistance for Needy Families program.

I am pleased that so much progress has been made on implementing welfare reform. The administration and the Governors have been working together to ensure that the transition to the new system occurs smoothly and on schedule. Madam Secretary, I want to commend you for your efforts in this regard. The committee will, of course, closely monitor the implementation of welfare reform.

My intention today is to let the President and members of this committee know that we are ready and willing to work with them on these extremely important issues.

Senator Moynihan.

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

Senator MOYNIHAN. Mr. Chairman, I would like to thank you for that generous and positive remark. I am sure the Secretary shares

this view. I do hope that others on the committee will join in sponsoring your proposal for a commission on Medicare and Medicaid.

I would just note that, in a time in the not-too-distant past, what seemed like a hugely accelerating cost of medical care has moderated quite substantially, just like that. There has been economic rationalizing going on. I think the cost to employers of medical care was below the rate of inflation just last year.

So there is no reason that government programs cannot have the same efficiencies as private sector programs, and we should do that. If we do, we will preserve this system that, not long ago, was in jeopardy not just because of costs, but because of partisan attacks.

I do not think the Democratic party did any service to this cause by the "Mediscare" campaign, as it was called, in the last campaign. I think it is very generous and open of you to say, let us get together and fix this thing, as it clearly is fixable.

The CHAIRMAN. Thank you, Senator Moynihan.

Senator Chafee.

Senator CHAFEE. I have no statement. Or I will put it in the record, and would encourage everybody to do the same.

[The prepared statement of Senator Chafee appears in the appendix.]

The CHAIRMAN. I would encourage everybody to do the same.

Madam Secretary, we look forward to your remarks.

STATEMENT OF HON. DONNA E. SHALALA, PH.D., SECRETARY OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Secretary SHALALA. Thank you very much, Mr. Chairman and members of the committee. Thank you for giving me the opportunity to testify today about the President's fiscal year 1998 budget.

Someone once described our country as the only country deliberately founded on a good idea. That good idea is, we, the people. It has emboldened our country to face, and overcome, great challenges with courage and unity. We overcame tyranny in the 1940's, and polio in the 1950's. We landed an American on the moon in the 1960's, and won the cold war in the 1980's.

Each of these triumphs came during times of great social and political change, and each of them defined generations, because in each of these moments Americans put aside partisan differences to achieve a critical National goal. Today we must do the same.

Right now, leaders on both sides of the aisle agree we must balance the budget. The question is, how? How can we balance the budget and reform Medicare, Medicaid, and welfare, while still keeping our promises to our children and families now and into the 21st century? The President's budget would allow us to do just that.

Mr. Chairman, you and I know that Medicare now faces several short-term challenges and a long-term financing challenge, all of which demand action. That is why the President has made it clear that he wants to work with the Congress to make 1997 the year that we forge a bipartisan agreement on Medicare.

The President's plan would reduce projected Medicare spending by a net $100 billion over 5 years, and guarantee the solvency of the Part A trust fund until the year 2007, 10 years from now.

The independent actuary for Medicare has written a letter confirming these numbers.

We are able to achieve these savings with real reforms, with solid policies, while still maintaining a system that guarantees access to a defined set of services.

To preserve Medicare for this and every generation, we believe we must, first, modernize it. We are doing that in six ways. First, by making Medicare a more prudent purchaser of health care services.

Second, by adding new choices to be consistent with today's market. Third, by strengthening our rural health care system. Fourth, by protecting our beneficiaries by ensuring that they receive high-quality health care.

Fifth, by continuing to root out waste, fraud, and abuse so that we spend our hard-earned tax dollars wisely and effectively.

Sixth, by adding new cost-effective benefits to reflect today's science.

In my written testimony, I have outlined these six steps in great detail, but I want to take a few minutes to highlight some of our proposals.

Mr. Chairman, it is imperative that Medicare, which is the largest purchaser of health care services in our Nation, be a more prudent purchaser. We have got to be more businesslike. Unfortunately, in too many cases Medicare is now paying the highest price in the market when we should be paying one of the lowest.

Let me give you an example. This is a gel pressure pad. It actually goes into a wheelchair, and people in wheelchairs sit on it to prevent pressure sores. We went out and bought it for $72.94. That is the retail price. The catalog price is $59. Medicaid pays as little as $38, but Medicare must pay $112.

Make no mistake about it, our reforms will make sure that Medicare is not paying retail when everyone else is paying wholesale. To do that, we have to spread our savings across all providers, but focus them, as should be, on those areas where we are currently overpaying: in managed care, in home health, and in hospitals.

Let me expand here on the first two. Most experts agree that Medicare's payment methodology for managed care results in serious overpayment. What we would do, is carve out from the payment methodology funds dedicated to graduate medical education and payments to disproportionate share hospitals and instead pay these funds directly to hospitals on behalf of managed care enrollees.

We will gradually reduce the regional variation in payments to managed care plans and create a floor for plans in low payment areas to encourage enrollment in managed care.

Beginning in the year 2000, we will reduce the Medicare payment from 95 percent of the average adjusted per capita cost, to 90 percent. While we do all of that, we will move forward aggressively to develop and implement a new payment system for managed care.

For home health care, we have a different strategy. We know that home health care is one of the fastest-growing components of Medicare. To curb these costs, we will immediately revise our home health care cost limits to curb excessive spending and institute a new per beneficiary limit for each home health care agency.

We will implement a new prospective payment system for home health care services in 1999. We will close loopholes in the home health benefit that invite waste, fraud, and abuse, and we will base our payments on where the services are delivered, not where the billing offices are located.

In addition to controlling spending, we want to return to the original intent of the Medicare statute by reassigning payment for those home health services not associated with post-hospital recovery from Part A to Part B. This reallocation is not—and let me repeat, is not—counted in the overall $100 billion Medicare savings number that we have submitted to Congress, it is budget-neutral.

In this budget we are also building on our record of increasing choice for Medicare beneficiaries, while continuing to protect the quality of care. Beneficiaries will now have two new types of plans to choose from: preferred provider organizations, or PPOs, and provider-sponsored organizations, or PSO.

Medicare will establish coordinated, annual, open enrollment periods and additional enrollment opportunities for managed care and for Medigap plans. To make sure that choice is a two-way street, we will prohibit Medigap insurers from imposing pre-existing condition waiting periods when beneficiaries enroll or switch plans. In other words, beneficiaries will be able to go back and forth.

To protect beneficiaries, we believe that we can balance the budget and preserve the Medicare trust fund and modernize Medicare for the 21st century and still protect vulnerable Americans who rely on it for their care.

The fact is, more than three-fourths of seniors have incomes of $25,000 or less. The average woman on Medicare has an income of only $13,000. Medicare enrollees today spend more than 21 percent of their incomes on out-of-pocket health costs compared to 8 percent for the rest of us.

Our plan keeps Part B premiums at 25 percent of program costs. For outpatient hospital services it brings the co-insurance rate down, from about 50 percent to the 20 percent charge, for most other Part B services by the year 2007.

Mr. Chairman, while the Medicare benefit package has remained relatively unchanged since 1965, science and medicine have not. From decades of research, we know that prevention services not only can save money, they can save lives.

Now we are putting our money where our science is. The President's plan will include 32 hours respite care for families of people with Alzheimer's disease, and a series of new preventive benefits, from colon cancer screening to annual mammograms, with no cost sharing.

Like Medicare, Medicaid also needs a new look, but probably not a new soul. That is why our budget strengthens the program, controls costs, and increases State flexibility, as you noted, without

breaking the Federal promise of coverage for our most vulnerable Americans.

We should all be proud that the growth in Medicaid spending has declined significantly over the past 2 years. The President's budget ensures that the success we have achieved with our State partners will continue. Our plan saves a net $9 billion over 5 years. Overall, our savings are about $22 billion. We achieve these savings in two ways.

First, to help make the disproportionate share payments smaller and better equipped to fulfill their original intent, our budget would decrease Federal DSH payments and re-target them to safety net hospitals and essential community providers.

Second, the President is proposing a per capita cap. Under this proposal, the Federal Government will continue to match State Medicaid spending for each individual enrolled. This means there are absolutely no incentives for States to deny coverage to a needy individual, or to a family.

Let me be clear. This per capita cap is neither a block grant, nor a cost shift to the States. It is a sensible way to make sure that people who need Medicaid are able to receive it.

The President's budget also increases State flexibility by throwing away mountains of red tape. We repeal the Boren Amendment for hospitals and nursing homes. Our plan allows States to expand Medicaid coverage to new groups, or to enroll beneficiaries in managed care without waivers.

It eliminates the requirement for cost-based payments for health clinics. It repeals the 75/25 rule for enrollment composition in Medicaid managed care plans. It gives States the option to extend Medicaid coverage to certain workers with disabilities, and it eliminates requirements for claims processing and information retrieval systems.

Mr. Chairman, I would like to now turn to the next challenge we must meet together. Today there are 10 million American children without health insurance, and the vast majority of them live in families where parents work.

Our administration's proposal is designed to cut the number of uninsured children by up to five million over the next 4 years. We do that with a strategy that builds on existing services and harnesses the skills of our private and public partners to improve our children's health and their parents' peace of mind.

Let me now turn to our final goal, moving our citizens from welfare to work. When the President signed the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, he made it clear that this was the beginning, not the end, of welfare reform.

We have made some progress. Because of the strength of our economy and State efforts, welfare rolls have gone down by 2.5 million. That is more than 16 percent since the beginning of the President's first term.

We are providing guidance to the States by spotlighting the flexibility they have to design their own programs, and at the same time emphasizing the importance of moving families from welfare to work.

Although the States have until July 1997 to implement the new program, we have already given the green light to 35 States to

begin their reforms. As we move forward, we will be closely monitoring State performance, examining the impact of the legislation, and compiling information so that the States and the Congress know what is working and what is not. We will be challenging States and communities to transform our welfare program into a Jobs program.

The President's budget includes two new initiatives that helps States, cities, and employers create new jobs and help our citizens to prepare for them. First, a welfare to work Jobs initiative to help States and cities create job opportunities for the hardest to employ welfare recipients. Second, an Enhanced Work Opportunities Tax Credit to provide powerful new private sector financial incentives to create jobs for long-term welfare recipients.

But the President has made it clear that real welfare reform does not mean punishing people who cannot work, and that is why his budget restores Medicaid benefits to disabled children, to legal immigrants who are either children or disabled adults, people who are part of our American community and cannot work. For refugees, it would lengthen the 5-year exemption to 7 years, to give them enough time to naturalize.

Overall, we believe these proposals address the concerns of State and local officials. They give a hand up to those who can work, and restore benefits to those who cannot.

Mr. Chairman, the budget I have discussed today discards tired, old solutions and meets our challenges creatively and cooperatively. It balances the budget without abandoning our values and commitments. It makes very tough choices, it shows tough management, now we must act upon it together.

As Teddy Roosevelt once said, "Nine-tenths of wisdom consists of being wise on time." This is our time and our test. Thank you.

[The prepared statement of Secretary Shalala appears in the appendix.]

The CHAIRMAN. Thank you, Madam Secretary. I understand from your testimony that the President's proposal to transfer about $82 billion in home health care over 5 years from Part A to Part B trust fund does not achieve any budget savings.

Can you tell me how many years of Part A trust fund solvency the President's plan achieves without this huge transfer of spending to the general fund?

Secretary SHALALA. If we did not transfer that to the general fund we would be at 2002.

The CHAIRMAN. Two thousand and two.

Secretary SHALALA. It has to do with how we ramp up the savings, obviously, and the interaction between the other savings and the transfer of home health care.

The CHAIRMAN. Well, my next question is, I do not really understand why it is necessary to make this huge transfer to the general fund simply to buy extra years of trust fund solvency. Do you think we need more than the next 3 or 4 years to decide on a course of action to address Medicare's long-term problems?

Secretary SHALALA. Well, I think that most of our discussion has been about securing the trust fund for a reasonable period of time. And most of the discussion has swirled around a 10-year period,

therefore, when we laid out our balanced budget we tried to achieve that 10-year period.

But the reason for the transfer was not simply for the solvency. We believe that the reason for the transfer has sound policy grounds. That is the original intent of Part A and of putting home health care in Part A, was home health care connected with hospitalization.

Therefore, we are leaving in Part A the part of home health care that was part of the original intent, and that is a number of days after a hospitalization, and moving to Part B, that which is not related to the hospital fund. We believe that is a sound policy reason to make this split, in addition to the fact that it helps on the solvency of the trust fund.

The CHAIRMAN. I understand from your testimony that you think that the President's home health transfer is consistent with the original intent. But was it not the original intent of the Medicare Part B program to have the program, in part, financed through beneficiary premiums? In fact, I think the original intent was to have 50 percent beneficiary financing.

So how is this policy, which transfers spending to Part B but does not include this spending in the Part B premium, consistent with the original intent?

Secretary SHALALA. Well, the Congress, in fact, moved that 50 percent and set it at 25 percent. But your question is a good one. Why is it, in making the transfer, we did not take the additional step of sliding the home health care under the 25 percent so that it would be included in a premium?

The reason is this, that if you look at what elderly Americans and disabled Americans are now paying out of pocket for health care expenditures, they are paying 21 percent of their out-of-pocket expenses.

One of the statistics I cited is that the average woman on Medicare has an income of $13,000 a year. We were able to achieve our balanced budget proposal without adding to the burden of elderly Americans. We believe that that 21 percent is something we all should be worried about.

So we made the decision not to slide in under the 25 percent and not to increase the burden on elderly Americans, which is already way beyond what any of us with incomes that are growing are paying.

The CHAIRMAN. For the record, could you tell me how much the Part B premium would be if the transferred home health spending were included?

Secretary SHALALA. Let me get that number for you. We will have to calculate it. We will supply it for the record.

[Information supplied follows:]

The Administration is concerned about the impact that an increase in the Part B premium would have on poorer Medicare beneficiaries.

However, if the Part B premium were allowed to increase due to this policy, this would be the effect:

Calendar Year	Increase due to HH Transfer
1998	$8.90
1999	9.00
2000	9.00
2001	9.80
2002	10.60

The CHAIRMAN. The record will be kept open until 6 p.m. for any written questions.

Let me turn to health insurance for children. I think we are all concerned about the 10 million who have no coverage. As I understand it, the percentage of children who are uninsured is basically unchanged. The decline in private insurance has been offset by an increase in Medicaid coverage. Certainly we do not want to see any further decline in private coverage; I am sure you agree with that.

Secretary SHALALA. Yes.

The CHAIRMAN. How do we extend health insurance coverage to more children in a manner that does not undermine the private sector's role?

Secretary SHALALA. Well, carefully. It is not easy to do. If you look at what we are attempting to do, the Workers Between Jobs initiative is the first thing on our list. There are large numbers of workers who are relatively low-income that lose their jobs and cannot afford to pay their COBRA, for example. We propose to give the States some money to help those workers keep their health insurance. That automatically keeps their children in health insurance, and that would account for 700,000 children.

Second, we suggest that, rather than extending Medicaid, we leave that decision to the Governors and give the Governors some grants. Some of them may well want to put a separate pool together, they may well want to work with private sector employers to make sure it is not substitutional. Many of the Governors are now moving to try to think up creative ways of getting the children in their State covered. That is the second proposal.

Low-income adolescents is what Congress has already done. You are adding an adolescent age cohort each year. I think we are up to 13, and we are adding one every year. That adds another one million over the next 4 years.

Regarding the 12-month eligibility, the managed care companies and the insurance companies have said to us, they go to a great deal of trouble to identify a child that is eligible for Medicaid. When that child's mother gets a promotion or a job at a minimum wage, and they go above whatever the State's cutoff is, they would like to be able to keep that child on insurance for a year as opposed to bouncing them off after a month, and then search for a program they can add to them.

Finally, the Medicaid outreach. There are three million American kids eligible for Medicaid and we need to go find them. We are not asking for any extra money as part of our overall strategy. Many of the Governors are going to managed care for all of the children

that are eligible in their State, the managed care companies are enthusiastic about going out and finding it.

This is not a single program, it is an overall strategy to define hundreds of thousands of kids in different places to make sure that every child has health insurance. The numbers of children who do not have insurance is actually rising a little bit, and I expect our numbers to be well over 10 million, something closer to 11 million, by the end of this year.

But, as you can tell, because it takes a while to explain it, we are not simply throwing a new, big program out there and substituting for private sector efforts, we are putting all the pieces together to try to expand coverage, the hard way.

The CHAIRMAN. In other words, this is a very difficult area.

Secretary SHALALA. It is very difficult. We have not overestimated what we think we can do in a 4-year period. It is going to take everybody pulling together. The Governors are enthusiastic about doing it, but no one thinks that this is going to be easy to do. Most of these children have working families. They are the children of low-income workers, often just above the Medicaid limit in their State.

The CHAIRMAN. Well, my time is up. I will have further questions.

Senator Moynihan.

Senator MOYNIHAN. Thank you, Mr. Chairman.

Madam Secretary, you say in the children's health initiative you are not throwing a great, big program out here. I take it this is something different than 4 years ago.

Secretary SHALALA. Yes, sir.

Senator MOYNIHAN. That is the way to answer.

Now, you are serious about the children's health initiative. But on Monday the President met with the Congressional leaders here in the Capitol, which was unusual, in the President's room, which has been around for a long while. They agreed on five initiatives, and children's health was not one of them. Does that mean that what you are proposing has already been dropped?

Secretary SHALALA. No, sir. I have great faith in you and Chairman Roth adding this initiative to——

Senator MOYNIHAN. But you do not have faith in the President?

Secretary SHALALA. Oh, I do have faith in the President. That was an initial step. They laid out the first few issues that they could agree on. It does not mean that any of us should give up on this particular initiative.

Senator MOYNIHAN. But you agree that it was not in the list of the five.

Secretary SHALALA. I do. But Medicare was not in the list, and already we have a bipartisan initiative on Medicare. So I just have confidence that both parties believe that no child in America should go without health insurance. We are proposing to do it in an incremental way, maximizing our——

Senator MOYNIHAN. If that is so, if that is your belief, why was it not on the list of initiatives agreed to?

Secretary SHALALA. Well, I cannot answer that question, other than they obviously identified those that they were prepared to go on initially.

Senator MOYNIHAN. Well, if they were not prepared to go on this, then it is not clear that everybody agrees. The President agreed not to do. But you have faith in Senator Roth?

Secretary SHALALA. I have faith in Senator Roth, I have faith in Senator Moynihan, and everybody here that I can convince that this is absolutely a top priority for our country.

Senator MOYNIHAN. And you will talk to the President about your faith?

Secretary SHALALA. I will, indeed.

Senator MOYNIHAN. Good. Thank you very much. I have faith in Senator Roth, too, I would like to record.

The CHAIRMAN. Thank you, Senator Moynihan. It is mutual.

Senator Chafee.

Senator CHAFEE. Thank you. It is Valentine's Day, and so I am glad you have faith with everybody up here, do you not?

Secretary SHALALA. It is my birthday, actually.

Senator CHAFEE. Oh. Well, happy birthday to you. That is wonderful.

Madam Secretary, follow me through this and see if I have missed something. You indicated that right now we know that the Medicare program, if nothing is done, would go broke by 2001. Now, when we are talking going broke we are talking about Part A. That is the part that goes broke, the hospital insurance.

Now, with all of the changes you have suggested, without the home health care transfer it would go broke by 2002, you just said.

Secretary SHALALA. That is correct. If I might add to that, if you did the provider savings only it would still go broke. You still do not buy more than 1 year. It is the interaction between the two that gets you to 2007.

Senator CHAFEE. Well, if you had been here yesterday and heard the testimony about where Medicare expenditures are going to go, I think you would have been—and maybe you saw the testimony—as deeply disturbed as I was.

For instance, the CBO testified that, under current law, Federal spending on Medicare is projected to overtake spending on Social Security within 30 years. Now, that is the CBO saying that. It seems to me that what you have done here has been characterized by some as flim-flam, a shell game.

What you have done is taken expenditures out of Part A for the home health care that have to be covered by the hospital insurance, and you take them out of there and you transfer them into Part B, but there you do not have them covered by the Part B insurance. Am I correct in that?

Secretary SHALALA. You are correct, but that is not where we get our savings. We do not count on that to get our savings.

Senator CHAFEE. But what you are doing is transferring it to the general fund of the Federal Government. I mean, they are the ones that are paying it. So in the overall budget you can say it is a wash, but as far as looking at Medicare as an entity that was set up to carry itself, and, as the Chairman pointed out originally, the insurance premiums that one pays in Social Security was to cover the hospital insurance and the Part B was to be covered by the premium 50 percent.

Now, that has eroded, and eroded, and eroded. Currently, we have it at 25 percent, but actually, as a result of our calculations, it is now up to 31.5 percent. At least, it was the year before last year.

Now, you are doing away with all of that. I really do not think you are doing much here. You have no means testing. You do not do a deal with that. You drop the premium. You expand the services. Everybody loves expanded services.

My next question is going to be, when the baby boomers come of age, what is the Alzheimer's going to cost? Everybody is for that, but what is it going to cost? First, just tell me, what have you done in this program?

Secretary SHALALA. What we have done, and one of the things that CBO pointed out when they pointed out the growth, in our proposal is to bring Medicare spending down to near where projected private sector spending is, around 5 percent.

Senator, with all due respect, I think the hospitals, the managed care agencies, and everybody else who are sharing in this savings, because we have laid out $138 billion over 6 years, believe that we have done a lot to slow down the growth of Medicare.

It is true that in the transfer we do not count that in our savings, but what we are doing is restoring the original intent of the hospital fund and at the same time bringing down Medicare growth to just above 5 percent a year. We have done a tremendous amount in a series of changes modernizing the program to slow down the growth of Medicare.

Senator CHAFEE. Well, it is no trick at all to shift things from Medicare into the general fund of the United States and, therefore, making a tremendous savings to Medicare and say that is bringing down the costs.

Secretary SHALALA. But, Senator, we are not getting savings by transferring home health care from Part A to Part B. Our savings, the $138 billion over 6 years, $100 billion over 5 years, is on top of that transfer. That transfer does not account for our savings.

It is our savings that reduces our growth rate to something around 5 percent. That savings is achieved by slowing down the growth on managed care, on hospitals, on home health, a whole series of savings that we have done. So, it is not in the transfer.

Second, Medicare is both parts, A and B. I think my point would be is that we are restoring the original intent of the hospital trust fund so that it can be financed out of payroll taxes.

On Part B, we are transferring home health care but we are taking savings out of Part A and Part B, most of it out of Part A, to account for slowing down the growth. So, we are doing a tremendous effort on Part A over that period of time to slow down the growth of Medicare.

Senator CHAFEE. Well, my time is up. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Gramm.

Senator GRAMM. Mr. Chairman, I just want to add a little bit to Senator Chafee's point. It is true that the transfer is not counted toward the $100 billion savings. But it does certainly count, and, in fact, it makes possible the claim that you saved the Medicare Part A trust fund for 10 years. The truth is, I could save it for 100 years by transferring hospital care out of Part A into Part B.

Secretary SHALALA. Then you would be violating the intent of the original designers of the Medicare program, which was to pay for hospital out of Part A.

Senator GRAMM. What I really think happened, Madam Secretary, is that we took home health care out of B—and I do not know this, but I am checking it out now—and put it into A so that we would not have to raise the deductible and so we could exempt it from the co-payment.

Now we are putting it back into B so that we will not endanger the trust fund in Part A. But the point is, no matter how we do that, it does not really change the financial picture of Medicare. I think that is what Senator Chafee is saying.

Let me get to my point. I want to thank you for coming today and I want to say, as the new chairman of the Subcommittee on Health Care, with Medicare jurisdiction, I look forward to working with you. I hope we can have a bipartisan program; I think the country can be a big beneficiary of it.

But I want to raise a very, very serious issue. For your outpatient services you have under your proposal, as best I can tell because we do not have the exact details yet, a 10-year phase-down from the 50 percent co-payment to a 20-percent co-payment. Now, you do not claim any real savings in the 5 years from making these changes, about $1 billion, you claim.

But let me give you the magnitude of the estimates that I have of what this means in the future. From 2003 to 2007, as you phase down this co-payment from 50 percent to 20 percent, it costs the taxpayer, or it costs Medicare and the taxpayer, $50 billion. As you phase it down from 2003 to 2012, I have an estimate, made by a former actuary and a former No. 2 person at OMB, that that costs $100 billion.

Now, let me be sure everybody understands what I am saying. We are talking about a new benefit. We are talking about lowering the only substantial upfront co-payment that we have in all of Medicare. This is a co-payment where you pay 50 percent for outpatient care. You propose to phased it down. You do not yet have a specific formula, but it is my understanding you have a 10-year phase-down so that in 2002, you are only beginning the phase-down.

The question is, once fully phased down, what does it cost? These estimates that I have from outside experts indicate that, between 2003 and 2012, we could be looking at as much as $100 billion of new costs. Yet that represents all the savings you claim to be achieving in the next 5 years.

Now, if that is the case, we need to be very careful about what we are doing, because if we do everything you say between 1998 and 2002, we save $100 billion, but if we do everything you say between 2003 and 2012 and we spend $100 billion, then we are right back where we were.

Secretary SHALALA. Senator, first of all, I do not have any projections beyond 2007, but we will work through the numbers for you. But let me explain what the current problem is now with co-pays.

An elderly person walks into a hospital or an outpatient clinic and gets some kind of service. It might even be surgery. They pay the hospital's price and pay their co-payment right there. Then

Medicare comes in afterwards and pays a different price. The reason Medicare pays a different price is because Medicare pays on the basis of what the actual cost to the hospital is.

So we have large numbers of elderly Americans who are paying a hospital price that is higher than what we actually are reimbursing on, which means that these elderly people are paying a higher co-payment than they need to if we actually had the original price right. So, one of the things we are trying to do, is to make sure that no one pays more than they should be paying, based on the Medicare system.

Now, it is complicated, but it all goes back to that original chart. In the process of reforming Medicare, we have to be extremely careful to understand that, as we get older, we get poorer and that elderly recipients are paying a very high percentage of their incomes in out-of-pocket costs because Medicare does not cover everything.

It does not cover all of the costs of health care, it does not cover all your drug benefits, it does not cover other kinds of things. So this is one of the areas where the interaction between this and other things we are doing we are happy to lay out with your subcommittee and have a careful discussion.

But the point I want to make, is that we have done a number of things here that bring down the growth rate of Medicare and try to protect the beneficiaries so they are not paying more and more out-of-pocket costs, and protect the basic benefit package.

We have got it down to somewhere near where the private sector growth rate is going to be, but to get there we did a whole bunch of things, a lot of different interactions in the system.

So taking just one out, what we would like to do is lay all the pieces out for you. I think that is the only point. We have got some quirks in the Medicare law, loopholes and other kinds of things, that need to be straightened out as part of this modernizing of Medicare.

So I beg your indulgence for my lack of detailed responsiveness, because we would have to go out and do the numbers. But I get your point.

Senator GRAMM. Mr. Chairman, if I could just make one point. I think one of the things that we have to do if we are going to be responsible is recognize this is a long-term problem.

Whatever savings we are going to claim in these first 5 years—and I am not much of a mind to get into a debate about what that number is—we need to look at these projections 20 years out. I can see some attractiveness to the change you are trying to make, but we need to be sure, in claiming these savings and thinking we have done something over 5 years, that we do not plant the seed for spending those savings over the next 5 years.

If you could get us the 20-year cost estimates on these items, it would be very helpful. We need to look at these new additions and what they cost over the next 20 years.

Secretary SHALALA. Senator, I absolutely agree with you. What we do not want to do is to get into some of the problems we have created, is we have added new services, or changed the co-payments.

My only point is, we need to look at all the premiums, all the co-payments, and all the places where people are charged, and be very sensitive to what is happening to people's incomes. So, you have to look at all of it together.

Senator MOYNIHAN. Mr. Chairman.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Senator Chafee has had to leave, and I have to join him at the Committee on Environment and Public Works, if I may excuse myself, and wish the Secretary a happy birthday, and a happy Valentine's Day.

Secretary SHALALA. Thank you. Thank you very much.

Senator BAUCUS. Mr. Chairman, I am joining the same committee, but I have a couple of questions I would like to have submitted for the record, please, and answered.

[The questions of Senator Baucus appear in the appendix.]

Secretary SHALALA. Thank you, Senator.

The CHAIRMAN. Thank you, gentlemen.

Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman. I am going to change subjects a little bit. I voted for the Welfare Reform bill, as you know. That was not the easiest vote I have ever made in my life.

One of the things that concerned me, looking in my own State and a lot of other rural States and States that have economic difficulties, is the question of job creation. That is fairly much left up to the States, and particularly job creation in rural areas where there just are not a lot of jobs to begin with. You have got unemployment that is chronically high.

Is your department in any way thinking about ways to be helpful to States on that?

Secretary SHALALA. Well, there are a couple of new proposals, as you probably know. Is a tax credit for employers, the other, which is part of these five areas that are going to go through this bipartisan discussion, is a welfare to work initiative that probably will end up as some kind of grants to States and communities for job creation.

Third, because of the Congress' commitment to support services, there has been a tremendous investment in child care which is another area of economic development for job creation, as well as a major commitment to Head Start, another place where jobs are being created that may provide entry-level jobs.

The other thing we are doing, is we are providing technical assistance to the States who are turning their welfare programs into job placement programs so they have a training and support system once someone gets into a job. There are a lot of model programs. West Virginia has been doing some of those as a way of maintaining. But for places that have no jobs, these new initiatives that Congress is starting to talk about will be critical.

Senator ROCKEFELLER. The Department of Labor is obviously going to be very active in that area.

Secretary SHALALA. Yes. The lead on these two issues.

Senator ROCKEFELLER. The Jobs Challenge program is $3 billion.

Secretary SHALALA. Yes. Right.

Senator ROCKEFELLER. Are you going to be working with them on that?

Secretary SHALALA. Yes. We are partners with Labor and with Treasury in the development of these proposals, but the lead will be at Labor.

Senator ROCKEFELLER. All right. Now, that leads me to my second question. One of the things that I fought hardest for and was only partially successful, was that if we are to undertake something like welfare reform, which is a massive thing to do, but I felt a right thing to do, because the present system, as it has been, has not been successful, either in West Virginia or in most other places, that it was important that we really monitor accurately, report accurately, and do research accurately, demographically, geographically, and every cross-cut possible on exactly what is happening in welfare reform.

I wanted to see $20 million go to your department for that, you ended up with $15 million. You can do a lot of research with $15 million, but I want to get a sense from you of what your thoughts are about how you plan to spend that $15 million just in conceptual form to monitor welfare reform so we know if we are hurting or helping.

Secretary SHALALA. Yes. First, there is the tremendous data collection effort that is going on that was mandated by Congress. The States have to provide us with a lot of information.

We are actually going to focus on two things, understanding both the implementation of the welfare bill, but specifically trying to understand where the jobs are, and how the placement is going, how long people are staying in those jobs, and what the impact is on children. That will be our emphasis, in addition to a lot of data collection, which will allow us to answer Congressional questions.

In addition to that, I have asked my colleagues, we need to coordinate and have a pretty good sense of other studies that are going on. As you know, this social experiment is about to become the most studied social experiment in American history. Almost every foundation, I think, has launched a study.

We will be monitoring those studies at the same time, so that when Congress asks us questions we will have multiple ways of answering those questions. There will be case studies State by State.

So we should have a pretty good sense, in States with different demographic characteristics, what the impact is. But it is going to take a while. I mean, we are not going to know this year.

Senator ROCKEFELLER. I understand that. I understand that, Madam Secretary. Following on from that, one of the champions of child support enforcement during the time that he was here was Bill Bradley. Back when I was chairing the National Commission on Children, although we did not vote on the minimum wage aspect, it was agreed by most of us on the commission that if you did four things, if you had a child tax credit, if you had expanded EITC, if you had the community employment aspect which I referred to earlier, and if you had child support assurance, which we figured, if you really went out to those mothers and fathers—mostly fathers—who have abandoned their responsibilities to their children, there was $30 billion in the private sector out there available to children.

As a result of those four things, we felt that we would be able to lift most families in poverty, if they were all implemented, out of poverty. Now, that puts tremendous pressure on, first, the work part of it, and second, the child support enforcement part. The President has made proposals on that, and I would just wonder if you have any comments to make.

Secretary SHALALA. Well, Congress, as part of the Welfare bill, put in resources for child support. We have all been pressing the States to get their computer systems up. It has been uneven in terms of their progress, but we are pressing very hard. By October 1, we hope everyone will have pretty sophisticated computer systems up.

We have increased child support over the last 4 years by 50 percent. That is the largest increase in the history of this country in terms of collecting payments. As you know, we have used——

Senator ROCKEFELLER. It is a small base, though, nevertheless.

Secretary SHALALA. It is a small base, but we have used the Federal tax system as a way of doing that. I believe this is going to be one of the big success stories, because we are going to be able to track people across State lines, we are going to be able to do this.

As for the other parts, we are getting the lift. I mean, people are going to move into jobs. The question is, are they going to be lifted out of poverty and are they going to be able to stay there? That is the hard question. The Earned Income Tax Credit, the minimum wage, child care money, obviously helps.

On children's health, if every child in America, no matter where their parents worked, had health insurance, that would help, too. We see that as an integral part of all of this. If you go to work, you ought not to lose health insurance for your children, which is the way in which public policy is currently designed.

Senator ROCKEFELLER. Thank you.

The CHAIRMAN. Senator Jeffords.

Senator JEFFORDS. Thank you.

Secretary SHALALA. Hi, Senator.

Senator JEFFORDS. I, of course, come from a rural State, and I am concerned a little bit about rural areas, especially in Vermont where we have both low cost and low utilization, and the difficulty in trying to get HMOs to be incorporated into the present system. Yet, we pay the same taxes that the other States do. I wondered if there would be any attempt made to rectify the inequities, to help us in that area?

Secretary SHALALA. Actually, we have a number of rural initiatives, but the major one is to change the way in which we pay that will provide a floor of $350 under our payment and will start to shift some resources to rural areas, recognizing that sparsity is also a high cost. Our hope is that that will help to attract rural HMOs to States like your own, so we are making some moves in that regard.

In addition to that, we have a number of different programmatic proposals that help to sustain rural hospitals, expanding demonstrations, and other kinds of things. If the managed care methodology is changed, we think that it really will, by creating that payment floor, help rural areas. It certainly is an improvement.

You are absolutely right, the current payment levels are too low to attract managed care to rural areas where it has not been before. In my own State of Wisconsin, we have had a 100-year tradition of organized care in rural Wisconsin, but in areas that have not had it before the payment rates will have to be different.

Senator JEFFORDS. I am not sure that will help us. I think our floor is right now at $365, so we will work with you on that.

The other area is the concern of children, which we discussed earlier. But I do know you have a new program coming out with $750 million in it.

Secretary SHALALA. Yes.

Senator JEFFORDS. Is that going to be by grant application, or is it going to be per capita; how are you going to distribute that?

Secretary SHALALA. Well, actually it will be both. I mean, the States will be eligible for the money. They will apply for the money. They will be putting together public/private partnerships. We have a pretty good sense, because we have been working with States, many of these managed care waivers are attempts to expand coverage to kids.

Since the States are going to be able to do that automatically, some States will try to expand Medicaid and use this, in part, as their match. Some States will actually set up their own pools, some States will work with private sector employers and try to figure out a way to subsidize, perhaps, the premiums. I cannot tell you exactly how it is going to work, because I think every State is slightly different.

If you look at the percentages of kids that are not covered, you cannot tell by socio-economic characteristics or demographics why some States do it and some States do not. But I think there is enough enthusiasm out there that I just do not know a Governor that would not like to figure out a way, if they had a little bit of money—and this is not a lot for them—to cover children, particularly since these children are children of working parents that are just too low-income to be able to pay for a full health insurance plan.

Senator JEFFORDS. Thank you, Mr. Chairman. Mr. Chairman, may I take 1 additional minute? I owe you a pound of cheese. We had a wager, which I probably should not mention here, on the Super Bowl. My New England did not do that well. They did very well, but not quite well enough. So I just wanted to make sure that I have publicly demonstrated that I have now paid you on the wager. I will have that delivered to you.

Secretary SHALALA. Thank you very much, Senator.

Senator ROCKEFELLER. It also looks like cheese with a substantial amount of toxicity. [Laughter.]

Secretary SHALALA. No. Actually, Senator Jeffords said that he was sure that it was beyond the ethics limit because Vermont cheese was priceless. [Laughter.]

So I am happy to have your priceless cheese.

The CHAIRMAN. And only he would say that. [Laughter.]

Senator Bryan, please.

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

Secretary SHALALA. Thank you, Senator.

Senator BRYAN. It is a pleasure to have you before us today. One of the concerns that States that have very high growth rates have, such as my own State of Nevada, is about the Medicaid cap per capita cap.

Would you explain how that works? And, would you tell us if you gave any thought to establishing some type of a differential formula recognizing that some States are experiencing very rapid general population growth, and with that also a very rapid growth in the Medicaid-eligible population, whereas other States, for economic and demographic reasons, are not experiencing the same kind of growth?

Secretary SHALALA. Senator, that is why we did a per capita cap, because that would accommodate States that really had expanding populations and wanted to add people on their rolls. The way in which this cap is designed, it is per person, so that the States will not be penalized if they want to add populations. Obviously, there are States, like yours, that will be adding populations.

Senator BRYAN. How do you achieve the $7 billion savings, which I believe is the proposal's savings scoring if this is just a cap, that we are all going to be fine, and States experiencing growth rates are not going to have any concerns?

Secretary SHALALA. It is a per person cap, so what we are doing is slowing down the growth per person, as part of our proposal.

Senator BRYAN. The growth per person.

Secretary SHALALA. We also do some things with the disproportionate share payments at the same time, so we get most of our savings there. But it is the growth per person that we are slowing down, so that, as you add someone, you can add that individual, but it is across the board growth per person.

Senator BRYAN. When you said growth per person, I am not sure that I am tracking with you, Madam Secretary. Are we talking about, the amount of the per capita grant, the individual dollar amount, that that is reduced based upon some population formula, even though the method of distribution is based upon a per capita allocation?

Secretary SHALALA. Well, let me go through it for you.

Senator BRYAN. Please.

Secretary SHALALA. We have four categories. What you do, is the cap for any given year is the product of three components: the total spending per beneficiary in the base year, so you take the total spending per beneficiary; an index for years between the base year and the given year; and the number of beneficiaries in each subgroup. And we have four groups, the elderly, disabled individuals, non-disabled adults, and non-disabled children.

So what you do, is make an adjustment knowing that the costs for the elderly are different than the costs for disabled individuals, than the costs for children. You build in that mix, and then you take the existing spending that you currently have and you take the number of beneficiaries.

Then what we are doing, is we are putting a GDP plus two, I think, on the first year, and a GDP plus one. The State gets that amount of money. So you adjust it for the differences in people that it has in that mix. You take what they have been spending up until

now, and you slow down the growth then with GDP plus two for the first year, and plus one for the years after that.

Obviously, we are still going to be talking to this committee, in particular, about that index. But what you are trying to do, is to slow down the overall growth without affecting the ability of those State, if they have some elderly that are eligible, to be able to bring in those elderly who are eligible.

Senator BRYAN. I appreciate the explanation. I want to particularly look at the GDP projections, because in States such as my own the 1 percent, the 2 percent, is totally divorced—and I say that with great respect—to the reality of what is occurring in our State where, in the city of Las Vegas, 6,000 people a month are arriving. That is 72,000 people a year. The population of the entire State in 1920 arrives every year in the metropolitan Las Vegas area. So, we need to work through those numbers and I look forward to doing that with you.

Let me ask you a question. I am a new member to the committee, but am not unmindful, having worked with Senator Conrad and others on the Centrist Coalition budget proposal, why not, as we look at the Part B issue, consider a means test? What would be wrong with that?

Clearly, you have indicated, and I am sure the numbers are correct, that 75 percent of the folks that are on Medicare are people whose incomes are modest, below $25,000, I believe, was the chart figure that I saw. But there are a substantial percentage of people whose incomes are substantially higher than that, many of whom make more, and deservedly so. There is no judgmental criticism on my part, but these individuals make a lot more than many working families who are struggling with young children going to school, and all of the other burdens of young families. What is the philosophical rationale for not placing some type of means testing upon those who are clearly much more affluent and ought not to have their Part B premiums subsidized?

Secretary SHALALA. I do not think there is any philosophical reason, because we already means test Medicare. In fact, for low-income individuals, their premiums are paid by the Medicaid system.

What the President has indicated, is that it is a concept and an idea that he believes should be on the table and we should talk about it. We actually did means test the program in our own health care bill 3 years ago, so we have already introduced the concept.

In that case, though, we were covering a larger number of people, but I do not think that it is philosophical. We got to our balanced budget without doing it, but the President has said that he is open to considering that as one of many ideas.

Senator BRYAN. Let me say that I am encouraged to hear that response, and again look forward to working with you to see if we might be able to craft something. I thank the Chair.

Senator GRASSLEY. Senator Conrad is next.

Senator CONRAD. I really like the job you are doing chairing this committee.

Secretary Shalala, it is always good to have you come and testify.

Secretary SHALALA. Thank you.

Senator CONRAD. You are very clear, very direct, and we certainly appreciate that in this committee. I hear a lot of criticism

from my friends on the other side of the table with respect to the administration's proposal on the transfer of home health from Part A to Part B, at least a part of it.

Frankly, I think many of their criticisms are misdirected. I think it is, perhaps, important to remind all of us that the portion of home health in question used to be primarily in Part B. That is how it started. it was not until the early 1980's that it was shifted to Part A, and that was done with minimal debate.

Then in the mid–1980's, the House, in one of their proposals, passed legislation moving it back to Part B as part of the Medicare Catastrophic Coverage Act. Similar action was not taken in the Senate, so it did not become law.

Then in 1995, the Republican Majority in the House, as part of their reconciliation, voted to transfer a portion of home health to Part B. It is not as though this is some big, new idea or some change from what we have had in the past.

In fact, Part A has historically contained acute and immediately post-acute benefits, while Part B has covered more chronic conditions. It seems to me that home health visits, beyond the first 100, really do not belong where they have been. The shift that you have recommended really makes more sense, conceptually.

The real question in my mind, is whether, when you shift over to Part B and do not include it in the premium calculation, if that does not create a problem. Now, I have asked this question of administration representatives before in the budget committee and they have said, well, we did not want to make it part of the premium calculation because that would boost premiums for some of the lower-income people in a way that is unacceptable.

But I think our Republican friends do have a point when they suggest that we think carefully about whether we want a portion of Part B costs covered by premiums to fall significantly below 25 percent, which would occur.

That raises the question in my mind of whether or not we should not consider an overall change to the way we calculate Part B premiums and co-pays. I would ask you for your reflection on that question. Maybe it is the time here to really think through carefully how we calculate the premiums. Maybe we ought to have a bit of means testing here. My own conclusion is that that is appropriate.

I have got some friends that are very well-to-do, and they have relatives who are less well-to-do who are still working. They say, I really cannot justify those kids subsidizing us, who are far better off. I would just ask you if maybe now is not the time to have a more thorough review of what we are doing.

Secretary SHALALA. Well, I think that one of the things that we did, at least internally within the administration in dealing with what is considered a short-term proposal, that is, to get 10 years, is we were doing so many things to Medicare that we wanted to be careful we were not adding to the burden and cost shifting to them as part of this, since we could get to a balanced budget without sliding home health care under the 25 percent. But, at the same time, we were holding to 25 percent. That number would have dropped in terms of the premium, so we were already making certain that the elderly and disabled continued to pay the 25 per-

cent. But, as I indicated in the previous questions of Senator Bryan, there is some willingness on the part of the President to think about these ideas.

Our bottom line here, is we want to be extremely careful, at the end of the day, to be guaranteeing a benefit package so that this is about health, not just about financing, and not to push elderly Americans deeper into poverty because, as you can tell from these numbers, they are paying a huge amount out of pocket. So whatever we do, it ought to continue to guarantee the benefit, and at the same time project the vast majority of beneficiaries who have relatively low incomes.

Within that context, thoughtful ideas such as yours obviously are things that we ought to be discussing when we get to these kinds of bipartisan dialogs that we are going to have.

Senator CONRAD. Just one final comment. I am very pleased to see the administration have the EACH–RPCH expansion, the sole community hospital rebasing, and the reauthorization of the Medicare-dependent hospitals. Those are very important steps and very much appreciated by those of us who represent more rural areas.

I would want to ask you, has there been any assessment done on how these things affect rural hospitals in combination? That is, when you look at the reduction in reimbursement to all hospitals and then you overlay it with what has been done for rural hospitals, has there been any kind of assessment done on the net effect on rural hospitals?

Secretary SHALALA. I am not sure we have. But I can tell you the most powerful thing that we are doing is to revise the managed care payment methodology, because if we really can bring up the reimbursements in rural areas so that it is more attractive for managed care, that will have the most powerful impact.

But we could go through and make some guesses about what the combination of these effects are. What we have tried to do, is every place where we could make an improvement or expand the demonstration that had been successful nationally, we tried to do that.

With the rural referral centers, for example, the large hospitals that provide tertiary treatment, they will receive an advantage versus other hospitals when they reclassify to a higher wage area payment. So, there are lots of different things that we are doing that, in combination, ought to be quite positive for rural areas.

Senator CONRAD. Thank you very much.

Senator GRASSLEY. Senator Moseley-Braun.

Senator MOSELEY-BRAUN. Tnank you very much, Mr. Chairman. Secretary Shalala, I am delighted to see you. As you know, I did not support the Welfare Reform bill, and I thought it was going to have all kinds of problems.

My mother used to say, you cannot make a silk purse out of a sow's ear, but I want to tell you, you sure are trying it. I very much appreciate your efforts to see to it that that legislative does not cause just horrendous impacts on the most vulnerable in our society.

I particularly want to congratulate you on some of the initiatives that are being made with regard to children, and what happens with poor children. Again, one of my reasons for not supporting the Welfare Reform was that I thought it was inappropriate for us to

abandon a national commitment to poor children at this time. But that is water under the bridge, and so we are going forward. I, again, want to congratulate you on what you are doing to try to moderate the effects of what.

Specifically, with regard to disproportionate share, as you know, the fact is, no one in this country does not get services; if they get sick and fall out in the street, somebody is going to take care of them somewhere. The only issue is, how it gets paid for.

Disproportionate share was a way of softening the impact of the bottom line of providing for the poor on hospitals and institutions that serve them. You were going to make some changes in disproportionate share. You are going to carve out those funds. Your details say you are going to hold harmless that, and pay directly to the safety net hospitals and essential community providers that provide for the poorest Americans.

So my question is, you say you are going to hold harmless in terms of money, except that, again, with welfare reform it is likely that there will be more people showing up at these disproportionate share hospitals that previously received care under Medicaid that will not be receiving it in the future, and if there is a cap, essentially, that could mean that these disproportionate share hospitals would be more greatly impacted than not.

So my question is, how will the payments be determined to these heavily impacted safety net and essential care providers, and do you plan to publish? Mr. Vladeck was here yesterday talking about this, but my question is if you plan to publish something in the Federal Register that will allow for comment from the disproportionate share providers.

I have two questions. Let me ask them both, and if you would not mind answering them both. That way I will not get in trouble with the red light.

Secretary SHALALA. Yes.

Senator MOSELEY-BRAUN. My second question is something that we have discussed before, in terms of data collection. I am very concerned, again, with the changes with welfare reform and the changes in Medicaid, that we could wind up with a Tower of Babel among the States in terms of what they report and how they are able to keep track of what is being spent for what, with changes in health care not only in terms of the dollars, but tracking the health care data that I think is essential for our country. The flexibility, of course, has a lot of benefits. But, clearly, information reporting has to be consistent.

So my question then is, to what extent are you comfortable we can achieve a single language, if you will, for health care and spending, data compilation and reporting? So the first is on DSH, the second on data collection.

Secretary SHALALA. We have not worked all the details on DSH, but the principles of what we are trying to do—the Federal Government spends about $10 billion annually on DSH—is to make sure that DSH is more carefully targeted to make sure that the hospitals that really are safety net hospitals are getting the money. That ought to help some of the hospitals that you are concerned about.

The second carve-out is in the Medicare program, and that is to make sure the academic health centers, which are also often safety net providers, are getting money that they may not now be getting because it is in the payment to the managed care plans.

Our proposal, which is similar to proposals that many of you have worked on here, is to carve that amount out and then target it to the academic health center. So there are a number of ways in which we are trying to help safety net hospitals.

We will have legislation that you will be voting on—the regulations will be done later—but you will have a pretty good sense of the impact of the DSH proposals once the details get worked out.

Senator MOSELEY-BRAUN. But would it be a cut, I guess, is my question? Is there going to be?

Secretary SHALALA. Well, it depends on who you are. If you are a hospital that is not really a safety net hospital and you have been getting DSH money, you may well not get additional DSH money in the future because you are not a safety net hospital.

Senator MOSELEY-BRAUN. Even if you are providing care for people who cannot pay for it?

Secretary SHALALA. No, no. I mean, that is the point. There are hospitals who are not safety net hospitals, who are not providing a lot of help to people who do not have health insurance that are getting DSH money. What we want to do, is to make sure that the hospitals that are needy and were designed for DSH payments are getting the money.

Senator MOSELEY-BRAUN. Well, that is wonderful. But if you are a hospital and you are taking in someone who cannot pay for it, that goes on your bottom line. So your incentive is increased to send that person to a second-tier institution somewhere in the inner city, or something, is it not?

Secretary SHALALA. Well, no. The point is, for hospitals who are currently serving low-income individuals, they are safety net hospitals, obviously.

Senator MOSELEY-BRAUN. I understand.

Secretary SHALALA. They will continue to get resources. But there are hospitals that are not serving safety net populations, and they are getting money. We have got to make sure that the money is targeted to places that are actually serving needy people. That is the point of what we are trying to do.

The issue of data is a complicated one. The Congress mandated all kinds of data for the States to give to us, and gave us $15 million to study what is happening to welfare, mostly to be able to answer pretty straightforward questions: did people move from welfare to work, did they stay there, what happened to their kids, were they pushed into poverty? I mean, they are straightforward questions, and we will be getting information from the States.

Whether it is adequate or not to answer the questions that Congress has, I cannot tell you right now. We are still in the stage where people are setting up the data sets and identifying and working with the States.

But I can tell you this, this is going to be the most studied social policy in American history. If we do not have the answer, someone else is studying it. There are going to be case studies in the States, the States themselves are doing evaluations, the national founda-

tions are funding huge studies. There is going to be a lot of information out there, some of it I am sure contradictory, and a lot of base data about what is happening. But we are not going to have it for a while.

It is not going to make sense for the first year because the States are phasing in the program differently, and because some States, like Iowa, for example, started their welfare reform well before the legislation was passed. Iowa was deep into their welfare reform two or 3 years before—Senator Grassley and I, in fact, discussed it—the legislation was actually passed.

So we will have different information about different States and we will do our best to be able to answer the most fundamental questions, are we lifting people out of poverty, what is happening to their children, are they getting jobs and staying in jobs?

Senator MOSELEY-BRAUN. I am sorry, Madam Secretary. My question was about Medicaid, specifically.

Secretary SHALALA. Oh, I am sorry, about Medicaid, about the health care. We have lots of data on Medicaid.

Senator MOSELEY-BRAUN. But with regard to the differences between the States, do we have a single language or do we have a Tower of Babel out there in terms of what the States collect regarding their Medicaid programs?

Secretary SHALALA. We can tell you what income groups they cover, whether or not they have nominal co-payments, what percentage of their populations are covered, what range of benefits they provide. Because there is a basic benefit package, we can tell you, State by State.

The States are different in terms of what they provide on top of that basic benefit package, but we can tell you the differences. We can tell you what percentage of children are not covered, what percentage of children are eligible for Medicaid in that State, and are enrolled in Medicaid. So do we have a basic data base on Medicaid? The answer is yes.

Senator MOSELEY-BRAUN. Thank you very much, and happy birthday.

Secretary SHALALA. Thank you.

Senator GRASSLEY. On the point that you were making about follow-up on welfare, even though that is not the point of this discussion, I think I could refer you, as you correctly said, to Iowa.

Iowa is going to have a social worker go to the home of everybody who was on welfare and is not now on welfare, to find out what their situation is. They will do that, except where they cannot find that person. But they are going to use every means possible to find out and have an onsite review of that family's condition.

My questioning is going to follow up on what Senator Jeffords brought up, what Senator Bryan brought up, and what Senator Conrad brought up. I would, first of all, thank the administration for working to reform the AAPCC. It is not as lonely a world out there for us as it was 2 years ago when we were trying to bring attention to this in the White House. Your support of this reform is very, very important.

I might be guilty of just a little bit of questioning today about, have you done enough for me lately, and please forgive me.

Secretary SHALALA. It is fair enough, Senator.

Senator GRASSLEY. For instance, just to make sure that there is no contradiction between some testimony that we got from somebody—and I forget the name—from OMB before the Budget Committee. Is your reform of AAPCC is going to start January 1, 1998? Because we were led to believe it was 3 years down the road. You decided to do it, but it was 3 years down the road.

Secretary SHALALA. Let me explain the difference and why there might have been some confusion. The 5 percent cut that we were talking about for managed care occurs in the year 2000.

Senator GRASSLEY. All right.

Secretary SHALALA. The payment methodology change that we want to put in place occurs in 1998.

Senator GRASSLEY. All right. Does that mean then that the $350 threshold starts January 1, 1998?

Secretary SHALALA. Yes.

Senator GRASSLEY. All right.

Secretary SHALALA. It does not, I guess.

Senator GRASSLEY. All right. I had better quit asking my questions then.

Secretary SHALALA. No. You said that you were asking, what could you give me now.

Senator GRASSLEY. Yes. Then I would express—and this is kind of an opinion, but you can respond to it, and it is about the $350 floor—based upon a minimum amount that it would take in some of the low-cost, efficient medical delivery States, as we were discussing this issue 2 years ago, it was felt that it would take $300 January 1, 1996, $350 in 1997.

So I guess I am prepared to make the argument in the ensuing months here that, in order to just meet the minimum—and this is based upon what experts in this area are telling us—if we are going to move managed care into low-cost States like Iowa and Minnesota, it would have taken $350 January 1, 1997, so it is going to take something more for January 1, 1998.

You may not be prepared to say that, but that is kind of our basis for thinking, not just wanting more, but that it was kind of a minimum, starting right now, you see. You may want to respond to that.

Secretary SHALALA. Senator, obviously we put down a number and closed our budget down in January. As we move through the months, we obviously want to make certain that the intent of our proposal, that is, to help rural areas so that they really do have some choices, and in particular, that managed care has an opportunity to compete in rural areas.

So, we would be happy to talk to you about what the floor is going to be. It obviously has financial implications in terms of what we are doing, because we are trying to do this within the context of probably budget neutrality. But we certainly are prepared to talk about those kinds of changes.

Senator GRASSLEY. This is an area where a relatively few hundreds of millions of dollars makes quite a bit of difference, an impact, in rural America. I would just suggest that to you.

Now, I would move on, if I could, to ask you to think in terms of Medicare being a national program, and the fringe benefits that come in Miami because of eyeglasses, lower co-pay, wellness pro-

grams, and everything they have that we do not have in rural America. Your 70/30 blend. It seems to me we are still going to have a tremendous difference between the high-cost areas and the low-cost areas of America.

Obviously, when cost-of-living makes a difference you can justify differentials based on that. But, based on the delivery of health care and the services that are connected with it, it seems to me we cannot justify much difference between the low-cost area and the high-cost area. So we would hope for 50/50, but you suggest 70/30. I guess I would just ask you to justify 70/30, in the sense that this is a national program.

Secretary SHALALA. Well, Senator, I think the fact that we are prepared to take the first step and start to change the methodology to be fairer to different parts of the country. If Senator Graham was here, he would have a different question for me about what we are trying to do because southern Florida is a high-cost area.

So I think the kind of blending that we are trying to do and even out, we are doing it gradually. It may not be fast enough for you, but it may be too fast for another part of the country.

Senator GRASSLEY. All right. But when you finally get to that 70/30, you still have a tremendous differential that may allow Senator Graham's managed care to give eyeglasses, and not in the State of Iowa. That is the point that I am trying to make, not how fast you get to where you are going to be when you get there, but when you get there you are at a 70/30 differential, are you not? You are never going to get to a point where it is going to be equal in Iowa and Miami. It could not be.

Secretary SHALALA. No.

Senator GRASSLEY. It does not necessarily have to be. Well, maybe you said all you can.

Secretary SHALALA. I think I have said all I can. Your point is very clear. What the price is, since I am not inside the books of a managed care company, what we do know is that we are currently overpaying them. But, in some parts of the country, as you point out, we are underpaying them if they are going to provide some of the extra kinds of benefits.

In general, they have been doing that for market share, not simply in areas where they are tight, or areas where they are getting more resources. That is, where they are competing against other managed care companies, they are coming in to adding extra benefits. But, clearly, you understand our intent.

Our intent is to make sure that Medicare recipients, no matter where they live, have some choices of different ways of getting their health care. The most difficult area is the rural area. Sparsity requires more resources. We know that and we are trying to get there, though obviously not as quickly as some people would like.

Senator GRASSLEY. We are starting dialog on this issue, so I think your approach to it is reasonable and we can just continue to speak to each other on it.

My last question would be this, and it would be following up on Senator Bryan's question about Medicaid and the caps, and that sort of thing. This budget proposes a per capita cap on expenditures for Medicare, as everybody knows. There could be different categories of recipients, with different cap levels in each State. So

the cap level for children could be lower than the cap level for people with disabilities, as an example.

My concern is that States may have the burden of paying when a beneficiary, such as a child who becomes disabled, incurs costs that exceed the cap. In other words, a combination of being a child, as well as being disabled. Who has that responsibility? If the State has a responsibility, what might be the State's choices?

Secretary SHALALA. The State would simply move that person to the disabled category. It does not make any difference whether they are children. The category is non-disabled children, non-disabled adults, disabled individuals, and the elderly, so the State would not have any problem there. That disabled child would move to a disabled category and more resources would be, obviously, available there.

Senator GRASSLEY. All right. If a State finds it necessary to increase its reimbursement rate or capitation rate in order to track providers to an area of a State because it wants to increase the number of providers available, say to provide in-home or long-term type care services or older beneficiaries, would the State be limited by the per capita cap?

Secretary SHALALA. No, because it has flexibility within the amount of money. The per capita cap simply determines the amount of money the State is going to get, and it gives it some flexibility.

Senator GRASSLEY. You are signaling a great deal of flexibility for the States.

Secretary SHALALA. There is tremendous flexibility here. In addition to that, they do not have to go through the hassle of coming and asking us to move people into managed care. The major flexibility they have been asking for, they are going to get under this. But we are obviously trying to get some fiscal discipline into every part of the budget. If you are going to get to a balanced budget, you have got to put a variety of different kinds of restraints in different parts of the budget.

Senator GRASSLEY. Senator Rockefeller, did you have a second round? Go ahead.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Just picking up on your last phrase, we have to take advantage of every opportunity to save money where we can, I am just looking here at the Medicare and the American Health Care system report to the Congress, which is from last year. The next one is coming out in March, so these are 1995 figures.

But it is interesting to go back, when you look at the PPS inpatient margin by hospital group, and you go back to 1984 and they have got a 13.3 percent margin. Then you come into the more current times, 1994 was minus 2.5. They took that cut. Then next year it was minus 1.2 percent, then it was a 0.2 percent increase. In 1994, it was 4.7. Then this year it is 7.9 percent. What interests me, is that if Medicare margins are averaging 7.9 percent, it is the first time, obviously, that they have been doing that in 10 years or more. Now, under the President's proposal, hospitals would get an 1.8 percent update for next year.

So in a sense I guess I am asking you, in the spirit of saving money and not to underestimate the advances that hospitals have

made in running themselves much more efficiently, why you did not adopt PROPAC's recommendations to freeze Medicare payments to hospitals?

Secretary SHALALA. First, PROPAC was talking just about the update, and only for 1 year was their recommendation. We actually closed down our budget before we had that recommendation, so we made our recommendation based on information that we had at the time. Their recommendation came after we had made our decisions.

What I have indicated is, while they have made that recommendation only for 1 year, we certainly need to go back and review it. But, at the moment, we are standing by our recommendation. We have taken enormous savings out of hospitals and managed care and lots of other parts of the health care system, and I would want to review that with great care in terms of what we have done in the past.

Senator ROCKEFELLER. I understand that, Madam Secretary. It is interesting, we use the word margin, and when you are talking about Medicare money, you could use the word profit. Margin is a different word for that.

So, I mean, I think that is something, as much as hospitals have taken over the years in the way of hits. Though that actually leads me to my next question, which I guess I am just as glad Senator Moynihan is not here—although Senator Moseley-Braun here—and this has to do with indirect medical education. It goes back to an ancient feud about the teaching hospitals. PROPAC has recommended that, based upon at least their research, which is precious to us here, IME payments to teaching hospitals could be reduced to 4.4 percent.

Now, PROPAC has recommended that, as a part of a phased-in reduction, IME payments could be reduced to 7 percent next year, that being 1998. The President's budget, however, reduces IME to 7.4 percent next year, and to 7.1 percent in 1999. It is not really until the year 2000, in a budget which is pretty much back-loaded anyway, that payments are reduced to 6.8 percent.

This is the old question of, are teaching hospitals, for Medicare purposes, being over-reimbursed? Has that been true historically? Is that true now? Is it going to be true in the future? How come you are doing it more slowly than PROPAC has suggested?

Secretary SHALALA. Well, PROPAC actually recommended something higher. I think they recommended 7.0. We actually get to 5.5 in the year 2002. We do it more gradually. Obviously, it would let the system adjust.

Again, these are all individual decisions which we did in the context of a balanced budget, and we got where we needed to get and we got the budget balanced during that period of time. With some industries we did it more gradually, with others we did it more up front.

So almost everything we do is phased over the period between now and the year 2002, when the budget had to be balanced. We could have moved it faster on the front end, but what we were trying to do is to help a various part of the health care business, in particular our sensitivity about academic health centers, make the transition as we slowed down their updates and their increases.

Senator ROCKEFELLER. All right. Mr. Chairman, I will just add one point that you do not have to respond to. This is something I had not been aware of at all. In this question of reviewing current law on Medicare disproportionate share, that rural hospitals have to have twice as high a standard of percentage of beds being used for hospitals over 100 beds than do, for example, comparable urban hospitals.

Now, that is not fair to throw that at you all of a sudden, but it is the case. I do not want to, at this point, call that a discriminatory payment practice, but I would just ask the Secretary about that, in the same spirit that I asked the IME question.

I understand the sensitivity to teaching hospitals, but I also understand the sensitivity that rural hospitals—another one of which closed within the last month in West Virginia—also have to face.

Secretary SHALALA. Well, without answering the specific question about that specific judgment, I think I will go back to the principle here. That is, I think that both density and sparsity cost more. If we want to maintain the same quality health care and as many choices as we can possibly do fairly in rural America that we have in other places of this country, then we have to expect that we are going to have a different kind of reimbursement arrangement.

It cannot be based necessarily just on historical precedent. We are committed to that. We are committed to being fair to rural areas. We have a lot of initiatives here that are the expansions of demonstrations that you and other Members of Congress have recommended over the years.

It is in this budget the President takes a strong step toward starting to deal with the issue, an issue I think is an issue of quality, and that is to make sure that rural America has the opportunity for the same quality of health care that people who live in other parts of the United States do.

Senator ROCKEFELLER. I cannot argue that he is taking steps in that direction.

Senator GRASSLEY. Senator Moseley-Braun.

Senator MOSELEY-BRAUN. Thank you very much, Mr. Chairman. To my friend and colleague from West Virginia, I just want to point out, with regard to the teaching hospitals, they are, in the first instance, central to maintaining the quality of American health care. It is my understanding that the PROPAC report says they are really being stressed at this time, based on some of the changes that we have already taken.

So I think we need to be very careful, because we do not want to wind up sacrificing quality in the name of trying to get some rationality on the budget. Obviously, the budget issues are vitally important to us, but people come from all over the world based on the quality of American health care. I think we have a fundamental obligation to do no harm in that regard. Plus, I will work on getting a teaching hospital down in West Virginia with you.

Senator ROCKEFELLER. My point is, we have several teaching hospitals in West Virginia, so my points are aimed at them, too.

Senator MOSELEY-BRAUN. Yes. I was just funning with you. The point is, the PROPAC report does say that they are stressed by some of the changes that they are undergoing. I really do appreciate my colleague's comments about DSH and the rural hospital

issue. Again, while we want to try to preserve the ability to address the special concerns of those heavily impacted institutions in urban centers, at the same time we have a real problem in rural areas, we have a problem in those areas that, if you will, just kind of sit right outside of the urban centers that do not have the 90 percent low-income patient mix, but may have a 50 percent, or 40 percent, patient mix, but still wind up serving people who cannot afford to pay for their health care.

I am concerned, Madam Secretary, that those institutions will be forced to again start to do more dumping and more shipping out of that patient load, and we will see their bottom line more heavily impacted as they make these changes. So I understand that your intent is to hold harmless the DSH operation and that you are developing a proposal to redefine the criteria and adjustment.

I would just ask that, as I think my colleague suggests, that you be mindful that these other institutions that are not the most heavily impacted still may be impacted sufficiently that the change here could impact their bottom line and cause them to close as well, or cause them to stop providing care where they are providing care today. I think that has to be a focus of our concern.

The last question I have, is I did want to get back a little bit in terms of Medicaid. Again, I may not have been real clear in putting my question to you regarding Medicaid data collection, but, given the flexibility that is accorded to the States, a State can start to redefine what health care it is giving, or redefine what will be reimbursed in ways that could mean that health care that is currently being provided will fall off the edge of the earth in terms of what it is they report.

So when I talk about a Tower of Babel, in light of the flexibility, in light of the changing definitions, in light of the changing comprehensiveness or level of services that the States will be providing, how will we be able to keep up with comparability and how will we keep the data going to the heart of what care is being provided?

I mean, right now we could well be faced with 50 different definitions of services that are or are not covered, and therefore 50 different sets of reports in terms of what is and is not available to the citizens of this country. So my question to you was, to what extent can you encourage the States to develop a single language?

Secretary SHALALA. Well, first of all, we leave a single language in our proposal. As we lay out our flexibility, we do not move into block granting Medicaid, so that the definition of the basic benefit package, when the decide to add services, treating people fairly across the State, they will be able to move people without waivers into managed care, but the benefit that is guaranteed in managed care will be similar.

So I do not see anything that we are doing in the flexibility that will impact on our basic information about what we are spending money on in the Medicaid plan. I will go back and look at that because I want to give you a very specific answer, but I do not see anything in our proposal that would do that.

Senator MOSELEY-BRAUN. All right. Finally, and this is switching gears altogether, this is on the welfare side and education. When I was in the State legislature I had to pass legislation to allow peo-

ple to count the time they spent in school against their work requirement. Of course, the TA&F now has a work participation requirement, which is a good thing.

I have never had any objection to people working who can work. But the only education and training activity that qualifies in meeting the first 20 hours are vocational education up to 1 year, and high school and GED, but that is only for single heads of households, under the age of 20.

So you have got a whole category of people out there for whom education could mean the difference in getting their lives together and being able to support their families for the long haul, and I know, while it is unlikely we are going to open the bill up anytime soon, at the same time it just seems to me that education is so central to people being able to care for themselves and their children, and to have a job in this changing economy. I would just, if I may just for a second, Mr. Chairman, say, again, when I passed the legislation at the State level I had the nicest thing happen.

About a year and a half, 2 years ago, now, I ran into a woman who came up to me with tears in her eyes. She had been a welfare recipient when that happened in the State legislature, and she said, you know, I was on welfare when you passed that bill and I was able to go back to school; now I am a nurse, I just got married, and my husband and I are buying a home in Country Club Hills.

So she had been able to make a real success out of the fact that she was able to get an education, a nursing education in this case, having been a welfare recipient. I just think it is central, and I hope that we can do something to encourage, as oppose to discourage and make inflexible, educational opportunities for people who want to get off of welfare and take care of themselves.

Secretary SHALALA. Well, it is a tricky issue, because obviously we want people to finish high school. The question is, to what extent does the State want to continue to provide cash assistance and child care to someone who is going to college. There are a lot of college loans and PELL grants for low-income people.

I once ran a university that had large numbers of welfare recipients going to school alongside large numbers of people from the same neighborhood who were working jobs at night so that they could go to school during the day, or worked during the day so they could go to school at night.

Again, one of the things that led us to welfare reform was a kind of fundamental unfairness. I think the States are struggling with it, but I think that some of us are struggling with it, too.

We have to be careful that, just because you came through the welfare system, you are not in a better position than someone who went directly to work and then went to school part-time to finish a degree.

So the States are struggling with, what is the fairness, what kind of investment you want to make in, for the most part, young mothers with children to make sure they get enough education so they really can support their families.

What the President is trying to do, is to make sure that everyone has an opportunity for at least 2 years of school, and that the support is there for those individuals. What we want to make sure, is

that the new welfare system does not create another kind of unfairness.

I think that the States are trying to struggle with providing opportunity for everyone that wants to go on and get some additional education after high school so they can do better for their families.

Senator MOSELEY-BRAUN. Well, including high school, I mean, for my people.

Secretary SHALALA. High school, absolutely. Finishing high school is part of the welfare plan. In fact, there is a requirement that people get to finish high school and your work requirement does not start counting until you finish that high school. It is the higher education where there is really a debate about how much subsidy ought to be provided.

The CHAIRMAN. Senator Grassley.

Senator GRASSLEY. I would like to ask you about the cost-benefit package in regard to the Workers Between Jobs initiative. That is a $9.8 billion new program.

Secretary SHALALA. Right.

Senator GRASSLEY. What is the cost of the benefit package, per family?

Secretary SHALALA. They have to provide it. The reason it is going to be hard—and we can try to provide it—is these are essentially grants to the State and the Governor decides whether he wants to use it to help low-income families pay their COBRA, for example, when they are in between jobs, or some other kind of program that helps them keep their health insurance.

So, the Governors will have different programs in different places. Some people will only need it for a month. This is for up to 6 months. It is our attempt to try to make sure people stay on their health insurance. There are low-income people who are eligible for COBRA, but cannot afford to pay for their health insurance.

This is an attempt to make sure that we have a seamless system. A lot of low-income workers actually are going to get a job pretty quickly, and you want them to be able to keep their health insurance.

[Information supplied follows:]

The Workers Between Jobs program is a direct spending program, providing grants to the States to assist unemployed workers and their dependents who meet certain conditions. In calculating the cost of the program, we used the Blue Cross/Blue Shield Standard Option Plan in the Federal Employees Health Benefit Program as the benchmark. The estimated cost of this plan in 1998 dollars is:

Plan type	Monthly premium
Single	$241
Couple	482
Single Parent	470
Family	639

Under the program, a State has two options. It may provide subsidies for COBRA coverage, regardless of the particular benefits available in the COBRA plan. This is administratively simple, allows the workers to remain in the program he or she has been in, and it assures the worker of the protections provided under the Health Insurance Portability and Accountability Act (HIPAA). The State has to provide an alternative for those ineligible for COBRA (generally, workers in firms with fewer than 20 employees) and may use the alternatives for COBRA eligible workers, as well, if the State can demonstrate cost-effectiveness and no loss of worker rights

under HIPAA. The alternative approaches must provide benefits that are comparable to the Blue Cross/Blue Shield Standard Option Plan.

Senator GRASSLEY. Yes. I want to go back to the very last question I asked you on my first round that I did not make very clear, in regard to the per capita cap per State. If a State tries to get managed care in there and cannot get it, is the Federal per capita cap binding, or if it took a few extra dollars would the Federal cap go up or do the States have to pay the difference?

Secretary SHALALA. They can do managed care without waivers under our proposal. The cap simply affects the amount of money that they are going to get, not what they get to spend. They are going to do the negotiations with the managed care companies.

Senator GRASSLEY. All right. But suppose to get that service through that managed care company they are at a point where they are above the State per capita cap. Then do they have to pay the extra, or, under those unusual circumstances to get that service, will the Federal cap go up?

Secretary SHALALA. I am not sure I understand the question. I have the question on the record. I will give you a written answer on that question.

Senator GRASSLEY. All right.

[Information supplied follows:]

The base year for the per capita cap policy will be 1996, and each State will receive a single limit for Federal matching payments based on the total spending that in State in 1996—excluding spending items such as payments for Medicare premiums and cost-sharing and Disproportionate Share Hospital payments—by each of four specific groups: disabled (including disabled children); elderly, children, and adults.

Once the State limit is determined, State spending will be able to grow by a yearly "index" to stay within the limit. Medicaid spending—including services purchased through managed care arrangements and/or Section 1115 demonstrations would be subject to the per capita limits.

Since each State would have a single total limit, the State has the flexibility to use savings from one group to support expenditures for other groups or to expand benefits or coverage. If a State keeps spending per beneficiary below the limit for one or more categories of beneficiary, it could spend above its per beneficiary limit for another group; use the funds to expand eligibility to new groups; or save the State share of the funds.

Secretary SHALALA. I do not think there is a problem here. If what you are saying is, in terms of the overall Medicaid budget the Governor has, he does not have enough money to be able to bargain with a managed care company to be able to bring them in, that this is going to slow down the growth so much that he will not be able to attract managed care into the State. Iowa is one of the States, for instance, that has brought in managed care for the mental health part, for example.

Senator GRASSLEY. Yes.

Secretary SHALALA. The Governor thinks that this growth rate that we are imposing, which is GDP plus two, then GDP plus one, is going to make it too tight and our reorganization of some of the reimbursement is going to tighten down too much, how much flexibility does he have above that, we will give you a detailed answer. I do not think it is a problem, unless you think that managed care rates are going to go up so high that he will not be able to negotiate with companies to come in.

Senator GRASSLEY. All right. You have stated the question.

Secretary SHALALA. Yes.

Senator GRASSLEY. The only thing I would add is, we think that at that point the State is going to have to pay the extra. If we are wrong, we hope we are wrong, but that is where we want you to focus. Thank you very much.

Secretary SHALALA. That is fair enough. That is obviously what we do not want to do. What we do want to do, is to make sure that the Governors, given this new flexibility, have a lot of flexibility to be able to attract other providers.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman. I want to continue, Madam Secretary, on this teaching hospital issue, because there are still some points I think that need to be made.

Let us start with the fact that the IME payment, the indirect medical expense payment, is one of the larger cuts for hospitals in the President's budget, so we grant that. He reduces it by $4.2 billion over 5 years.

But what is interesting, is that PROPAC—and I am talking Medicare now—which takes into account Medicaid, Medicare, and other factors before they make recommendations, says that, in fact, the administration could cut substantially more out of the margins of teaching hospitals than they are doing, without jeopardizing those teaching hospitals. That is PROPAC saying that. That is moderately biblical.

Then let me just read this, for the education of my colleagues who are not here, and for some of their staff who are here. For major teaching hospitals—the big city ones—their PPS inpatient margin was 15.6 percent at the last data available, and that other teaching hospitals, which would refer probably to the ones in my State, it was not 15.6, it was 4.8. Then non-teaching, it was 0.4. So there is a gigantic difference between the PPS inpatient margins for large urban teaching centers.

All I am saying, Madam Secretary, is that PROPAC takes the disproportionate share factor—large teaching hospitals are disproportionate share hospitals for the most part, they are taking a lot of Medicaid beneficiaries, a lot that cannot pay, a lot of charity care—into account before they make their recommendations. They are saying that teaching hospitals could be cut substantially more.

All I am asking, and the President's program is out there and I understand that and respect it, that these things be policy-driven. Sometimes I think when we get to teaching hospitals, to be quite honest, things are not as much policy-driven as they are sometimes politically driven.

Secretary SHALALA. Senator, the only thing I would say is the PROPAC study that you are talking about was not their recommendation. Their recommendation was actually much higher than ours. It was a 7 percent recommendation, even though their internal study suggested that they could take some more cuts.

Our proposal, as I indicated, was 5.5 percent in the year 2002. It sounds like we are in the sensible middle on this. But it really is policy-driven. We really believe that we have to be careful to make the critical investment in our teaching hospitals.

They are going through a transition as the Health Care Financing system is destabilizing what has been an unbelievably productive investment by this country, both through the Medicare system, as well as through the National Institutes of Health.

So I think that we talked a long time about what we thought were the appropriate recommendations here. Just carving it out has been controversial, because we clearly are taking some resources away. There were other proposals that add money and do not take it out of Medicare or out of managed care, in particular. We also expand the reach of this program by reimbursing HMOs that are clearly participating in the teaching process.

When I was at Wisconsin, one of the difficulties we had was that there were lots of managed care institutions that wanted very much to participate in the teaching process, but we could not reimburse them. This gives us a chance to do that.

Senator ROCKEFELLER. You do that, and it is good. It is more than just HMOs, you do it in rural referral centers.

Secretary SHALALA. But what is the appropriate number, obviously, is open to debate. We looked very hard at what we thought was the appropriate number, and this is a policy-driven proposal. My view is, it is somewhere in the middle of what the other recommendations have been.

Senator ROCKEFELLER. All right. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. I just have one more question; the rest we will put in writing and request of you. I appreciate your patience.

I would like to get some information on what the decline in welfare rolls means dollar-wise to the States. Now, as you noted in your testimony, the welfare rolls have declined significantly from the historically high levels in 1993 and 1994, and the President has spoken about reducing the rolls by another two million people.

Now, this seems to suggest that something is working. But the States should be realizing some significant savings from the reduction in the welfare rolls which can be used to serve other individuals such as non-citizens, or to pay for training programs, if the States believe that is effective.

I would like to get some information from you on what this does mean in savings for the States. Let me give you the background, as we calculate it. The average AFDC payment per family is roughly $375 per month, or $4,500 per year. If the case load has been reduced by more than two million people, that approximates roughly 700,000 families.

So the case load reduction would mean savings of $3.15 billion, of which the State's share, as we calculate it, would be $1.35 billion. So even if there are no further reductions in the case loads, the States would save nearly $9.5 billion from 1997 to 2002.

But if the States meet the President's goal of reducing another two million people by 2000, the States may save as much as $11.8 billion, much of which will be used to serve needy citizens. Of course, the States must meet the maintenance of effort requirements.

Moreover, bear in mind that the Federal Government's share of savings through this case load reduction will remain with the

States. Even if the case load is not reduced further, the Federal share of serving 700,000 families would be nearly $10.8 billion from 1997 to 2002. Again, if the President's goal is met, that would be $15.6 billion that the States would be using to serve the low-income population.

So it seems to me that there are very significant savings being made by the States which are available for some of the programs you have advocated. As I say, it looks like roughly $11.8 billion of savings for the State share, and roughly $15.6 billion for Federal fund savings that would be retained by the State.

Do you have any figures on this?

Secretary SHALALA. I do not have figures, but I have some thoughts on this. That is, when we first discussed welfare reform, numerous people came in here to testify before you that talked about how difficult it was to move people from welfare to work.

The fact is, the first populations that have moved from welfare to work have not been the tough people to place. The economy has played a great role, and people who already had some work experience, had good education levels, they have moved off first.

The one thing we know from the State experience, and the one thing the Governors will come in here and tell you over the next 2 or 3 months, and I agree with them, is that it costs money, and it costs more and more money for them as they reach deeper into their welfare populations.

They have to put together packages that are more expensive than their former AFDC payments. It includes some child care, and some other kinds of resources to really move people successfully from welfare to work.

This experiment relies, for the Governors, on the assumption that they would have considerable flexibility to take the extra resources they got as part of the block grant to design different approaches.

Not one of them has the perfect formula yet, and we have to be extremely careful over the next few years, after having signed this compact, so to speak, with them not to start to take their resources away at the most sensitive and fragile period as they are trying to get their welfare programs and their reform programs up and going.

Moving people to jobs costs money up front, as Governor Thompson in Wisconsin, or Governor Bush in Texas will tell you. A lot of them would take some of this money and add extra child care and other kinds of things. So we are prepared to tell you what we think the numbers are now, but those resources are critical to the success of welfare reform, particularly as they reach deeper into the harder-to-place welfare recipients.

The CHAIRMAN. Well, the point I am making is that, through the reduction in welfare, very significant savings are being made by the States and they not only get to use those funds in whatever manner they wish, as long as they maintain the maintenance of effort, but they also are able to retain the funds that are being saved with respect to Federal funds.

It could be—and I am just using the President's belief that there will be another two million taken off of welfare—that you have a very significant amount of money. It could be as much, as I said,

roughly $26–$27 billion that can be used for these other purposes. I am not disagreeing with you.

Secretary SHALALA. Senator, if the other purposes are some of the other initiatives in the President's budget, the only point I would make, is we got to a balanced budget and did the initiatives and left the creative resources that the Governors need in their budget.

So I think that we think that these modest proposals to help with health care for children, some of the education proposals, can be done within the context of a balanced budget without threatening the resources that we have left in the State so that they can get their welfare programs up and going.

The CHAIRMAN. Nobody is disagreeing about doing something to help ensure children have health care, to ensure they have the opportunity for education. The only point I am trying to make is that there are vast funds available because of the reduction in the welfare load for some of these needs for which the administration has asked an increase.

But what I would appreciate having from you, and we will put it in writing, is a breakdown of what savings are made, both by the States and the Federal Government, which is retained by the States. I think that is significant.

Secretary SHALALA. I apologize, Senator. Let me just make one additional point. Where the problems are located in terms of shifting costs, where large numbers of legal immigrants who are disabled are located, is uneven across the country.

So the real issue is whether New York, California, Illinois, and Florida, the places that have large percentages of the populations that we suggest ought not to be shifted in terms of costs to those States, the overall number could be large, but the specific number that is relevant is for those States that have these populations in which, if they are cutoff in their nursing homes, the State is going to have to assume the cost. So let us also look at the State numbers.

The CHAIRMAN. I have no disagreement with that. I recognize that there will be differences because it depends on what work load reductions are made State by State. But I would also say to you, and I would say to the Governors, that it is also true that we treated them very generously in the allocation, and by the reduction of welfare they are making significant savings that can be used for the good purposes they talk about. I think it is important that that be laid on the table, and understood that those funds are available.

Secretary SHALALA. Yes.

The CHAIRMAN. I want to thank you again for appearing today, and we appreciate your testimony. I look forward to working with you.

Secretary SHALALA. Thank you very much, Senator.

The CHAIRMAN. The committee is in recess.

[Whereupon, at 3:20 p.m., the hearing was adjourned.]

PRESIDENT'S FISCAL YEAR 1998 BUDGET PROPOSALS (VIEWS OF CONGRESSIONAL ADVISORY COMMISSIONS ON MEDICARE)

THURSDAY, FEBRUARY 27, 1997

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

The hearing was convened, pursuant to notice, at 10:09 a.m., in room SD–215, Dirksen Senate Office Building, Hon. William V. Roth, Jr. (chairman of the committee) presiding.

Also present: Senators Chafee, D'Amato, Murkowski, Mack, Rockefeller, Moseley-Braun, and Bryan.

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

The CHAIRMAN. The committee will please come to order. Today we have the pleasure of hearing recommendations from the two commissions that advise Congress on Medicare policy.

The chairmen of these commissions are, of course, well-known to us and we are privileged to have two such recognized experts in health policy serve the Congress in these capacities.

Dr. Joe Newhouse is the chairman of the Prospective Payment Assessment Commission, referred to as ProPAC. Although Dr. Newhouse has testified many times before this committee, this is the first time he has testified as chairman. We are pleased to welcome him in that capacity.

Dr. Gail Wilensky, chairman of the Physician Payment Review Commission, or PPRC, is also very well-known to this committee, having testified many times before when she served as administrator of HCFA for President George Bush. So it is a pleasure to welcome you.

Before we turn to our witnesses, I would like to express my sincere appreciation for the work done by these commissions. The members of these commissions are all experts in health policy, committed to helping Congress develop sound public policy regarding Medicare. The staff of these commissions is excellent and has been very responsive to this committee in providing expert analysis of very difficult and complex issues.

So I would like to just take a moment to recognize the executive directors of the commissions that are here today, Don Young, executive director of ProPAC, and Lauren Leroy who is executive director of PPRC.

Today the commission chairmen will present the recommendations that will be formally sent to Congress in their annual reports later this spring. These recommendations will cover a broad array of Medicare issues facing this committee, including policies relating to provider payment, as well as issues related to Medicare and managed care.

At this time it is my pleasure to call on you, Dr. Newhouse.

STATEMENT OF JOSEPH P. NEWHOUSE, PH.D., CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, CAMBRIDGE, MA; ACCOMPANIED BY DONALD YOUNG, M.D., EXECUTIVE DIRECTOR, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Dr. NEWHOUSE. Thank you very much, Senator Roth, for your kind welcome, both to me and to Dr. Young. I'd like to discuss with you this morning our report. I will focus on our recommendations for the fee-for-service part of Medicare and start with our recommendations about the annual update factor in the prospective payment system.

If you look at Chart 1, you will see a quite remarkable story. Cost growth in hospitals, which is shown here, over a 12-year period has been fairly steadily falling, both unadjusted for inflation and adjusted for inflation.

In the last 2 years, costs have actually declined, even unadjusted for inflation. That has, in part, reflected a falling length of stay for Medicare beneficiaries, which is a combination of earlier discharge to post-acute care settings and improved productivity.

That drop in cost has enabled hospitals to make a profit on Medicare patients, despite payment updates that have been reasonably low. If you look at Chart 2, you will see that, starting from a low point of 1991 where the commission projected that hospitals were actually incurring a loss on Medicare patients, margins have steadily improved and in 1995 were around 8 percent.

Moreover, we project that in 1996 the margins—this is on Medicare PPS patients—will increase to about 10.5 percent, in 1997 to around 12 percent, and in 1998, under current law, to around just under 14 percent.

Senator CHAFEE. Mr. Chairman, could I ask a question to see if I understand these charts? Dr. Newhouse, on Chart 1 are you showing that, as far as Medicare, paying the bills, the cost has gone down?

Dr. NEWHOUSE. These are the costs in the hospital that are allocated to Medicare.

Senator CHAFEE. Yes, the hospitals cost.

Dr. NEWHOUSE. It's not Medicare reimbursement, it's the hospital's costs.

Senator CHAFEE. Oh, I see. So the hospital costs have decreased and their profits have increased.

Dr. NEWHOUSE. That's right. The profit is Chart 2, the next chart.

Senator CHAFEE. Yes. That's a very satisfactory achievement, I would say, for the hospitals.

Dr. NEWHOUSE. Yes.

Senator CHAFEE. Thank you.

Dr. NEWHOUSE. Now, the last point I made, which is not on the chart you are looking at, is that the profit rate in Chart 2, if I put that out a few more years, would be continuing to increase.

The CHAIRMAN. To make sure we understand, in Chart 2, is that the profit?

Dr. NEWHOUSE. That is the margin or the profit, you can think of it, although there are obviously a lot of non-profit hospitals.

The CHAIRMAN. And for 3 years they had a loss.

Dr. NEWHOUSE. That is correct. This is just on the Medicare PPS business in Chart 2.

The CHAIRMAN. Sure. Sure.

Dr. NEWHOUSE. Now, the next chart goes to all patients, Chart 3, and shows that margins have also been improving on all patients and, in fact, in 1995, which is the most recent year for which we have data, we are at the highest point they have been since the first 2 years of the prospective payment system.

The CHAIRMAN. But they are making a higher profit on Medicare than they are on the other activities.

Dr. NEWHOUSE. Yes, that is correct. It is for that reason that the commission is recommending to the Congress that the update factor for 1998 should be zero, which would correspond in traditional terms of market basket, plus or minus some adjustment factor—roughly market basket—minus two, after a correction for an error in inflation in the market basket.

Let me turn, since my time is limited, to post-acute care. In my statement, this begins around page 11. You see in Chart 4 that the two main components of post-acute care, skilled nursing facilities, which I call SNFs and home health agencies, and that the dollars have been increasing very rapidly, indeed, faster than any other component in Part A. Post-acute care, in total, amounts to about a quarter of the spending in Part A.

Both the Congress and the President have proposed moving away from cost reimbursement to fully prospective payment, and the commission agrees with doing that.

We are also recommending a demonstration that would link payments for the acute and the post-acute care of patients, that is, put payments for an entire episode of care, together rather than break it apart into a payment to the hospital and a separate payment for post-acute providers.

One of the problems with developing a prospective payment system for post-acute care is a case mix measure adjusting for how sick the patients are and what their needs are. There has been a case mix system developed for rehabilitation facilities, but not for skilled nursing facilities and home health agencies, which is why we are recommending a system of limits, in the short run.

Let me call attention to one other feature on skilled nursing facilities. We are recommending that the exceptions or the exemptions for new providers be eliminated.

Senator MACK. Mr. Chairman, can I ask him just one question here. What did you mean by limits? I'm not sure I understood.

Dr. NEWHOUSE. We have several different kinds of limits, depending on the post-acute care that you are talking about. But, on skilled nursing facilities, we are recommending that either there could be prospective rates or cost limits, especially for ancillary

services. These are various kinds of therapists, typically, speech therapists, physical therapists, and so forth, which are now reimbursed on the basis of cost.

For home health, we would convert to a prospective rate or a set rate away from a cost basis and we think that there could be some limits, either imposed per month or per year, along with a co-payment for home health.

Most home health visits do not occur following a hospital stay, which makes any solution that would try to link payment for acute care and post-acute care together not really workable for those visits, because they are not preceded by a hospital stay.

Senator CHAFEE. Is your co-payment 20 percent?

Dr. NEWHOUSE. No, we left it modest, and we would cap it in some fashion. My own personal definition of modest would be something like a few dollars a visit.

Part of the issue with home care, though there is no firm evidence, there are certainly allegations of fraud in this area. At least, I hear them more than I do for other areas of Medicare. We think that a co-payment might help limit that, at least a modest co-payment.

The CHAIRMAN. May I ask a question there?

Dr. NEWHOUSE. Yes, please.

The CHAIRMAN. You said modest. In other areas you have 20 percent, is that right, as a co-payment?

Dr. NEWHOUSE. Yes. This is the only part of Medicare for which there is no cost sharing. Now, in many parts of Medicare, of course, the cost sharing is covered by some kind of Medigap insurance. But, nonetheless, this is the only area where the program has no co-payment.

Now, many of the beneficiaries are the old, old, particularly the heavy users of this service. We may be talking about somebody who uses 200 visits a year for which a 20 percent co-payment could be a very substantial financial burden. That is why I would limit it to a quite modest sum and try to cap the beneficiary liability.

The CHAIRMAN. All right.

Dr. NEWHOUSE. So I am sure I am at the 5-minute limit that the sign in front of me is reminding me of. If you would like me to go into our at-risk program recommendations I can, or I can stop here and await your questions.

The CHAIRMAN. No, I would like you to proceed with the at-risk program.

Dr. NEWHOUSE. All right. The issues with the at-risk program are several. First of all, at one level this program has been a success. As you see in Chart 5, the number of enrollees in the at-risk program has been increasing rapidly, now around 11 percent of the enrollees.

But in Chart 6 you will see that there is a very substantial geographic variation in the rate that Medicare pays plans in different parts of the country. The true variation, in some sense, is much greater than what you see even in the chart, because these numbers have been adjusted by the hospital wage index.

So, for high-wage areas they are pulled down, for low-wage areas they are pulled up. The actual variation goes from around $220-some per month in counties in western Nebraska and South Da-

kota, to around $760 a month in Richmond County, NY, which is Staten Island.

But here you see the variations by deciles or 10ths of the distribution, split apart for both urban and rural areas. For example, the lowest 10 percent of the urban areas are paid, on average, $365 per person, per month. That is the number there on the far left. The highest 10 percent, which would include the Staten Island example, are paid $550 a month, on the right.

Similarly, the gray lines show the distribution for rural areas and that goes by about roughly the same amount, $350 to $568. So for both urban and rural areas, there is substantial variation here.

The Congress, the President, and the commissions all agreed upon some kind of floor or pull up for very low areas, which would be primarily rural areas. That we would finance, in a budget-neutral way, taking it out of the higher areas.

Now, for the higher areas, if you do take it out of the higher areas you see, if you skip to my last chart, Chart 8, that this would probably result in some reduction in extra benefits in the high-rate areas. The high-rate areas do pass back some of these high payments to beneficiaries in the form of extra benefits. For example, they are more likely to provide an outpatient prescription drug benefit.

You see in the highest 10 percent of payments, the 1.37 there means that they are paid 37 percent above the national average, and the extra benefits we value at around $80 per month that are passed back.

Then as you go down from there in payment, you see in the middle column the numbers are falling, so that in the bottom decile the areas are paid 83 percent of the national average, and the average value of the extra benefits is only $21. So these reductions would not be for free, as it were.

The other point I would make to you, is there is a substantial variation within metropolitan areas. So if we take the Washington, DC area, for example, the District itself and Prince George's County, if a Medicare beneficiary enrolls in an at-risk plan who lives in those counties, the plan is paid about $600 a month.

If a beneficiary lives in Montgomery County, the plan is paid about $500 a month. If the beneficiary lives in Fairfax County, the plan is paid about $400.

Senator CHAFEE. But, still, that would be only 95 percent of the amount that the beneficiary costs to the Government in that area. Is that right?

Dr. NEWHOUSE. That is correct.

Senator CHAFEE. So, in other words, even though you show these disparities in your various charts, as far as the Government goes, we are still winning on——

Dr. NEWHOUSE. Well, that goes to my second point, which is, most of the evidence I read—some of which comes from the Physician Payment Review Commission—suggests that you are not winning, that even though you pay 95 percent of the fee-for-service average, on average, the people signing up would have used even fewer dollars in the fee-for-service system. That is, on average, roughly a 5–7 percent overpayment, which is the genesis of the ad-

ministration's proposal to cut this rate from 95 percent to 90 percent.

My own view is that would achieve some short-run savings, but this so-called selection problem could well re-emerge because it would, in effect, move the line for who were a profitable and an unprofitable enrollee.

The people who are unprofitable to enroll at 95 percent would be still more unprofitable, people that were marginally profitable would become marginally unprofitable, and the people that were profitable become a little less profitable. Gail says she will handle this in detail.

Let me just mention one other feature of the at-risk program that I think both the commissions, and the administration, and the Congress, as evidenced by the last Congress' bill, agree on, which is, we would break the link between the update in what an at-risk plan is paid and fee-for-service payment in the county.

We would move toward something like what we have for hospitals and physicians, where there is a certain percentage that is decided as to what the increase should be.

The reason for that, is that right now, as you noted, we pay the average of the fee-for-service system. As enrollment increases over in the HMO, it seems to us likely that the average in the fee-for-service system and the average of what would have been paid for the people in the HMOs had they remained in the fee-for-service system will further diverge.

This is contrary to a claim that is sometimes made, as the enrollment increases that this selection problem will reduce. It is sort of like the old story of the student that went from Harvard to Yale and raised the average in both places.

So the average in the fee-for-service system will go up if the lower risks leave, and, similarly, the average on the HMO side will also go up. But our estimates are that the fee-for-service side will go up faster. So, for that reason, we would break the link.

Senator CHAFEE. I suggest you use a different analogy than you did.

Dr. NEWHOUSE. All right. [Laughter.]

Dr. NEWHOUSE. I somehow guessed that you might respond that way.

The CHAIRMAN. Can I ask where you are a professor?

Dr. NEWHOUSE. I am a professor at Harvard.

The CHAIRMAN. Have you completed? Go ahead.

Dr. NEWHOUSE. Yes. I think I have summarized the gist of our recommendations for the at-risk program, yes.

The CHAIRMAN. All right. Thank you, Dr. Newhouse.

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

The CHAIRMAN. Dr. Wilensky.

STATEMENT OF HON. GAIL R. WILENSKY, PH.D., CHAIRMAN, PHYSICIAN PAYMENT REVIEW COMMISSION, WASHINGTON, DC; ACCOMPANIED BY LAUREN LEROY, EXECUTIVE DIRECTOR, PHYSICIAN PAYMENT REVIEW COMMISSION

Dr. WILENSKY. Thank you. Thank you for inviting the Physician Payment Review Commission to share some of the recommenda-

tions. I would briefly like to talk about the recommendations in four areas. Obviously there are many other areas that will be covered in our report to you.

They are the payment for the risk plans, the managed care plans we have just been talking about. The second issue has to deal with how to make adjustments for risk selection, this problem that some plans may get healthier patients, on average, and some plans may have sicker patients.

The third issue, which I know is of interest to you and your committee members, has to do with provider service organizations. The commission has some suggestions about how to proceed in that area.

The fourth area has to do with an adjustment that is scheduled by law to go into effect with regard to physician payment that is bringing the practice expense component into a relative value process.

Let me go back and talk a minute about both the payment issue with regard to managed care plans, HMOs, and the risk adjustment issues. As you know——

Senator CHAFEE. Doctor, if you could give us the pages you are on as you go through each of these four things, that would be helpful, to me, anyway.

Dr. WILENSKY. All right. I will for some of them. The summary recommendations, as we get to it, I will reference it. Thank you.

As you know, there has been very substantial growth with regard to the enrollment in managed care. In our Figure 1, we just reminded you that, while the growth in Medicare has been very substantial—now 13 percent of seniors are part of managed care in Medicare—it actually has been much, much slower than what has gone on in the private sector where managed care, in all its forms, HMOs, these preferred provider organizations, dominates the type of insurance.

There are a number of reasons for that, including the fact that the options to seniors are far fewer and the fact that the payment is subject to many of the constraints that come with having it be a part of legislation.

That is really what I would like to talk about, the fact that the linkage occurs between what is going on in fee-for-service, as you have just heard, and what the HMOs get paid.

There is a process where an attempt is made to estimate what it would cost in a particular county area for the average senior if they wanted to go into an HMO, say in Providence, or in Delaware, in an area, and then there is an adjustment made for the fact that whoever goes in that plan may be older, younger, or may have other characteristics that would make them more expensive. But it is basically that you have the plan payment following what goes on in the payment in fee-for-service, and that can lead to a lot of variations.

Let me show you in Figure 5 the kind of variations that have occurred. Dr. Newhouse mentioned some of these variations. They are very substantial and they happen for a couple of different reasons.

In large part, there are many different ways of providing health care, different practice styles around the country. If we look at fee-

for-service medicine, we see much higher spending rates in, say, some areas in Florida, some areas in New York, some areas in California, than we see in Minnesota or in Oregon.

Some of it has to do with the fact there may be older or sicker people, and some of it has to do with the way medicine is practiced in different parts of the country. We bring that variation into the managed care program and it means that there are very different benefits that get offered, as Dr. Newhouse already has mentioned.

What also happens, however, is the concern that how we set these payment rates may be exacerbating the kinds of problems that we already think are there, and that when you start to change the payment rates you have to remember that you will have a lot of interactions going on.

Our recommendations from the commission is that there are ways to improve the actual per capita payment that now goes on, and that there are different ways to set that payment rate, including the use of bidding or other arrangements, and that we have to make sure that when we change the payments we remember that there are other aspects of importance.

But let me go to the specific issue with regard to risk selection, because this is something that you not only hear about, but you are now going to have that as an issue because the President's program has suggested reducing the payments from 95 percent to 90 percent.

And the argument that has been used, is that there are healthier people that come into the Medicare program and, therefore, although we pay 5 percent less than fee-for-service, if these people would have only spent 80 percent of the average in fee-for-service it could still be costing you money.

Now, there is a picture in one of the figures, Figure 8, that will show you why there is concern. But then I want to explain to you why an overall reduction is not, in my opinion, the best way to fix the problem. There is a real problem that is being addressed.

If you look at Figure 8, what you see is when someone is entering an HMO, the information that we have about them shows that in the year before they went in they were using substantially less health services and that, while very few people leave HMOs to go back to fee-for-service—three percent, a very small number—those that do leave tend to use a lot of health services when they leave.

Now, this has a number of implications. What it means, is that you need to make some adjustments or you will end up paying more than these people would have actually cost you if they had stayed in the fee-for-service program. But it is not just a program of fee-for-service versus managed care, many plans have different mixes of people. So some plans have primarily people who have been there a long time.

If you look at Figure 9, the very last figure, what you will see is that there are some plans—and we have shown, in this example, Plan D—where more than 70 percent of the people in the plan have been there for more than 6 years, whereas a lot of plans have mostly new enrollees. That is because there has been so much growth in the last few years.

What it means, is that it is not good enough to just say, if the people going into an HMO are healthier, on average, we should pay

all the HMOs less. What you are going to do is invite the very problem you are trying to address, which is, some plans get healthier people. If you just reduce the payments overall, you are going to make sure that sick people look like someone a health plan does not want to have.

So what is critical, is to say, yes, there is a problem, and on average it is costing the program money, but we have to figure out a better way to do it. Now, fortunately, I think that while there are difficulties in fixing this problem, it's not impossible.

In fact, the Physician Payment Review Commission recommends that right now, as soon as legislation can be written, it is time to start phasing in better ways to make this risk adjustment.

We have some very specific suggestions. The first thing, is that we know that in that first year people are healthier, that that is who is changing, who is willing to leave their old physician, plan, or they are moving to a new area and tend to set up new relationships anyway, so that we can pay plans the first year, or maybe the first year or two, less than we are now paying and not exacerbate this risk selection problem.

But we ought not to do that on an across the board basis because, as I have just shown you, some plans are predominantly people who have been there a long time, some plans are predominantly new enrollees. These are maybe relatively new health care plans, at least in that area. So, reduce the payment in the beginning, but just do not reduce it across the board.

But we have got to start getting some better information. Right now there is a requirement that plans provide information on hospital stays, but if you are a risk plan you do not get a payment like you do in fee-for-service.

In fee-for-service you know you get good information, because that is the only way you can get paid. It is possible to be a little more serious in demanding the same kind of information from the risk plans. There are ways to do that, and that would help us get better information.

So our second recommendation is, start now, start with what we have, phase in better adjustors as you go along. Our estimate is that you could correct, right now, half the problem instead of the very small amount of the problem that our current age and sex adjusters are fixing, and, as we get better information, we can make this into a better process.

Let me go on and make a couple of points about the other two areas so we can be sure to have enough time to answer your questions.

The next has to do with the provider-sponsored organizations. This is an area that has been of great interest to the physicians and hospitals around the country who feel like they have been at a disadvantage when it comes to competing with HMOs to continue providing services to the seniors.

While we think it is important that we make sure that consumers are protected and that they do not run the risk of having these plans go under, we think that there are things that can be done which will help the plans get going.

One of the issues that has stopped many of the plans if they want to only provide services to the Medicare population, is that,

under current rules, there has to be 50 percent of the membership that is under 65, that is part of the commercial plan, and the other can be Medicare.

This was done as a way to try to ensure quality, but it is a very clumsy, indirect quality indicator and it has a lot of disruptive effects if you want to have new types of organizations, or sometimes even just HMOs.

Our recommendation is that there be a replacement with direct quality measures. We are much better now at trying to introduce the measures than we were 7 or 8 years ago when this first came up, and that would help other plans like provider service organizations that want to come in.

Now, I know Senator Rockefeller and Senator Frist have some legislation, and others of you may also have thought about this issue. It is something that is very important to the physicians and hospitals now to be dealt with.

We think there are ways to have the same standards, but to have some flexibility with how those standards are met and to allow for those plans that only want to address the Medicare population.

Finally, let me talk about an issue that has concerned many of the physicians around the country, and that is the requirement now in law that, in January 1998, the practice expense component be used on a relative value measure. There has been concern about both the accuracy of the information that the Health Care Financing Administration has, and about the size of the change that may occur.

While we think both of these are legitimate concerns, we think the way to handle them is not to postpone the introduction, but rather to phase it in over a 3-year period, which limits the amount of change that any physician's practice will feel, and to use what has been used in the past, that is, a refinement process where the Health Care Financing Administration, when it announces its proposed rule in May, make clear how it will go about making better estimates of these values over time, how it will refine the process, and how it will include the physician community explicitly in this process.

We think that is a better way to address the concerns that have been raised by the physician community rather than just postpone any move. That will not help get better data and it will not help move away from what we know are biased historical costs. This is a lot of information to cover. Let me stop here. Thank you.

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

The CHAIRMAN. Well, thank you. Let me ask you one question with respect to the risk adjustment. What kind of a bureaucracy is it going to require to implement it, how expensive?

Dr. WILENSKY. I do not want to say it will not require any bureaucracy. I think you have been around government too long to know better.

The CHAIRMAN. Let us say staff.

Dr. WILENSKY. I think that you will see a change in the responsibilities of government as Medicare moves more to health care plans. Right now, 33 million of the 37 million on Medicare are in traditional Medicare. What that means, is that there is a large bu-

reaucracy of carriers, the people who pay the hospital bills, the people who pay the physician bills, the people who are in the Health Care Financing Administration, the 4,200 direct employees, who worry about whether an individual service that the 33 million people are using is necessary, whether it is of high quality, whether the payment is right. You have a lot of people worrying about individual payments.

As you move to plans, as more seniors choose HMOs, or PSOs, or any of the other options you have talked about, the role of government starts to change. You do not have to worry about whether the visit that Mrs. Jones had to Dr. Smith last week should have happened, whether the quality was there, and whether the payment was right.

You can start worrying about whether the quality that the plans provide overall, in terms of consumer satisfaction, sickness rates, death rates, performance of any kind, information is adequate and whether the information that the Government needs to make adjustments for the plans that have very sick people or very healthy people is available.

I believe that, overall, with substantial numbers of people moving to health care plans, instead of being in traditional Medicare—which I think, if you allow it to happen, will happen—will put less requirements for personnel, not more requirements.

The CHAIRMAN. Dr. Newhouse, as you actually mentioned in your testimony, the administration is saying hospitals are over-paid or discharging patients much earlier to another facility.

The President's budget includes a proposal to establish a new hospital transfer policy that would change reimbursement so that moving a patient to another facility would be considered a transfer and the hospital would be reimbursed on a per diem basis, not to exceed what the hospital would get under the DRG payment.

In a sense, I believe that is taking a step away from the PPS hospital payment system, but it is taking a longer look at what happens to a patient's care. Do you care to comment on that proposal?

Dr. NEWHOUSE. I would be happy to, Mr. Chairman. The first thing to say, is that this policy may not affect that many people. I do not have an estimate of how many people it will affect, but the commission has done work that shows that the beneficiaries who use post-acute care tend to stay in the hospital longer, that is, they are sicker. That is not real surprising.

Therefore, they are disproportionately going to be patients for whom the hospital would get the full DRG anyway. That is, the transfer payment only matters for relatively short-stay patients, and these tend to be disproportionately long-stay patients. That is the first point.

I have not had a chance to inspect the methodology the administration used for its budget estimates. I assume that was factored in, but if it wasn't, it certainly should have been.

A second point to make, is the way I personally tend to think about this is the incentive for the hospital to discharge the patient on the last day of the stay to a skilled nursing facility, let us say. By the way, the skilled nursing facility may just be another floor of the hospital.

Right now, in most cases if the patient stays in the hospital, the hospital gets nothing more for the additional day because of the DRG payment. If, however, the hospital moves the patient to the skilled nursing facility, and in an extreme case let us say the skilled nursing facility is just part of the hospital, the hospital collects an additional payment. It collects the per diem for that patient, any capital payment, and so on.

There is a clear financial incentive to transfer the patient under this arrangement. Now, going to the transfer rule, for those patients where it actually matters, that is, the short-stay patients, would help even this up. The hospital would get more if it kept the patient in the hospital, and would get more if it transferred the patient.

I, myself, would, I think, do this a little differently. But, in principle, I agree with the thrust of this change to try to make the payment system more neutral as to where the patient goes in the last day of the stay, or the last day plus one, if you will.

The CHAIRMAN. How would you prevent that gaming of the system?

Dr. NEWHOUSE. Well, I think this is a move toward neutrality, so I think there would probably be less gaming. But, overall, I would prefer, as was indicated in our recommendations, a demonstration linking the acute and the post-acute payment so that the hospital was then neutral and would move toward the more efficient alternative.

The CHAIRMAN. Thank you.

Senator Mack.

Senator MACK. Thank you, Mr. Chairman. When I came in, you were really addressing this issue, so you may have answered the question before I have asked it. But, let me go back to it.

The hospital Medicare prospective payment margins dropped to a low in 1991 of minus 2.4, and then reversed and rose to an estimated 7.9. There are really kind of two parts to this. The first one is really kind of, what caused that, was it Medicare guidelines, market basket inflation, just what was it? Did Medicare manage this, or did it just happen?

Then, second, if we do go to zero, what evidence do you have that you will not recreate the situation of 1991?

Dr. NEWHOUSE. All right. Good question. The first order effect as to why the margins increased was that the hospital costs fell, it wasn't that Medicare payments fell markedly. The base fell, or the difference between the payments and the costs increased because the costs fell. So, that is largely the story of what you are seeing in these margins.

Senator MACK. Was that a management response to anticipating what was happening in the system and, therefore, they managed to reduce their costs?

Dr. NEWHOUSE. Well, in some sense it almost has to be. That the costs fell, I do not think was an accident, but I would say that it probably reflected what was going on in both the private sector and in Medicare.

I mean, if I am running the hospital and I am hiring the nurses, I have got to consider my entire book of business, as it were. We certainly believe that the private sector was getting to be a more

price-sensitive customer through this period and putting more pressure on hospitals. So I think that is the main part of what happened.

Now, the story about, would we recreate 1991, I do not think so. The first point to make, is actual Medicare payments to hospitals will probably increase, and will almost certainly increase, even if you went to zero.

You can ask, why is that? It is because there is a feature of the Medicare payment that adjusts payments according to how sick the patients are, the so-called case mix index.

So, for example, if the DRG weight is roughly five if I have a bypass operation, it is roughly a half if I have a cataract operation. So if there are more bypass operations and fewer cataract operations, Medicare pays more for the same number of admissions.

That, historically, has gone up and in recent years it has been going up around 2 percent a year. So, even with a zero update in the rate, if this case mix index goes up, as it always has, hospital payments go up. That is part of the answer.

The second part of the answer is that, although the "freeze" makes for a dramatic headline, if you recast this, as I tried to indicate, into a market basket minus, it comes to market basket minus two, which is not so different from what you have been doing for lo, these many years, it is just that the increase in the market basket has fallen.

So back in the days when the market basket was 5 percent, say, then the market basket minus one or two still left you with a 3 or 4 percent update. But now with the market basket down around two, it is a rather small update anyway.

Senator MACK. All right. Thank you. I want to touch on the disproportionate share issue for a moment, because they are quite important to small hospitals throughout the country. What are you recommending that will improve the financial integrity of those community hospitals that do serve the poor in their towns?

Dr. NEWHOUSE. The Congress has asked our commission to take a look at the disproportionate share payments and report back, and we have been pleased to do so. I think we have some sound recommendations to make in this area, and I will touch on three different aspects of those recommendations.

If you go back to what is the intent of this program, their intent is at two levels, at least as I read Congressional intent here. First, is to preserve access by Medicare beneficiaries to hospitals that might otherwise be in financial difficulties because they have a large number of low-income patients. The second, is an effort to do something about access for low-income patients themselves.

Now, the first problem is, how is a low-income patient defined? We are now putting these moneys out among hospitals on the basis that a low-income patient is a Medicaid patient. The actual formula distinguishes between SSI patients and other patients, but to first approximations it refers to Medicaid patients.

Now, the first problem is, of course, a Medicaid patient actually does have insurance and the hospital will be paid for the Medicare patient. I am sorry. I launched off on a longer answer than I apparently had time for.

The CHAIRMAN. Please proceed.

Dr. NEWHOUSE. So our first step, which we think would be a major step here, would be to broaden the definition of who is a low-income patient to not only include Medicaid patients, but also uncompensated care patients and patients from indigent care pools. One way to think about this would include everyone who is not privately insured and not a Medicare patient who is not also eligible for Medicaid.

There are some other technical parts in this definition, such as how we count their costs, but the first order effect is to broaden the definition. So this is particularly important as States adjust to the reforms in Medicaid. Some States, for example, have greatly broadened Medicaid eligibility which means that, under the old definition, they will get a bigger share of disproportionate share payments.

The second issue, is what economists call a notch problem. That mans if you get just a little bit more, in this case, Medicaid patients, you get a lot of money at some point. For the usual urban hospital, at this point that is a 15 percent threshold, if you are just under 15 percent in Medicaid you do not get anything, and if you are at 15.1 percent you get a 2.5 percent add-on, I believe.

We would eliminate that jump so that if you went from 14.9 to 15.1, or whatever you would get, you would go from zero to a little bit, and then you would ramp up smoothly.

The third thing we would do is that, as the program is now set up, the deck seems stacked in favor of urban hospitals. This threshold at the point at which the payments kick in, the bar is quite a bit higher for rural hospitals than for urban hospitals, with a result that the payments go disproportionately to urban hospitals.

We are recommending that you put the bar at the same height for both urban and rural hospitals. Those are the three basic recommendations we are making to you.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman, also Dr. Newhouse. I usually only ask questions to Gail Wilensky, so I am going to practice asking questions of somebody else.

Dr. NEWHOUSE. I assume you are going to start out with the easy ones.

Senator ROCKEFELLER. Several years ago when we had that big health care plan—is that not the way we refer to it—which did not pass, I remember sort of the amendment that was just about to take place on the floor of the Senate, and then that was sort of the last amendment and the whole argument.

Then the one that never did actually get offered was the one that I had with Senator Kennedy about the whole question of GME and urban hospitals. There was kind of a natural emphasis on New York since New York has, I think, either 15, 16, or 17 percent of all the residents in the country, so obviously, they have a lot at stake.

Then there was the question of the over-supply of specialists, the under-supply of primary care physicians. What our amendment was going to try to do, was to try to rectify that.

Now, the marketplace is evidently doing a certain amount of that. What I would like to get from you, Dr. Newhouse, is a sense

of how much of that is going on, and how long do you think it is going to last? You have HMOs and managed care now kind of really viciously biting into what teaching hospitals are doing and, therefore, affecting some of their decisions.

You have young people, for some reason, deciding they want to go into primary care all of a sudden, even though the money, in spite of RBRVS, is not that much greater than it was before. What you really have is the New York teaching hospitals now kind of agreeing to go along with a lot of things in exchange for different payment formulae.

Now, what do you think that the New York teaching hospitals, or teaching hospitals, in general, of their somewhat greater willingness to go along with all of this says about the beginning of a long-term, real solution to work force supply?

Dr. NEWHOUSE. Our commission has not looked at what I gather is the thrust of your question, but I will want to say what we do say about teaching. The thrust of your question, as I heard it, was what about the primary care/specialty care work force and how fast is the resident training adapting to the new market realities. PPRC has always had a chapter in their report, and I believe they will this year, so I think Dr. Wilensky may well want to comment.

Our recommendations on graduate medical education, I think the most important is that we would move toward severing or partially severing the link between how many residents you have at your hospital and how much Medicare pays you.

Senator ROCKEFELLER. The automatic factor.

Dr. NEWHOUSE. The automatic factor. So that from our point of view, Medicare has basically subsidized hospitals to add residents. And, given that carrot, the hospitals have responded and they have gone up, in 1981, from just under 70,000 residents, to now just under 100,000 residents, which is a fairly large increase. As I recall, nobody in 1981 was really complaining about a shortage of residents. But Medicare has made it worth their while to do that.

We would break the link, as I say, or partially break the link. The thrust of the New York demonstration is to do that. That is, if the New York hospitals cut back they would not lose the full amount that the formula would otherwise cost them and we would, in effect, do something like that. We have not specified exact details, but the general thrust of that we would do nationwide.

The other thing we would do, is we would try to move the indirect medical education component more toward its so-called empirical level, that is, we have an estimate of how much or what the association is between a hospital's cost and its additional residents. Right now, the payment is above that level and we would try to gradually move it down toward that level. That is also part of the administration proposal.

Senator ROCKEFELLER. Let me just add, to Gail Wilensky, then. One of the things, frankly, that I have always worried about is the foreign medical college graduate component of that. That has actually been a very large proportion of, for example, the New York post-medical school Medicare-funded training.

In places like the State that I represent, foreign doctors are very important to us because they will often be in places and serve in situations where others do not naturally gravitate.

On the other hand, one of the phenomenon, as I remember 3 years ago, was that foreign-trained doctors—I do not even like to use the word—come over. Then they, actually in greater percentages, I think, than our own doctors, would head right into the specialties as opposed to going into general practice.

What do you see as the impact of all of this on the numbers of foreign medical graduates and also what it is that they prepare to do?

Dr. WILENSKY. PPRC follows what is going on in the labor market for physicians in general, tracks numbers, it tracks their income changes over time, and it tracks also the issue of residents. It is a little difficult because of the different specialties to know exactly how many you have.

You are correct that foreign graduates are a substantial portion—not the majority, but a substantial portion—of residents. They tend to be specialized in certain parts of the country, and they do tend to be more in the specialties. They have been very heavily involved in the hospital-based specialties, particularly anesthesiology and pathology, and less so in primary care areas.

I believe it is time that the Congress ask why they have a direct subsidy to institutions to train graduate physicians when there is not a general shortage perceived of graduate physicians, and in particular areas there is probably an over-abundance of trainees.

It is a very big question, including the issue of, should these subsidies go to those who are foreign-trained and may also not be residents as well. If there were not the specialties, this issue would really not be a question for the Congress.

But it does get to the larger issue, which is why you are doing it, in general, and how do you try to wean away the incentives by either reducing payment or retargeting the payment, or trying to target to individuals rather than institutions.

If you made an abrupt change you could do great damage to institutions, these academic health centers, and you would also disrupt the flow of health services. But it is a lot of money. It is about $8 billion a year. Trying to decide where you want to go, then move gradually to that direction, is a good idea.

We are seeing some signals of modest market changes. There has been a decline in anesthesiologists income. There has been a flattening and slight decline in general surgery and in other areas of medicine. There have been less declines or small increases in some of the primary care, but not enormous changes, as you have noted.

It is possible, especially if the Government is putting money in, to target better either in the areas you want to go or in the specialties that you think are in under-supply.

But it does force you to look at this larger issue, and this is also going to be true with managed care with the risk payments, where it has been proposed, and the Physician Payment Review Commission has also recommended, taking the payment out from the capitation payments.

But you have to make decisions on what you do with it, and I hope the Congress will not just make these very limited looks at what to do, such as what is being done in New York, or very specifically about the foreign trainee, but the broader issue about how much the Federal Government should be paying to subsidize grad-

uate trainees when we think we have an excess supply, either in general or in certain areas.

Senator ROCKEFELLER. Mr. Chairman, obviously I am way over my time. Will we have another round of questions?

The CHAIRMAN. Yes, we will have another opportunity.

Senator ROCKEFELLER. Thank you.

The CHAIRMAN. Senator Murkowski.

Senator MURKOWSKI. Thank you, Mr. Chairman. I wish you all a good morning. I am going to dabble into the rural area very briefly. First of all, as far as our credentials, I will ask with a pretty big piece of real estate. It's 33,000 miles of coastline and four time zones. If you overlay Alaska and the United States, we run from Canada to Mexico and Florida to California. I do not know if anybody is sensitive about Texas, but we are about three times bigger than Texas. I will not belabor that point. Enough of that.

The Alaska Family Practice Residency is the first medical residency program in our State. We will take volunteers on the question when I get to it. But it is specially designed to train physicians for practicing medicine in rural Alaska.

For the first time, eight residents are going to be admitted to the Providence Hospital in Anchorage and they are going to travel throughout the State in the rural areas for 3 years in order to complete the rural residency requirement.

Medicare pays for much of this program, and the questions of cutting costs are of great concern to us. As you know, we do not have a medical school. Until this year, we had no medical residency program. As a result, recruitment of physicians to rural Alaska has been pretty sporadic, at least.

Many of the physicians who come to the State do so, in part, to experience the Alaska lifestyle, but chose not to stay because of the isolation and the rigors of the job. In short, the aspects of life in isolated, rural Alaska can be difficult to attract physicians trained in the continental United States.

So the residency program is designed specifically to deal with this. All residents will be selected for training based, as I understand it, on the likelihood of their successful practice in Alaska.

Applicants will be given a preference based on the fact that they are Alaska residents, have been brought up in Alaska, or have a strong rural background and familiarity, and, of course, an interest in rural health, which is mandatory.

So, the program would eliminate the notion that rural medical practice in Alaska can only be temporary. To give you some idea, in Bethel there are 16 physicians at the INS hospitals. The average is, four of those 16 leave after the first year, and the same thing happens the second year, and the third year, and the fourth year.

Now, the President's budget reform of the graduate medical education program and Medicare is to achieve an $8 billion savings over 5 years, with caps on the numbers of residents that a hospital can be reimbursed for, according to my understanding.

We are just starting the program in Alaska. I want to make sure that we understand that the program getting under way is clearly distinct from the situation with regard to the urban hospitals, where I understand there is a legitimate concern on the abuse on some of the spending that was not what it was designed for.

So it is my understanding that your proposal wants to give the hospitals a lump sum payment based on an historical share of graduate medical education spending. But we are new, we do not have an historical record. So we are concerned.

The bottom line is to make sure you are not lumping the small rural residency programs like Alaska in with the larger urban programs that may not be using Medicare dollars more effectively. We need some assurance that is going to recognize the uniqueness and the dilemma, that we do not have any historical base to start again.

Can you give us some assurance that our fledgling efforts will be supported and continue to do what we want it to do, and that is provide the services and save some money?

Dr. NEWHOUSE. Yes. Our commission did not consider in any real detail the question both you and Dr. Wilensky have raised about how the moneys will be allocated. Insofar as we did consider it, we talked about historical share because we didn't think we could really get beyond that within the commission.

We certainly did not talk about treatment of new programs, but there would have to be some administrative mechanism set up to handle new programs. We did believe, if the moneys were moved off to a separate trust fund or a similar kind of device as was proposed in the Congressional bill in 1995, that however the moneys were allocated at this point in time, somebody would need to take a relook at that on a periodic basis.

My own thinking on that was something on the order of 3–5 years to see how they would be allocated. But you are raising a very good question. We really did not get to that level of detail.

Senator MURKOWSKI. Can I help you do something, introduce something or write something?

Dr. WILENSKY. Well, I think the issue that you raise points out how serious the need is to rethink why exactly the Federal Government is subsidizing graduate education. It does so in a very blanket way, wherever the residents are. The amount that is paid varies enormously from $11,000 or $15,000 a resident to, I think, as high as $150,000 or $160,000 a resident, even $170,000. It is a very large spread.

It does not reflect the fact that there is a lot of concern about training too many specialists in general, and this is done in a very blanket way. It is not small money. It is $8 billion, roughly, of direct and indirect expenditures from Medicare.

If it was targeted to the areas where we thought we had a problem, either by specialty or by location, and some consideration given to having it go to the physicians rather than only to the institutions, you could have a far greater effect.

My concern about the New York program is not that it is not doing something that has some general residents, that is, encouraging hospitals to train fewer residents and not drop the number of primary care physicians, but that all of these other problems are locked into the next 5- or 6-year period where there is no other reform going on. I think the program is more broken than just training too many residents.

Senator MURKOWSKI. My concern is, I am not asking for a commitment, but a resolve, of how we address the rural dilemma that

we find ourselves in. We do not need specialists, we just need doctors.

Dr. YOUNG. If I might, Mr. Chairman. The commission's recommendation, as well as the President's proposal, is going to require legislative action. Any changes in these policies require legislative action, so you certainly have an opportunity.

If I might say so personally, I am a physician and I am very impressed with the program that you have put forward. I think it would be quite easy to think out how one might find a few really unusual circumstances and unique situations that the Secretary would be given authority to deal with in order to allow them and promote them to grow, so I think——

Senator MURKOWSKI. You would be willing to help us draft the legislation?

Dr. YOUNG. I would certainly be happy to talk to your staff.

Senator MURKOWSKI. Maggie, stand up and be recognized. I want you to get to know Dr. Young. Thank you very much. Thank you, Mr. Chairman.

The CHAIRMAN. Are there any hazards in the Government setting the rules as to what kind of physicians are trained?

Dr. WILENSKY. Absolutely. Our history of predicting correctly what we need in the future is dismal, on its best day. I mean, we had gone into the 1980's, and certainly into the 1970's, thinking we were in a physician shortage, a throw-back from earlier concerns, but it turns out that subsidies, both to the capitation programs for medical schools and for training residents, went far beyond that to a point where we were probably exacerbating the problem of excess supply.

There is a tradition, however, of having the Government try to encourage certain kinds of choices, loan forgiveness programs, trying to make sure that under-privileged or minority students can have access to expensive programs, and I think that is a very important historical precedent to use.

It is why I think having money available to incent physicians to go to rural parts of the country or to stay in certain specialties is very consistent with how we encourage certain decisions.

But a blanket subsidy to institutions to train more of everything or to try to predict how many psychiatrists, general surgeons, or thoracic surgeons we are going to need in 2010 has not had a good historical basis for the future.

The CHAIRMAN. Dr. Newhouse, would you agree that the decrease in hospital cost is a result of more efficiency?

Dr. NEWHOUSE. Well, there is a problem in defining efficiency, Mr. Chairman. If efficiency is defined as the number of admissions or the number of patient days that hospitals are producing, yes, we can say they have become more efficient.

Now, the patient who is in the hospital whose nurse is later to arrive because there are fewer nurses on the floor may not feel that was just all an efficiency gain, and we do not have a good way to measure that. But our conventional measures are something like the number of admissions, the number of patient days, and by those measures the hospitals are producing more with fewer resources.

The CHAIRMAN. What about the quality of care?

Dr. NEWHOUSE. Well, again, our ability to measure quality is far from perfect, but, from the gross indicators that we have that I, at least, read, there is no evidence that quality has deteriorated.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman. This will be my final questions. Actually, I am going to use a superb new technique. I am going to ask two questions, and then I will just be quiet. That way I will not be guilty of over-talking.

First, for Gail Wilensky. In terms of physician payments, you favor both the single conversion factor and the change to the resource-based practice expenses, and then you say that there should be a transition period. Now, these first two have been discussed for a number of years and there has been a general agreement that we need more primary care physicians in this country.

Now, a 3-year transition, I understand why that is attractive for surgeons, these thoracic surgeons that you just referred to, et cetera, and others, it gives them a chance to adjust over a period of 2 or 3 years to reduced Medicare payments.

On the other hand, if there is a shortage of primary care physicians—and Frank Murkowski was making that point very dramatically, and it is one that I think applies also in my State—then we have to recognize that through how we put in a transition period. So, that would be my question to you, how do you sort of explain the 3-year transition when there is a clear need for primary care?

In terms of Dr. Newhouse, you freeze, for next year, hospitals. But, on the other hand, we have got to look at, in Congress, a 5-year approach. The President has proposed market basket minus one over the next 5 years. So the reconciliation of those two, the freeze for 1998 that you propose and what he proposes, how do those two interact, do you think?

Second, when you do a net reduction of $32.7 billion over 5 years, I just want to very frankly ask you, I think hospitals are being over-paid, they are making a profit.

Now they have done the things they should have done and they are saying, well, do not penalize us for doing what we should have done. You could also say, well, that is what you should be doing, and we are reflecting reality here with scarce dollars. Can hospitals, in your judgment, absorb the kinds of cuts that you are talking about, as well as the President? Starting with Gail, and I apologize.

Dr. WILENSKY. You raised a good issue, which is the balance between achieving the various objectives that you have. There is no question that if you have a 3-year transition, that it will take longer to come to what has been the place that the Congress says they want to go to, which is the single conversion factor, so you do not have the rates of spending for primary care, for other medical specialties and for surgical specialties, growing at different rates.

For the last 4 or 5 years since the transition to the relative value scale for the work effort that has gone on, you have been continuing to have half the payment, roughly, be reflective of historical costs for practice expense.

My concern is that there is a lot of requests to postpone the move to the resource-based practice expense, period, just not start it, because of concerns about how accurate the data is or how big the

change would be. I would be, and the commission is, very much against postponement.

I am concerned about the size of the changes between going to a single conversion factor that is based at the primary care level, added to the changes that would go from the resource-based relative value scale. You could be talking about changes of 40–50 percent.

While you could say that was money that never should have been paid to certain practices, whenever Medicare has made a change in the DRG and in the first part of the relative value scale there has been a real effort to mute the effect that happens in any one year. That is why the DRG had a transition, and that is why the first phase of the RBRVS had a transition.

So I am sympathetic to the issue, but I think that the magnitude of the change is so great that you really do need the transition. I would take some of the money out of the excess payments going to institutions to train more specialists than we need and use that to do some selective loan forgiveness or other ways to encourage physicians to go to the specialties or areas that we need them in.

Senator ROCKEFELLER. Thank you.

Dr. NEWHOUSE. On the 5-year point, we were timid, I am afraid. We were only willing to look forward 1 year in the commission and did not want to project beyond that. We said explicitly we would try to take another look at the end of that year. So, we did not make a recommendation about the out years.

I would say, in terms of comparing where we are and the President, roughly since 1990 the updates, as recommended by the President, have been around market basket minus 1.5, give or take a little bit. The 1998 and out recommendation of market basket minus one is actually the most generous payment that has been recommended since PPS was implemented. So I am personally having a little hard time squaring that with the numbers that I showed you.

My judgment, from the increased margins, is that, yes, hospitals probably can bear this cost without any major deterioration. That probably will not be true at all hospitals. I am sure there are some hospitals that are hovering on the margin, but that will always be true. So, in the aggregate, we are charged with making policy at 30,000 feet here, in terms of a uniform update. This was our best judgment on that.

Senator ROCKEFELLER. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Well, we appreciate very much your being here today. Obviously, we look forward to continue working with you. Thank you very much.

The hearing is adjourned.

[Whereupon, at 12:30 p.m., the hearing was recessed.]

42-162 98 - 3

PRESIDENT'S FISCAL YEAR 1998 BUDGET PROPOSALS (CBO AND GAO VIEWS)

TUESDAY, MARCH 4, 1997

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

The hearing was convened, pursuant to notice, at 10:34 a.m., in room SD–215, Dirksen Senate Office Building, Hon. William V. Roth, Jr. (chairman of the committee) presiding.

Also present: Senators Grassley, Baucus, Conrad, Graham, Moseley-Braun, 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. Senator Moynihan had to attend another function and will be here later, but we will proceed in the meantime. I will not read my entire statement, but without objection, we will include it as it reads.

The committee will hear from two panels today. First, the Congressional Budget Office will present its analysis of the President's Fiscal Year 1998 Budget. Then the General Accounting Office will report what happened in the Medicaid Program in 1996.

Balancing the budget of the Federal Government will be a thing even more difficult than recognized by the President's fiscal year 1998 budget. And while I applaud the President for submitting a plan for balancing the budget, the plan itself will not take us to our goal of balancing by 2002, at least according to CBO. It falls significantly short by $69 billion.

So today's hearing is a hard, but realistic assessment of what lies ahead before us as a test of our National will. Medicare is already technically insolvent because it does not meet its own trustees' financial test for a short range solvency.

The Hospital Insurance Trust Fund is spending beyond its means; rapidly depleting its reserves until it will be empty just 4 years from now.

And to put the future cost of Medicare and Medicaid in perspective, let us compare spending for these programs to Social Security. Under current law, the January 1997 CBO baseline predicts Medicare spending will increase nearly twice as fast as spending for Social Security between 1997 and 2007. And the cost of Medicare and Medicaid together, including State funding for Medicaid, now exceeds the cost of Social Security.

In 2003, the Federal costs of Medicare and Medicaid alone will exceed Social Security expenditures. Between 1997 and 2002, Social Security will spend a total of $2.5 trillion. Just the Federal share of Medicare and Medicaid will total $2.3 trillion, and then when the State share is added, all Medicare and Medicaid spending will total $2.8 trillion.

The major welfare programs, Supplemental Security Income, Food Stamps, the Earned Income Credit Program, and the various family support programs consolidated under the new welfare law will cost another $601 billion between 1997 and 2002, yet the President has called for $22.5 billion in additional welfare spending at a time when the welfare case loads are declining.

The costs of these programs should be compared to the wages and incomes of our working families who shoulder the burden of paying for these programs. For example, the CBO baseline anticipates Medicaid will still increase at an average rate of growth of 7.8 percent, a level far beyond what most families can hope for in their own earnings.

Today's families are working longer just to keep up, not to speak of getting ahead and preparing for the future of the next generation.

When Senator Moynihan comes, we will yield to him for a statement.

Our first witness is Dr. Paul Van de Water, who is the Assistant Director for Budget Analysis at the Congressional Budget Office. He is accompanied by Murray Ross and Paul Cullinan, of CBO.

Dr. Van de Water, your entire statement will be made part of the record. Would you please summarize your opening statement? Thank you.

STATEMENT OF PAUL N. VAN DE WATER, PH.D., ASSISTANT DIRECTOR FOR BUDGET ANALYSIS, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC, ACCOMPANIED BY PAUL CULLINAN, PH.D., UNIT CHIEF, HUMAN RESOURCES COST ESTIMATES, AND MURRAY ROSS, PH.D., CHIEF, HEALTH COST ESTIMATES UNIT

Dr. VAN DE WATER. Thank you, Mr. Chairman, members of the Committee. I am pleased to be with you this morning to present the Congressional Budget Office's analysis of the President's budget. In my oral remarks, I will give a brief overview of our findings and go into some more detail about our analysis of the Medicare and Medicaid proposals.

As he did last year, the President has submitted a budget that is intended to eliminate the deficit by 2002. To help ensure that that goal is reached, the President has proposed two sets of policies: one that would produce a $17 billion surplus under the administration's own technical and economic and estimating assumptions, and an alternative set that would reach budgetary balance in 2002 under CBO's more cautious assumptions.

CBO estimates that the President's basic policies would save $84 billion in 2002 and produce a deficit of $69 billion in that year. Over the 5-year period, from 1998 to 2002, the President's basic policies would reduce the deficit by a cumulative total of $133 bil-

lion. Reductions in projected spending for Medicare and Medicaid account for two-thirds of the proposed savings.

The budget also briefly mentions an alternative set of policies that are designed to eliminate the deficit in 2002 under CBO's current economic and technical estimating assumptions. If CBO's assumptions are used for budget planning, the President would allow most of his tax cuts to sunset at the end of calendar year 2002.

On the outlay side of the budget, the President's alternative policies include a 2.25 percent across-the-board cut in non-exempt mandatory programs in 2002; a 0.46 percent limit in 2002 on cost-of-living adjustments, except for Social Security; and a 4-percent cut in discretionary programs.

Turning to Medicare, the President's budget contains many proposals intended to reduce the growth of spending. Those savings proposals would reduce Medicare outlays by $99 billion over the 1998–2002 period, compared with spending projected under current law.

That reduction comprises $53 billion in lower payments to fee-for-service providers, $30 billion in savings in payments to managed care plans, $8 billion in higher receipts from premiums paid by beneficiaries, and $8 billion in other savings.

At the same time, the administration is proposing expansions of benefits that CBO estimates would cost $17 billion. Taking these savings and expansions together, CBO estimates that the President's basic proposals would reduce Medicare spending by $82 billion over 5 years and would slow the growth of Medicare spending from 8.8 percent under current law to 6.6 percent a year over the 5-year period.

In contrast to CBO's $82 billion figure, the administration estimates that its basic Medicare proposals would save $100 billion over the 1998–2002 period. CBO estimates that the President's proposed benefit expansions would cost $4 billion more and that the proposed reductions would save $15 billion less than the administration assumes.

CBO's estimate of the reductions in payments to fee-for-service providers is $11 billion smaller than the administration's estimates, and its estimate of savings in payments to managed care plans is $4 billion less.

In addition to these proposals, the administration also would transfer spending for about two-thirds of home health visits from the Hospital Insurance to the Supplementary Medical Insurance program.

After taking account of the proposals in the budget, the administration would shift to a total of about $86 billion in spending from HI to SMI over the 1998–2002 period. The transfer would have no effect on total Medicare spending, but it would help preserve the solvency of the HI trust fund. CBO estimates that the administration's policies, taken as a whole, would maintain a positive balance in the HI fund through at least the end of 2007.

In the Medicaid program, the President's basic budget would achieve savings primarily by limiting payments to disproportionate share hospitals. The administration would also place caps on Federal payments to States for each beneficiary and limit the growth

of those caps to slightly more than the rate of economic growth per person.

Those proposals would save $23 billion dollars over the period. The President also proposes several new initiatives that would cost $16 billion over five years.

The net effect of the President's basic policies is to reduce Medicaid spending by $7.5 billion over the 1998 to 2002 period. Although CBO's baseline projections for Medicaid are slightly higher than those of the administration, our estimates of the President's proposed changes in policy are similar.

In conclusion, Mr. Chairman, I would like to make two points. First, although the staffs of the Office of Management and Budget and the Health Care Financing administration have been extremely helpful to CBO, our estimates are based on general specifications of the administration's policies and not on specific legislative language. Therefore, our estimates of the policies in the budget are necessarily preliminary.

Second, making budget projections 5 years into the future and beyond is a very hazardous business. The likelihood that the budget will veer off its plotted course because the economy does not perform as assumed or because of some other unexpected events should make us wary of staking too much on the accuracy of any particular projection.

That concludes my summary, Mr. Chairman.

The CHAIRMAN. Thank you, Dr. Van de Water.

[The prepared statement of Dr. Van de Water appears in the appendix.]

The CHAIRMAN. I would like to make sure that we understand the difference between CBO's estimates and the President's estimates of his budget.

Now, you start out by saying part of the difference is of course, the different economic assumptions, and the other part is a result of CBO not attributing as much savings or a greater cost to certain proposals as the administration to the spending cost. Is that correct?

Dr. VAN DE WATER. That is exactly correct, Mr. Chairman. Those figures are displayed in table two, which is on page five of my prepared statement. That table divides the differences in our estimates into two parts.

The first part of the differences is attributable to our baseline projections. And, as you said, those differences stem primarily from fairly small differences in economic assumptions, particularly regarding the share of national income represented by corporate profits.

The second part of the difference is our re-estimates of the savings from the President's proposed policies. They are concentrated in two areas. First of all, we have lower estimates of the Medicare savings, and second, there is a difference in our estimates of the savings from the proposed auction of additional portions of the electromagnetic spectrum.

The CHAIRMAN. I would like to turn to the transfer of the $86 billion of home health care spending from Part A to Part B, the trust fund. Now, CBO anticipates that this transfer would extend the Medicare Part A trust fund solvency date to 2007.

What I would like to know, if we do not make the home health care transfer, when does CBO estimate that Part A trust fund will become insolvent.

Dr. VAN DE WATER. In that case, Mr. Chairman, the insolvency date would be 2003.

The CHAIRMAN. That is an extension of 1 year. Is that correct?

Dr. VAN DE WATER. Two years.

The CHAIRMAN. Two years. And what would be the amount of the Part B premium if the transferred home health care benefit were included in the premium calculation?

Dr. VAN DE WATER. As your question suggests, Mr. Chairman, the administration proposes not to include the additional HI spending that would be shifted to SMI in the calculation of the premium in that program.

If their proposal were to be modified so that the additional home health spending were counted, it would represent an additional $9 on the premium in 2002. The difference would be smaller in earlier years and greater in later years.

The CHAIRMAN. Nine dollars per year?

Dr. VAN DE WATER. Nine dollars per month.

The CHAIRMAN. Per month. All right.

Now, not including that in calculating the premium, is that consistent with the basic policy?

Dr. VAN DE WATER. Well, it is certainly a difference from the approach up to now.

The CHAIRMAN. Now, the President has proposed a number of policy changes related to Medicare managed care plans, including some dramatic spending reductions in payment rates. What do you estimate the effect of these policy changes will be on enrollment in Medicare managed care plans?

Dr. VAN DE WATER. Mr. Chairman, as you suggest, the President does have a wide range of proposals. There are some proposals that would encourage enrollment in managed care plans. Others, particularly the reduction in the payment rate from 95 to 90 percent of the average adjusted per capita cost, would tend to discourage enrollment in managed care plans.

Our preliminary assessment is that the two effects would roughly offset each other and that the President's proposals overall would neither encourage nor discourage enrollment in managed care plans.

Now, as you probably know, we already are projecting a fairly substantial increase in enrollment in managed care plans under current law. The present rate of enrollment in risk-based plans is, about 11 percent of the Medicare program, and we are projecting it to grow to about 25 percent by 2002 and about 35 percent by 2007. But the administration's proposal, we think, would not change that path very much.

The CHAIRMAN. I would like to refer to spending on physician services. CBO's prediction of increases in this area has dropped sharply.

For example, in 1995, CBO predicted physician spending would increase 8.8 percent in 1997—last year 6.4 percent—and now CBO predicts only a 0.5 percent increase for this year. Essentially, as I understand it, CBO believes that the physician spending growth

will be flat in 1997, which is, of course, a dramatic change in physician spending.

My question is this: What do you see as the factors responsible for this drop in physician spending growth? Is there any evidence that the annual update formula for physician fees, a formula that adjusts physician fees for inflation, but is also intended to control the volume of services provided to beneficiaries, is that responsible for slowing physician spending? To what do you attribute this record?

Dr. VAN DE WATER. Mr. Chairman, I would cite three factors, one of which you mentioned. It seems reasonably clear that the areas of Medicare in which the Congress has attempted to slow the growth of spending have indeed tended to slow down. The downside of that is that the spending has tended to pop up somewhere else.

The slowdown in the growth of physician spending, as you have indicated, compared to our projections of only 2 years ago is very dramatic. The slowdown in the projected rate of growth of overall Medicare spending is much smaller because other categories seem to have been speeding up, in part making up for the slowdown in physician spending.

One other reason for the slowdown—an almost arithmetic reason—is the more rapid projected increase in enrollment in managed care plans. The figure that you cite for the rate of growth of physician spending is, of course, payments to physicians in the fee-for-service sector. So we have indeed upped our projections of spending from managed care plans, and that represents a shift within the total so that the slowdown that you cite is less dramatic than it might seem at first pass.

Ultimately though, one has to admit that there is a third factor, which is the residual of all other things that we really cannot explain, as is the case in so much of Medicare and Medicaid. The projections are very volatile. And as best we try, we continue to be surprised by changes in one direction or the other.

The CHAIRMAN. Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman. I would like to focus on the Medicaid aspects of your report and particularly the two areas in which you state most of the Medicaid savings are proposed; the disproportionate share hospital and the per capita cap.

On the disproportionate share hospital, GAO has submitted several reports over the past 5 years evaluating the disproportionate share hospital program.

I wonder if you have any comments as to the policy basis behind the method that the administration proposes to use to get to these savings in the disproportionate share hospital? That is, is the methodology consistent with the diagnosis of what had been the ills or abuses in disproportionate share hospitals?

Dr. VAN DE WATER. Senator Graham, I am afraid I cannot give you a clear answer to that question, in part, because it is our understanding the administration is still refining the distributional details of its proposal.

For our purposes, we had a less ambitious job, which was to merely estimate the budgetary savings for the administration's proposal. And that was not difficult in this case because the adminis-

tration is proposing to establish aggregate dollar limits that would phase down to $8 billion a year in a few years.

So our job was relatively simply. We had to project what we thought would happen under current law, compare that to the $8 billion figure the President would establish, and the difference, of course, is the savings. The savings estimate does not depend upon how the remaining $8 billion is apportioned among different hospitals, although that is a critical issue from a policy point of view.

As I said, the administration has indicated they are still working out exactly how that might work. So I could not comment on the details. But you might ask Dr. Ratner, from GAO, who is following, to comment on how the proposals relate to the GAO recommendations.

Senator GRAHAM. The second question I have may elicit the same answer as the first, and that is there has also been several studies by the GAO on the issue of the Medicaid method of allocating resources, which, as I understand it, under the per capita cap proposal, would essentially be the beginning step for future distribution. That is, the current method of allocation would be the starting point for the constraints that are now proposed to be imposed.

Have you had an opportunity to look behind the policy basis for that distributional recommendation?

Dr. VAN DE WATER. You are correct, Senator, in anticipating my answer. It is essentially the same. Once again, the distributional consequences, while important, were not critical to our estimate.

I should add, of course, as you well know, the distribution of Medicaid spending across States is quite varied because it depends not simply on the features of law as established by the Congress, but the extent to which these States have elected to have more or less generous programs and to take advantage of the Federal matching.

Any program which starts to establish per capita caps or block grants, or something along those lines, based on the current distribution is to some extent, locking in these historical figures. And clearly, you may want to address that as you consider the course of Medicaid in the coming years.

Senator GRAHAM. Given that I have little time left, let me move to Medicare and the area of reimbursement to health maintenance organizations.

This is an area in which there has been a substantial amount of practical experience. Many large businesses and State and local governments have had relationships with managed care organizations.

Are you in a position to comment as to the degree which that experience was taken into account in the administration's proposals on managed care, both in terms of arriving at what were reasonable savings to the Federal Government in using that form of health care financing, and the specific relationships between Medicare and HMOs?

Dr. VAN DE WATER. Yes, Senator. I would be happy to comment on that.

As far as the examination of the private sector experience, the administration is certainly making an effort to expand the types of managed care plans that would be available to beneficiaries. Cur-

rently the managed care plans available are primarily the traditional group- and staff-model HMOs. The administration proposes to expand the range of plans to include provider sponsored networks and preferred provider organizations.

So, to that extent, they are proposing to make Medicare catch up with recent developments in the private sector.

On the second aspect of your question having to do with the payment rates, I think the issue there is less the private sector experience than the analyses that have been made of the risk characteristics of enrollees in managed care plans.

As I suspect you know, the preponderance of evidence is that the people enrolled in Medicare HMOs tend to be slightly healthier, on average, than the people who remain in Medicare's fee-for-service sector; their new enrollees are particularly healthier and the disenrollees are noticeably less healthy.

Again, as always, there is a range of estimates, but the consensus is that Medicare is currently overpaying on the order of five percent. So the administration's proposal to reduce the payment rate from 95 to 90 percent of the AAPCC could be considered consistent with those findings.

The downside, of course, as I indicated in answer to Senator Roth's question, is that the reduction in the payment rates, while producing savings for the Federal Government, would at the same time tend to discourage enrollment in HMOs because the plans would not be able to offer as comprehensive a benefit package.

Senator GRAHAM. Thank you.

The CHAIRMAN. Senator Kerrey.

Senator KERREY. Thank you, Mr. Chairman.

Dr. Van de Water, do you believe the administration has used good economic assumptions? I mean, this is not a rosy scenario budget that they have set up here?

Dr. VAN DE WATER. Yes, Senator. We think the administration's assumptions certainly are reasonable. We think that they are a bit on the optimistic side, and we think that ours are more prudent. But we would never suggest the administration's assumptions are not reasonable.

Senator KERREY. And indeed, as I have heard Mr. Raines describe it, in recent years OMB has done a slightly better job of forecasting. Their assumptions have been slightly more reliable than your assumptions. Is that correct?

Dr. VAN DE WATER. Well, there I would take issue with Director Raines. I think he has not stated the record completely.

If we look at the history of CBO and OMB of the 10 possible projections of the deficit since the current administration came into office including the projections that they made at the beginning of 1993, which extended for 4 years through 1996, and the projections made in 1994 and 1995 and last year—and we compare each of those projections to the actual outcome, CBO has turned out to be better on seven of the 10.

So we do think that there is some evidence on our side. But again, the differences are not large. Both we and OMB are examining the same information. Their professional staff is highly capable. So we think——

Senator KERREY. I appreciate that. But I must add clarification. I do think, for the public's consumption, that it is important to note that we do have a President who submitted a balanced budget—the first time since 1958, as I understand it—and they are making at least an effort to use economic assumptions that are getting closer to what you at CBO are doing.

I have got two concerns I would like you to comment on. The first is the trend of the deficit. It actually goes up in year one, which implies that the first year's vote is the easiest vote, and then it looks to me like the votes in the out years get harder and harder and harder.

It looks like the year 2000 is going to be a fun vote. That year we will reduce the deficit by $40 billion. Then I have got another $30 or $26 billion in the out years.

Again, can you comment on that? Would you say that the votes are going to be easier under this resolution in the early years and more difficult the further we get out? I mean, I am not presuming you understand politics at all here, but——

Dr. VAN DE WATER. Now, one comment at first, Senator. The administration is proposing to attempt to lock in all of these policies up front, including through the continuation of the aggregate limits on discretionary appropriations.

Senator KERREY. What do you mean by the word "attempting to"?

Dr. VAN DE WATER. They are proposing to. I was not meaning to suggest that their proposals would not be technically sound. They are proposing to lock in these policies up front through, for example, the establishment of aggregate caps on discretionary spending, and you and your colleagues would have to vote on those caps this year.

The decisions that would be delayed to the future would be the decisions on how actually to cut appropriations to fit within those limits, and those subsequent appropriation decisions certainly would be extremely difficult.

Senator KERREY. Yes. It would be interesting to just sort of, for an exercise, to vote on those right now to see what sort of enthusiasm, because those are pretty substantial non-defense discretionary cuts. I mean, as I read it.

Dr. VAN DE WATER. Yes, Senator.

Senator KERREY. Let me take you into a different area. One of the concerns that I have got is that although the President does have some structural changes on the mandatory spending side, mandatory programs will still grow from 64 percent of the budget to 70 percent of the budget in the year 2002. That would be ten more years until 2012, when the baby boomers begin to retire.

And as I see it, we are going to continue to move in a direction of mandatory programs and presuming it is hard to forecast these things, eventually 100 percent of the budget is dedicated to mandatory programs.

Do you agree that this budget fails to control adequately the growth of mandatory programs?

Dr. VAN DE WATER. Senator, clearly it is not my place to suggest whether the proposals are adequate or not, but I think I can point out that at least in the areas of Medicare and Medicaid there are

a number of proposals which would move in the direction that you would like.

In Medicaid, certainly the per capita cap proposal, depending upon the level at which it is set, does provide a basis for controlling the growth of Medicaid into the long run.

Senator KERREY. Six percent growth though, from 64 to 70, is a little over $100 billion in current dollars. I mean, that is a pretty substantial increase.

Dr. VAN DE WATER. Oh, yes. Certainly. I am not in the position of either defending or throwing stones at the administration's proposal. But their proposal for the per capital cap would gradually phase down growth rate, so the growth rate of the program is slowing over the period.

Senator KERREY. I would like to submit a question for answering in writing on this issue because I do think that we are postponing, not only at our peril, but at the beneficiaries's peril as well, an eventual decision that is going to have to be made to reign in the overall growth of mandatory programs.

It is unsustainable to go to 100 percent. I mean, we can at least agree on that one. I do not think anybody wants the government to just simply be an ATM machine. Thank you.

[The question by Senator Kerrey appears in the appendix.]

The CHAIRMAN. The record will be kept open until 5:00 this afternoon for additional written questions. Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman.

It is my understanding that the administration, particularly HCFA, has indicated—and I think we have discussed this briefly—that managed care is somewhat overpaid in their per capita reimbursement rates, partly because people who go to managed care facilities, or sign up, tend to be healthier. Is that an accurate conclusion?

Dr. VAN DE WATER. Yes, Senator, it is.

Senator BAUCUS. And for those reasons? Or are there other reasons why many organizations conclude that perhaps managed care facilities are overpaid, besides healthier people tend to sign up compared with those that sign up for fee-for-service?

Dr. VAN DE WATER. That is the primary reason, Senator.

Senator BAUCUS. The document I have here, prepared by Health Care Finance Administration, HCFA, refers to two or three separate studies. One is the PPRC study of 1996, which concluded—I do not know if this is accurate or not—the payment, at 87.6 percent of AAPCC, would affect a favorable selection of managed care plans.

Is that number about in the range of overpayment in your experience or based on what you know?

Dr. VAN DE WATER. Yes, Senator. Again, we do not have any firsthand data sources on this. We look at the findings of the Physician Payment Review Commission (PPRC) and other analysts. But the consensus is that the current rate of overpayment is probably about 5 percent or, if you use the PPRC figures, a bit more than that. But that is certainly the range we are talking about.

Senator BAUCUS. And if those reductions were made, that would be a savings to the budget?

Dr. VAN DE WATER. Yes, sir.

Senator BAUCUS. And also, that there would not be a significant reduction in enrollment? Or would there be? Your best estimate on that point.

Dr. VAN DE WATER. Our conclusion is that if you take all the President's policies together, there would not be a significant change in enrollment. But if you focus just on that particular piece that you have been discussing, the reduction in the payment rate from 95 to 90 percent of the AAPCC, that piece itself would tend to discourage enrollment in managed care plans.

Senator BAUCUS. Are you aware of the rather wide disparity in AAPCC payments to managed care plans, depending upon where they are located?

Dr. VAN DE WATER. Yes, Senator. The range currently, in unadjusted terms, is about three to one, from the highest to the lowest. If you adjust for regional differences in input cost, the difference is still about one and a half to one.

Senator BAUCUS. For example—and my colleague from Florida is not here. So it is a bit unfair—I think Dade County receives at least $700.00 per person per month. In my State of Montana, the payment rate is only about $350.00 per person per month.

Many providers in my State say that that is the reason why there are so few managed care facilities. There is so little sign up. That is, their rate is so low that a plan cannot make a go of it.

And I am wondering if there might be more savings still in the long term basis if the AAPCC to rural managed care plans were higher, which would encourage people to sign up. Theoretically, those would be the healthier people again, rather than those who would be getting Medicare payments under fee-for-service.

So is it logical to reach a conclusion that in the long term there would be savings if the rural reimbursement to managed care plans were increased, to the degree that it is the low payment rate which discourages people from participating?

Dr. VAN DE WATER. As your question indicated, Senator, under current reimbursement rates, the policies that would lead to additional enrollment in managed care plans might actually tend to cost the Federal Government money, as long as you were still bringing in additional people who were relatively healthy compared to the average.

Under the administration's proposal, with the payment reduced to 90 percent, except to the extent that it further exacerbated selection problems, that would be less of a factor. But you still would not have net savings simply from moving people into managed care plans.

I would add, however—and this relates to Senator Kerrey's question—that moving Medicare toward some sort of a plan with people able to choose from alternative insurance arrangements, such as managed care plans, HMOs, PPOs, provider sponsored networks, or fee-for-service, or any scheme which encourages more enrollment in managed care plans early on, may be conducive with achieving long-run savings, even if it does not produce any short-run savings.

Senator BAUCUS. One very brief question, if I might, Mr. Chairman. This is just an informational question.

Does the administration's reduction in payments to managed care plans reduce payment proportionately? Or does it advise some

reduction in some areas, geographic or otherwise, compared with some other areas?

Dr. VAN DE WATER. It both reduces the overall rate and changes the distribution. In particular, it has two policies which would tend to raise the payment rates. In States such as yours, it would establish a $350.00 floor on payment rates.

Senator BAUCUS. That is what it is today. Right.

Dr. VAN DE WATER. So that one is not too much help. But, in addition, it would phase in a blend of payment rates so the payment rate would not be based simply on the local rate, but it would be based on a blend of the local and the national rates.

Senator BAUCUS. And the net result of that blend for the most rural States would be what?

Dr. VAN DE WATER. There is no generic answer. But it would tend to raise the payment rates in the areas where they are now low and lower them in the areas where they are now high.

Senator BAUCUS. Thank you, Mr. Chairman. This is an issue that we are going to be exploring later on obviously, to make sure that the payment rates are fair to all parts of the country.

If payments are excessive, as the administration believes—and I think most objective observers believe—we must make the adjustment and reduce the payment rate nationwide. We have to make sure the reduction is done in a fair way because I will say that it is so low for some parts of the country that it is impossible to develop any managed care plans at all. So we have to have some kind of payment rate that allows managed care to develop, not only in the most populous parts of our Nation, but also in the more rural parts. Thank you very much.

The CHAIRMAN. Senator Bryan.

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

In your comments on your testimony, you indicated that part of the difference in the conclusion that you reach with respect to the administration and your own scoring of the budget proposal is based upon different economic assumptions. You may have covered this more comprehensively before I came into the room, but can you just indicate generally what those differences in economic assumption are?

For example, do they deal with growth rates, the interest rates in the out years? Generically, if you could just point to some of the major areas where you have reached a different conclusion from the administration in terms of the economic assumptions.

Dr. VAN DE WATER. I would be happy to do that, Senator. I did not go into that in detail earlier.

There are numerous small differences between our economic assumptions and those of the administration. For example, the administration has a slightly higher rate of growth of overall GDP, so that by 2002, their projection of nominal GDP is about $80 billion higher than ours. There are also slight differences in interest rates and in the CPI.

The single difference, however, that has the biggest effect on the budget numbers has to do with the share of national income that is represented by corporate profits. There are three or four major categories of national income. One is wages and salaries. That is

the biggest. Corporate profits are another major chunk, and interest income received by individuals is the third major item.

The different types of national income are not all subject to the same effective tax rates. In particular, corporate profits tend to be taxed at a slightly higher rate. Therefore, under OMB's assumptions, which have a slightly larger proportion of national income showing up as corporate profits, they end up with slightly higher tax revenues than we do.

It is a very obscure technical point, if you will, but it is one where we think the administration is a bit on the optimistic side. In fact, we just saw yesterday a new report from the Wharton Econometric Forecasting group which was addressing this very question, whether the currently very high rate of corporate profits in national income was likely to be sustained. They, like CBO, reached the conclusion that it was not.

Senator BRYAN. To some extent when you are forecasting, it is really like a weather prediction that a meteorologist makes. You would make an informed assessment based upon what you think the likelihood is of certain economic conditions occurring in the out years, but it does not lend itself to the precision of an arithmetic computation.

With respect to the differences that you have with the administration's proposal, are they, as you responded to Senator Kerrey's question, within the zone where reasonable economists can reach different conclusions as to what the growth rate would be, whether it is corporate income or personal income? Are these in the ballpark, so to speak?

Dr. VAN DE WATER. Absolutely, Senator. There is no doubt that they are in the ballpark.

Senator BRYAN. So it could very well be that the administration may be more accurate than you all are in the out years as to what the revenue derived from the corporate profits might be?

Dr. VAN DE WATER. It is certainly possible.

Senator BRYAN. Let me ask you a Medicare question. This is an issue that I think we are all struggling with.

I am led to believe, that HMOs have been most effective, even critical, and some say somewhat heavy handed in terms of ratcheting down the provider reimbursement rate. That has been particularly true in my State of Nevada.

Is it accurate to say that the provider reimbursement rates that many of the HMOs have been able to negotiate are lower than the Medicare reimbursement rate?

Dr. VAN DE WATER. I am afraid I cannot answer that question, Senator.

Senator BRYAN. Is it possible to get that data? I am not asking you to respond right now, but is it possible to get? What one hears out there a good bit is that in some instances the HMOs have been, in effect, negotiating an exclusive contract, saying to a different group of providers, "Look, we want your best offer."

The group, whether it be an oncology or cardiology or pathology, whatever the medical sub-specialty may be, the understanding being you only get one shot at making an offer. If you are the lowest, you get it and nobody else gets to participate, even though those providing are willing to provide the service at the same rate.

That has a tremendous amount of economic leverage as the HMO groups become more pervasive in terms of their penetration of the market.

If they are able to get a more favorable rate, it suggests that perhaps the Medicare reimbursement rate is too high. And I gather from your answer you do not, at this point, have the data available to suggest whether that is true or not.

Dr. VAN DE WATER. Senator, there have been various studies of this. I am afraid that neither my colleagues nor I happen to remember their findings off the top of our head.

What I do remember, however, is that those comparisons are extremely difficult to make, in part because Medicare, by its very nature, is dealing with a different population from the population under 65 who are receiving care through private sector HMOs. Even if you look at two medical procedures that are superficially the same, they are really not, because a given procedure for an over 65 year old person or for a disabled person may be more complicated than a similar procedure for a younger individual.

So it is very difficult to make those comparisons, first of all. Second, Medicare has attempted to use its leverage to ratchet down payment rates. Not in the same way, but, the Congress has placed various limits over the years on hospital payments, physician payments, and other aspects of Medicare spending. I do not mean to suggest that Medicare has been ignoring its ability to get more favorable deals to some extent as well.

We will be happy to go and research that and provide that additional information to your staff.

Senator BRYAN. I appreciate that, Dr. Van de Water. Thank you, Mr. Chairman.

The CHAIRMAN. Just let me ask one follow up question. Historically, is it true that the OMB has normally been more optimistic then CBO? And if so, why?

Dr. VAN DE WATER. It is certainly true as you say, Mr. Chairman, that over the long haul, looking over the past 15 or 20 years, that the Office of Management and Budget has tended to be more optimistic, particularly on its long-range projections. When you compare our projections to those of OMB a year or so into the future, we tend to come out a little bit better, but the difference is not very large. The difference is more noticeable when you compare the projections 5 years ahead.

I cannot explain that, but I think it is reasonable to assume that any administration, whether it be the present one or one of its predecessors, always wants to make it appear that its policies will produce a robust economy, and they, therefore, use assumptions which tend to be a bit more favorable than CBO or the typical private forecaster would produce.

The CHAIRMAN. Senator Grassley.

Senator GRASSLEY. I am glad you brought up that subject, Mr. Chairman, about the optimism that we have, whether one has more than the other. A problem we have here in Washington is everybody has got too much optimism. It is kind of like a narcotic. We get hooked on it, and it is hard to get away from.

It is a real habit with those of us in government at all level, either political party, and it makes us think that we can get by with

doing less because we fool ourselves into thinking that the reality is rosier than it really is.

So one of these areas obviously is Medicare. And when we are involved with this optimism, it kind of hurts the integrity of our process and undermines the credibility of us as elected officials.

You say—and I do not dispute you—that the President's proposal will save $82 billion in Medicare by the year 2002? That is $19 billion less than what he says, and there is probably even a lot of optimism in that $82 billion figure as much as there is in the President's. I should not say as much optimism even in that because we all have that optimism here.

So it kind of makes me nervous when we have these difference in proposals. So my question to you is something that maybe you answered for other panelists, but it is what do you think can be the sustainable rate of spending in Medicare, not just for the short term, for the long haul, and I mean at least to the point where the baby boomers are starting to come on?

Dr. VAN DE WATER. Senator, I cannot give you a definite answer because that ultimately is a question of policy, which is for you and your colleagues to determine. Clearly, over the extremely long haul the Federal budget overall cannot be expected to grow more rapidly than the underlying growth of the economy whose resources have to support government programs. So, in the very long run, that surely is the answer.

During any shorter period, certain programs can grow more rapidly and others can shrink. And dare I say it, there is even at least the theoretical possibility that the Federal Government could decide that it should spend more as its share of GDP then it is now spending.

For example, when the baby boomers were attending elementary school and high school, there was a very rapid run up in the cost of education—of course, a cost borne primarily by State and local governments. It is conceivable that there should be at least some increase in the share of GDP devoted to Social Security and Medicare as the baby boomers retire, although the levels that are projected under current law appear to be far outside the range that could be sustained.

Senator GRASSLEY. Well, policy changes obviously are involved. In fact, they are the key to it. But there is, at some rate, times the rate of inflation that we thought that we could be twice the rate of inflation—at least in 1995 we thought this—and we would be able to sustain it until the year 2008, 2009 and 2010, in that period of time.

That was what I was asking you to comment on, based on what it can grow, more than at presently, and is going to have to grow more than existing programs and still sustain itself for a period of time to the baby boomers.

Dr. VAN DE WATER. Senator, if we look at CBO's baseline projections, total government spending over the next 10 years is not projected to grow much faster than the economy overall. Currently Federal Government spending represents just under 21 percent of gross domestic product and 10 years out, by our projections under current law, it would only be a little bit over 21 percent.

But, as Senator Kerrey was suggesting earlier, the composition of spending is projected to change rather substantially over that period primarily, as you say, because of the very rapid growth of Medicare and Medicaid. Mandatory spending would grow from about 11.5 percent of GDP to 13.4 percent. So what is going on is that the growth in mandatory spending is being compensated by a reduction in discretionary spending.

As long as you can make tradeoffs like that, individual programs can grow more rapidly. But clearly, discretionary spending is being squeezed quite hard, and you are not going to be able to continue to make reductions of that sort in the indefinite future.

So, as you say, in the long run the rate of growth of Federal spending would have to be limited to the rate of growth of the economy.

Senator GRASSLEY. Thank you.

The CHAIRMAN. Thank you, Senator Grassley.

Gentlemen, we appreciate very much your being here today. We are going to leave the record open for written questions.

Senator GRAHAM. Mr. Chairman, could I ask one question? Excuse me, Mr. Chairman.

The CHAIRMAN. Sure. Please.

Senator GRAHAM. Looking at the chart that you have on page three of your statement, under revenues, you show increases in revenues over the period to 2002 of $81 billion, which offset reductions of $120 billion, for a net of $39 billion. Is that correct?

Dr. VAN DE WATER. Yes, sir.

Senator GRAHAM. Could you tell us something? What is the composition of those revenue increases, and do you have an assessment as to their solidity? That is, how reliable those revenue increases are likely to be?

Dr. VAN DE WATER. I am afraid that was not something I focused on. I was asked to come and talk primarily about Medicare, Medicaid and welfare, and I have not looked into the tax proposals.

Senator GRAHAM. Thank you.

The CHAIRMAN. I have just one more question I would like to ask now in order to get a clear understanding of what the President is proposing in Medicaid savings. As you know, it is sometimes difficult to find the bottom line when there is a difference in baselines.

So I would like to set aside the Medicaid improvements and other health initiatives proposed in the present budget and focus just on the savings side. Counting the reductions in spending, but not the cost of the new initiatives, the President's budget assumes the Medicaid program will spend approximately $578 billion during the period 1998 to 2002. Is that correct?

Dr. VAN DE WATER. I am afraid I did not follow the question, Mr. Chairman.

The CHAIRMAN. All right. Let me reiterate. Again, we are setting aside the so-called Medicaid improvements and other health initiatives and just concentrating on the savings side.

Counting the reductions in spending, but not the costs, as I said, the President's budget assumes the Medicaid program will spend approximately $578 billion during the period 1998 to 2002. Do you agree with that figure?

Dr. VAN DE WATER. Your arithmetic may be better than mine, Mr. Chairman. The figure I come up with is 595. If we look at table five on page 20 of my prepared statement, we see that projected outlays under current law cumulate to $618 billion over the period. The savings proposals would reduce that by 23. So, if you subtract 23 from 618, you get 595. But perhaps you are doing another calculation that I am not following.

The CHAIRMAN. But are you not using the CBO baseline and not the OMB?

Dr. VAN DE WATER. Yes, sir. Of course.

The CHAIRMAN. But what if you use the OMB baseline?

Dr. VAN DE WATER. Well, we cannot combine our estimates of the proposals with their baseline. That is an apples and oranges comparison.

The CHAIRMAN. No. That is not what I am asking. It is my understanding the President's budget assumes the Medicaid program will spend approximately $578 billion during the period.

Dr. VAN DE WATER. Now I understand. I am sorry, Mr. Chairman, to be so slow in perceiving your question. I would assume that is the correct number. Yes. And that is a bit lower than CBO's estimate.

The CHAIRMAN. Let us assume that that $578 billion is correct. In order to meet this target, how much would spending need to be reduced from the CBO baseline?

Dr. VAN DE WATER. The answer to that question would be the difference between our 595 and 578, which is an additional $17 billion.

The CHAIRMAN. An additional $17 billion.

Gentlemen, I appreciate it. We will have some more written questions. We appreciate you being here and your candor and look forward to working with you.

Dr. VAN DE WATER. Thank you, Mr. Chairman, Senators.

The CHAIRMAN. Our next witness is Dr. Jonathan Ratner, who is Associate Director, Health Financing and Systems Issues, at the General Accounting Office.

The growth in Medicaid spending has slowed in recent years, and I am pleased that GAO is with us today to help explain why the national Medicaid rate of growth in 1996 was at a historical low.

Let me say that GAO is here today courtesy of the Budget Committee. Senator Dominici had asked GAO a couple of months ago to look at what happened in the Medicaid program in 1996, so we are reaping the benefits of that request.

Your full statement, Dr. Ratner, will be included in the record, and we ask you to summarize it. And please introduce your sidekicks. We are delighted to have them here.

STATEMENT OF JONATHAN RATNER, PH.D., ASSOCIATE DIRECTOR, HEALTH FINANCING AND SYSTEMS ISSUES, GENERAL ACCOUNTING OFFICE, WASHINGTON, DC, ACCOMPANIED BY KATHERYN ALLEN, ASSISTANT DIRECTOR AND RICHARD JENSEN, SENIOR EVALUATOR

Dr. RATNER. Thank you, Mr. Chairman, and members of the committee. I am accompanied today by Katheryn Allen and Rich-

ard Jensen. We are pleased to be here today to discuss recent Medicaid trends, as you said, and what they mean for the future.

My comments are based on work that we have in progress, as you noted, at the request of the Chairman of the Senate and House Budget committees, who are interested in what contributed to the recent drop in the growth rate of Medicaid spending to its 1996 level of 3.3 percent.

Data are not yet available for 1996 on spending by service category, the number of eligibles, and service use. Consequently, we analyzed HCFA and Treasury data on spending and enrollment and also contacted Medicaid officials in 18 States, which account for almost 70 percent of Medicaid spending.

As you know, the national growth rate in Medicaid spending masked striking variation among the States and 1996 was no exception. For example, spending in one State went down 16 percent, but in another went up 25 percent. Notwithstanding the striking examples, most States' 1996 growth rates were moderately lower—a small change from their 1995 growth rates.

My remarks today address two questions. First, what factors accounted for last year's deceleration in spending growth?

For States with substantial declines in spending growth, several factors are at the heart of the story. One is slowdowns in several State-initiated eligibility expansions. For example, Hawaii, Oregon and Tennessee, which saw their growth rates drop substantially between 1995 and 1996, had previously widened Medicaid eligibility. As these expansions leveled off, so did their Medicaid spending growth.

Another factor is some States shifting 1996 payments into 1995. As you undoubtedly recall, in 1995, the Congress was considering legislation to cap each State's spending based on its level in a benchmark year. A few States told us that they had anticipated the passage of the legislation, so they accelerated some of their payments into 1995 to establish a higher base.

The CHAIRMAN. How important a factor was that?

Dr. RATNER. It turned out not to be as big as people had thought. The conversation that we had with State officials indicated that there was only one State where a substantial change was effected by this kind of acceleration.

A final factor is a decrease in funding for DSH payments. Congress acted in the early 1990's to bring DSH payments under control, as you know, which helped bring down Medicaid spending growth from its 1992 peak. In one or two States the decline in DSH payments continued to play a role through 1996, as they brought their DSH spending in line with the new limits.

However, for most States, those with moderate declines or slight changes in Medicaid growth, the key factor was better economic conditions. Between 1993 and 1995 most States' unemployment rates dropped—some by 2 percentage points. And while data from HCFA on Medicaid eligibles and recipients are not available for 1996 yet, State officials told us that, as expected, the number of people on Medicaid had also declined.

In addition, there was moderation in price inflation for medical services, and this helped with reducing pressure on Medicaid reimbursement rates.

In discussions of Medicaid, the effect on cost of recent State initiatives, like managed care, is often raised. The movement of more Medicaid beneficiaries into managed care is often cited as a potential factor moderating spending growth. However, much of that movement is relatively recent and has been undertaken at times with objectives other than immediate cost control.

States have sought to increase the number of eligibles or improve access or quality in the short term, while looking for possible savings for managed care in the longer term. With such limited and diverse evidence, managed care's effect on Medicaid spending is, as yet, uncertain.

My second question is: what does the 1996 growth slowdown imply about the future course of Medicaid spending?

Although it is chancy to extrapolate future spending from the experience of 1 year, signs point to a higher rate of Medicaid growth in the near term. Here is why: First, DSH. The fact that DSH payments have been frozen in some States helped moderate the 1996 Medicaid spending increase.

However, DSH may add to future growth as the freezes on additional spending are lifted for more States and DSH is allowed to grow in line with the rest of the program.

Second, economy. The current expansion has been a prolonged one, but unemployment cannot be expected to stay at its current level, especially in States with rates below four percent. Furthermore, any rise in medical price inflation will likely push up those Medicaid reimbursement rates.

Third, long-term care. The continued rise in the number of elderly people adds to the demand for long term care and to the presumption of program cost growth. Alternate ways of delivering this care can moderate the growth, but not eliminate it.

Now, working against these factors are factors that may dampen future spending growth. For example, the recent welfare reform legislation ends automatic eligibility for Medicaid of persons receiving cash assistance and may affect participation by eligible persons.

Additional States are likely to expand the use of Medicaid managed care. Over the longer term, of course, many believe that managed care will slow spending growth or help do so. But again, the effect in the near term is less clear.

In sum, the net effect of these forces is likely to raise Medicaid spending growth in the next few years, but the size of that increase is subject to considerable uncertainty.

Mr. Chairman, this concludes my statement, and I would be happy to answer any questions.

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

The CHAIRMAN. Well, in a sense, you have anticipated my first question and that was whether 1996 is an anomaly or a trend. What factors should the policy makers be considering and what modifications, if any, should be made in Medicaid?

Dr. RATNER. Well, the fundamental problem that policymakers face is that there are forces pushing up spending in Medicaid, just as there are in the private sector and elsewhere in the health care marketplace. So that is the tide against which you have to swim.

In particular with Medicaid the rise in the elderly population and the disabled population are going to add to the spending pressures

there. The areas for modification are things like DSH, and then trying to design ways of introducing managed care and other innovative programs into Medicaid's long care term sector so that spending is moderated. But, as you know, this is not an area where there are magic bullets.

The CHAIRMAN. So you see choice as being an important factor?

Dr. RATNER. Choice and other elements of managed care and capitated payment offer some potential for Medicaid. One of the things that we have seen is that managed care is an elastic term, which covers lots of different things going on in the States. Some of the States have done things that are fairly limited. Others, like Arizona, have had a mature managed care program with competitive bidding and have been pretty successful.

So there are a wide range of programs and possibilities for learning from successful examples.

The CHAIRMAN. As you know, the administration has offered—I think to its credit—a number of proposals which make it easier for the States to manage their Medicaid programs. One area of particular interest is to eliminate or reduce the need for waivers by allowing the States greater flexibility.

Is there reason to be concerned about flexibility from the Federal Government's standpoint, that it may mean higher Medicaid costs? Will they be able to game the changes?

Dr. RATNER. Flexibility vis-a-vis managed care arrangements may not be as subject to gaming. One of the things that the Congress has done, as you know, in 1991 and 1993 was to close some financing loopholes that enabled States to shift costs to the Federal Government.

One of those loopholes is still open involving intergovernmental transfers, and that is an area where some gaming and some abuses are possible. devising a mechanism to detect and control those abuses though is pretty challenging. I wish I could say that I had it here for you.

The CHAIRMAN. Should we try to adopt some type of spending constraints as greater flexibility is provided to the States?

Dr. RATNER. The goal of having spending constraints, in particular, having something that enables the Federal Government to have some control over Medicaid outlays and some predictability is widely shared. The possibilities for doing that are limited by some technical problems.

An example is the per capita cap, where estimating the number of eligibles poses a technical challenge to setting a good cap. But the potential for constraining Medicaid spending definitely is there.

The CHAIRMAN. As the administration has granted Medicaid waivers, what are some of the provisions of Medicaid law they are most commonly waiving?

Dr. RATNER. Do you want to speak to that?

Mr. JENSEN. Yes. Normally the first thing States will ask for is to waive the beneficiaries' freedom of choice to select a provider. It is usually a necessary piece of putting a managed care program together. As States get into what has been referred to as the demonstration waivers, section 1115 waivers, they ask for a variety of other things, including a waiver for some of the conditions that are in place to monitor quality of care.

For example, the 75/25 rule, which requires a managed care plan to have at least 25 percent enrollment. Quite often States ask that that rule be waived when they pursue managed care under a demonstration waiver.

There are others, but that is the nature of the waivers that States seek.

The CHAIRMAN. My time is up. Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman.

You mentioned that one of the areas that has been most significant in terms of the change in Medicaid cost has been the DSH program, the Disproportionate Share Hospitals.

Dr. RATNER. Yes, sir.

Senator GRAHAM. The GAO has done several studies over recent years on the program. Could you evaluate the policy recommendations contained in the administration's budget in light of the GAO's studies of the DSH program? To what degree has your diagnosis of the abuses of that program been dealt with in the administration's budget?

Dr. RATNER. I would be glad to try. We have not analyzed the proposal in detail, but I have some general comments.

The administration's proposal tightens the spigot on the flow of DSH payments, and since this has been an area of some abuse, this seems like a plus. The administration proposal does not, though, close off the opportunities for abuse of the intergovernmental transfers that I spoke of a moment.

But in fairness, I have to recognize that devising a mechanism to see where those things are happening and to control them is pretty challenging. We have thought about it a bit, and I do not yet have a satisfactory answer.

So on the DSH story, I think the proposal has a positive feature, but some questions remain.

I would add one other thing: DSH does involve paying hospitals that are supposed to have a disproportionate share of low income patients. I think that it is wise to see to it that, in fact, those payments are well targeted to such hospitals. I see this as an area where further examination of the administration proposal is warranted.

Senator GRAHAM. I understand the proposal calls for holding harmless all DSH payments which are above 12 percent. That is, where a State is receiving more than 12 percent of its Medicaid reimbursement from DSH, the amounts above 12 percent would be undisturbed, and therefore, all of the savings from DSH would be focused on that portion of States' payments which were less than 12 percent.

Is that an accurate depiction of the administration's DSH proposal?

Dr. RATNER. I am not aware of that. We would have to pursue that with them.

Senator GRAHAM. I would be interested in your analysis of the proposals for Disproportionate Share Hospital, taking into account your previous studies of abuses, the degree to which those abuses have been eliminated or ameliorated, and the degree to which the administration's proposal for restrained DSH payment will enhance the prospect that funds will flow to those hospitals upon which the

program was originally predicated, that is, those that serve large numbers of indigent and low income families.

Dr. RATNER. We would be glad to take a look at that for you.

Senator GRAHAM. If I could turn to the other major cost saving area in Medicaid, and that is the per capita cap. Again, the GAO has done studies on the distributional effects of Medicaid. Could you comment on how the per capita cap, as proposed to be implemented, would relate to the GAO's previous diagnosis of allocations?

Dr. RATNER. The description of the administration proposal that I have seen does not have that level of detail and does not really spell out that mechanism. Certainly it is a fundamental part of the per capita cap story to set that base year amount appropriately, and there is some discussion in the documents that we have seen about the factors that they would call for.

I think that we would have to look at that cap proposal more carefully and see how that relates to the work that we have done. Again, I would have to defer that to another time until we had a chance to examine the issue you raise.

Senator GRAHAM. I would appreciate that analysis. And one aspect of that, in your previous studies you talked about the disparity that exists from State to State and the desirability of having policies that will, over time, begin to narrow that disparity, whether the per capita cap proposal, as submitted by the administration, will have that feature of beginning to reduce current rates of disparity.

I would appreciate it if you would include that in your analysis.

Dr. RATNER. Yes, sir. I would be glad to.

Senator GRAHAM. Thank you.

The CHAIRMAN. Senator Grassley.

Senator GRASSLEY. I want you to speak a little bit about inflation and Medicaid and what you expect, projecting that inflation for the future, but I want to put it in this context.

Private sector medical costs are very, very low, and we think that is because of managed care. Medicare stayed pretty constant here over the last few years. Medicaid has been way up. Some of it has come down because of policy changes that have either built into the system or we have actually changed some things that were costly.

I want you to kind of focus on that, on what is related to the delivery of health care in Medicaid, if anything, that brought the costs down. And would those be sustainable?

Dr. RATNER. You are hitting on a very interesting area because it highlights that there are both some similarities between Medicaid and the rest of the health sector and some important differences. The similarities, as you know, are all those forces that lead to the advance of medical technology and new kinds of services and also to general population growth.

But some of the differences are the nature of that Medicaid population. A part of the Medicaid population is roughly similar to what the private sector encounters with women and children, but those are the least expensive parts of the population. The most expensive part—about 30 percent of the Medicaid population—accounts for about 60 percent of the spending. This part is the elderly and the

blind and disabled. That is a very challenging area for managed care to get a handle on.

What we have seen in our discussions with the States and in our own analysis is that there are some real bright spots. An example is Arizona, which has had a mature managed care program and has used competitive bidding to get rates down. But there are other States which have not sought cost control as their first objective. For them, managed care has been a way to expand access or expand quality, increase and improve quality, rather than getting the cost savings up front.

That is why the potential for managed care savings is likely to be spread out over the future and may not appear in the next few years as much as one might think.

Senator GRASSLEY. In the case of Arizona and the competition that has reduced the costs there, what are the implications for managed care programs when States cannot sustain that competition?

Dr. RATNER. The challenge that a State has is to set reimbursement rates for managed care plans in a way that does not overcompensate the plans, on the one hand, but then, on the other hand, does not spend too little and get the plans to skimp on care.

Arizona has found that it is a real challenge to design that competitive bidding system. When you do not have a State that is large enough or has a well enough developed managed care industry to sustain competitive bidding, then you are into the kinds of difficulties that Medicare has encountered in setting reimbursement rates.

Senator GRASSLEY. Then are you saying that Arizona cannot continue to be this successful at maintaining costs?

Dr. RATNER. No. I would think that the indications are that it can be. Arizona has a lot of the favorable conditions. It has been using this approach for a long time and has figured out good ways of doing it. Some States could be in a position to replicate that. Other States may have to use other methods of setting their rates to try to get good savings out of managed care.

Senator GRASSLEY. Well, can you identify differences between Arizona, on the one hand? And another couple of examples you used was Minnesota, California, on the other hand, where they have not been able to make significant changes, the reason for that?

Dr. RATNER. The reason, according to State officials, in the case of California, is that they designed their program to be budget neutral. So by definition, it is not going to yield savings. Their purpose was different, at least for the short term.

Senator GRASSLEY. So they are really policy decisions?

Dr. RATNER. Exactly.

Senator GRASSLEY. The motive was not necessarily to save money?

Dr. RATNER. Exactly.

Senator GRASSLEY. In Arizona's case it was?

Dr. RATNER. I think in Arizona's case they were definitely focused on saving money.

Senator GRASSLEY. Let me ask you one question. My time is running out there. That is in regard to the Boren amendment. There is an interest with the President now to repeal that. A lot of mem-

bers of Congress are getting involved in it. Governors have supported it a long time.

Is it possible to repeal the Boren amendment; that this could lead to inadequate reimbursement for some providers in some States?

Dr. RATNER. When you give a State flexibility in setting reimbursement rates, there is that chance. And this is why it is one of these balancing acts to figure out a way to have some monitoring of access and quality so that you know what is going on, but still preserve a wide range of flexibility for the States in setting the reimbursement rates.

Senator GRASSLEY. Along that line though, would there not be an incentive for the States not to be so conservative? The extent to which they do not provide adequate reimbursement, it is going to hurt the quality of care; the number of professionals that are in health care for the entire population of their State, I mean, because if you reduce this area and it cannot be picked up somewhere else, you are going to just have people leave the State.

Dr. RATNER. Well, the State's focus usually is on reimbursement to the institutional providers, particularly the nursing home. That population often is heavily financed by Medicaid.

Senator GRASSLEY. But it does not involve reimbursement to individuals, like practitioners? It is just the institutions in the case of the Boren amendment?

Dr. RATNER. The Boren amendment applies to both nursing homes and hospitals and ICFMRs, not to individual providers, such as physicians.

Senator GRASSLEY. All right. In my State, for instance, my State would have to be careful because we have got the problem of maintaining hospitals in rural areas that are very touch and go.

The CHAIRMAN. Senator Moseley-Braun.

Senator MOSELEY-BRAUN. Thank you very much, Mr. Chairman.

Mr. Ratner, your analysis is very helpful. You looked at the most recent 2 years. But I wonder, in terms of the trends, whether or not this two year window can be seen as an accurate predictor or to what extent it can be seen as an accurate predictor of future trends.

In the first instance, some of the more recent economic reports say that the decline in Medicaid reimbursement rates due to managed care and all the rest of that, that that has bottomed out and that there is an up-tick now in health care costs and medical care costs, a price inflation that was not seen at the end of last year. That is one issue.

Another is, of course, we are still faced with the demographic bubble that affects us all. In fact, Mr. Chairman, I actually got my invitation to join AARP the other day. I was just absolutely destroyed by it.

The CHAIRMAN. You are growing younger and younger. [Laughter.]

Senator MOSELEY-BRAUN. Is that it? Thank you.

But the demographic bubble is driving a lot of this and health care costs, particularly with regard to long-term care costs, are inevitably going to rise.

And so my question to you is, this analysis that we have, based on the 2-year window, to what extent has it taken into account the up-tick and the demographic bubble and to what extent can we expect that those will be accurate predictors of future performance?

Dr. RATNER. Well, I think the premise of your question is exactly right. Our analysis does indicate that this 3.3 percent growth in 1996, which was a very pleasant surprise—about a $4 billion surprise according to CBO's analysis, is something that is not likely to be repeated very closely in the near term.

Some of the forces from the rest of the health care system are likely to be increasing Medicaid spending growth. Then there are some cost drivers that are peculiar to Medicaid, such as DSH payments, as well as the growth of elderly and disabled who are such an important part of the Medicaid population.

Consequently, those factors are indeed likely to raise the growth rate of Medicaid spending in the next few years.

Senator MOSELEY-BRAUN. With regard to DSH specifically—and this is a sore and touchy subject because coming from Illinois—Illinois is a big State, and we have got a number of areas in the State that have relied on disproportionate share because they are impacted by the populations that put additional demands on health care services. And so these chances, frankly, nobody knows exactly how it is going to flesh out.

But one of the concerns that was expressed when we went through the welfare debate was essentially what I call the food chain effect, that is to say that as you make one set of changes, it pushes the cost and the payments off to another level. Like poking a balloon essentially. As we change DSH, it is, I think, predictable that those costs will just be shifted elsewhere, more likely to local governments, county governments and the like.

Have you looked at that? Is there any analysis ongoing right now in terms of the impacts of the changes in the DSH formula and the impact on local governments from those changes?

Dr. RATNER. I am not aware of an analysis that goes at that question specifically, but I do think that your question raises an important point. On the one hand, it is important to be able to target DSH payments to hospitals that actually have these higher cost patients who are low income. On the other hand, there is analysis—for example, an Urban Institute study—that found that about one-third of DSH payments left the health care system entirely. They were part of elaborate schemes that enabled States to use those funds for other non-health care purposes.

So this is an area where you need to pay attention to both of those concerns—both targeting DSH funds on the patients and the hospitals that have those more costly patients, but also being aware of the possibility for abuses.

Senator MOSELEY-BRAUN. Oh, there is no question. I think we all recognize that the settlement or the compromise that we have reached is in response, in large part, to the abuses that you mentioned.

But the concern, again, has got to be, I think, in the final analysis, making certain that you do not wind up with hospital closures and people not able to have access at all to health care services be-

cause of those hospital closures, and the impacts again, the food chain.

So I would just urge you to be mindful of the concern regarding those impacts so that we can try to do some analysis of the extent to which the changes in DSH may well give us closed hospitals and a limitation of access to health care by the poor.

Dr. RATNER. I understand your point. I agree with it. Yes.

The CHAIRMAN. Thank you, Dr. Ratner and Ms. Allen, Mr. Jensen, for being here. We will leave the record open until 5:00, so there may be some written questions.

Dr. RATNER. Thank you.

The CHAIRMAN. Thank you very much. The hearing is adjourned.

[Whereupon, at 12:09 p.m., the hearing was concluded.]

PRESIDENT'S FISCAL YEAR 1998 BUDGET PROPOSAL ON MEDICARE

WEDNESDAY, MARCH 5, 1997

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, Moynihan, 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. Today we are holding our fourth hearing on the Medicare program in the 105th Congress. Yesterday, this committee heard from CBO and received the sobering news that the President's budget falls short of a balanced budget by the year 2002.

In Medicare, the President's budget saves only $82 billion rather than the $100 billion as promised, and we will have to come up with additional savings which, obviously, will make our job much more difficult.

Moreover, without the transfer of substantial home health care spending from the Part A to Part B, the President's budget will extend the Part A trust fund life span to only 2003.

Today we will hear from representatives, and we welcome each and every one of you, from groups who represent some of the greatest stakeholders in Medicare, beneficiaries, physicians, and, of course, the hospitals.

In my view, the input of these stakeholders in our review of the President's Medicare budget proposal is critically important. This committee needs to know how the President's proposals, which rely almost exclusively on savings from fees paid to health care providers, will affect them.

Apart from specific saving proposals in the President's budget, we also need advice on how to solve the longer term problems of Medicare. As Chairman of this committee, and I am sure you will agree with me, Pat, it is our responsibility and commitment to protect Medicare, not only for today's seniors, but for our children and children's children as well.

So at this stage I would call upon Senator Moynihan for any statement he might care to make.

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

Senator MOYNIHAN. To say nothing more, Mr. Chairman than to thank you for pursuing this matter and to note that you and I have introduced a bill to establish a National Bipartisan Commission on the Future of Medicare, and to note that this year the combined revenues of the Medicare health insurance and the Old Age, Survivor's and Disability Insurance, the social security payroll taxes, do not equal outlays.

So we are having to find general funds with which to cash in some remaining Treasury bonds that are held in the health insurance trust fund, but by the year 2001 they will be gone. But that is a mode of fiction. Right now we have to find general funds to pay for this program. That was coming, and it has come. I think your commission is a very good idea, sir.

The CHAIRMAN. Well, we certainly will be proceeding to move forward, because it is an important initiative. I thank you for being a principal co-author of that.

We will now begin to hear testimony from each witness, we will do it in alphabetical order, and then turn to the questions.

I am very pleased to start the hearings with Ms. Jane Baumgarten, who is a member of the board of directors of the American Association of Retired Persons. The AARP, of course, represents millions of Medicare beneficiaries. We will be interested in hearing about AARP's two-step approach to solving Medicare's fiscal crisis.

Welcome, Ms. Baumgarten. We look forward to hearing your oral report. Your total statement will, of course, be included in the record. Please proceed.

STATEMENT OF JANE BAUMGARTEN, MEMBER OF THE BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS, NORTH BEND, OR

Ms. BAUMGARTEN. Thank you. Mr. Chairman and members of the committee, I am Jane Baumgarten from North Bend, OR, and a member, as you said, of AARP's board of directors. I want to thank you for the opportunity to share AARP's views on the President's fiscal 1998 Medicare budget.

Medicare is at a critical juncture. The projected insolvency of Part A means we must act now to protect the program. Agreement on short-term improvements is essential in 1997, and we encourage you to work diligently toward this goal.

As we have stated for the last 2 years, AARP believes the best way to protect and strengthen Medicare for the next generation of retirees involves a two-step approach.

The first step, is to extend solvency of the Hospital Insurance Trust Fund for a few years. The second, and the more challenging step, involves a broad public debate and policy changes to keep Medicare strong for the next generation. My testimony today, however, focuses on the short-term solvency and the President's budget.

AARP is pleased that the President's budget recognizes what beneficiaries already pay for health care. On average, older persons, whose income is only about half of families under 65, spend

already 21 percent of that income on health care, compared to 8 percent for younger persons.

Yet, older Americans are willing to share the responsibility of strengthening Medicare, but they depend on Congress to ensure that changes do not create financial burdens or undermine Medicare's guarantee of affordable quality health insurance coverage.

Let me now turn to some of the proposals in the President's budget which affect beneficiaries. Shifting home health to Part B would help to extend a Part A solvency without jeopardizing access or quality, but it also raises issues like whether these costs would eventually be included in the calculation of the beneficiary Part B premium and subject to 20 percent co-insurance.

According to preliminary estimates, including the home health benefit in the premium, the premium would result in beneficiaries paying $8.90 more per month for that in 1998, which would be on top of the $47.30 projected premium.

If you project this out, by 2002 home health would add another $10.60 to the projected premium of $63.80, so you come to a total in 2002 of $74.40.

We have very serious concerns that these additional out-of-pocket costs could prove unaffordable, particularly for those with low incomes. Imposing a co-insurance could create a serious barrier for users of this benefit, who tend to be older and more vulnerable economically.

Since this proposal has benefits and drawbacks, we urge you to see how much can be saved from traditional spending reductions before adopting the home health shift.

To continue, there is merit in a fixed contribution that asks all beneficiaries to pay a portion of Part B costs. The President proposes that the Part B premium continue at 25 percent of costs. This would save $10.2 billion.

AARP has supported this policy in the past, but always in the context of the larger budget package so that we could see the package was fair. In any case, we believe that low-income beneficiaries should continue to be protected.

Although an additional premium for higher-income individuals is not in the administration's budget, both the President and Congressional leadership have expressed interest in this.

AARP believes that, in the interest of fairness, if higher income persons are asked to pay more for the cost of their care, then a similar policy should apply across all higher income age groups. We are very pleased that the President's budget begins to correct the serious problem with hospital outpatient co-insurance.

A glitch in the law allows hospitals to base co-insurance on the amount they charge rather than on the amount Medicare approves. As a result, many beneficiaries pay about 50 percent in co-insurance in outpatient care.

The President's proposal is to phase down co-insurance to the standard 20 percent, as other Part B co-insurance is, but since the proposal would not be implemented for a few years, co-insurance should be frozen at the 1997 percentage level.

I notice the light, Mr. Chairman.

The CHAIRMAN. Take a couple of minutes more.

Ms. BAUMGARTEN. All right. I am almost done.

The CHAIRMAN. Sure. Go ahead.

Ms. BAUMGARTEN. With respect to managed care, it is critical that Medicare develop an accurate means of paying for managed care, including risk adjustments. The budget proposal also expands Medicare's managed care options to include PSOs and PSNs.

Now, additional coverage is a good thing, as long as it also provides beneficiaries with the quality, consumer protections, and balance billing protections that are guaranteed under the Medicare coverage options.

The President's budget establishes Medigap affordability and requires insurance to take all comers. This proposal has merit. However, it should go one step further, by requiring plans to have community-rated premiums.

Finally, we are pleased that the budget includes modest respite care and broader preventive benefits in Medicare. I thank you, Mr. Chairman. AARP looks forward to working with this committee and with other Members of Congress as the budget process continues. Thank you.

The CHAIRMAN. Thank you very much, Ms. Baumgarten. We will have the questions when we complete the testimony.

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

The CHAIRMAN. Mr. Linden, president and chief executive officer of Grinnell Regional Medical Center, Grinnell, IA, it is a pleasure to welcome you here. You are here on behalf of the American Hospital Association, and we look forward to your testimony.

STATEMENT OF TODD C. LINDEN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, GRINNELL REGIONAL MEDICAL CENTER, GRINNELL, IA, ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. LINDEN. Thank you, Mr. Chairman. I am delighted to be here representing the American Hospital Association on the Medicare issues contained in the President's budget. These issues are tremendously important to hospitals and to the Medicare patients that we serve.

For me, health care administration is more than a job, it is a calling. For our hospital, it is a mission. Mother Theresa was quoted once that, "When we spend our energies against something, it weakens us. When we spend our energies for something, it empowers us." I am here to talk a little bit about what we are for.

Mr. Chairman, let me begin by saying the Nation's hospitals support a balanced budget. I have got three children. It is the right thing to do. Moreover, we understand that Medicare will face budget reductions in the name of achieving that goal.

The AHA has evaluated the President's budget proposal, as we will any of the Congressional proposals to follow, according to three criteria. First, whether Medicare budget reductions are shared by all with a stake in the program. Second, whether significant Medicare restructuring accompanies those reductions. Finally, whether Medicare budget proposals go beyond short-term savings to include a long-term solution to Medicare solvency.

Let me tell you what shared responsibility, restructuring, and long-term solvency mean to me, as someone who runs a small hos-

pital in Iowa. If I am to help you change the Medicare program for the future, I need to know first, that as a hospital CEO, I am not alone in this important endeavor. If any one segment of the current system is hit too hard, it will ultimately affect the patient negatively.

Second, that you will help me and others like me with sufficient program flexibility to do the job. Finally, that the Medicare program will be around, not only for Jeanne Henry and Robert Reno, two Medicare beneficiaries that my hospital is caring for today, but for all the Jeannes and Bobs to come in the future.

On the first principle, are Medicare budget reductions shared by all those with a stake in the Medicare program, the President's proposal falls short on this standard. Of its proposed $82 billion in Medicare reductions, the great majority comes from health care providers, $38 billion directly from hospitals alone.

Furthermore, in the new world of more integrated delivery systems, other Medicare provider reductions also have an effect on hospitals. For example, the proposed reductions of $13 billion in home health and $8 billion in skilled nursing will, in part, fall on hospitals' shoulders.

At Grinnell Regional Medical Center, we provide acute care, skilled care, and home health, so it all has an impact. The hard truth is, there can be no truly serious effort to balance the budget or preserve long-term Medicare solvency without a contribution from all the parties involved, not just providers.

Unfortunately, recent ProPAC hospital financial performance data may encourage the belief that reductions in payments to hospitals can be achieved without inflicting pain. This does not really reflect what is out there. Many hospitals are struggling financially, so reductions in Medicare payments to hospitals will hurt.

Forty percent of hospitals lose money when they treat Medicare inpatients. In the aggregate, including inpatient and outpatient, Medicare pays only 97 cents on the dollar, and Medicaid pays even less. Twenty percent of hospitals have negative total margins, meaning that, overall, they are losing money.

Our second principle, does the budget proposal include the kind of Medicare restructuring that will help ensure long-term viability? On this count we are encouraged by the President's plan.

It allows Federal certification of provider-sponsored organizations directly contracting with the Medicare program. We hope the administration's language is similar to S. 146, which is bipartisan legislation introduced by Senators Jay Rockefeller, of this committee, and Bill Frist.

It modifies the payments to Medicare managed care plans and the AAPCC. AHA believes the current payments can be made more equitable and thereby encourage increased use of coordinated care by blending the current AAPCC with the national average, adjusted for geographic costs of doing business.

Coming from a State where the AAPCC is well below the national average, I am particularly supportive of getting to a more equitable payment as soon as possible. I would acknowledge Senator Grassley's legislation and leadership in this area.

We would also like to note that we are pleased to see in the President's proposal that there is a carve-out for payments for

graduate medical education and disproportionate share from the AAPCC, with the intent of paying them directly to those hospitals performing these missions.

While we are encouraged by the President's proposals in these areas, we also agree with many members of this committee that there is further room for restructuring.

Our final Medicare principle: Does the President's budget go beyond short-term savings to include a long-term solution to Medicare solvency? The President's plan does move us in the right direction, keeping the trust fund solvent for 10 more years, but does not set out a mechanism to help Congress make the tough choices necessary in the future.

We applaud the Chairman and Senator Moynihan for their recent introduction of S. 341 to create a commission to help address the long-term solvency of the trust fund. We would like to suggest some additions that could bring it closer to the type of commission we envision that could, because it would be permanent and would require Congress to make tough choices, continue to respond to future needs of the Medicare population.

In conclusion, I would like to comment on just two more of the President's proposals. First, prospective payment for outpatient services is the right move, rather than piecemeal changes in payment policy. Moreover, we are heartened to see that the President recognizes the problem of beneficiary co-insurance as one between the Medicare program and its beneficiaries.

Second, while we believe the prospective payment for skilled nursing services is also the right policy, we cannot agree with the President's proposed redefinition of transfers. This undermines the basic philosophy of PPS and was rejected by ProPAC.

So as a relatively young hospital administrator—I am just 35—I am not resistant to change. At the same time, I am deeply committed to serving my community, including the elderly at Grinnell and the surrounding countryside. I am committed to people like Jeanne Henry and Robert Reno.

I hope to be serving my community 20 years from now. So my worry is whether I will be able to keep the Medicare promise in the future, as I believe we do today, the promise to Jeanne, Robert, and to all those that will be following in their footsteps. I would be happy to try to answer questions, when we get to that part of the program. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Linden.

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

The CHAIRMAN. We are very pleased to welcome Dr. Alan Nelson, who is the executive vice president of the American Society of Internal Medicine. As I think everybody recognizes, internal medicine is the Nation's largest medical specialty.

Dr. Nelson.

STATEMENT OF ALAN R. NELSON, M.D., EXECUTIVE VICE PRESIDENT, AMERICAN SOCIETY OF INTERNAL MEDICINE, WASHINGTON, DC

Dr. NELSON. Thank you, Mr. Chairman. Yes, indeed, internists do care for more Medicare patients than any other specialty, and they are committed to ensuring the viability of the Medicare pro-

gram and making improvements in that program. We pledge our organization to working with the committee toward that end.

ASIM is pleased also that the administration's proposal takes into account the fact that expenditures on physicians' services are growing slower than any other category of Medicare spending.

According to the CBO, total outlays for physician services will grow by an average of only 2.4 percent per year over the next decade, and fee schedule payments to physicians will actually decline by 21 percent in constant 1996 dollars. Payments to other providers will all exceed the rate of inflation.

ASIM urges Congress to support the administration's approach of targeting savings toward higher growth areas of expenditures. It is not reasonable to expect that total outlays on physician services can be reduced below the inflation rate on a continuing basis without compromising access and quality.

Second, Congress should ensure that the 1998 budget allows for correction of flaws in the Medicare fee schedule. They have resulted in payments that are not truly resource-based. A separate and higher conversion factor for surgery, coupled with the fact that Medicare payments for practice expenses are based on historic charges and not resource costs, has resulted in surgical procedures being paid at a much higher rate than primary care and other services that require the same resources.

We urge support for the administration's proposal to mandate a single dollar conversion factor, or multiplier, equal to the current primary care conversion factor, updated for inflation, effective January 1, 1998.

ASIM also urges continued support for implementation on January 1 of resource-based practice expenses, as mandated by Congress in 1994. Although some advocate a delay in implementation, Dr. Gail Wilensky, chair of the Physician Payment Review Commission, told this committee last week that there are no new or better data that would be available to HCFA if it were given another year to develop its proposal.

She also said, and I believe rightly, that given how long the current flawed methodology has been in effect, it is important that improvements be made without further delay. There will be an opportunity for review of HCFA's proposed rule in the spring. There will be further refinements between publication of the proposed rule and the final rule.

If it wishes, Congress can revisit the timetable for implementation then, but there is no reason to conclude now that sound resource-based practice expenses cannot be implemented on January 1 of next year.

Third, ASIM supports reforms in payments to Medicare managed care plans. We agree with the PPRC's view that, regardless of how payment rates for Medicare HMOs are set, as long as Medicare beneficiaries can choose among options, improved risk adjustments will be essential. We also support measures to correct the geographic inequities in payments to HMOs.

Fourth, ASIM supports expanded choice of health plans, including offering beneficiaries the option of enrolling in provider-sponsored organizations. We commend Senators Rockefeller and Frist

for their advocacy of legislation to eliminate the barriers to the formation of PSOs.

Fifth, Congress should mandate that the Secretary develop beneficiary protection standards for Medicare managed care. Beneficiaries should be given the information they need to make an informed choice of health plan.

Pre-authorization requests and reconsideration of denied claims should be heard in a more expeditious fashion, and policies that affect clinical decisionmaking should be made in consultation with physicians an their patients.

Sixth, ASIM urges support for the administration's proposal to expand Medicare coverage for preventive and screening services and to eliminate the cost sharing for mammography studies.

Finally, ASIM favors long-term reforms that would move Medicare toward a defined contribution program, similar to the Federal Employees' Health Benefits program, with appropriate safeguards.

The defined contribution should be sufficient to afford a wide choice of plans that offer benefits at least equal to the current program, and all plans should meet uniform quality, access and service standards in order to participate.

ASIM's proposed long-term reforms would require physicians, other providers, and health plans to compete on the basis of cost, value, and quality, and empower beneficiaries to make informed choices of health plans and delivery systems. Thank you, sir.

The CHAIRMAN. Thank you, Dr. Nelson.

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

The CHAIRMAN. It is now our pleasure to introduce Dr. Seymour Schwartz, who is chairman of the board of regents, American College of Surgeons.

Dr. Schwartz.

STATEMENT OF SEYMOUR I. SCHWARTZ, M.D., CHAIRMAN OF THE BOARD OF REGENTS, AMERICAN COLLEGE OF SURGEONS, WASHINGTON, DC

Dr. SCHWARTZ. Mr. Chairman, members of the committee, I am chairman of the Department of Surgery at the University of Rochester in New York, but I am here as chairman of the board of regents of the College of Surgeons, and am speaking for that constituency.

I would like to thank you for the opportunity to comment on the President's latest Medicare budget proposal. The fellowship of the college view portions of the budget as fundamentally at odds with other positions and policies being championed by the administration.

For example, the administration has expressed concern about women's access to mammography and the problem of drive-through mastectomies. However, this budget includes proposals to substantially reduce payment to those surgeons who treat the women with breast disease.

As another example, President Clinton has shown great concern about patient access to organ transplantation. Yet, while the budget proposes doubling funding for the division of organ transplantation, it would also implicate Medicare policy changes that

significantly reduce payment to the surgical teams performing these transplants.

Let me now address some of the President's specific policy proposals. In regard to the proposal to adopt a single conversion factor for all physician services and to modify the formula used to calculate the MVPSs, it appears that most of these savings would come from reducing payment for surgical services.

Adopting a single-fee conversion factor would cut Medicare payments for all services by about 13 percent. The college continues to support the concept of separate MVPS and fee schedule conversion factors for various physician services.

Congress must remember that the MVPS was created specifically to address the problem of volume of service and it is the only mechanism available for this purpose. Proceeding to a single conversion factor would diffuse the issue of volume of service and provide less incentive for physicians.

If the notion of a single MVPS and single conversion factor is pursued, these changes must be phased in over a minimum period of 3 years. We are also troubled by the proposal to use changes in GDP to determine the appropriate utilization of physician services under Medicare. Used this way, the GDP could be labeled as merely an affordability factor. It has nothing to do with Medicare beneficiary health care needs.

We are also concerned about the arbitrary performance adjustment factor, the so-called minus four adjustment, that is used in determining the current MVPS. This adjustment produces expenditure targets that are unfair and impossible to meet. This is especially true for surgical services because they comprise the category of physician services with the lowest historical growth in volume and intensity.

The administration is proposing to save $400 million over the next 5 years by adopting what is euphemistically called single fee for surgery. This means that the additional payment now provided to a physician who assists the principal surgeon in an operation would not be made.

Instead, the payment for the operation would be split between the principal surgeon and the assistant. Since an assistant in surgery is paid 16 percent of the primary surgeon's payment, this proposal, combined with the proposed single-fee schedule conversion factor, would result in the principal surgeon receiving 73 percent of what he or she currently receives for the same operation.

I would point out, this has been proposed in the past, only to be rejected by Congress. We are confronting a proposal in which the potential for cost saving is far outweighed by the potential adverse impact on quality of surgical care.

Also, I want to comment on the pending regulatory effort to implement new practice expense relative values in January. HCFA's current efforts to develop these values are a cause of great concern for surgeons. We strongly urge Congress to put this process on hold to provide adequate time for the issue to be re-examined.

Data recently released by HCFA indicate that the new values could reduce aggregate medical care to surgical specialties by up to 44 percent, while increasing payments to other practitioners by as much as 54 percent, even with no additional changes.

These reductions and redistributions are unacceptable, especially when the administration is proposing a number of other policy changes that would simultaneously produce even further reduction in Medicare payments for surgical services.

Mr. Chairman, I must State that the surgical community has a strong sentiment. The combined efforts on payment resulting from, No. 1, a single adoption of a single conversion factor, No. 2, the refusal to pay fairly for medically necessary assistance at surgery, and No. 3, the implementation of a flawed medical practice expense value is too much.

If all three proposals were implemented, the Medicare payment to the principal surgeon for a coronary artery bypass operation would be reduced by 60 percent. By reducing payment per procedure, treatment modifications will be encouraged and physicians and surgeons could indicate that they were unable to provide high quality care at the reduced price.

Unfortunately, a point may be reached at which surgeons would have to refuse care because it would represent a net loss to them as providers. It may be time to address the scope of the Medicare program and the issue of volume of service. Perhaps we cannot provide every type of service or unlimited access for noncritical conditions under Medicare.

Thank you for this opportunity to share our views.

The CHAIRMAN. Thank you, Dr. Schwartz.

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

The CHAIRMAN. Our final witness is Mr. Tim Size, who is the executive director of Rural Wisconsin Health Cooperative. We are very pleased to have you here to speak on behalf of the National Rural Health Association.

Mr. Size.

STATEMENT OF TIM SIZE, EXECUTIVE DIRECTOR, RURAL WISCONSIN HEALTH COOPERATIVE, SAUK CITY, WI, ON BEHALF OF THE NATIONAL RURAL HEALTH ASSOCIATION

Mr. SIZE. Thank you. Good morning, Mr. Chairman and members of the committee. I appreciate this opportunity, on behalf of National Rural Health Association.

It is somewhat difficult for us to have a detailed reaction to the President's budget proposal because there are not many details currently available to us on exactly how the President would reach the generally laudatory goals outlined in his reforms. With Medicare and rural health in particular, the meat of the matter is usually found in the fine print.

Nonetheless, NRHA and rural communities oppose an across-the-board Medicare freeze or reduction, for several reasons that we feel make us somewhat unique. Rural beneficiaries have significantly lower utilization rates and lower access to care, but pay the same taxes as all Americans.

Rural hospitals have lower reimbursement for the same work. Rural hospitals have lower Medicare operating margins, taken as a class. Rural hospitals serve disproportionately more Medicare patients.

We come into this discussion with a 12-year history of inequitable payments under the current prospective payment system. In the first year, urban hospitals enjoyed an average operating margin of 14 percent on the inpatient side, while rural hospitals received 8 percent.

Over the following years, Medicare margins fell for all hospitals. From 1990 to 1992, both groups averaged negative operating margins. Since 1992, the margins for both urban and rural hospitals have improved, but urban hospital margins much more so.

I guess I would like to be clear, it is not in the written remarks, I think we understand that the inpatient margins are not necessarily representative of total margins because outpatient margins are significantly negative.

However, as we look at the current figures for 1995, what we see is basically a 6 percent gap between urban hospitals which very closely approximates all hospitals, and a much lower number for rural hospitals.

In general, I guess we are asking for some care when one looks at the data in disaggregating it rather than headline after headline saying how well all hospitals are doing.

As Medicare spending is considered, it is critical to understand how significantly disadvantaged rural hospitals already are by the current system. Across-the-board cuts that fail to recognize Medicare payment equities that discriminate against rural communities are destructive of rural health and the maintenance of local access to appropriate care.

I would like to go on and point out some of the specific programs mentioned in the budget that we had hoped would be in the budget. Quickly, the sole community hospital program is a crucial part of the rural health care delivery system and we support continuation and potential improvement of that program.

Rural hospitals with a high Medicare patient loan often struggle to remain open. The Medicare-dependent hospital program expired in 1993, but because of the potential impact Medicare reform will have on hospitals, NRHA supports reinstatement of this program.

The President's budget proposes to expand the current rural primary care hospital program. We agree with the idea of expanding this program, but would take it one step further by recommending a more comprehensive, limited service hospital approach. Legislation recently introduced by Senators Rockefeller, Baucus, and Grassley moves in that direction and we strongly support that approach.

We agree with the Prospective Payment Commission's recent recommendation that disproportionate share hospital payments should be concentrated among hospitals with the highest share of poorer patients. The same general approach for distributing payment should apply to all PPS hospitals. ProPAC believes with a change in the measure, should also come one common threshold shared by both urban and rural hospitals.

Another very important category for us are payment rates for rural managed care. They have been receiving a lot of welcome notice recently. NRHA supports a regional national blend, closer to 50/50, in conjunction with a payment floor of 85 percent of the national input price adjusted capitation rate.

Eliminating wide geographic variations that currently exist will encourage managed care participation in rural areas. While managed care is not a panacea, it is important to be on a level playing field so that those wishing to participate in these type of plans can have access to them.

Rural communities currently are placed in an untenable steel vise when Federal policy aims to move Medicare and Medicare beneficiaries into managed care, while at the same time Federal policy has the effect of prohibiting the development of rural Medicare managed care.

In conclusion, several other key issues. Not much has been said about the potential effects of the fail-safe mechanism in the Clinton budget proposal. The President proposes a trigger mechanism that will cut Federal programs across the board 2.25 percent in fiscal year 2001 and 2002 if the budget is not balanced.

Many times when we talk about cuts to this program or that program, it does not take into consideration the cumulative effect of these cuts on any particular sector. Rural providers are at a significant risk for devastating effects of cumulative cuts because the communities they serve rely so heavily on the Medicare fee-for-service system and Medicaid. Others have mentioned GME, and we have provided you with a white paper on that. We are very supportive of the carve-outs that have been suggested.

I want to thank the committee for the opportunity to share our views, and we would like to encourage you to use NRHA as a resource in the future. We are aware of the legislation introduced to establish a commission, and we only strongly request that you have rural representation on that commission so that the views of rural Americans are fairly represented. Thank you.

The CHAIRMAN. Thank you, Mr. Size.

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

The CHAIRMAN. We will now begin the questioning. Ms. Baumgarten, I will start with you, if I may. In your testimony, you expressed strong reservations about the transfer of home health spending from Part A to Part B in order to meet the President's goal for 10 years of solvency. I certainly have some of the same concerns about this transfer.

In your testimony, you urge Congress and the administration to see how much more could be saved from traditional spending reductions. Does AARP have any specific suggestions in this regard?

Ms. BAUMGARTEN. The recommendation that I made in the testimony was to look at the traditional methods. The traditional methods have been in reducing provider fees and in increasing beneficiaries out of pocket. We asked you to look at those traditional methods and, if that falls short, then to re-look at home health care transfer, but to look at those, first.

The CHAIRMAN. Now, you recommend in your testimony a two-step approach. The first step, is a savings package to keep the Part A trust fund afloat in the short-term, and the second would be a broad public debate followed by policy changes to keep Medicare strong for future generations. I have several questions.

First, Senator Moynihan and I, as has been pointed out, proposed a Medicare commission that would take a year to report recommendations. Is that long enough, do you believe, for this debate,

and would you be worried about the impact of any longer delay on our ability to fix Medicare?

Ms. BAUMGARTEN. I would like to come at this at sort of an oblique angle, Senator. Having a commission and using technical advisory committees, like the Physician Payment Review Committee and the Prospective Payment Committee for hospitals, ProPAC, is certainly very useful. But, eventually, it is Congress that ultimately will have to make the decisions and the public debate does have to take place. The commission cannot do the public debate. The debate has to take place.

All you have to do is look at the lack of a full-blown long enough debate on health care reform to see what happens when you try to make changes if the debate is not there. The debate has to be there before people will look at the alternatives and the changes that we are facing.

The CHAIRMAN. Well, I certainly agree as to the importance of public debate. I would ask, are you concerned that the longer we wait to make the long-term reforms the more difficult it becomes?

Ms. BAUMGARTEN. Certainly, the sooner you can make the reforms the less drastic one needs to be. However, we have found public reaction, if the debate is not thorough, can create a lot more problems.

The CHAIRMAN. Mr. Linden, I am concerned that in your testimony you stated, I think on page 8, that 40 percent of the Nation's hospitals lose money when they treat Medicare inpatients. Now, according to ProPAC, this is based on 1995 Medicare hospital margins. What this committee needs to understand is the current year and projected financial health of American hospitals.

We had the chairman of the Prospective Payment Assessment Commission, Dr. Newhouse, before us last week. He stated that current hospital margins on Medicare payments are better than they have ever been before. In fact, he stated that, under current law, hospitals now have, and will continue to have, positive Medicare margins, 10.3 is anticipated in 1996, 11.7 in 1997, and 13.8 in 1998.

These margins are, in fact, the average percent profit hospitals are making on the Medicare program. Would you agree that, as these margins increase to 13.8 percent, there will be a steady decrease in the number of hospitals that have negative Medicare inpatient margins?

Mr. LINDEN. Well, that could well be true, Mr. Chairman I think the difficult part of looking at ProPAC information like that is that it is aggregate. Obviously there are hospitals in many different situations across this country, and one of the things that we simply want to make sure that Congress recognizes is, it is difficult to set policy for the entire Nation when we have so many people that are in very difficult situations.

Now, I am very proud of what hospitals, physicians, and other health care providers have been able to do in the last few years to make health care more efficient. We have responded to some of the kinds of incentives that Congress and the marketplace have dictated in terms of moving toward more outpatient services, moving toward more home health services. These are lower-cost ways to deliver care.

In some respects, the last few years, hospitals in particular have responded well to decreasing some of our costs, and so some margins have increased. In my case at Grinnell Regional Medical Center, in 1990 and 1991 we actually lost money from operations.

We were looking at the need for major improvements in the infrastructure of our facility, air conditioning systems, boilers, electrical systems, and simply did not have the resources to do that.

Our board needed to make some tough decisions, and I am proud to say we did restructure things, we decreased our costs, and we did a better job of generating margins so we could reinvest those dollars in our community.

So I even have a hard time with the word profit. I mean, our organization is driven toward having a margin, yes, so we can continue to meet the needs, have the technology that people are interested in having, but doing it in such a way that we are able to continue for the future.

Senator GRASSLEY. May I interject a point on the profit here?

The CHAIRMAN. Yes.

Senator GRASSLEY. I do not know whether it would be true of Grinnell, but some hospitals in rural America, particularly in Iowa where some are supported by property tax, if there is a property tax levy and they still show a profit, it includes income from the property tax levy.

Mr. LINDEN. That is correct.

Senator GRASSLEY. So operation wise, the hospital would be showing a tremendous loss if it was not receiving support from the property tax.

Mr. LINDEN. That is accurate, yes.

The CHAIRMAN. Well, the point I want to underscore is that I think some significant progress has been made. I think the fact that we anticipate 13.8 percent margins shows that we have a pretty robust financial health of American hospitals.

Admittedly, in any such situation there will be those that are not enjoying that, but I think we ought to look at the pluses that we are enjoying and the benefits of what we have done in the past in bringing about this condition.

My time is up. Senator Moynihan.

Senator MOYNIHAN. In that regard, Mr. Chairman, could I suggest that the changes, the corrections that have been proposed before this committee in order to obtain an accurate cost-of-living index, as applied to the Social Security and Medicare system, would make most of the problems we are talking about just go away.

I would hope Ms. Baumgarten, whose testimony was very helpful, would take back to the AARP the message that, if you do not have a revenue base which would be created by this adjustment for getting an accurate cost-of-living index, you will spend the rest of your time talking about reductions and in time you will see the whole Social Security system dissolve. I pledge that to you. I have been around it long enough.

But, sir, the more momentous event today is that, I believe for the first time, we have before us the author of the definitive study on the French and Indian War in the person of Dr. Schwartz, and a cartographer of eminence.

I would like to say, sir, if you think it is of no concern to you, the Delaware river rises in upstate New York and, had it not been for the outcome, very narrow, of that war, Duquesne and his Iroquois hordes would have descended on Wilmington in no time at all and the Swedes would not have had a chance. [Laughter.]

Senator MOYNIHAN. I would, if I could, speak to Dr. Schwartz and Dr. Nelson on a subject that has just puzzled us and we have not addressed a great deal, which the proposal, as it first appeared in President's Clinton's health care proposal of 1993 never discussed, which was a proposal to limit the number of residents in the country to 110 percent of the graduates of our medical schools, which would be a reduction of about a quarter, about 145 percent now. Dr. Schwartz is nodding.

Dr. SCHWARTZ. That is correct.

Senator MOYNIHAN. To reduce the number of physicians by about a quarter, which would be to exclude the foreign-trained, for the most part. Then, even more troubling to me or I need to be taught something on this, in the President's present proposal, as Dr. Schwartz writes, to have a total number of physicians devoted to non-primary care training, which is to say, specialties.

We have certainly heard it said, and I believe it makes sense on the face of it, that the number of primary care physicians is a function of population. You need about 85 doctors per 100,000 people, something like that. But the number of specialists is a function of science, and science goes where it will.

Do we want the Federal Government telling the University of Rochester School of Medicine what it can teach? I wonder if the two doctors could address this, because it is a big idea that has not been given much attention.

Dr. SCHWARTZ. First, I would be negligent, Senator Moynihan, if I did not express my appreciation for your publicity related to my nonsurgical interest.

It is a point that concerns us at the college, and me as an academic surgeon responsible for residency training. I had the opportunity at the House Ways and Means Committee Health Subcommittee to address this point, and the college came out with a position that the 110 percent figure of American graduates was appropriate.

A series of studies have been carried out in an attempt to assess, No. 1, the needs of the country related to the various specialties, and it is true that there are certain sub-specialties in which there are an excess of physicians, according to the needs of the populace.

There are others in which it has been flat. In my own field, for instance, in general surgery, the numbers of people who have passed the examination of the American Board of Surgery has remained flat over the last 13 years, and it is proposed that in the year 2005 there will actually be an insufficient number of general surgeons to satisfy the needs of our country. I think that is accepted by all who have reviewed the figures.

Now, we could take a subset of other surgeons and there will be an excess; we are not arguing that point. But when we discuss the issue of residency, what I would like to bring into focus is that the residency program is put in place, No. 1, to educate and address the needs of the future.

The question as far as defining the number of residents who should be trained relates to the appropriate training that can be addressed to that given number of residents. In my own institution, I train six surgeons per annum. Actually, it is insufficient to satisfy the needs of the hospital, but, nevertheless, we feel that is what we can educate.

So I think when we talk about residency training we ought to address the issue of what is good training for the future of American care where we consider the numbers. I feel personally, the college feels cumulatively, that the 110 percent is a reasonable figure to address. The residents should not be regarded as a service solely to a given hospital or a given institution.

Senator MOYNIHAN. Thank you, Dr. Schwartz. I appreciate that. I offer the unsolicited comment that if the French and Indians had won that war, we would need a hell of a lot more surgeons than we now have. I will wait for the next round to get back to Dr. Nelson.

The CHAIRMAN. Mr. Grassley.

Senator GRASSLEY. Yes. In regard to your question to Ms. Baumgarten about the commission, I would in no way denigrate the efforts of the Chairman and the Ranking Member to establish a commission to find a solution to this problem, but I hope that we do not have to lose a year in the process.

I hope that we in the Congress, hopefully with the President's help, will bite the bullet and try to get it done right now. We lost 2 years with the Presidential veto, and then a political campaign that had the Medicare tactics that were used, and everybody was scared to deal with it.

Then we lost a year on the other end because last Congress Medicare was predicted to go bankrupt in the year 2002, now it is in 2001. So, we have lost 3 years in this process.

Now that we are in the new Congress, I hope that we can have some dialog on this. I hope that the President would either say we want to get this done right now in a bipartisan say, or I would hope that he would invite the Congress to move ahead and that he would sit it out and accept what we give him, because we cannot afford the sort of time-outs that we have had on something that is so imminent as the disaster that would occur if we let Medicare go bankrupt.

So I hope that we can be in a situation now, where the President has been re-elected, where he had a tremendous victory followed by a pledge of bipartisanship, and where he cannot run again, that we would have this sort of cooperation and get it done this summer, or maybe for the President just to say that he would accept what we do if we get it done. But we cannot have this sort of time-out that we are having right now, and over the last 2 years, on Medicare.

Also, Ms. Baumgarten, not a question, but just an admonition. I do not know for sure, your organization may already be in support of this. But I would plead for a respected organization like the AARP to help us with the AAPCC formula. In cost-effective States like Iowa and the upper Midwest, we have costs on a State-wide average of $322 per month per beneficiary, with some counties as low as $221, and some as high as $411, compared to Miami, where

they are $768, and in Richmond, New York, where they are $760 something and have eyeglasses, wellness programs, lower co-pays and pharmaceuticals as part of their program. We need to get some sort of a threshold that is higher so we can get managed care in rural America so our people, who also pay the 2.9 percent Medicare tax, can get a fair reimbursement and have these programs and have a more level playing field.

Your organization may already support that. I just urge them, if they do, to really get in the middle of that fray and help us bring some fairness for the entire country.

Mr. Linden, in regard to some programs that we are proposing, and I think you made mention of what Senator Baucus and I are doing, some programs like the Medicare-dependent hospital program, the EACH/RPCH program, you know the programs I am talking about. We do not introduce those as the solution to the problems of people in hospitals in rural America, but do you see these as helpful?

Mr. LINDEN. No question about it, Senator. It is not a solution nationally, but it is a solution to individuals that happen to reside in areas where there is a disproportionate share of care being provided to Medicare beneficiaries. There is an added burden to those providers, because they cannot pass on the shortfalls to other payors. So those programs have been very important.

I think in Iowa, 30 of the 120 hospitals would benefit because they have a disproportionate share, more than 60 percent of their revenue comes from the Medicare program. So I think, clearly, 30 hospitals in Iowa would be benefited from that sort of program and be able to make the transitions that we need.

I spoke of flexibility in my testimony, and that is one of the keys. We need flexibility to be able to continue to make the transitions in health care so we can continue to keep the promise.

Senator GRASSLEY. Yes. You mentioned the carve-out for medical education. Tell the committee, particularly for rural hospitals, how that might benefit rural hospitals, I suppose, any place in America, not just Iowa.

Mr. LINDEN. Yes. The idea of the carve-out simply is in the current program with the way the funds flow through many of the payment plans, those dollars do not always get, and often are not, sent on to the actual providers that are providing the mission of education.

So the idea of the carve-out simply makes sure that the dollars that are intended to help support the actual education make their way actually to the folks that are carrying out that mission.

Senator GRASSLEY. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman. In keeping with our historical reference, I would like to point out that, had it not been for the successful conclusion of the French and Indian War, the Floridas would not have been transferred from Spain to England in 1763 and created a chain of events which eventually resulted in our becoming the 27th State in 1845, Senator Mack and I having the opportunity to be your colleagues, and also the highest AAPCC rate in the country. [Laughter.]

Senator GRAHAM. All of those are a result of the outcome of the French and Indian War.

Let me ask some questions about managed care. First, in the last Congress we took up several provisions relative to Federal standards for the relationship between managed care and beneficiaries, the most noteworthy had to do with the length of stay in hospitals after delivery.

There are other proposals pending now. I have introduced one with some of my colleagues relative to the conditions in which emergency room services would be reimbursed.

What is the appropriate role of the Federal Government in terms of setting standards for beneficiaries and their managed care plan, first, generically, then second, as it relates specifically to Medicare beneficiaries?

Dr. NELSON. With respect to Medicare beneficiaries, it is clear to me that the Government has a responsibility to make sure that the beneficiaries, No. 1, know what the rules of the plan are and whether there are restrictions on their ability to access specialty care, whether there is a restricted formulary.

So there needs to be a requirement for them to receive the information that they need to make an informed choice of plans. They need to know right at the front end what the utilization management requirements are, whether there is an appeals process in place if they are denied coverage for an emergency room visit, or whatever.

These rules that are set that govern utilization should be set with the input of the medical profession, and they should be informed also about financial solvency of the plans before they enroll. They should be informed if there are perverse incentives that may lead to under-service. That is, if there is a risk pool of sufficient magnitude that the physician's judgment might be adversely affected.

ASIM has developed a white paper on reinventing Medicare managed care that we will make available that details all of these recommendations. If, indeed, we have a change in the Medicare program so that Medicare beneficiaries have a choice of a number of kinds of plans that might include PSNs, or even perhaps MSAs, along with PPOs and other plans, then of course there should be requirement for adequate benefits that are provided for all those plans.

We have a series of recommendations also on managed care in general that covers many of these same points, protections for non-Medicare patients, so that they know what the rules of the game are when they sign up and they are protected from a plan becoming insolvent and leaving them without coverage in the mid-part of the year, for instance.

Senator GRAHAM. I would like to, if I could, go on to a second question. But if any of the other organizations represented here today have a set of recommendations on the relationship between HMO beneficiaries, their plans, particularly for Medicare beneficiaries, I would be very interested in receiving your thoughts on that. Yes?

Ms. BAUMGARTEN. Senator, I would like to make some general comments. First of all, with managed care, what the consumer is

interested in is having the quality, the consumer protection, and the standards apply that apply to other Medicare programs.

Also, you need to have field's procedure and referrals looked at and the use of consumer-oriented information, the type of information a consumer can use when he compares across the plan and certainly a great deal of information and outreach, so that when people choose a managed care plan, they know what they are looking for and that those standards that are provided by Medicare and other programs are there.

Senator GRAHAM. Mr. Chairman, I am going to hold my second question for the next round, because I would like to pursue that comment. What do you see as the role of organizations like yours in helping to provide that kind of information, particularly where it relates to non-medical professional information, but rather reliability, financial status, and reputation for positive relationships with beneficiaries?

Ms. BAUMGARTEN. Senator Graham, AARP has already been out there with their members in public forums providing information about managed care in general, questions to think about and ask if you are thinking of entering a managed care plan, things to think about should you decide you do not like managed care and you may want to come back to regular Medicare.

These are all questions that people need at the time they are trying to make a decision. We have already done quite a few forums throughout the country trying to provide background information in different areas. A consumer organization can play that type of informational role.

Senator GRAHAM. Thank you.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. Thank you, Mr. Chairman, and thank the panel members. I appreciate that response to Senator Graham's question about AARP trying to make more information available. I really think that all of you at the table, although you have different ideas and perspectives, have to come to the same conclusion that we have got a problem here and we are not going to be able to solve it just with doctors and hospitals, and just with seniors.

It is going to have to be a combination of all of us eventually holding hands and coming up with a common solution. We have got to quit trying to divide groups and providers in separating each other, because we will continue down this path of a system that is in danger of collapse with no solutions being obvious that we can reach. We are going to have to reach this together.

For those who try and play organizations against each other, I think they do a disservice to the organizations that they say they are supporting, as well as to the system at large. I mean, we are going to have to get together to solve these problems because they are immense.

One of the criticisms, I think, of the President's plan, quite frankly, is that it is not any kind of real major initiative, it is a short-term solution. It is the traditional, cut hospitals, cut doctors, cut providers, and it will be all fine. Well, we all know that that is not true. What is out there waiting to happen is going to collapse the whole system.

So I think that these discussions are very important, but we eventually are going to have to come up with some recommendations and hopefully we will do it in this Congress.

My question to maybe Ms. Baumgarten, on behalf of the folks that you speak for, give me some discussion on your thoughts, perhaps, of the Medicare program moving more toward a type of program that we have for Federal employees.

I look at it as sort of a combination of defined contribution, defined benefits, where the Federal Government pays on the average, I think, 71 percent of the costs of the Federal worker's insurance, but the beneficiaries, us, get about 10–30 different options.

So it is really not defined benefits or defined contributions as I understand it, because the contribution can vary from 60 percent to as much as 71 percent of the cost of the plan. Then you have about 10–30 different options. So it is not just one set of benefits. There are a lot of options out there.

You look at Medicare that is increasing at 11 percent a year and the private insurance business is increasing at 4 percent, it seems that there is some benefit in looking at what we have on the Federal level and trying to incorporate that into a Medicare system. I was just wondering if you had some comments and thoughts about that.

Ms. BAUMGARTEN. Senator, you talk about there being a joint contribution there. I would like to mention that, in Medicare, the beneficiaries do pay a certain portion and, of course, 25 percent and then the general revenue does the 75 percent.

But remember, these people have been contributing through taxes and some of them working still do contribute through taxes. Looking at the restructuring of Medicare, if you look at the program, it does not mean that we cannot see that the types of care, the traditional types of care, are there for the people, for the Medicare beneficiaries.

The question is, in the restructuring will they be getting affordable health care that they are getting? That is the question. Our staff is certainly willing to work with the committee and to discuss things.

Senator BREAUX. Well, I think that is encouraging. I think that the Federal employee, you pick a plan that you think meets your needs. I mean, healthier people will take one, more sick that expect to have problems will pick a different type of plan.

As long as you have the options, I think it encourages competition and many of the plans, I mean, offer more benefits than others. I think that more as we get seniors to understand the options that are available to meet their needs is important.

Ms. BAUMGARTEN. That is the reason for the public debate. You have to have thorough public debate about all of the different options and the bottom line is, will health care that is affordable and accessible be there for the people?

Senator BREAUX. Well, everybody fears the unknown. I think that is why this education is very, very important as we try to make these changes.

Let me just ask the doctors one question about the PSOs, if I may. It seems to me that on the question of the Physician Spon-

sored Organizations, and I guess Senator Rockefeller and—who else has the legislation?

Dr. NELSON. Bill Frist.

Senator BREAUX. Senator Frist have the legislation to exempt the PSOs from the State regulations. The figures I have, is about 14 percent of all currently State-licensed HMOs are, in fact, PSOs. My point is, it seems like that is not causing a problem for these PSOs to meet the standards that the States have set up for the other HMOs, and they are doing quite well.

So my question is, why is it necessary to have them carved out as some special exemption to not be subjected to State solvency rules and others, can you comment on that?

Dr. NELSON. As I understand it, it is variable from State to State in how much difficulty that they have. There is uncertainty about ERISA preemption. I think the value in the legislation that is being suggested is that it clarifies all of that and makes everyone clear about where the bright line is.

Senator BREAUX. It does more than clarify it, it exempts them. That is a pretty big clarification. I was just wondering, I am not sure that the reason for that has been established yet as to why they should be carved out from the State solvency laws. HMOs have to meet that and it varies from State to State and they seem to be doing quite well under that.

Dr. NELSON. Well, one of the justifications is that the physicians who are establishing this kind of a network have sweat equity at stake and are willing to put themselves at risk for the viability. That makes it different from capitalizing other kinds of entities.

But I think also there are areas where physicians and hospitals would be much more willing to engage this process if they had a little better assurance that the FTC was not going to give them some grief.

Senator BREAUX. I agree with that.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Kerrey.

Senator KERREY. Thank you very much, Mr. Chairman. This kind of a panel could provide a pretty constructive opportunity for us in a longer session of discussion. I must say, as a person that co-chaired, along with Senator Danforth, the Entitlement Commission, that I hear people talking about supporting options and reasonable decisions. I did not have any options on my list that were easy to support and I did not have anything on my list that would, after a wide open public debate, be supported by 50 percent of the Congress.

I mean, these are not easy decisions when you are trying to adjust to a program that has got to compensate for a rather unusual event that started in 1945. The Nation, as a python, began to absorb 77 million people who were born and survived over the next 20 years.

Sort of paradoxically, in 1965 the baby boom generation ended, at the same time that Medicare began. Medicare starts as a relatively inexpensive program, with no cost controls on the system at all. As my uncle, a urologist up at Stoneybrook says, we all kissed Medicare to death over the next 20 years. The health care industry

grew, and grew, and grew. Now the definition of affordable is much different.

When I defined affordable in 1974 when my son was born, and 1976 when my daughter was born, you could have a baby, and pay for it out-of-pocket. Today, I would have to be insured to cover the cost. There has been a big, big change.

I look at the problem of this baby boom generation and what you must do to compensate for them coming on board, especially the budget itself. The budget is going from 64 percent mandatory spending this year to 70 percent at the end of the President's balanced budget plan.

In 6 years of the 1990's, college student loans have exceeded all the student borrowing that occurred in the 1960's, 1970's, and 1980's. What is happening out there is the young people, who are paying the taxes by the way to pay all these bills—I mean, that is where the money comes from. I appreciate that people have paid in over the course of their lives. Thirty-seven million people by law, are guaranteed health insurance under Medicare—and all kidneys, by the way, we have socialized one organ without much difficulty. In addition to that, I have got 41 million people out there in the work force paying taxes with no health insurance.

I wonder, when you all talk about restructuring and think about restructuring, you have all sort of mentioned it, if any of you come back—God strike me dead for even saying it out loud—to the idea of perhaps we should change the law and just say that if you are an American or a legal resident, you are covered. You have a responsibility to pay according to your capacity to pay.

I think today's system is wrong. I mean, I make over $100,000 a year. I did before I got in the Senate, I will after I leave. I have got a claim on a person's income because I am a service-connected disabled veteran.

Colin Powell, after 35 years in the U.S. Armed Forces, he gets $70,000 a speech. He has got a claim on people's income to pay his health care bills. He wants affordable health care just like I do. Well, what I am basically saying is, I want somebody else to pay my bills. That is my definition of affordable.

I wonder if any of you have given some thought to the idea that maybe as we consider restructuring Medicare, we have got to come back to this idea, sort of counter-intuitively. Rather than restricting the entitlement, maybe the best way to control the costs is to expand under the law the entitlement and require everybody to face the true cost of health care, with no subsidies unless you need them, and get everybody in the system rather than trying to just deal with the most expensive group of all.

We have insured the most expensive group of all, over the age of 65, and this country is getting older, and older, and older. Twenty-five percent of us are going to be over the age of 65 in 2030.

A baby girl born today has a one out of three chance of living to be 100. It is all good news. You have all been enabling us to live longer and live healthier, but it gets more and more expensive for us to do so.

I would be very interested if, in your quiet thoughts about restructuring, whether or not this idea of trying to get everybody in with a change in the Federal law makes any sense to you.

Dr. Schwartz, you are the intellectual.

Dr. SCHWARTZ. Well, I took a course in college as an undergraduate, before I thought I was going to become a physician, on mathematics. I was a mathematics major. One of the courses I took was the theory of imaginary numbers. That is what the Medicare issue has come up to, because you pointed out a variety of issues that have evolved, namely, an aging population, an expanding population.

What you did not include, which is also a contributory factor, is the technology has increased to such an extent that medical care has expanded and incorporated more.

I looked at the operating schedule in my institution. Last Tuesday, there were five cases on the schedule for cardiac bypass, one aortic aneurism resection, all over the age of 82. So there were five operations done in patients who, in the year that the Medicare Act was enacted, you would never have anticipated. Therein resides part of the problem.

I think everybody knows the problem. The question is, how do you address it? Yours is an intriguing issue. The one that I alluded to, is I wonder whether there comes a point that you have to consider as a dominant issue that of scope and that of access, and can you do all of these things. Are all of these things affordable?

Senator KERREY. Well, I have overstayed my welcome on my question. I would appreciate any kind of written response that you can give me so I do not drag this committee's attention off onto this subject.

But one of the most effective anti-health care return bumper stickers that occurred in 1993 and 1994 was not Harry and Louise, but a bumper sticker that said, "If you think health care is expensive now, wait until it is free."

Well, unfortunately, very often that is the implied statement. I think it is very important, if we are going to have an open debate about this, that we open up the sheet of paper and include all kinds of thinking, including the possibility that the law which reduced the rates of uninsured in 1965 of Americans over the age of 65 from 50 percent to zero, perhaps should be used again in a different fashion.

We have learned a lot since 1965 about cost controls and the way the market can work and do things. We have learned a lot since then. I would say with great respect, that I am going to start coming to these hearings, Mr. Chairman and Senator Moynihan, and I am going to bring the list. Every time people start talking about, well, we ought to have this restructuring and we can support this, I am just going to read them and ask, do you support this, this, this, and this. It is likely to be the answer is going to be, no, I do not support moving the eligibility age, I do not support increased co-payment, I do not support increased Part B premiums.

It is a very limited universe when you are just dealing with Medicare as an intact program. My own intuition tells me, and that is all I have got right now operating on intuition, that we need to look in a broader way at this problem.

Senator MOYNIHAN. Mr. Chairman, could I just say to my colleague and friend, I support all three of those things.

The CHAIRMAN. Let me turn, just for a moment, to a little broader aspect of what is going on. The spending for physicians has pretty much flattened out, less than 1 percent. I wonder, and I will direct this particularly to Dr. Nelson and Dr. Schwartz, but would be interested in any of your opinions as to what the factors are that have brought this about?

Dr. Nelson.

Dr. NELSON. Well, there has been a continuing, intense effort for us to bring costs under control and the medical profession is committed to that. The emergence of managed care is having an impact on that, but it is hard to know how long that can be sustained. I think at some point the system has been made as lean as it can be without impairing access to the kinds of services that the public wants.

So I am sure that there are multiple factors. Some of those relate to public policy that this committee, among others, is responsible for. Some of it, I believe, is a sincere effort on the part of physicians, hospitals, and other care-givers to do a better job of stewarding the resources.

The CHAIRMAN. Do you have any specific thoughts as to what policies may have helped or not helped, because I think that would be of use to the committee, if you could be a little more specific.

Dr. NELSON. Yes. Let me give a little more thought to that, and I will make that available.

The CHAIRMAN. Dr. Schwartz.

Dr. SCHWARTZ. I think there are two elements to be considered. The first, is that, unquestionably, the fees for a variety of services have decreased during that period of time of assessment. That is one issue. The other issue, if you consider cumulatively physician expenditures as part of the equation, there has been with the HMOs a reduction in access to specialty people.

So, the gatekeeper concept has certainly reduced some of the gains for individual practitioners, but at the expense, I feel, to the participant, to the patient, because access has been not on the same level playing field as with other providers.

So I think there are two issues. One, there has been a reduction to some extent in access, but I think, unquestionably, if you look at the panorama of fees for all aspects of medical care, they have reduced significantly over the last several years.

The CHAIRMAN. Now, as I recall in your earlier testimony you did talk about whether we can afford to have unlimited access.

Dr. SCHWARTZ. That was the last sentence that I threw out in my statement. My question is, if you have a finite amount of expenditure that you are looking toward and an expanding group of populace who are going to be satisfied by that expenditure, the only part of the equation that can be addressed is the issue of scope.

I think that is what has happened in other societies, that you have to consider how much can be afforded and what is the appropriate scope of care. That is what the MVPS, in some way, attempted to address. They presented the surgical group with a target, and, accepting that target, the surgeons came in, 4 out of the 5 years, under that targeted amount. So I think that there is a history behind providing a target and working toward that target.

Dr. NELSON. Mr. Chairman, might I also add?

The CHAIRMAN. Yes.

Dr. NELSON. There is not any question that fees have been under control because of government policy, but the volume has also been kept down, not according to an assumption that was made at the front end by HCFA when they assumed that those whose fees were reduced would game the system and volume would go up. That turned out not to be the case. But I think there have been sincere efforts to try and hold the line on unnecessary care. So the total costs, I think, have been held under some control through a variety of means.

The CHAIRMAN. Mr. Size, if I could ask you a question about disproportionate share payments. As you point out, they are not equitably distributed. The President's proposal would freeze current payments for 2 years and in the meantime study how to formulate a new DSH payment. Do you think a change in DSH payments could be made in less than 2 years?

Mr. SIZE. I think, yes. I mean, one of the difficulties I have coming into a discussion of disproportionate share, is we have never had any so it is hard to know much about it. I do not think, though, that the underlying concept is very complicated.

It is meant to provide assistance to those hospitals, urban or rural, who have the additional costs related to serving an unusually poor population. I think we just need to do a better job with the formula. It should not take 2 years.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. I never did as much mathematics as I ought to have done, but in response to Mr. Size's comment about Wisconsin, I have been able to establish that there is a correlation of about 0.7 between educational scores and distance of State capital from Canadian border.

It is very clear to me, if we want to improve education in this country, that we should just have our States move closer to Canada. It is quite obvious and anybody could show you that. Wisconsin does not have any disproportionate share problems, and Manhattan has but little else.

Can I just say to the doctors and to all of you, in our committee—it will be 3 years ago, Mr. Chairman—we heard a wonderful testimony from a fellow from Fordham named Fahey who said, what you are seeing is the commodification of medicine.

He said that down where Ms. Baumgarten is sitting and down where you are, Mr. Size. He is a doctor who is head of the UCLA hospital in Los Angeles. He said, can I give you an example? In Southern California we have a spot market for bone marrow transplants. That is going to happen. Markets will do that.

That is why we on this committee proposed a trust fund, a tax on health care premiums, that would provide for graduate medical education for the hospitals and for the residencies which will not do well in any market. A lot of what government is about is providing for things that markets will not allow. For example, the Strong Memorial Hospital, sir.

But I wonder if Dr. Nelson would comment on this issue of, ought we not be fairly careful about deciding the number of specialists we can teach, since this is a function of science and science goes its own way?

Dr. NELSON. First, I would want to make it clear that we would favor continuing adequate support for education and research, and processes by which all payors would contribute to that so that Medicare is not the only one.

Senator MOYNIHAN. We have this graduate medical education trust fund, as an idea. Yes.

Dr. NELSON. Yes. With respect to specialty mix, the market already is doing something about that and an increasing number of students are selecting primary care careers, just as for some specialties that in many areas there appears to be an over-supply, the market is also working. For instance, anesthesiology programs this year were substantially down in the number of residents seeking anesthesiology as a career.

I agree with your premise that government has to be very careful in how it gets into those processes. However, as long as government is paying $66,000 a year per resident through the Medicare program for GME training, they have a legitimate interest in making sure that the output of those programs more nearly meets society's emerging needs.

In many areas of the country, there is not an excess of primary care specialists, although in some areas there is beginning to be. But, conversely, we are hearing that particularly if managed care staffing needs are applied, in many areas of the country there will be a serious surplus of specialists. As a taxpayer, I would wonder why my tax dollars were going to train people who would not be able to practice their specialty because there was not the need for them.

Senator MOYNIHAN. I would simply say, I would hope this might be debated more. It was an important fact of the President's 1993 proposal, that there this was, right there in the middle of it, and there was no debate. Universities were not talking about it.

I was up at the University of Rochester on occasion and I asked, would the Department of Philosophy at Rochester be willing to have it understood that the condition of receiving Federal aid of any kind was that they teach three schools of philosophy and none other? The answer was, no, no. You could be a Wittgenstein whatever, and Cartesian, period. Well, the answer is, no, we teach what we think is important.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman. I would like to turn to a second issue on managed care, and that is the method of reimbursement, this great deal of concern about the appropriateness and equity of the current 95 percent of fee-for-service in an accounting basis of HMO reimbursement.

This is an area, compensation of managed care plans, in which there is quite a laboratory of experience. Many large, private sector businesses have contracts with managed care organizations. States, either on behalf of particular groups of people such as Medicaid beneficiaries or on behalf of their own employees, have had experience.

What do you think should be the basic approach that Medicare takes to arriving at an appropriate compensation level for managed care plans? Yes?

Dr. NELSON. May I start, sir?

Senator GRAHAM. Yes.

Dr. NELSON. Ultimately, I think we should go to a defined contribution that is risk-adjusted and do away with the AAPCC. In the absence of that kind of fundamental reform of the Medicare program that would allow that to happen, it seems to me that there should be serious work on narrowing the wide differences in payments from one part of the country to another. I am not so sure that an across the board 10 percent reduction in the AAPCC is the best way to go.

I think that more thought should be given to processes by which there can be some risk adjustment perhaps, but also compress those differences so that areas such as where I practiced in Utah, where Medicare managed care would be at a serious disadvantage because the payments would be so low, the Medicare patients there would have a wider range of choices from which they could choose.

Mr. SIZE. The co-op started an HMO in Southern Central rural Wisconsin about 13, 14 years ago, so it is not true that you cannot do managed care in rural areas and it is not true that rural citizens will not be attracted to it.

That HMO has been sold and it is part of another configuration which we are still very much involved in, and we are looking at the Medicare piece. The problem is, we cannot currently get it out of Dane County, which is where Madison, the capital, is. The numbers are too low.

I mean, with the national variance going from $220 to $767, I think most reasonable people would say we have got to narrow that. It has got to be done in a prudent way so that those, such as Florida, who have some advantage under the current system have a time to adjust. But we have to be very explicit and move pretty rigorously in that direction.

Senator GRAHAM. Yes, ma'am.

Ms. BAUMGARTEN. AARP believes that there has to be a more adequate way of paying HMOs. There needs to be some type of risk adjustment available. As HMOs have matured as managed care has progressed, they are beginning to treat more people with chronic care and more people with severe health problems than when they started out with employers they were dealing with a younger group.

So, we certainly need to look at a more adequate way of compensating HMOs, or managed care, generally, I should say, for taking care of the higher-risk patients, because there is a greater demand on the resources there. The question of defined contributions could create problems.

One needs to think, when you look at a defined contribution, you are looking at a dollar. The question is, would the dollar amount buy the coverage or the health care that is out there. So there would be a lot of problems to look at in looking at that type of a situation.

Senator GRAHAM. Yes.

Mr. LINDEN. Senator, one of the issues that Mr. Size mentioned is a critical one. For some of the activity transition taking place, such as PSOs, the AAPCC rate is going to be a critical factor.

There is a huge variation, as has already been mentioned, in Iowa, in particular. I think ours is somewhere in the $260 range.

We cannot hope to begin to attract enough people to offer enough benefits for that to make sense. Where we have seen a lot of the activity is in areas where it is high enough that they can bring people in because they are offering more services.

I think that one of the ideas is to begin to get more of a national level playing field in that regard so that we can embrace providers that already understand—the physicians, the hospitals and others—what patients need and who can begin to control the utilization as well because it is all provider-sponsored.

Senator GRAHAM. I guess, in conclusion, Mr. Chairman what I do not understand is, this is not rocket science. There are a lot of people that have been engaged in these relationships for a number of years, at a substantial scale.

Why we cannot identify some of the models that are currently functioning and adapt them to Medicare, and we do not have to have one model for Medicare nationwide, we could experiment and have some alternatives and learn something in the Medicare setting specifically, but this fixation on a percentage of fee-for-service, it seems to me, has not served us well.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman, very much. Before I came in a little bird came and told me that the distinguished Senator from Louisiana sitting directly to my right made a great error of interpretation.

So as to take him out of his agony, I want to say that in the bill that Senator Frist and I have put in on PSOs, that we set Federal solvency standards. These are written based upon the National Association of Insurance Commissioners' HMO solvency standard. We do not exempt PSO from solvency or quality standards. Our bill does set Federal standards. So, we do not mess with State standards. I want that to be clear.

A question to Mr. Linden, I guess. This may seem self-serving, but that is fine. I generally agree that when we make across-the-board cuts, people say it is fair. Well, it never is fair. We have done that in the past and that has been one of the disadvantages of reconciliation as we have practiced it.

In the past, on the other hand, we have given differential updates to hospitals and we have tended to do it to give somewhat more to rural hospitals than urban hospitals.

Now, that is tricky because the budget is going to affect graduate medical education, medical expenses, and all of the rest of it. Not every hospital is a teaching hospital, but a lot of urban hospitals are.

But, nevertheless, my question to you is, in a world where it is more costly in rural settings, do you think there ought to be a differential update which gives some benefit to rural hospitals?

Mr. LINDEN. Well, the answer is as complicated as the question, I guess, because there certainly are circumstances where the differential is necessary because of the uniqueness of that rural market.

Clearly, there are rural hospitals out there that perhaps do not need a differential, and yet I think Mr. Size would probably agree

that many rural hospitals have been struggling from the very beginning of PPS, because the system was based historically and—especially in the upper midwest where we were providing care in a much more conservative manner—many of the original payments were based on utilization and not necessarily the actual cost.

I guess the comment I would make is, as we move toward prospective payment for outpatient, home health, and some of these other things which I support, because I think it helps us focus on efficiently providing care, let us not make some of the same mistakes we made in PPS on inpatient care and simply go back historically looking at cost, but let us try to not need differentials, I guess, as we begin some of the new prospective payment ideas.

To answer your question directly, I think differentials are important, especially where there is disproportionate share, where we have got rural communities that are struggling to deal with meeting patient care needs because they have been disadvantaged so long under some of the early PPS legislation.

Senator ROCKEFELLER. I thank you for that.

Dr. Nelson, good morning. Good to see you, sir. I guess you will remember fairly well, it was 1989 that Dave Durenberger and I helped put together this whole resource-based relative value scale, and it was very interesting legislation, and important legislation. I worked at that time with your predecessor, I guess, who retired the next year.

Now, it is 8 years later. I still think we did the right thing. HCFA roundly messed it up, as they often do, after the law passed in their interpretation of the law. But, nevertheless, it has kind of shaken down. I would like to know, from your point of view, whether that relative value scale which is already in place has met the expectations, as indeed that was the philosophy of primary care physicians.

Dr. NELSON. No. 1, you did the right thing. It made sense then to have payments based on the resources that are needed to provide the service. That still makes sense. The problem is, we are only half-way there because we have two conversion factors, one that rewards surgical services——

Senator ROCKEFELLER. There are three.

Dr. NELSON. Yes, that is right. Thank you. There are three. One that rewards surgical services greater than primary care services, and another one that deals with other services, like EKGs and so forth. We need to have a single conversion factor, so it is truly resource-based from that end.

The second thing is, almost half of the payments are still based on historic charges. The practice expense factor is still based on the charges that were made before 1989. We need to have that component also based on the resources that are necessary. It takes 115 office calls overhead to equal the overhead of one coronary bypass graft surgery that is done in the hospital anyway. That is clearly not fair.

Now, we are sensitive to our surgical colleagues' concerns about possible disruption in access, so we believe that the process should be conservative in the way that it goes about implementing true resource-based RBPEs.

When assumptions have to be made, they should be conservative assumptions. But, nonetheless, it has been 8 years. It is time to get it done and get back to your original goal in better rewarding primary care services.

Senator ROCKEFELLER. My time is up. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Breaux, we skipped you.

Senator BREAUX. Oh. Rockefeller just wanted the first shot. I think we need to explore the situation with the PSOs, as my colleague, Senator Rockefeller, mentioned. I am not opposed to it, I am not supportive of it. I am still looking at the reason for it.

I have not yet understood, Doctor, why HMOs would be subjected continuously to State regulation and somehow would carve out PSOs, and say we are going to regulate you on the Federal level and HMOs will be regulated on a State level, then after a 4-year period, we will kick it back to the States. I think that needs to be explored more, and that is not the subject of today's hearing.

The last time that I remember we did wholesale Medicare reform, and this committee remembers it very well in 1988, was the Catastrophic Medicare Act. We overwhelmingly passed it, Republicans and Democrats, the House and the Senate, and Reagan had this huge signing ceremony, and the next year we repealed it.

So if anybody out there is looking for wholesale Medicare reform, which I happen to think we really need to be doing, it is probably not likely, so we are going to be tinkering around the edges. I just hope we can do more tinkering in a positive way than has been suggested by the budget proposal, because I think we do need to do more fixing than that is calling for.

Let me ask you, Ms. Baumgarten, maybe just thoughts that are out there. I mean, the problem is very simple. We have got fewer people paying for more people's health care, and it is just not going to be able to continue in that fashion. But some of the things, just brief comments on them, that have been suggested, all of them controversial. Increasing the payroll tax to cover the costs. What are AARP's thoughts about that?

Ms. BAUMGARTEN. Senator, we need to discuss all of the ramifications that occur when you change anything within Medicare. You need to think of the younger generation, of what's going on with their taxes. You have done that in the past.

Depending on how it came out in the total budget, depending on how it plays out with beneficiaries. I do not think you can look at anything in isolation and we would have to look at how all the other things play out and the fairness overall.

Senator BREAUX. All right. It has been suggested by some that we increase the eligibility age. The AMA supports raising it from 65 to 67, like we are doing with Social Security. What do you think about that?

Ms. BAUMGARTEN. I think in that situation what you are trying to do is compare apples and oranges. You are talking about Social Security, you are talking about Medicare. Now, Social Security already lets people retire at 62 at a reduction in benefits. We do not let people come into Medicare under 65. So, the comparison is not there.

The only thing I would say is, if you raise it to 67, what you then do is create again a larger pool of the uninsured because a major part of the uninsured runs between 50 and 64. So you are creating more problems if you do that, for people without health insurance.

Senator BREAUX. I take it that is not enthusiastic support. How about tying premiums, deductibles, and other costs to the beneficiaries' income, means testing, which has been suggested by some?

Ms. BAUMGARTEN. I think we are talking about two different things here. Means testing, to me, has a different connotation. What I think I am hearing you saying, we are talking about an extra premium for high-income individuals.

I would like to point out that there are not as many of those very high-income individuals in retired seniors as you think. The median income for Medicare beneficiaries is $19,900 a year. I do not consider that high income.

Senator BREAUX. That is a given, assuming that. But how about that for those who are not there?

Ms. BAUMGARTEN. But let us go a little bit further, if you will give me a minute. I had better hurry up, your light is flashing.

Senator BREAUX. I do not have a minute.

Ms. BAUMGARTEN. What we are really talking about here, is we want to put a premium on it because we think the high-income is getting a Federal subsidy. I would point out that, if that is the case, then let us be fair and let us look at all generations, because there are health care subsidies for people of other ages, in that corporations get a tax deduction for their payment of the health care for their employees. Also, the employee gets a Federal subsidy indirectly because his benefit of health care is not taxed.

So if we are going to tax high-income individuals who are getting health care, we need to look at all high-income individuals, in the interest of fairness.

Senator BREAUX. See, that is part of the problem. I mean, no matter what is out there, there is always a problem with anything we suggest. Thank you.

The CHAIRMAN. Senator Bryan.

Senator BRYAN. Thank you very much, Mr. Chairman. Let me follow the line of questions that Senator Breaux was asking Ms. Baumgarten. Philosophically, does the AARP object to means-testing with respect to Medicare Part B premiums?

Is AARP's position that you are opposed to it philosophically? I gather that you are open to it, if it includes other generational benefits. I think that is what I heard you say in response to Senator Breaux's inquiry.

Ms. BAUMGARTEN. No. What I am saying is, there is a difference between means-testing and talking about a higher premium for the people who have higher incomes, because in means testing there are certain economic baselines that have to be met, as well as income. It is a different concept. We are against means testing Medicare.

Senator BRYAN. Without getting involved in these terms of art, means-testing, is AARP philosophically opposed to having those who are in an upper income category more for their Medicare

Part B premium than those who are at the lower end of the income scale?

Ms. BAUMGARTEN. I would just like to make this statement. That statement is, there are many of our members who maybe could pay a bit more, but we have many, many members who would be seriously affected economically, and the question of whether or not these low-income people would be protected. I will also point out that Medicare is across a group of people, and in that way is sort of a form of a social contract.

Senator BRYAN. But as I understand it—excuse me. I did not mean to interrupt you.

Ms. BAUMGARTEN. No, I stopped.

Senator ROCKEFELLER. Senator Bryan, she has done an interesting thing. One, in the end of her answer to the last statement she said, we are opposed to means testing. Now she is equivocating. So I think it is important to get an answer.

Ms. BAUMGARTEN. No.

Senator BRYAN. Let me just press this issue, if I may, a little bit. As I understand it, when Lyndon Johnson persuaded the Congress to approve Medicare in 1965, the basic predicate at that time with respect to the Part B premium, was that 50 percent would be paid by the general taxpayer, and 50 percent would be paid by the recipient.

We all understand, and I am not critical of my predecessors who sat on this committee, that with the escalating costs of medical care there was a reluctance on the part of the Congress to keep that 50/50 ratio. Of course, the premium split is not that today. You are arguing for the retention of the 75/25.

I just want to press you a little bit on that issue. When we are discussing upper income individuals, we are not talking about $19,000 a year people. I think everybody would acknowledge that that is certainly not an upper income. Those folks have a very tough time making it in our society with the costs as they are. So I want to be very clear, I am not talking about individuals at that level at all.

Where I have a little difficulty, and I would ask for your guidance and response, is that there are a lot of families in America that are struggling, and not making much either. It seems to me inherently unfair to ask those folks, some of whom may make $25,000 a year and have two or three children, to continue to subsidize Part B premiums for those people who are in the upper income, let us take $100,000 a year, or whatever cutoff figure. Philosophically I do not understand how we can justify and support that, recognizing that Medicare has some solvency problems that we all want to address. Let me get your response. Is that Neanderthal thinking from the perspective of the AARP, or are you open to some dialog on that?

Ms. BAUMGARTEN. What we need to look at when we look at anything is to remember that there are a lot of high out-of-pocket health care costs that seniors are already paying that amounts to approximately $2,600 a year right now. They are paying premiums, they are paying co-pays, they are paying deductibles. They are paying for things that are not included in Medicare, such as prescrip-

tion drugs and prevention, that has nothing to do with nursing home care.

Senator BRYAN. I am trying to get you to share with me what your position is. If we have a senior who makes $500,000 a year, should we subsidize the Part B premium for that individual, acknowledging that individual is, by the hypothesis that we are using here, also someone who has out-of-pocket expenses.

No question, the elderly have more medical expenses than do those who are in the younger profiles of our demographics. But at what point would AARP concede that maybe it is not unreasonable for the Congress to say, look, for this individual we ought not to subsidize his or her Part B premium?

Ms. BAUMGARTEN. I am going back to the previous statement that I made, that I think it is a fairness issue. If you are going to deal with the elderly, with the high-income payment, then you need to look at high income across all of the generations for their health care subsidies.

Senator BRYAN. So you believe it is a question of linkage, even though Medicare faces some serious, serious financial problems in the short-term, Congress should not make any change with respect to this Part B premium unless we link it to other health care changes with other generational groups?

Ms. BAUMGARTEN. All I am saying is that that is one of the many different things that we are going to have to look at as we look at Medicare and the changes that are needed. We cannot take anything out of isolation, we have to look at the total package, Senator Bryan.

Senator BRYAN. I would just say, with all due respect, that strikes me as a prescription for inaction. I thank the Chair.

The CHAIRMAN. It is 12 o'clock.

Senator ROCKEFELLER. Could I ask one final question?

The CHAIRMAN. Sure. Senator Rockefeller.

Senator ROCKEFELLER. This is to Dr. Schwartz. This, again, is on RBRVS. When that was set up, it was based upon both work performed and practice expenses. Then there really was a period of years that it took, predictably, to fine-tune what was meant by physician work and all kinds of things, and the time was probably necessary.

Now it is 8 years later. The other two conversion factors, so to speak, are for implementing this in 1998, for going in 1998. You all are for delaying it beyond January 1, 1998, even though we all understand that when something is implemented, that there will be fine-tuning of it after it is implemented, just as in the previous case. Why would you be against that?

Dr. SCHWARTZ. I think you alluded to that when you presented the concept of RBRVS, which you introduced. Then you pointed out the problems that arose from HCFA's interpretation and the massaging of figures and coming forth, with specifics and the details with the problems that arose.

In reference to expenses, our statement is the same. We feel that the analysis of these expenses have not been appropriate, No. 1. The American College of Surgeons has already developed a committee to study very specifically what the expenses of surgical practice are. We have had 15 groups of a variety and broad spectrum of sur-

geons addressing this. The college has already expended something in the range of $800,000 to determine what true practice expenses are.

Our only statement related to delay is concerned with the issue that, when this is implemented, we want it implemented with the appropriate details that do define appropriate expenses. That is the reason for the delay statement.

Senator ROCKEFELLER. But the other two conversion groups, so to speak, have said they are willing to go ahead, in spite of what I would assume might be some difficulty in practice expenses for them.

Dr. SCHWARTZ. Well, that is because the major impact on the program is in surgical practice.

Senator ROCKEFELLER. Well, that may be part of my question.

Dr. SCHWARTZ. Well, we think that the unfairness issue pertains mainly to surgical practices, in defining the expenses or considering the expenses.

Senator ROCKEFELLER. This is 8 years now already. I mean, what are you talking about?

Dr. SCHWARTZ. But nobody has come up with the appropriate expenses. The analysis of what the expenses should be have not been defined. We have a committee across all surgical specialties that can present you with data. We have a document to define what surgical expenses actually are by polling the surgeons who are subjected to those expenses.

Senator ROCKEFELLER. I will just end by saying, can you give me an approximate date when you think you might be ready to do this?

Dr. SCHWARTZ. Well, I can give you the data that are available. We have the document here.

Senator ROCKEFELLER. No, data. I said the approximate date when you think you might be ready to join the other two.

Dr. SCHWARTZ. I do not think I could commit myself to a specific date, no.

Senator ROCKEFELLER. Probably not. All right. Thank you.

The CHAIRMAN. Thank you, Senator Rockefeller.

Well, I think the hearing this morning reflects the difficulty of developing a consensus. I would stress to each of you, we appreciate your being here, No. 1. It has been a long morning, and we appreciate your willingness to stay and answer the questions raised. But somehow we have to find some answer to these problems, some kind of broad consensus.

I would urge that each and every one of you try to help us do so, because we are going to act. We have no choice. We are facing bankruptcy. So please go home and talk to your colleagues. Let us try to see if we cannot develop a broader consensus than we have now. Thank you very much for your patience and willingness to come forward.

[Whereupon, at 12:05 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF HON. JOHN H. CHAFEE

[FEBRUARY 13, 1997]

Thank you, Mr. Chairman. I welcome Secretary Shalala here this morning and I look forward to learning more about the Administration's budget proposal. I would like to take just a minute to address a few key items in the budget.

While I am pleased to see that the President has begun to acknowledge the problems confronting Medicare, I am concerned that his proposal to save $100 billion over the next five years does not go far enough in addressing the long term financial problems we heard CBO describe yesterday during our Health Subcommittee hearing on Medicare.

CBO testified that two ways to slow the long-term growth in federal spending for Medicare would be to reduce the number of people eligible for benefits, and to collect more of the costs from beneficiaries. I am particularly concerned, therefore, that the President has not included either means-testing of the Part B premium, or increasing the age of eligibility to coincide with the Social Security age.

I was also disappointed to see that the President has continued to rely upon transferring a large share of home health spending from Part A to Part B—much more, even, than he proposed last year—as a way of extending solvency of the Part A Trust Fund. We all know this will have no effect on the real crisis facing Medicare and does nothing to affect the overall growth of the program.

I was pleased to see the President has adopted many of the Medigap protections that I proposed last year along with Senator Rockefeller, and introduced again yesterday. The improvements are important for the millions of Medicare beneficiaries who buy Medicare supplemental insurance, although some aspects of the President's Medigap proposal do concern me.

Moving on to the subject of Medicaid, I was pleased to see some of the changes to the program with regard to state flexibility. Repealing the Boren amendment is a good first step toward giving the states some breathing room. I am also in favor of allowing states to bypass the waiver system and enroll Medicaid beneficiaries into managed care, but I would only support such a move if there are standards in place to protect eligibility and benefits. We also need to pay careful attention to how managed care works for certain groups with special health care needs such as the disabled or special circumstances such as foster children. I will be interested to learn more about the Administration's proposal in this area.

On the subject of expanding health insurance for children, I am very interested in finding a way to cover at least some of the ten million children who are currently uninsured. You have taken some steps in your budget proposal with the grant program to the states and outreach to those who are eligible but not enrolled. I am very concerned about this last part—there are almost three million children who are eligible for the Medicaid program but are not enrolled, for one reason or another. Add to that all the changes in welfare reform which are confusing to many families, and we may see enrollment drop even more. I think we are going to have a whale of a job to do in just ensuring that those who are eligible for Medicaid continue to get benefits.

Finally, let me just say a few things about welfare. The budget proposal contains $21.6 billion for changes to the welfare bill. Some modifications may be necessary—legal immigrants, for example, in my view were treated too harshly—but this figure is an extraordinary amount given that $21.6 billion represents a significant chunk of the overall savings of the 1996 welfare bill. I also support continued Medicaid cov-

erage for children who are going to lose their SSI eligibility and, as a result, their Medicaid coverage. But I would caution the Administration not to try to undo the entire welfare bill before we have given the states a chance to make it work.

Thank you, Mr. Chairman, and I look forward to the Secretary's testimony.

PREPARED STATEMENT OF HON. ALFONSE D'AMATO

[FEBRUARY 27, 1997]

Mr. Chairman, I commend you for holding this hearing on Medicare Payment policies. This hearing is really about preserving one of the world's best health insurance programs, and providing protection against the burden of hospital and medical care costs to more than 38 million older and disabled Americans.

Medicare is the world's largest insurance program, and it is perhaps the most efficient program run by the government. It has been largely successful in meeting its goal of protecting the elderly and the disabled against financial loss and in expanding their access to quality health care. For these reasons, it is an immensely popular program.

At the same time, Medicare faces a very serious fiscal challenge. We have the short-term problem, that the Hospital Insurance (HI) program trust fund will be depleted by 2001, and in the long term, the vast number of baby boomers who will retire in the future. Mr. Chairman, I applaud you and the distinguished Ranking Member, Senator Moynihan, for introducing legislation to establish a national commission on the future of Medicare.

As we consider changes in payment policies, it is imperative that we do so in a fair manner, and that we provide peace of mind to older and disabled Americans by protecting them against unpredictable and burdensome medical costs.

Millions of older and disabled Americans are counting on us, as well as every American who will need Medicare in the future. Any changes to the Medicare program must preserve the delivery of essential services to those who need them. Medicare must continue to provide the highest quality of health care and protection against financial hardship.

I look forward to the witnesses' comments and recommendations as we work to preserve the Medicare program.

PREPARED STATEMENT OF HON. JAMES M. JEFFORDS

Thank you Mr. Chairman. I appreciate the opportunity to discuss ProPAC's and PPRC's recommendations for strengthening Medicare in advance of their reports to Congress next month. I look forward to working with the Chair, today's witnesses, and the Administration to ensure that Medicare is protected for the next generation.

Part of our job is to ensure that Medicare, as well as other health systems, compete for patients not on a cost-basis, but on the basis of quality. As one of the largest purchasers of healthcare in the world, Medicare can and must move in this direction. I am pleased to see that our witnesses have recommendations in this area.

Further, we must assure that the benefits of innovations in healthcare delivery are available to all Medicare beneficiaries. Today, while all Americans pay in to Medicare under the same rules, many in rural areas like Vermont have few or none of the options available to citizens in urban areas. This is inequitable and must not continue. I commend the witnesses for their work in identifying remedies to the geographic variation in managed care plan benefits and payments. We must ensure an adequate floor under payments to managed care plans, and consider other steps which may be necessary to create a truly level playing field in the managed care Medicare market. In addition, I am interested in the role provider sponsored organizations may provide in introducing competition and a degree of local control, especially in areas traditionally underserved by managed care plans.

Finally, I look forward to addressing the issue of adverse selection under managed care plans. My goal is to ensure that health plans will no longer have an incentive to market to and enroll only the healthier Medicare beneficiaries. I intend to explore methods to reinsure the aberrational high costs that risk contractors may incur as a result of contracting for Medicare patients. I suggest that we focus on those patient costs that are both high and unpredictable. We know that a certain portion of Medicare patient costs are both high AND predictable. There is no reason we should not be able to fairly compensate for these costs with the newly formulated

capitated payment made to the plans. However, I do not believe the current reimbursement methodology covers the aberrational costs.

PREPARED STATEMENT OF HON. CONNIE MACK

[FEBRUARY 27, 1997]

I welcome Dr. Newhouse and Dr. Wilensky, two distinguished health economists, to our hearing today and look forward to their testimony on Medicare payments and their suggestions on how to responsibly improve, and more effectively manage, this important program for both its beneficiaries and for health care providers.

With Medicare as one of the highest priority items facing our nation today, it is important that we get costs under control, improve the delivery of care and effectively serve the needs of Medicare beneficiaries. Medicare has been growing at a rate that is just not sustainable and there is general agreement that this will deplete the trust fund. The only disagreement is by how much and by when.

Medicare has encouraged beneficiaries to enroll in HMOs as a means of controlling program costs. And, in many locations around the country it gives enrollees the option of selecting an HMO as the system from which they will receive care. In a way, HMOs cap costs for individuals no matter how much care they may need. Inviting the private sector to expand their product line to include Medicare was smart business since it offered more choices for individuals and it shifted the risk for open ended expenditure growth away from the government. HMOs now are at risk both to satisfy their customers needs and to control expenditures—to live within their means—something that has not been possible under the Medicare program. It is essential that we in Congress agree on ways to cap the costs of Medicare for our nation.

Today we will hear testimony on the Medicare program from the Chairman of the Prospective Payment Assessment Commission and from the Chair of the Physician Payment Review Commission on steps to be taken to further control costs in both the fee-for-service and risk contracting programs. The fee-for-service program accounts for the great bulk of Medicare expenditures to doctors and hospitals and provides payment for a majority of beneficiaries. It is clear that we need to remain very alert to Medicare usage patterns and be in a position to act far more quickly, than in the past, to correct situations where there is excessive utilization with resulting overpayment.

The wide discrepancies in costs to the Medicare program depending on the geographic area where the care is given were not referred to in today's testimony. Understanding these differences and reporting on them would be another useful tool in uncovering the reasons for Medicare's high costs.

It is important to revise the method of payment for hospital outpatient care so that beneficiaries do not pay more than they should out-of-pocket. Hospitals should not have an incentive to shift costs to outpatient activities because this is where the payment system is presently allowing overcharging.

Components of home health care have experienced tremendous growth in services provided and in increased costs. We should know, on a measurable basis, whether these services have improved the health of the recipients and what are the long term benefits of these exploding costs. These are important quality of care issues that need to be addressed before making major changes in the program. I look forward to hearing your observations and recommendations.

PREPARED STATEMENT OF TODD LINDEN

Mr. Chairman, I am Todd Linden, President and Chief Executive Officer of the Grinnell Regional Medical Center, Grinnell, Iowa, a community of 9,000. The medical center, the result of a merger of two local hospitals in 1968, includes an 81-bed private, not-for-profit hospital as well as a rehabilitation center. I am pleased to appear today on behalf of the American Hospital Association (AHA) and its 5,000 hospitals, health systems, networks, and other providers of care.

The President's budget proposal for fiscal year 1998 sets out to achieve a number of important goals: balancing the federal budget; extending solvency of the Medicare trust fund; and expanding access to health insurance for children and the temporarily unemployed. While we support reaching each of these goals, we have serious reservations about some of the methods the President has outlined for achieving them. His proposals have potentially significant, and in some instances negative,

implications for hospitals and health systems—and therefore for the Medicare beneficiaries that we serve.

Let me be clear at the outset: hospitals and health systems support a balanced federal budget. We also understand that some reductions in Medicare payments to hospitals are likely to be part of any balanced budget proposal. As we make these funding decisions, however, we must focus not just on budget-driven fiscal policy, but on other issues such as the long-term financial viability of Medicare and the future of the health care delivery system. In this larger context, we have three criteria by which we will evaluate all budget proposals:

- Reductions must be accompanied by significant program restructuring.
- Reductions must reflect shared responsibility among all those with a stake in Medicare.
- Proposals must include a long-term solution to Medicare solvency.

We believe these criteria reflect sound health care, as well as fiscal, policy.

Program restructuring: Any Medicare reductions must be made together with a broader restructuring of the Medicare program that would bring efficiency, cost-effectiveness, and high-quality coordinated care to Medicare. One important step is to allow seniors to choose to receive Medicare services directly from local provider-sponsored organizations (PSOs). These community-based, integrated networks of physicians, hospitals, and other caregivers can directly provide the full Medicare benefit package. PSOs achieve the cost efficiency necessary to hold down health care costs by managing both the utilization of services and the cost of producing those services. And they do it by providing services through the same hospitals and physicians many patients, including the elderly, are already familiar with. Those PSOs providing services to Medicare beneficiaries would be federally approved, with appropriate solvency, accountability and quality standards in place. This approach is embodied in S. 146, bipartisan legislation introduced by Senators Jay Rockefeller (D-WV) and Bill Frist (R-TN).

Also key to restructuring and expanding Medicare beneficiary opportunities to receive such coordinated care is fixing Medicare's flawed managed care payment system. Given the wide variations in historic fee-for-service utilization patterns, there is a resulting wide variation in health plan payments—more than 300 percent among counties across the United States. We believe these payments should be made more equitable across the United States in a way that will allow more communities to establish coordinated care networks.

In addition, we believe Medicare should move to greater use of prospective payment in areas such as hospital outpatient, skilled nursing, and home health services. Prospective payment is a potentially simple, easy-to-administer system that offers payment predictability. Its fixed resources also gives providers incentives for delivering care efficiently.

Shared responsibility: Any Medicare reductions must also be accompanied by equitable, shared responsibility from all those with a stake in the Medicare program—hospitals, physicians, other providers, and beneficiaries. A long-term, fiscally viable solution cannot be achieved without greater participation from beneficiaries than the President has proposed in this budget—particularly as health care costs continue to rise and baby boomers begin to retire. Excessive reliance on savings from any one group could weaken that portion of the program—to the detriment of seniors.

Long-term solvency: Finally, Medicare budget reduction proposals must include a long-term solution to the financial solvency of the Medicare program. AHA has long advocated creation of a permanent independent commission on Medicare, empowered by Congress to make recommendations on the important fiscal and benefit design issues the program faces in the future.

The President's Medicare budget proposals for fiscal year 1998

Restructuring the Medicare program: The President's budget does provide encouragement regarding Medicare restructuring by providing some of the tools needed to expand seniors' coordinated care choices within Medicare. While we have yet to see the kind of detail that would allow truly informed judgment, preliminarily we are pleased that PSOs that meet federal standards will be allowed to contract directly with Medicare. As we outlined above, PSOs give beneficiaries greater opportunities—and, we believe, opportunities that are more appealing to them—to choose alternatives to today's traditional fee-for-service Medicare. Additional benefits of PSOs, beyond those already mentioned, include: provider-driven, not insurer-driven; offer consumers stable relationships with providers (consumers don't have to change plans to follow their providers; providers are the plan); reduce administrative layers common to insurance companies and HMOs; community-rooted and therefore focused on improving the health of the entire community.

In addition, the President's proposed changes in payment for Medicare managed care plans move in the right direction. The current system, based on adjusted average per capita cost (AAPCC) rates, inappropriately reflects wide variation in historical utilization patterns. It also reflects varying levels of provider efficiency. We advocate Medicare managed care payments that are uniform across the country, but then adjusted for differences in the cost of delivering health care services that are beyond the control of the health care system. And, payments should also be adjusted to reflect differences across the country in the cost of delivering care due to the fact that some areas may care for less-healthy, more costly Medicare beneficiaries. The current AAPCC should be blended with a new payment rate that eliminates differences in historical patterns of use across counties. In addition, a payment floor should be quickly established to raise payments in the lowest-rate areas.

In addition, we are pleased to see that the President has "carved out" payments for graduate medical education (GME) and for those hospitals treating a large volume of low-income individuals—the disproportionate share hospitals (DSH)—from Medicare managed care payments. The carve out is needed because traditionally the Medicare program has paid hospitals directly for the special, additional costs associated with teaching and with treating large numbers of low-income individuals. As these special payments remain buried within a fixed, Medicare health plan payment, health plan organizations receiving the payment are not passing on the funding to those institutions actually incurring the added costs. Medicare payments for clinical education and for hospitals treating a disproportionately large share of low-income individuals should paid directly to the organizations fulfilling those responsibilities.

On the fee-for-service side, the President's proposals would also make important progress toward restructuring. Today, for example, providers can be paid in as many as 13 different ways for outpatient services. The proposals to implement prospective payment systems for skilled nursing and home health, as well as hospital outpatient services, could give providers more payment predictability as well as incentives to deliver services more efficiently. As the details of these proposals are revealed we hope, however, they meet a basic standard: a prospective payment system that simplifies, not complicates, our ability to efficiently manage hospitals and health systems.

In a related matter, the President's budget appropriately addresses the concern about beneficiary cost sharing for hospital outpatient services by recognizing that this is an issue to be resolved between the Medicare program and its beneficiaries. Due to the Medicare program's complicated formulas for some hospital outpatient services, beneficiaries have been paying a greater share of the bill each year while the government's share has declined. The President's proposal would gradually increase the government share so that ultimately beneficiaries will pay only the 20 percent coinsurance the law intended to be applied.

Shared responsibility: Of the $100 billion in total Medicare savings proposed over the next five years, *the President's plan includes reductions in payments for inpatient and outpatient hospital services of $43 billion.* We are disappointed that his Medicare savings proposals rely almost entirely on reductions in payments to providers. Nevertheless, we recognize that these proposed payment reductions for hospital care for seniors are no higher proportionally than the President set out last year. Any truly serious effort to balance the budget *and* preserve long-term solvency of the Medicare program requires a willingness to ask *all* parties involved to contribute, not just providers.

It is important to note that while we can measure direct Medicare payment reductions to hospitals and health systems, it is more difficult to measure the impact of other proposals in the President's budget on institutions that have dramatically restructured themselves in adapting to today's rapidly changing delivery system.

For example, today more than half of all community hospitals offer home health services. Nearly one-third have added skilled nursing care, as an interim step between acute hospital care and home care. Over time, as hospitals seek to provide a continuum of care, they have become a large part of the delivery network for seniors. In 1995, hospital-based providers (including swing-bed hospitals) represented 22 percent of all Medicare-certified skilled nursing facilities and 27 percent of home health providers, according to ProPAC. The proposed $7 billion in reductions in payment for skilled nursing and $14 billion for home health services will further reduce payments to hospitals, and affect the level of care they are able to provide in their communities.

Moreover, reductions in payments to Medicare managed care plans also affect hospitals that contract with managed care plans—since plans pass along Medicare payment reductions to hospitals and other providers. The Congressional Budget Office projects that almost one-quarter of all Medicare beneficiaries will be enrolled in a

managed care plan by the year 2002. As a result, a growing share of Medicare payments to hospitals will come through the managed care gateway, making hospitals and other caregivers increasingly affected by reductions in Medicare managed care payments. In short, hospitals—directly *and* indirectly—would be adversely affected by the President's proposals.

Unfortunately, recent ProPAC hospital financial performance data may encourage the belief that reductions in payments to hospitals can be achieved without inflicting pain. This is not true. Many hospitals are struggling financially—so reductions in Medicare payments to hospitals will hurt. First, it's important to note that ProPAC's findings apply solely to Medicare inpatient services. Second, at the same time ProPAC reported these Medicare PPS inpatient margins, it also estimated that approximately forty percent of the nation's hospitals lose money when they treat Medicare inpatients.

More important, twenty percent of hospitals have negative total margins, meaning that, overall, they are losing money on all patients served. Government payment sources pay less than the cost of providing care. In the aggregate (including both inpatient and outpatient services), Medicare pays only 97 cents on the dollar, according to ProPAC, and Medicaid pays less—a critical difference for those hospitals that do not have a level of private-pay patients to make up the difference. For roughly 1,000 hospitals, representing one in five of the nation's community hospitals, Medicare and Medicaid combined represent more than two-thirds of total revenue. Seventeen percent of these hospitals are sole community providers; another 16 percent are located in the core city of metropolitan areas. Many are already in weakened financial positions, with roughly 10 percent of these hospitals experiencing bottom-line losses for three years in a row, considering all sources of revenue.

These hospitals are vital resources to their communities; many serve a large number of elderly citizens. While it's true we need to rationally reduce our excess hospital capacity, placing at risk many hospitals in rural and inner-city areas with high Medicare and Medicaid populations does not qualify as a rational approach.

Clearly, it's inaccurate to assume that all hospitals are faring well under the Medicare program. Any Medicare reductions will have an adverse impact on a significant number of hospitals.

Long-term Medicare solvency: We need to put the Medicare program on solid financial footing for the next 30 years, and any budget proposal needs to adequately address how this is to be done. The President clearly takes a step in the right direction. He suggests that his budget plan would keep the Hospital Insurance Trust Fund solvent for 10 years. But, that decade only takes us to the brink of the baby boom retirement years. We urge this Committee and the Congress to put the Trust Fund on solid long-term footing by implementing a permanent independent commission.

In our view, an independent commission should, each year, provide information and advice to help Congress set a Medicare spending target. Using that target, the commission would hold public hearings, and recommend how to achieve the spending target; what benefits that money will buy and for whom; and how to ensure quality. Then, the whole package would be voted on, up-or-down, by Congress. With this kind of independent commission, decisions having a lasting impact on the design and viability of the Medicare program could be made outside the day-to-day politics of the budget process. We commend Chairman Roth and Senator Moynihan for their recent introduction of S. 341 to create a commission to make recommendations to address the long-term solvency of the Trust Fund. We would like to suggest some changes in that proposal that would bring it closer to the type of commission embodied in H.R. 406, introduced by Rep. Phil English (R-PA).

Other issues

We have concerns about other issues included in the President's budget, including:

Transfer cases: The President's proposal would redefine transfer cases. Under the proposal, payments to hospitals will be reduced for beneficiaries who are sent from a hospital to a skilled nursing facility or specialty hospital (such as a rehabilitation or psychiatric hospital) after a shorter-than-average hospital stay.

This proposal undermines the basic philosophy of the prospective payment system for hospitals. Under the prospective payment system hospitals are paid an average amount for each patient. This is intended to reward hospitals that can keep costs below average. This proposal would penalize this good behavior by simply reducing the payment for some patients with below-average costs.

In its March 1996 report to Congress, ProPAC rejected the Administration's transfer proposal. The Commission argued that the policy change "would discourage the use of post-acute providers" and "could result in longer inpatient stays which may not be desirable or cost-effective in the long-run."

Fraud and abuse: Congress, as part of the Health Insurance Portability and Protection Act of 1996, greatly expanded existing Medicare and Medicaid fraud and abuse laws, significantly increased penalties, established health care fraud as a federal crime and provided new funding for enforcement activities. Balancing this extraordinary enhancement of powers for enforcement agencies, Congress also included additional guidance from the Office of the Inspector General on the application of fraud and abuse laws in the form of advisory opinions on the legality of proposed specific transactions; an exception from the broad anti-kickback statute for risk-sharing arrangements; and, clarification of the level of knowledge required for imposition of civil monetary penalties. The AHA and others in the health care industry strongly supported the latter three provisions that provide important balance to the legislation.

The President's budget, however, seeks to repeal these three provisions. We believe, given the complexity of reimbursement rules and the significant penalties for noncompliance, that the provisions should be maintained—that it is appropriate for the government to devote resources to providing guidance to those seeking to comply with the law. And, that in a rapidly changing environment, hospitals have the flexibility to reconfigure services, and to seek advice in advance on whether they are making these changes legally.

Clinical Education: The President proposes to reduce spending for clinical education by capping the number of resident positions and by reducing indirect medical education (IME) payments to hospitals. It is important to understand that if enacted, teaching hospitals would have their payments reduced twice. That's because when the DRG update is reduced, the IME payments are also reduced automatically. Moreover, the President's budget does not address the need for explicit contributions from private payers and Medicaid to fund the costs of clinical education.

Rural hospitals: We are pleased that the President recognizes the special needs of hospitals serving rural areas. For the 20 percent of Americans who live in rural areas, their local hospital is an essential source of health care services. The President's plan invests roughly $0.8 billion over five years to support access to health care for rural Medicare beneficiaries.

Conclusion

Hospitals and health systems are deeply aware that the health care system is changing. Indeed, we have been, and will continue to be, profoundly affected by these changes. In 1985, there were 5,732 community hospitals in the United States. By 1995, that number had fallen by almost 10 percent to 5,194 facilities. Over the same time period, trends in the use of hospital services have changed dramatically, primarily in a shift from inpatient care to outpatient services: annual admissions to community hospitals declined from 33.4 million to 30.9 million; the average length of a hospital stay fell from 7.1 days to 6.5 days; the number of outpatient visits almost doubled from 219 million to 414 million.

Demand for care will continue to increase as the number of beneficiaries grow and the average age of beneficiaries rises. Advances in medical technology also foster increased demand, and contribute significantly to increased costs. The Medicare program must be maintained in a way that allows hospitals and other providers to meet this demand and still provide the quality care that Medicare beneficiaries deserve and have come to rely on.

The members of the American Hospital Association look forward to working with this Committee, and with Congress as a whole, to help find the elusive and complex answers to these difficult questions. If there is one central message we hope to impart with our testimony today, it is that we cannot preserve Medicare by weakening the hospitals and health systems that serve Medicare beneficiaries. We must remember that Medicare is more than a name of a program. It is more than Function 570 in the federal budget.

The Medicare program is, overall, a tremendous success in delivering health care to this country's seniors, one beneficiary at a time. While fewer and fewer of us remember the situation of the elderly before Medicare's inception in 1965, reports from that era show us that today the elderly have greater health care access, and lead lives of infinitely better quality, than they did before Medicare provided them a significant measure of health care security. Seniors count on Medicare today. And they count on the caregivers who provide Medicare services—hospitals, physicians, other providers.

We want to work with you throughout the budget process to arrive at the right solutions for the impending Medicare solvency crisis. To make sure that fixing the federal budget in the short-term doesn't take precedent—or even undermine—thoughtful, long-term policies that will put Medicare on a firmer foundation. We be-

lieve that while struggling with these issues is difficult, it is not an impossible task. It is, however, one that grows more challenging with each passing month.

RESPONSES TO QUESTIONS FROM SENATOR HATCH

Question: I appreciated your comments in your testimony regarding the President's proposal to repeal some of the anti-fraud and abuse provisions in last year's Kassebaum/Kennedy health insurance bill.

And, in particular, the provisions providing for a clarification to the anti-kickback statute as well as requiring the HHS and the Justice Department to issue advisory opinions that would give health care providers advanced guidance on structuring new and innovative health care delivery systems.

This whole debate about Medicare reform is about providing seniors with choices in health care plans.

The issuance of advisory opinions will foster this development because it will provide some guidance to industry as to what is permissible and what is not.

The advisory opinions and clarification to the anti-kickback statute are provisions I strongly support, and will continue to do so.

Would you comment in more detail why these provisions are important and how they will help provide greater choice for seniors as well as reduce health care costs?

Answer:

Advisory Opinions—The American Hospital Association strongly supported provisions in the Kassebaum-Kennedy Health Insurance Portability and Protection Act (HIPPA) that would clarify the fraud and abuse statutes and provide useful guidance as to what conduct is prohibited. We applaud your efforts, Senator Hatch, that led to the enactment of key provisions such as intent standards and establishment of an advisory opinion process that are essential to protect honest providers from what has become an exceedingly complex and vast web of fraud and abuse laws and regulations. Unfortunately, the President's Fiscal Year 1998 budget calls for repeal of these important provisions.

The antikickback laws are full of overly broad and inexact language. As a result, many hospitals avoid activities that in many cases would benefit patients, precisely because they fear their activities might be in violation of the antikickback statute. The variety and complexity of financial relationships in today's health care market make it impossible for physicians and hospitals to depend solely upon statutes and regulations of general applicability. In addition, the regulatory process simply cannot keep pace with developing new and innovative integrated delivery systems. Without advisory opinions to guide providers, many beneficial arrangements that would provide high quality health care more efficiently will never see the light of day.

The Office of the Inspector General of the Department of Health and Human services, as required by HIPPA, has issued a final rule with comment, establishing an advisory opinion process. While we agree with the general philosophy of the rule, we believe several modifications are necessary to make the rule workable. The Internal Revenue Service has a similar process for giving such advice on specific transactions, in the form of private letter rulings. We believe this is an appropriate model for use by the OIG.

Clarification of Level of Interact Required for Imposition of Civil Money Penalties—The intent standard for imposing civil money penalties is clarified in HIPPA to require that a person "knowingly" present a false claim or make a false statement rather than the current "knows or should have known" standard. This important clarification will help prevent applying penalties for honest mistakes and inadvertent billing errors. A provider would have to have actual knowledge or act in ignorance or reckless disregard of the truth or falsity of the information submitted to the government.

Risk Sharing and Discount Exception to the Antikickback Statute—This amendment to the antikickback statute will help bring laws governing the Medicare and Medicaid programs up to date. It will provide Medicare and Medicaid beneficiaries more choices and make our federal health programs more efficient.

This provision expands the current antikickback exception to include arrangements that contain *substantial* financial incentives to control costs in federal programs. Previously the law allowed an exception only for Medicare risk contracts that are fully capitated. This amendment will open up these programs to a greater variety of arrangements designed to reduce costs and improve quality.

The provision also ensures that providers are not forming fraudulent arrangements that result in higher costs to the program, by requiring that there is true

risk sharing. The Secretary, through a negotiated rulemaking process, will define what is "substantial financial risk" and has the authority to revise that definition every two years to protect the program and patients against any fraudulent arrangements.

The government is constantly encouraging the development of more cost-effective health care arrangements. However, without a viable and sensible exception to the antikickback statute for such arrangements, their development will not continue. Why be innovative if you run the risk of severe financial penalties or exclusion from the Medicare and Medicaid programs? Congress should reject any effort by the Administration to repeal this exception. These arrangements have worked in the private sector to help control health care costs, while giving providers and patients who do not participate in full capitation plans, the flexibility to choose those that include risk-sharing incentives to control costs and quality.

PREPARED STATEMENT OF ALAN NELSON, MD

AMERICAN SOCIETY OF INTERNAL MEDICINE
Testimony to the Senate Finance Committee
FY 1998 Budget Proposals on Medicare

March 5, 1997

Introduction

The American Society of Internal Medicine (ASIM) represents physicians who specialize in internal medicine, the nation's largest medical specialty. Because internists provide both primary and consultative care to more Medicare patients than any other physician specialty, our members are particularly concerned about the potential impact of the FY 1998 budget--and of longer term reforms of the Medicare program--on the quality and accessibility of care provided to their elderly and disabled patients. ASIM supports long-term structural reforms that would expand choice of health plans available to beneficiaries; create incentives for patients to choose less costly plans; make providers accountable for the quality, cost and effectiveness of the care provided to patients; provide beneficiaries with a "defined federal contribution" to be applied to the purchase of a health plan; require income-related premium contributions from beneficiaries; and maintain a viable fee-for-service program.

We recognize that it will be difficult to reach consensus on such long-term reforms, particularly in the aftermath of the highly-charged debate over the past two years over the future of the Medicare program. Our testimony today will present our ideas for short and long-term reforms that merit consideration.

Savings Should Target Higher-Growth Areas

ASIM believes that structural reforms are preferable to attempting to squeeze more savings out payments to "providers." In repeated budget bills, Congress and the President have agreed to major reductions in the rate of growth in payments to physicians and other providers. Such approaches have done little or nothing to address the underlying problems with the Medicare program, however, and have taken a toll on the ability of physicians to provide their patients with the best care possible. We recognize, however, that some savings in the rate of growth in payments to providers is inevitable. In deciding where savings might be achievable without compromising access and quality, Congress should take into consideration which categories of spending are growing at a rate that may not be sustainable. By the same token, categories of spending that are growing so slowly that they are not contributing to Medicare's fiscal problems are not the place to look for further reductions.

ASIM is pleased that the administration's proposed budget takes into account the fact that expenditures on physician services are growing slower than any other category of Medicare spending. Of the $100 billion in Medicare savings over the next five years proposed in the President's budget, seven billion comes from outlays on physician services. According to the administration, thirty-four percent of the savings will come from reductions in payments to HMOs; 33 percent from lowering payment updates to hospitals and from cuts in GME outlays; 14 percent from limits on outlays on home health agencies, 7 percent from physicians, 7 percent from skilled nursing facilities, 2 percent from "other providers," and 10 percent from maintaining the current law requirement (which would otherwise expire) that the beneficiary premium contribution covers 25 percent of program costs. *Even without any additional budget savings*, physician payments have already been reduced so much in the past is that there just is not room to take much more. The January "baseline" projections from the Congressional Budget Office show how much spending on physician services has already been curtailed. According to the CBO, *total* outlays for physician services *will grow by an average of only 2.4% per year* over the next decade.

By comparison, payments to hospital, home health agencies, skilled nursing facilities, and most particularly HMOs will all exceed the rate of inflation. The CBO estimates that Medicare fee schedule payments--as expressed by the weighted separate conversion factor updates-- will actually *decline* by about one percent over this period of time--or by 21 percent after inflation is taken into account. Fee schedule payments to physicians therefore have the dubious distinction of being the *only* category of outlays that are projected to actually drop, in both real (after inflation) and nominal dollars. ASIM urges Congress to support the administration's approach of targeting savings toward higher growth areas of expenditures. It is not reasonable to expect that total outlays on physician services--which will now barely keep pace with inflation--can be reduced further without compromising access and quality. Although we concur with the administration's approach of targeting higher-growth areas for most of the savings, ASIM has concerns about the impact of several of the administration's proposals for further limiting spending on physician services.

Making Medicare Payments Resource-Based

Although nine years have passed since Congress first mandated that Medicare payments be resource based, the fact is that some services continue to be reimbursed more for the resources involved than other services. Congress should assure that the 1998 budget allows for correction of two distinct flaws in the Medicare fee schedule that have resulted in payments not being truly resource based:

1. **Separate volume performance standards, conversion factors, and updates have resulted in surgical procedures being paid at a much higher rate than primary care and other nonsurgical services that require the same resources to perform.**

2. **Medicare payments for practice expenses continue to be based on historical charges, not resource costs.** As a result, services that historically were overvalued prior to implementation of the resource based relative value scale (RBRVS) continue to be overpaid for their overhead expenses, while services that were undervalued continue to be underpaid for their practice expenses. Concern about the inequities created by the current charge-based formula led Congress to enact legislation in 1994 that mandates implementation of resource-based practice expenses on January 1, 1998.

Single Conversion Factor

ASIM strongly supports the administration's proposal to enact a single dollar conversion factor for the Medicare fee schedule, effective 1/1/98, and to establish the single conversion factor at a level that is no less than the current primary care conversion factor, updated for inflation. We appreciate this committee's support in the past for enactment of a single conversion factor. Under the 1997 default conversion factors, surgical procedures are reimbursed at a rate that is 14% higher than primary care services, and 21% higher than other nonsurgical services, that involve the same amount of physician work. In an effort to correct this inequity, Congress included a single CF in the Balanced Budget Act of 1995. The single CF would have been effective on January 1, 1996. As the committee is well aware, however, President Clinton vetoed the BBA, with the result that the policy of separate conversion factors and updates remains in effect. There continues to be strong bipartisan support for enacting a single CF, however, as evidenced by the fact that it not only was included in the BBA and in the President's current budget, but it has also been included in other proposals such as the recently-unveiled "Blue Dog" budget proposal.

Current law requires that separate target rates of increase in expenditures--or volume performance standards (VPSs)--be established for surgical procedures, primary care services, and nonsurgical services. If actual spending is below the applicable VPS, the services in that category get a bonus

increase (the Medicare economic index plus the percentage that actual spending came in under the VPS). If spending exceeded the applicable VPS, the Medicare economic index (MEI) is reduced by the percentage that spending exceeded the VPS unless Congress specifies otherwise. After adjustment for demographic changes and changes in law that may affect annual growth in expenditures on physician services, the VPSs represent a target rate of growth that is equal to the previous five year historical average expenditures for the category of services, minus a performance standard adjustment factor.

Payments for surgical procedures benefited from this formula because changes in practice patterns over the past five years resulted in surgical volume increasing at a slower rate than other physician services. The reduction in surgical volume is due principally to changes in practice patterns--specifically, the substitution of non-surgical treatments for surgical procedures. The Physician Payment Review Commission, citing the Agency for Health Care Policy and Research, reported in 1994 that "Reductions in the volume of prostate-related procedures mostly reflect changes in treatment through increased use of drugs, less invasive surgical procedures, and watchful waiting" (PPRC, Fee Update and Medicare Volume Performance Standards for 1995, May 15, 1994). The evidence also suggests that much of the reduction in surgical volume is due to an inevitable "bottoming out" of the number of patients who have a need for cataract surgery and several other surgical procedures that experienced explosive growth in the mid-1980s. In the same 1994 report from the PPRC that is cited above, the Commission noted that "The period of greatest growth in volume for a new medical procedure or technology is often the first few years following introduction, largely because it is during this period of diffusion that patients with existing indications are treated along with those newly identified. In the mid-1980s, the volume of new technologies such as cataract surgery was growing at double-digit rates, because there were tens of millions of patients who needed--and could benefit--from those treatments. As time has passed, however, the demand for such procedures has naturally declined."

ASIM opposes any additional transition or delay in mandating a single CF. Given that Congress intended for a single conversion factor to go into effect on January 1, 199[illegible] (as would have been required under the BBA), physicians will already have had two years of [illegible] facto transition to a single conversion factor under the administration's proposals for implementation on January 1, 1998. We also urge Congress to support the administration's proposal to establish the single conversion factor at a level that is no lower than the current primary care conversion factor, updated for inflation. Payments for primary care services, which have been undervalued in the fee schedule updates for most of the past five years, should not be rolled back below current levels. Establishing the conversion factor at anything less than the primary care conversion factor, as updated for inflation, would also require deeper cuts in payments for surgical procedures, and provide less relief for the other nonsurgical services that have been most disadvantaged under the current update formula. A transition would also reduce the savings that the administration projects from a single CF by easing the reductions in payments for overvalued surgical procedures.

Implementation of Resource-Based Practice Expenses

ASIM continues to strongly support implementation of methodologically sound resource-based practice expenses. Because current practice expense payments are not truly resource-based, some services remain grossly overvalued while others remain substantially undervalued. An internist who provides 115 level 3 established patient office visits--typically requiring 29 hours of face-to-face time with patients--receives the amount of practice expense reimbursement that a surgeon gets for one bypass graft that takes only a few hours to perform. *Medicare also ends up paying surgeons for operating room overhead expenses that the hospital, not the physician, incurs and that are already paid under Part A.* In 1992, the Physician Payment Review Commission noted that "54% of the Medicare fee schedule payment for a coronary bypass graft in the final rule represents payments for practice expenses. However, this service is provided in hospital operating theaters that are equipped and staffed by the

hospital, not the physician. In this case, the Medicare Part A payment includes the costs of virtually all of the expense payment for this service besides the physician work."

Some have argued that because highly preliminary data released by HCFA in January indicate that major redistribution of income may occur under resource-based practice expenses, this means that the Health Care Financing Administration's approach to this issue is fundamentally flawed. ASIM does not believe that the test of HCFA's proposed methodology should be the degree that it does or does not redistribute payments. Rather, it should be whether or not the methodology that HCFA will propose is methodologically sound and more fair than the existing charge-based methodology. HCFA project staff have repeatedly stated that the data, methodological options, and specialty-impact estimates released in January for review and comments are "highly preliminary" and meant only to be "illustrative" of the impact of a range of approaches to determining RBPEs--and that *none* of the specific options presented will be adopted by HCFA to develop the proposed rule. Given the preliminary nature of the information that was released, we do not believe that it is appropriate to conclude now that implementation of RBPEs needs to be delayed. ASIM has provided HCFA with detailed recommendations for making improvements in the methodology and data that will be used to develop resource-based practice expenses.

We urge this Committee to withhold judgment on changing the timetable for implementation of resource-based practice expenses until a proposed rule is published, and until HCFA explains the process that will be used to refine the initial resource-based practice expenses. In its upcoming report to Congress, the Physician Payment Review Commission rejects any delay in implementation of RBPEs, on the basis that sufficient data are available and that no better data would be forthcoming should a delay be granted by Congress. We agree with the Commission's view that the unfairness inherent in the current system demands that methodologically sound RBPEs be implemented as soon as possible, and that there is no reason to conclude now that this can't be accomplished on January 1, 1998.

ASIM also strongly supports the Commission's view that unproven assumptions of a behavioral offset should not be incorporated into the RBPEs. A behavioral offset will magnify the reductions for overvalued services and reduce the gains for undervalued ones. The Commission correctly points out that the administration's contention that physicians offset 50 cents of every dollar that is lost when payments are reduced was not borne out when the RBRVS was implemented. HCFA should learn from its experience with the RBRVS, rather than repeating the same mistakes. If necessary, Congress should consider enacting legislation that would limit HCFA's ability to apply a behavioral offset.

We also agree with the Commission's view that HCFA should propose a refinement process -- allowing for sufficient input from practicing physicians and other experts on practice expenses--to permit re-examination of the proposed practice expense RVUs prior to implementation of the final rule. Such refinement panels should be used to address major areas of disagreement with the proposed RBPEs for specific codes or families of codes, if a specialty has compelling evidence to suggest that the proposed RBPEs may be incorrect. We also believe that a process should be developed so that further refinements can occur in 1998 of the interim RVUs.

Because all of the interim RVUs will be subject to further refinement, ASIM has urged HCFA to exercise caution in implementing the interim practice expense RVUs to avoid the problems that would be created by "overshooting" or "undershooting" in the interim RVUs. "Overshooting" would occur if HCFA implements interim practice expense RVUs that call for major reductions in payments that are later found upon refinement to have been set too low. This can be avoided if HCFA errs on the side of being cautious in the magnitude of the reductions required for services that will undergo refinement.

ASIM is not persuaded that a three-year transition to RBPEs is merited, as the Commission

recommends. A transition not only would perpetuate current inequities for several more years, but it also makes the process of implementation far more complex, with the potential for creating the same kinds of unintended budget-neutrality problems that occurred with the transition to the RBRVS. When the proposed rule on implementation of the RBRVS was published in 1991, HCFA proposed a much larger budget neutrality adjustment than otherwise would have been necessary because the transition formula specified by Congress resulted in an asymmetrical transition (more services initially experienced gains in payments than received reduced payments, thereby creating a larger budget-neutrality offset). The result was that the reductions for some services were much greater than was appropriate, while the gains for others were less than intended. Expressions of concern by Congress ultimately led HCFA to apply a lesser offset to deal with the asymmetrical transition. The complexity of developing a transition that would not have unintended consequences supports the wisdom of Congress' original plan to implement RBPEs on January 1, 1998 without further delay or transition.

Replacing the VPSs with a Sustainable Growth Rate

ASIM agrees with the administration that the current volume performance standards (VPSs) should be replaced by a single sustainable growth rate (SGR). We are concerned, however, that the proposal to establish the SGR at an amount equal to per capita GDP plus one percent does not allow for sufficient growth in the volume of services that beneficiaries will require. As noted earlier in our testimony, after adjustment for demographic changes and changes in law that may affect annual growth in expenditures on physician services, the VPSs represent a target rate of growth that is equal to the previous annual growth in five year historical average expenditures for the applicable category of services, minus a **performance standard adjustment factor.** In OBRA 93, Congress increased the performance standard adjustment factor from 2 to 4 percent. To illustrate, if the average growth in expenditures on primary care services in a particular five year period was 4 percent, the VPS would allow for *zero* growth in volume and intensity of primary care services. No matter how low the growth in expenditures is during a five year period, physicians will always be required to reduce growth by another 4 percent in order to get an update equal to inflation as measured by the Medicare economic index.

It is not reasonable to expect that physicians can continually reduce growth by 4 percent per year from the prior five year average. Because OBRA 93 established an unreasonable and unrealistic target rate of growth, expenditures will in most years exceed the VPSs, resulting in updates that do not keep pace with inflation -- and a 21 percent reduction in the weighted conversion factors (in constant dollars), according to the CBO. It is essential that Congress enact legislation that would replace the VPSs with a single sustainable growth rate that would give physicians a reasonable opportunity to earn inflation updates if volume growth is kept to a reasonable level.

Although a single sustainable growth rate would appear to be better than the current VPS formula, ASIM is concerned that the administration's proposed 1 percent add-on to per capita GDP for volume and intensity is too low to give physicians a realistic opportunity to earn updates equal to inflation. Although current estimates from the CBO, the administration, or the PPRC on the impact of an SGR based on GDP plus one percent were not available to ASIM when this testimony was prepared, estimates that were prepared by the PPRC in 1996 indicate that the add-on will need to be higher than one percent to allow for reasonable levels of growth in the number of services provided to beneficiaries. Assuming a per capita GDP growth of 1.5%, the add-on would need to be at least GDP plus two percent (or a total of 3.5%) to assure a full inflation update, based on the CBO's projected average per annum increase in expenditures on physician services of 2.4% per year. An SGR of GDP plus one would require growth to stay within 2.5 percent, which is only slightly above the current baseline projections. *Therefore, the administration's proposal for an SGR of per capita GDP growth plus one percent would not appear to be sufficient to prevent the automatic cuts in the Medicare conversion factor under OBRA' 93.* In its

upcoming report to Congress, the PPRC will express a preference for the SGR to be set at GDP plus two percent. ASIM urges Congress to support the Commission's preference for replacing the VPSs with a single SGR that is no lower than per capita GDP plus *two* percent.

ASIM is also concerned that the administration may apply its behavioral offset assumptions in an inconsistent manner for the purposes of calculating the SGR and the single conversion factor as proposed in its budget. The legislative language for the President's budget indicates that the SGR in 1998 and subsequent years will include an allowance for "changes in expenditures for all physicians' services in the fiscal year (compared with the previous year) which will result from changes in the law, *determined without taking into account estimated changes in the expenditures due to changes in the volume and intensity of physicians' services resulting from changes in the update in the conversion factor ...* " (emphasis added). This would seem to indicate that the administration plans to assume that a behavioral offset will occur as a result of changes in the conversion factor (i.e., in response to the reduction in payments for surgical procedures that would occur under a single conversion factor), but that it does not intend to incorporate this change in calculations of the SGR. If the administration's baseline projections assume an increase in volume due to a behavioral offset, this should be reflected in the SGR as well as the CF updates. Otherwise, physicians will have no opportunity to recoup the losses triggered by the behavioral offset adjustment to the conversion factor update should volume not increase as assumed by the administration in its behavioral offset. ASIM would prefer, of course, that the administration not incorporate a behavioral offset adjustment at all. But if an offset is assumed for the conversion factor update, then the administration should be consistent in applying this to the SGR.

Other Budget Proposals Affecting Payments to Physicians

ASIM has concerns about two other proposals in the administration's budget affecting payments for physician services. One is the proposal to reduce payments to "high cost medical staffs." This proposal, which has been included in past budgets from this administration, could have the effect of inappropriately reducing payments to hospitals with higher costs because they have a sicker patient population. In the absence of a sound methodology to measure differences in the severity of illness of the patient population being treated by the medical staff, it is too risky to put in place a formula- driven process that could inappropriately lower payments for physicians on hospital medical staffs that are treating patients who are more expensive to treat because they are sicker.

The budget also proposes that competitive bidding be instituted for certain covered services, including clinical laboratory services. ASIM is not opposed in concept to competitive bidding for certain supplies and services. We are concerned, however, that the administration's proposal could be unfair to physician office labs, which do not generate the volume of laboratory testing required to match the price that a commercial laboratory might be able to offer Medicare. If competitive bidding for laboratory services is mandated, payments for laboratory tests performed in physician office laboratories should be exempted from having to meet the "winning bid" price.

Payments to HMOs

The President's budget proposes that the average adjusted per capita cost (AAPCC) be reformed by (1) setting local rates at 90 percent of the prevailing fee-for-service rates, rather than 95 percent under current policy (2) subtracting graduate medical education payments from the AAPCC and instead giving them directly to the training institutions and (3) lowering the AAPCC in certain high cost areas and increasing them in low cost areas.

ASIM has no specific policy on the proposal to lower payments from 95 percent to 90 percent of the prevailing fee-for-service rates. Given that the CBO projects that outlays on Medicare HMOs will increase at an average rate of 71 percent per annum, it is reasonable for the Congress and the administration to review ways to achieve savings in this category of spending, especially if this will reduce the need to further slash fee-for-service payments. Although not conclusive, there are some studies that suggest that Medicare HMOs do enroll a healthier patient population than the fee-for-service program, and that the current formula may on average overcompensate HMOs for the care of the healthier patients that they typically enroll. ASIM also supports the goal of reducing geographic inequities in AAPCC payments, but we have not yet determined if the administration's proposal is the best way to correct such inequities.

ASIM is concerned that in the absence of a risk adjustment for the AAPCC payments to HMOs, HMOs that treat a sicker mix of patients will be penalized, especially if the AAPCC rate is lowered to 90 percent from 95 percent. This would increase the disincentive for HMOs to enroll sicker patients. ASIM supports the PPRC's view that:

> regardless of how payment rates are set, as long as Medicare beneficiaries can choose among options, improved risk adjustment will be essential. Otherwise, health plans will not be fairly paid for enrollees with better or worse-than-average status (for example those with chronic conditions or functional disability). Without improvements in risk adjustment, plans will continue to have an incentive to avoid enrolling patients who will be expensive to care for. The commission recommends that improved risk adjustment be implemented immediately. (Statement before the Subcommittee on Health, Ways and Means, on Medicare HMO Payment Policy, January 25, 1997)

ASIM supports the proposal to remove GME payments from the payments to Medicare HMOs and to instead dedicate them directly to the hospitals that conducting the training.

Other GME Proposals

ASIM believes that the administration's proposal to cap the total number and the number of non-primary care residency positions reimbursed by Medicare at the current level is a step in the right direction toward controlling the overall surplus of physicians. We also support allowing GME payments to non-hospitals for primary care residents in those settings, when a hospital is not paying for the resident's salary in that setting. We believe, however, that the Congress and the administration must go further in addressing the problems created by an oversupply of physicians and the imbalance between the number of physicians who enter primary care and specialty practices. ASIM specifically believes that policies must be instituted so that the number of entry level positions in the country's GME system should be more closely aligned with the number of graduates of accredited U.S. medical schools. We also believe that a national all-payer fund should be established to provide a stable source of funding for the direct costs of GME. Payments should be made from this fund to the entities that incur the costs of GME, whether they are hospital based or not, or to other entities, such as consortia, that have been designated to receive funds on behalf of the entities incurring the costs.

Oppose Repeal of Fraud and Abuse Provisions

ASIM does not support the administration's proposals to modify the fraud and abuse provisions enacted last year by Congress as part of the Health Insurance Portability and Afford ability Act of 1996. Elimination of the requirement that the government prove that a provider "knowingly" intended to violate

the law will open the door for physicians to be investigated and possibly subjected to civil monetary penalizes for unintended mistakes. Similarly, elimination of the requirement that HHS issue "advisory opinions" would make it more difficult for physicians to get the guidance they need to *prevent* unintended violations of the fraud and abuse laws.

Expanded Coverage for Preventive Services

We commend the administration for its proposals to expand Medicare coverage of preventive services and to increase payments for flu shots. Coverage of services that will *prevent* or allow for early detection of diseases not only will improve health care for the elderly, but may save Medicare money as well. Adequate payments for the costs incurred by physicians in providing influenza, pneumoccal, and hepatitis B vaccinations will encourage more physicians to provide those shots in the office, which could significantly increase the number of elderly persons who are inoculated against potentially life-threatening diseases. ASIM supports the administration's proposal for coverage of blood sugar self-management programs for diabetic patients, provided that it is modified to require that such programs be conducted under the direction and supervision of a physician.

Expanded Choice of Health Plans

ASIM supports the administration's proposal to expand choices of health plans, including offering beneficiaries the option of enrolling in provider-sponsored organizations (PSOs). We are currently assessing the details of the administration's proposal to assure that it adequately addresses the regulatory barriers at the state and federal level to the formation of PSOs, while still assuring that PSOs meet appropriate solvency and other standards to protect patients. PSOs have the potential of giving beneficiaries the option of enrolling in plans that are organized and directed by their own physicians as an alternative to the traditional insurer-directed HMO. We also support the administration's proposals to move towards an open enrollment period for Medicare HMOs and to provide comparative information to beneficiaries to enable them to make an informed choice of plan. As discussed below, ASIM believes that the administration's proposal falls short of instituting needed protections for beneficiaries who enroll in Medicare HMOs and other managed care plans.

Developing Standards for Medicare Managed Care

ASIM believes there is a need for Congress and the administration to make improvements in the standards used to evaluate Medicare managed care organizations (MCOs). The federal government must implement revised standards to assure that beneficiaries are given the information they need to make an informed choice of health plan, that beneficiaries receive reasonable assurances that they will have access to the physicians and services that they need, and that requests for reconsideration of denied claims are heard in a timely manner.

In recent years, the enrollment of Medicare beneficiaries in health maintenance organizations (HMOs) and competitive medical plans (CMPs) has grown rapidly. Currently, approximately 14 percent of beneficiaries belong to a Medicare managed care plan. The CBO projects that the share of total Medicare outlays that goes to HMOs and other Medicare managed arrangements will increase from 9.4% in FY 1996 to 32.9% in FY 2007--even without enactment of additional incentives for beneficiaries to enroll in managed care.

With increased enrollment, there is an increased need for the federal government to exercise

appropriate oversight over the care provided to Medicare beneficiaries who are enrolled in MCOs. Recent reports from the Institute of Medicine, the General Accounting Office (GAO), and the PPRC all support the need for improved standards for health plans that contract with Medicare. In its 1996 report to Congress, the PPRC recommended that all health plans that contract to provide services to Medicare beneficiaries meet standards relating to quality, access, disclosure of information and due process. The GAO, in a recent report titled "HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance" supports ASIM's views that HCFA needs to do more to implement measures that will enable beneficiaries to make an informed choice of plan. The GAO concluded that HCFA can readily provide indicators of beneficiary satisfaction and other plan-specific information, including statistics on beneficiary disenrollments and complaints, medical loss ratios (the percentage of HMO revenues spent on medical care) and other financial data, and visit monitoring results. The percentage of claims that are appealed to HCFA, and then reversed or upheld upon appeal, is another indicator of HMO performance that can immediately be made available to beneficiaries. Although HCFA plans to require a standardized beneficiary satisfaction survey "beginning with the upcoming calendar year," the GAO expressed concern that HCFA has no plans to provide this information automatically to beneficiaries, and that the comparison chart that HCFA plans to develop will be available only through the Internet--a forum that may not be easily accessible to most Medicare beneficiaries. We agree with the GAO's conclusion that HCFA should provide comparative information on each plan directly to beneficiaries.

ASIM urges Congress to:

1. Direct the Secretary to mandate that Medicare MCOs disclose to current and prospective enrollees and providers information needed to make an informed choice of plans, including:

A. Requirements that limit access to services (i.e. extent to which enrollees may select the provider of their choice, restrictions that limit coverage to prescription drugs approved by the MCO, and rules that limit access to laboratory tests in physicians' offices);

B. Indicators of health plan quality, access, and patient satisfaction (including disenrollment rates; number and percentage of claims that were denied and then reversed upon appeal to the Secretary; the MCO's medical loss ratio--defined as the proportion of total revenue spent on medical care, as opposed to administrative expenses or funds retained or distributed to owners; and the results of standardized patient satisfaction surveys).

The GAO found that beneficiaries often are unaware of the restrictions on access to certain services that are typically required by MCOs. Disclosure of such restrictions will enable beneficiaries to make a more informed choice of plans, and will reduce subsequent misunderstandings and dissatisfaction. Information on disenrollment rates, claims denials, and medical loss ratios can be useful indicators of the quality of care rendered with a plan. HCFA has begun to provide beneficiaries with more information but its efforts to date fall short of providing the kinds of information discussed above.

2. Mandate that Medicare MCOs review pre-authorization requests for urgent care services within one hour and all other pre-authorization requests within 24 hours. Direct the Secretary to streamline the appeals process for denials by Medicare MCOs by reducing by half the days that MCOs are allowed to consider an appeal of an initial denial.

Although the administration has stated that it intends to make changes in the appeals process to provide more timely determinations on denials of care by Medicare MCOs, it is our understanding that the administration's proposal will not go far enough in assuring timely rulings on pre-authorization requests, and in reducing the amount of time that MCOs have to rule on appeals of initial denials. According to the GAO and the PPRC, MCOs are currently given up to 60 days to make their initial determination.

They have another 60 days to decide on an appeal of the initial determination--a total of four months when patients are effectively being denied access to care that they and their physician believe to be necessary. Cases that require HCFA review can take even longer--sometimes up to 270 days. Further, GAO found that MCOs and HCFA's own contractor often failed to meet the current deadlines for review and reconsideration of denied claims, but HCFA has been unwilling to take action against MCOs or the contractor for failing to process reviews and reconsideration in a timely manner. In the meantime, beneficiaries are the ones hurt by the failure to get a timely answer to their request that payment be authorized for medical services that they and their physicians believe to be appropriate.

3. Mandate that Medicare MCOs establish mechanisms to incorporate the recommendations, suggestions and views of enrollees and participating physicians into the medical policies, medical management, utilization review, and quality and credentialing policies and criteria developed by the MCO.

Physician involvement in establishing managed care policies that have a direct impact on clinical decision-making is essential if patients are to have confidence in their HMO. Rather than attempting to legislate the lengths-of-stay for given procedures, it would be far better to mandate a process that would assure that managed care plans do not adopt restrictions on coverage that lack the support of the physicians who are ultimately responsible for patient care.

Recommendations for Long-term Reforms

ASIM believes that the proposals included in the administration's budget fall short of the long-term restructuring of Medicare that is needed. ASIM has developed a detailed set of long-term proposals for keeping Medicare affordable and solvent. Our recommendations include:

1. Moving towards a defined federal contribution system. Beneficiaries would be given the option of remaining in the traditional Medicare program, or using their voucher to purchase coverage from HMOs, PSOs, indemnity plans, PPOs, and other competing health plans in their community that meet Medicare's standards for participation. The defined contribution must be set at a level that would enable beneficiaries to afford a wide choice of competing plans in their own locality, and it should be updated annually to reflect increases in the average premiums charged by the plan.

2. Requiring that all competing health plans meet minimum federal standards relating to access, quality improvement, physician and patient involvement in utilization review protocols, minimum benefits, and disclosure of information required for patients to make an informed choice of plans.

3. Increasing premium contributions for higher-income beneficiaries.

4. Phasing in a delay in eligibility age for Medicare.

5. Maintaining the Medicare fee-for-service program as a viable alternative to purchasing coverage from a competing health plans.

The reforms advocated by ASIM would hold physicians, other providers, and health plans to higher standards of accountability than is now expected. They would have the option of competing for enrollment of Medicare beneficiaries, but would have to show that they are able to meet some basic minimum standards of accountability to do so. Competition between health plans would create an incentive for the plans themselves--and the physicians who participate them--to seek innovative ways to deliver high quality services at lower costs.

ASIM strongly encourages the Congress and the President to make a commitment to build upon any agreement on short-term reforms that is reached this year to address the long-term solutions to Medicare's fiscal problems. We offer our assistance as you address the difficult choices that will be required.

RESPONSES TO QUESTIONS FROM SENATOR HATCH

Question: I appreciated your comments in your testimony regarding the President's proposal to repeal some of the anti-fraud and abuse provisions in last year's Kassebaum/Kennedy health insurance bill.

And, in particular, the provisions providing for a clarification to the anti-kickback statute as well as requiring the HHS and the Justice Department to issue advisory opinions that would give health care providers advanced guidance on structuring new and innovative health care delivery systems.

This whole debate about Medicare reform is about providing seniors with choices in health care plans.

The issuance of advisory opinions will foster this development because it will provide some guidance to industry as to what is permissible and what is not.

The advisory opinions and clarification to the anti-kickback statute are provisions I strongly support, and will continue to do so.

Would you comment in more detail why these provisions are important and how they will help provide greater choice for seniors as well as reduce health care costs?

April 15, 1997

The Honorable Orrin G. Hatch
United States Senate
Washington, DC 20510

Dear Senator Hatch:

On behalf of the American Society of Internal Medicine (ASIM), I am pleased to respond to the question you raised during the March 5 hearing on Medicare Reform regarding the issuance of advisory opinions on compliance with fraud and abuse statutes. You specifically inquired why the advisory opinions are important and how they may provide greater choice for seniors as well as reduced costs.

ASIM strongly supported the provisions in the Health Insurance Accountability and Portability Act that mandates that HHS and the Justice Department issue advisory opinions on how to structure new and innovative delivery systems without violating fraud and abuse provisions. We commend you for your leadership in the 104th Congress in getting this requirement included in the law. ASIM also appreciates your continued support for maintaining the advisory opinion requirement in the face of an administration proposal to repeal it.

Congress' goal should be to *prevent* fraud and abuse from occurring whenever possible. If it can prevent a fraud and abuse violation from occurring, the government won't have to spend millions of dollars later on investigating, prosecuting, and sanctioning violations after they've occurred. The advisory opinions will help prevent violations of fraud and abuse laws, since physicians and other providers will be able to find out in advance how to structure financial arrangements so that they don't run afoul of the law.

Beneficiaries benefit when they have a wide choice of innovative delivery systems from which they can receive their medical care. Advisory opinions will help physicians, hospitals and other providers develop cost-effective, integrated delivery systems, such as provider-sponsored organizations (PSOs), without worrying that they will later be found to violate fraud and abuse laws. It's important to note that even if a proposed arrangement is initially structured to comply with the advisory opinion, the Office of Inspector General or the Justice Department would not be precluded from investigating and sanctioning an entity that later restructures the arrangement in a manner that could be in violation of the law.

When entering into any financial arrangement, physicians want to do what is the right. It is in everyone's interest—the government, beneficiaries, taxpayers and providers—to make advisory opinions available to help physicians and other providers make the right choices on how to structure financial arrangements without violating the law.

Please let me know if you require further information.

Sincerely,

Alan R. Nelson MD

Alan Nelson, MD
Executive Vice President

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April 15, 1997

The Honorable William V. Roth Jr.
United States Senate
Washington, DC 20510

Dear Senator Roth:

During the March 5 Finance Committee hearing on Medicare Reform, I promised to get back to you with my thoughts on your question on what policies may have helped or not helped in the dramatic reduction in the rate of increase in expenditures on physician services. As you know, the Congressional Budget Office (CBO) projects that Medicare expenditures on physician services will increase by less than 3 percent per year for the next decade, well below historical trends. No other major category of Medicare spending is projected to grow at such a slow rate. I think there are several reasons why this is occurring, only some of which can be directly or indirectly attributed to federal health policies. As explained below, policies such as resource-based Medicare payments may have contributed to lower expenditure growth. But much of the change is likely due to underlying shifts in practice patterns that would have occurred even in the absence of federal legislation. Specifically:

1. There has been a major change in practice patterns over the past decade. Using medical outcomes research, profiling of practice patterns, and cost-effectiveness analyses, physicians have found ways to manage and care for patients that are less costly than those used in the past. Specifically, conditions that in the past would have been treated in an inpatient setting, using surgical procedures and other invasive interventions, now often can be treated in the less expensive ambulatory setting using less invasive (and less costly) methods. As noted in our written testimony, many heart patients that in the past may have eventually required coronary bypass surgery can now be treated through medication and careful management by an internist of their diets and lifestyles, and when necessary, by a procedure called angioplasty that can clear blocked arteries without resorting to more invasive (and costly) bypass surgery. Similarly, the Physician Payment Review Commission, citing the Agency for Health Care Policy and Research, reported in 1994 that "Reductions in the volume of prostate-related procedures mostly reflect changes in treatment through increased use of drugs, less invasive surgical procedures, and watchful waiting" (PPRC, Fee Update and Medicare Volume Performance Standards for 1995, May 15, 1994).

2. There has been a dramatic reduction in the "demand" for cataract surgeries and certain other procedures that were growing at double-digit rates in the 1980s. In the same 1994 report from the PPRC that is cited above, the Commission noted that the demand for cataract surgery had decreased substantially in recent years as fewer patients were available who needed such treatments. As explained more fully in our written statement, the PPRC found that "The period of greatest growth in volume for a new medical procedure or technology is often the first few years following introduction, largely because it is during this period of diffusion that patients with existing indications are treated along with those newly identified. In the mid-1980s, the volume of new technologies such as cataract surgery was growing at double-digit rates, because there were tens of millions of patients who needed—and could benefit—from those treatments. As time has passed, however, the demand for such procedures has naturally declined."

3. The shift to cost-effective medical management of conditions that in the past would

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have been treated more expensively has been encouraged by federal policies, particularly resource-based payments for physician services. By enacting legislation in 1989 to mandate resource-based payments for physician services, Congress intended to reduce the incentives that rewarded physicians for ordering expensive surgical and other procedural services while financially penalizing them if they relied on cost-effective evaluation and management, or cognitive, services. Under the customary, prevailing and reasonable charge system that was then in effect, surgical procedures were paid far more for the work involved than evaluation and management services, such as office visits and consultations. The result was that physicians who provided a large volume of procedural services were paid more for their work than physicians who principally provided visits and consultations. This inequity was at odds with the goal of encouraging practice patterns that relied more on careful watching and non-invasive treatments of patients' conditions and less on surgical and other technological interventions. Resource-based payments, by paying the same amount for services that involve equivalent work, were intended to level the playing field. Despite flaws in the way that the RBRVS has been implemented, I believe that the RBRVS has helped equalize the incentives, and by doing so, has contributed toward the shift in practice patterns noted above.

The impact of Medicare volume performance standards (MVPSs) is more mixed. The MVPSs may have contributed to slowing the growth in expenditures on physician services--not by encouraging physicians to be more efficient (as Congress intended), but because they triggered automatic reductions in Medicare payments whenever the MVPSs were exceeded. I am not aware of any evidence that suggests that the MVPSs have had any impact on decisions by individual physicians to lower volume in order to stay within the MVPSs. But they have led to lower updates for primary care services and other nonsurgical services in years when volume growth in those categories has exceeded the applicable MVPSs. Unfortunately, separate MVPSs and updates for surgical procedures, primary care services, and other nonsurgical services also re-created the distortions that resource-based payments were intended to correct, by resulting in higher conversion factor increases for surgical procedures than primary care services and other nonsurgical services that require the same amount of physician work.

Changes mandated by OBRA 94 in how the MVPSs are calculated will result in Medicare fee schedule payments declining by 21 percent over the next decade in constant 1996 dollars, according to Congressional Budget Office. Although these reductions are unquestionably contributing to lower expenditure growth, we are concerned that they may adversely affect access to care, particularly access to primary care services--a risk that will be even greater if further reductions are enacted this year. ASiM recommends replacing the separate MVPSs with single sustainable growth rate of at least per capita GDP plus two percent. We also recommend mandating a single conversion factor to replace the separate conversion factors for surgical procedures, primary care services and other nonsurgical services. Our testimony explains these recommendations in more detail.

In conclusion, I believe that changes in practice patterns that have occurred largely independent of federal health policies are principally responsible for the slowing of Medicare expenditures on physician services. Physicians deserve credit, I believe, for supporting outcomes-based research and changing their practice patterns based on such research. I also believe that Medicare resource-based payments have contributed to the change in practice patterns, by reducing the economic incentives to provide high cost invasive procedures.

Please let me know if you require further information.

Sincerely,

Alan R Nelson MD

Alan Nelson, MD
Executive Vice President

PREPARED STATEMENT OF JOSEPH P. NEWHOUSE, PH.D.

Good morning, Mr. Chairman. I am Joseph Newhouse, Ph.D., Chairman of the Prospective Payment Assessment Commission (ProPAC). I am accompanied this morning by Donald Young, M.D., the Commission's Executive Director. We are pleased to be here to discuss the Commission's recommendations on Medicare policies. These recommendations will be published in our forthcoming *Report and Recommendations to the Congress*, which will be released on March 1. During my testimony, I will refer to several charts. These charts are appended to the end of my written testimony.

Mr. Chairman, the Medicare program is at an important crossroads in its evolution. Never before have beneficiaries had so many choices among providers, sites of care, and delivery options. At the same time, however, Medicare spending is growing at a rate that is unsustainable. Without any intervention, the Medicare Trustees estimate that the Part A Hospital Insurance Trust Fund will be depleted by the year 2001. The challenge is to enact policies that maintain quality care for Medicare beneficiaries while at the same time ensure the fiscal viability of the program for future generations.

In H.R. 2491, the Balanced Budget Act of 1995, the Congress passed a number of reforms to Medicare's payment policies. In his recent budget proposal, the President also proposed a number of modifications. ProPAC agrees with the Congress and the President on the need to reform Medicare policies to preserve it financially as well as to tailor it to conform to the changing health care environment. Our recommendations have elements in common with both of these proposals.

These recommendations address needed changes in both the fee-for-service and risk contracting programs. The Commission believes that improvements in both areas are necessary if Medicare is to control overall expenditures. Medicare must take advantage of the invigorated heath care marketplace and tailor its payments to correspond to providers' lower costs in delivering services. At the same time, Medicare must reevaluate its payment methodologies for certain services where increasing utilization is a major reason for rising expenditures.

This morning, I first would like to discuss the Commission's recommendations on the traditional fee-for-service program. This program is responsible for almost 90

percent of total Medicare spending, and it will continue to provide the funding for the care furnished to a majority of beneficiaries for years to come. Our recommendations cover a number of areas, including payment policies for hospitals paid under the prospective payment system (PPS), PPS-excluded facilities, hospital outpatient departments, and kidney dialysis centers. We also make a number of recommendations on payment policies for post-acute care providers. These include skilled nursing facilities (SNFs), home health agencies, rehabilitation facilities, and long-term care hospitals. In addition to fee-for-service policies, the Commission recommends a number of changes to improve Medicare's risk contracting program. I will summarize these in the second part of my testimony.

Mr. Chairman, while the bulk of our recommendations focus on payment methods, our first recommendation emphasizes the need for the Medicare program to be vigilant in monitoring and improving the quality of care delivered to beneficiaries who receive services under both the fee-for-service and capitation options. This is increasingly important given the cost-containment pressures and the rapid structural changes occurring in the health care financing and delivery systems. In our March Report, the Commission recommends that the Secretary pursue a comprehensive approach to quality assurance that includes not only analyzing patterns of care to raise quality standards, but also reviewing individual cases to identify poor performers.

MEDICARE PAYMENTS TO PPS HOSPITALS

Estimated to be about $74 billion in fiscal year 1997, payments to PPS hospitals represent the largest share of Medicare outlays. In addition to payments for routine operating and capital costs associated with hospital admissions, Medicare makes additional payments to hospitals that have teaching programs and those that treat a disproportionate share of low-income patients.

In its evaluation of Medicare policies, the Commission annually reviews the financial performance of hospitals. I would like to share with you some of our findings.

Hospital Payments and Costs

Remarkable changes are occurring in hospitals. Since 1993, the growth in Medicare real operating costs per discharge (adjusted to reflect inflation) has been less than general inflation. In 1994, these costs' actually decreased, in absolute terms, for the first time (see Chart 1). This 1.3 percent decline was 3.9 percent below the overall inflation rate. Preliminary data for 1995 indicate that costs fell an additional 1.2 percent in that year, or 3.8 percent relative to general inflation. Other data indicate this trend is continuing.

Reduced cost growth partly reflects changes in the amount and timing of services furnished during inpatient stays. The average length of stay for Medicare beneficiaries in PPS hospitals dropped 20 percent between 1990 and 1995. Shorter stays are due to a combination of earlier discharges to post-acute care settings and improvements in hospital productivity.

The rapid drop in hospital cost growth has enabled hospitals to begin making a profit on Medicare patients despite payment updates that have been as low as at any time since PPS began. Through the late 1980s, PPS margins--which compare Medicare capital and operating payments to costs--dropped steadily, to a low of -2.4 percent in 1991 (see Chart 2). This trend then began to reverse, and in 1994 PPS margins jumped to 5.0 percent with a further jump to 7.9 percent estimated for 1995.

The dramatic decline in hospital costs also has enabled hospitals to improve their overall financial positions despite the pressures imposed by Medicare and private payers. Total margins--which reflect gains and losses from all payers on inpatient and outpatient services as well as non-patient care activities--increased from 4.4 percent in 1993 to 5.0 percent in 1994; preliminary data for 1995 indicate continued improvement to 5.6 percent (see Chart 3). These margins were the highest over the past 10 years, and higher than at any time prior to the implementation of the Prospective Payment System .

PPS Operating Update

Mr. Chairman, the trends I have just described portray a hospital industry that is adapting rapidly to a more competitive environment. The Commission considered the declines in hospital cost growth as it developed its fiscal year 1998 update recommendation for operating payments paid to PPS hospitals. The formula-based approach we have used is the same one we have used over the years. It takes into account the effects of inflation on hospital costs, changes in the mix and complexity of admissions, added costs of new technology, and hospital productivity improvements.

This year our recommendation also reflects the effects of changes in the services provided by hospitals. Some of the recent decline in hospitals' inpatient operating costs may be because patient stays are shorter. This may be due to improvements in technology, the availability of less invasive procedures, and an increased use of post-acute care providers. The Commission believes that Medicare payments should be adjusted to reflect the reduced service content of Medicare discharges.

ProPAC believes that the operating update for fiscal year 1998 should be zero. We believe a zero update fulfills Medicare's responsibility to act as a prudent purchaser while allowing hospitals sufficient funds to furnish quality care. I should add, Mr. Chairman, that if the Commission's recommendation is adopted, per case payments will still increase next year. This is because PPS payments rise in proportion to the rise in complexity of patients that hospitals treat.

Although the Commission believes that PPS rates should not be increased for fiscal year 1998, we emphasize that our recommendation applies for only one year. ProPAC will continue to monitor changes in hospital costs and financial condition to ensure that quality of and access to care do not suffer.

Capital Payment Rates

Mr. Chairman, Medicare's current capital payment rates are 15 to 17 percent too high. In addition to recommending an update of zero for fiscal year 1998, the Commission believes that flaws in the current rates must be corrected to avoid overpaying capital costs in future years.

Medicare payments for inpatient capital currently reflect a transition from a cost-based to a fully prospective system which began in fiscal year 1992 and will be completed in 2002. Hospitals' capital payments are based on 1992 capital costs, updated to reflect subsequent costs increases. The data used to estimate the 1992 costs were flawed, however, resulting in inflated base payment rates. Moreover, the update applied to the base rates in 1993 through 1995 was based on historical costs increases, rather than an update framework. (Such a framework has been used to set capital payment updates since fiscal year 1996.) These flaws had little effect on Medicare payments for fiscal years 1992 through 1995 because capital payments were subject to a budget neutrality adjustment that limited total capital payments to 90 percent of hospitals' projected capital costs, regardless of the base payment rates. In fiscal year 1996, though, the budget neutrality adjustment expired and capital payments jumped 23 percent.

The Commission is recommending that the current base rates be adjusted to achieve more appropriate payment levels. There are several ways this could be done. The 1992 base rates could be recalculated using actual cost data and then updated to the present year by an appropriate update factor. Alternatively, the current base rates could be replaced with the rates in effect in 1995, which reflected the budget neutrality requirement, updated to the present. We do not believe, however, that the budget neutrality adjustment should be reinstated for fiscal years 1998 and beyond. This approach would continue to link capital payment rates to hospitals' capital costs, which is inconsistent with the goal of prospective payment.

PPS-Excluded Facilities

Five types of specialty hospitals (rehabilitation, psychiatric, long-term care, children's, and cancer) and two types of distinct-part units in general hospitals (rehabilitation and psychiatric) are exempt from PPS. They are excluded primarily because the diagnosis-related groups (DRGs) used under PPS fail to predict their resource costs accurately. Payment limits for these providers' operating costs are based on their costs per discharge in a base year, known as a target amount for

each hospital. This target amount is increased by an annual update. Based on its update framework, the Commission believes that the target amounts should be increased by an average of 2.0 percent in fiscal year 1998.

The Commission also recommends that the initial payment exemption period for new PPS-excluded facilities should be eliminated. Currently, new providers are exempt from the payment limits for up to their first three cost reporting periods. Because no limits are applied during the exemption period, providers have little incentive to keep their initial costs low. In fact, they have a strong incentive to have high base-year costs to establish higher target amounts, allowing them to receive more payments in subsequent years. The Commission believes this exemption should be eliminated and payments to new providers be based on an average target amount for comparable facilities.

Payments to Teaching Hospitals

In addition to their PPS operating and capital payments, Medicare makes two special payments to teaching hospitals to account for their higher costs. The indirect medical education (IME) adjustment to PPS payments recognizes the higher patient care costs associated with these hospitals' teaching and related missions. Direct graduate medical education (GME) payments pay for Medicare's share of residents' salaries and benefits, plus the general operating costs of running hospital residency programs. In fiscal year 1996, Medicare payments for IME and GME were an estimated $4.3 and $2.2 billion, respectively.

The Commission believes the IME and GME policies should be revised. Structural changes occurring in the health care marketplace are eroding support from private payers for teaching activities. In a price-competitive environment, it may be difficult for teaching hospitals to finance their multiple missions of teaching, conducting medical research, and developing technological innovations. At the same time, however, it is important that Medicare payments not influence the number or type of residents trained or the setting in which teaching occurs.

Currently, both IME and GME payments rise approximately in proportion to the number of residents at each hospital; hospitals, therefore, have an incentive to train more physicians. In fact, since 1990, the number of residents Medicare recognizes for payment has increased by 18 percent. In addition, the current payment methods are biased towards training in the hospital setting, although training in other settings may be increasingly necessary for future practicing physicians.

I would like to take a moment to briefly summarize the views of the Commission related to each of these specific adjustments.

IME Payments–Currently, PPS payments are adjusted 7.7 percent upward for every 10 percent increase in teaching intensity, measured using a ratio of residents to beds. ProPAC analyses indicate, however, that Medicare operating costs per discharge go up by only 4.1 percent for each 10 percent increase in teaching intensity. The Commission recommends that for fiscal year 1998, the IME adjustment should be lowered to 7.0 percent and that ultimately the adjustment should more closely correspond to the actual relationship between teaching intensity and costs.

The Commission also believes that the IME payment formula should be modified so that payments do not change with variations in the number of residents or beds. Moreover, in contrast to the current payment method, which reflects only those residents that are training in the hospital, IME payments should be flexible enough to allow and to support training in settings outside of the hospital.

GME Payments–As with the IME adjustment, the Commission recommends that GME payments not change based on variations in the number of residents a hospital trains. Instead, hospitals could receive a lump-sum payment for resident costs based on their historical share of GME spending. Alternatively, the current method could be revised so that a change in the number of residents would result in only a slight change in payments. In this way, hospitals would still receive partial payments for residency slots they eliminate and not receive full payment if they decide to take on

additional residents. At some point in the future, however, Medicare GME payments will need to be adjusted to reflect the changes in residency positions.

Establishing Broader-Based Financing for Teaching Hospitals—The Medicare program is the only payer to make separate payments to teaching facilities nationwide for their higher teaching-related costs. While other payers have implicitly helped fund these costs though higher prices for inpatient care services, these purchasers are becoming less willing to pay more to these facilities in an increasingly price-conscious environment. The Commission believes separate funding mechanisms should be developed that would include contributions from a broader range of sources. While there would be a number of technical issues to decide, explicit financial support for medical education and teaching hospital costs would enable these facilities to compete with other hospitals for patients and enhance efficiency, while supporting their multiple missions.

Disproportionate Share Hospitals

Since 1986, Medicare has made special payments to PPS hospitals that treat a disproportionate share (DSH) of low-income patients. DSH payments have increased almost four-fold between fiscal years 1989 to 1996, from $1.1 billion to $4.3 billion. Almost 2,000 hospitals receive DSH payments, but the top 250 hospitals account for about half of the total.

As Medicare seeks to reduce the overall growth in payments, it is especially important that DSH funds be targeted to those hospitals most in need of financial support because of their role in serving poor people. The current method is increasingly inadequate to achieve this goal. A primary reason is because the formula used to distribute DSH payments relies, in part, on Medicaid utilization to identify low-income patients. This measure has never been a good overall indicator of service to the poor because the portion of the low-income population covered by Medicaid varies markedly from state to state. As states implement Medicaid and welfare reforms, this disparity is likely to be exacerbated. The DSH formula is flawed

also in that it excludes other measures of identifying care to the poor, primarily uncompensated care.

The Commission believes that the current DSH payment method should be changed. Our March report sets forth a number of technical details to guide the development of a new formula. Briefly, the Commission recommends that DSH payments be determined using a measure based on providers' costs of treating poor patients. In the Commission's view, such a measure would be the best way to determine the amount of low-income care hospitals furnish. Under our proposal, the DSH measure would include the costs associated with Medicaid patients and Medicare patients who receive Supplemental Security Income (SSI) payments, but it also would include the costs of care furnished to patients in other indigent care programs and hospitals' uncompensated care costs.

Revising the DSH formula would target DSH payments more precisely, thus ensuring access to these safety-net hospitals. It also would ameliorate the current inconsistencies arising from differences in definitions and eligibility requirements across states. To implement the Commission's proposal would require collecting some additional data from hospitals, but this requirement could be met without substantially increasing hospitals' current reporting burdens.

Hospital Outpatient Services

The Commission believes that the payment system for hospital outpatient services needs revision. Medicare payments for all outpatient facility services have been growing, on average, about 14 percent annually since 1983. In 1995, payments were about $16.3 billion; HCFA estimates that about 70 percent of these payments, or $11 billion, were made to hospitals for outpatient services.

Many hospital outpatient services are still paid on the basis of costs or charges. This method of payment contributes to growth in Medicare spending because it provides few financial incentives for hospitals to furnish services efficiently. In addition, a large share of the growth in outpatient spending is due to the volume and complexity of services delivered, as providers shift more care historically delivered in

an inpatient setting to the ambulatory arena. Thus, a new payment system should include both per service prospective rates and a mechanism to control volume. In addition, because almost all services provided in the hospital outpatient department can be obtained in other settings, the Commission believes that Medicare should move towards a payment system that is consistent across all facilities.

For a number of years, the Commission has recommended reducing beneficiaries' over-inflated liability for hospital outpatient services. Under the current system, beneficiary coinsurance is set at 20 percent of the hospital's charges. However, because these charges are higher than Medicare payments, beneficiaries end up paying substantially more than 20 percent of the total payment. For certain surgical, radiological, and diagnostic procedures, the average beneficiary copayment is more than half of the entire payment. The Commission believes that hospital outpatient coinsurance should be limited to 20 percent of the Medicare-allowed payment, as it is in other settings. We recognize that reducing beneficiary coinsurance requirements would increase Medicare outlays. This increase should be offset in part by correcting the flaw in the current hospital outpatient payment formula which systematically pays hospitals more than the Congress intended. If necessary, the reduction in beneficiary liability could be phased in over several years.

UPDATE TO THE COMPOSITE RATE FOR DIALYSIS SERVICES

Medicare payments for end-stage renal disease (ESRD) beneficiaries are growing rapidly. Between fiscal years 1986 and 1994, spending grew at an average annual rate of 13 percent, to $8.4 billion. A large part of this increase is due to an expanding ESRD population. The number of recipients increased, on average, nearly 9 percent per year over the same period. While these enrollees represent only 0.6 percent of the Medicare population, they account for about 5 percent of total program expenditures.

The Omnibus Budget Reconciliation Act of 1990 requires ProPAC to recommend an annual update to the prospective payment--called the composite rate--that Medicare pays to covers all of the services routinely required for a dialysis treatment.

Unlike Medicare payments to other providers, the composite rate has not been updated since 1983; it is $126 per treatment for hospital-based providers and $122 for independent facilities. While their payment to cost ratios have declined, independent dialysis facilities--which account for about two-thirds of dialysis providers--have consistently received payments that are higher than their costs. Payment-to-cost ratios for hospital-based facilities are considerably lower, but this may be related to their overhead allocation practices.

Because Medicare is the dominant payer for chronic dialysis, it has a unique responsibility to monitor the quality of these services. While there is no conclusive evidence indicating that quality of care has actually declined, recent studies suggest that almost half of all U.S. hemodialysis patients are underdialyzed, which raises the risk of morbidity and mortality. The Commission believes that a payment increase would allow facilities to make quality improvements. Therefore, we believe that the composite rate should be increased by 2.8 percent in fiscal year 1998. At the same time, HCFA should regularly audit dialysis cost reports and track quality indicators for these providers. Future recommendations to increase the composite rate will depend upon whether the Commission finds that higher payments raise the standard of care.

POST-ACUTE CARE PROVIDERS

Medicare payments to post-acute care providers, including skilled nursing facilities, home health agencies, rehabilitation facilities, and long-term care hospitals, are one of the fastest growing components of the Medicare program. Spending for services provided by SNFs and home health agencies make up the bulk of these payments. Between fiscal years 1992 and 1996, Part A payments to these two provider types increased nearly three-fold, from $11 billion to $29 billion (see Chart 4). While spending for SNFs and home health agencies has begun to slow, the Congressional Budget Office projects that these payments will continue to rise faster than overall Medicare spending between now and 2002.

The rapid rise in post-acute spending is driven primarily by the increasing number of beneficiaries receiving post-acute care and the number of services they receive.

Medicare has modified its policies over the years to slow the rise in payment per unit of service, but controlling the number of services furnished has remained elusive. The overlap of similar service capabilities across different types of providers, variation in payment policies based on type of provider, and the absence of good measures to assess the value and outcome of care all have contributed to the difficulties in correcting the problem.

Both the Congress and the President have proposed prospective payment systems for skilled nursing facilities and home health agencies. The Commission strongly supports fully prospective payment for these, and all, providers. Moving away from cost-based reimbursement systems can slow expenditure growth while encouraging providers to deliver care in the most efficient manner possible. Consistent coding of services provided would further the move to prospective payment as well as permit Medicare to evaluate the services for which it is paying.

ProPAC also recommends initiating a demonstration project that links payments for both the acute and post-acute portions of an episode of care. Such a system would provide Medicare with greater control over outlays and could reward providers who successfully minimize total episode costs.

A major component of a prospective payment system is a case-mix measure. Case-mix relates patient characteristics to their resource needs. Prospective payment rates that do not accurately reflect appropriate resource use have the potential to either increase expenditures if they are too high or reduce access to care if they are too low. While a case-mix system has been developed for rehabilitation facilities that predicts resource use for their patients, case-mix systems for skilled nursing facilities and home health agencies lag behind. Consequently, it is critical that other mechanisms be put into place that will begin to slow spending in the short term. In our upcoming report, the Commission recommends additional policies that could be implemented immediately to help curb spending for these providers. I would like to briefly summarize these recommendations.

Improvements to Skilled Nursing Facility Payments

Until all-inclusive prospective payment rates are implemented, the Commission believes that overall SNF expenditures could be constrained by limiting payments for ancillary services, the fastest growing component of Medicare SNF expenditures. For the vast majority of these services--which include physical, speech, occupational and respiratory therapies, as well as laboratory and radiological services--providers are paid their costs subject only to Medicare's definition of reasonableness, which is very broad. HCFA could impose cost limits for these services or develop prospective rates using national or regional costs, or the resource-based relative value scale used for Medicare physician payment.

The Commission also believes that the exemption from Medicare's routine cost limits for new SNF providers should be eliminated. Currently, new providers can be reimbursed their costs for up to four years before being subject to the routine cost limits. The number of new providers has increased by 50 percent in the past six years and, thus, the Commission believes these exemptions are no longer necessary to encourage the growth in new providers.

Home Health Care Agencies

The Commission believes that an interim payment method for home health should be implemented immediately. Medicare should establish per visit payment rates and limit total home health payments for each beneficiary. This would help constrain home health spending until a fully prospective system is implemented. Beneficiary limits would encourage home health agencies to control the number of visits and adjust the mix of services provided to each user. The limits could be associated with payments for services provided over a specific period; a year or a month, for example.

The Commission also believes that ensuring that home health services are ordered appropriately would be easier if the benefit were more clearly defined. In addition, Medicare beneficiaries pay no coinsurance or deductibles for home health visits. The Commission believes modest copayments, subject to an annual limit,

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should be introduced so that beneficiaries would share some financial responsibility for the services they receive.

IMPROVING MEDICARE'S CAPITATION PROGRAM

Finally, Mr. Chairman, I would like to briefly turn to the Commission's recommendations relating to the risk contracting program. This program is expanding rapidly, growing 32 percent annually since 1993. Today, 11 percent of the Medicare population is enrolled in a risk plan (see Chart 5). As you know, however, the Medicare program has not achieved the savings from managed care through its risk contracting program that were originally contemplated and that the private sector experiences suggests is possible. This is primarily because the capitation payments to risk contracting plans do not reflect their enrollees' lower-than-average probability of using health care services. Another reason is that Medicare's capitation rates are based on the spending experience of beneficiaries in the fee-for-service program rather than the costs that would be expected under a managed care arrangement.

Better risk adjustment of payments is necessary to reduce overpayments and to distribute risk payments more appropriately. An adequate risk adjustment would reduce risk plan payments relative to fee-for-service spending to reflect the healthier population of risk plans. It also would increase payments to plans that serve sicker beneficiaries and reduce them to plans that have healthier enrollees.

Another fundamental problem with the risk program is its reliance on fee-for-service spending to set risk payment rates. This approach has resulted in wide variation in those rates. Even after adjusting for differences in local prices, per person payment rates this year vary by as much as $200 per month across both urban and rural areas (see Chart 6). This variation can result in risk enrollees receiving different levels of benefits because risk plans use payments in excess of their costs to fund extra benefits to attract enrollees. ProPAC analyses reveal that the value of the extra benefits offered by risk plans ranged from less than $1 per enrollee per month to over $100 in 1994 (see Chart 7). Our examination also

indicated that plans serving areas with higher payment rates tend to provide richer benefit packages (see Chart 8).

The current degree of payment variation across areas is greater than plan costs would be expected to differ. Because of this, there are areas where payments are much higher than the costs anticipated by risk plans. At the same time, payment rates may be too low in other areas, discouraging plans from participating in the program.

The Commission makes several recommendations to reduce the variation in payment rates. These include removing special payments associated with teaching and disproportionate share hospitals; we believe that a separate mechanism should be developed to make additional payments to teaching and disproportionate share hospitals for the risk enrollees they treat. Other changes the Commission recommends include accounting for services provided in military and Veterans' facilities, increasing minimum risk payment levels, and making other changes that would further reduce payment variation.

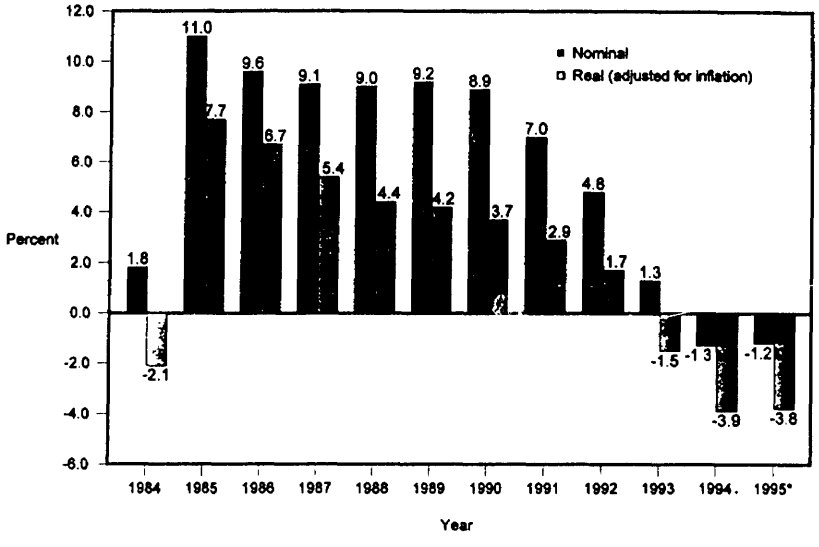
The Commission also believes that the method for updating risk payments must be replaced. Currently, risk payments change each year based on the spending experience in the fee-for-service sector. This method provides no way for Medicare to share in savings that occur when risk plan costs increase more slowly than fee-for-service payments. In addition, it can result in profound year to year changes in plans' payment rates. ProPAC believes risk payments should be updated by a method that is analytically-based--similar to the formula approach the Commission uses to recommend hospital payment increases. Under such an approach, Medicare could break the link to fee-for-service spending and share in the savings associated with any increases in risk plan efficiencies.

While the Commission believes its recommended changes to the current system will improve the risk payment methodology, it also believes Medicare should begin looking at alternative ways for determining capitation rates. Market-based methods such as competitive bidding and third-party negotiations should be explored. These approaches also would break the link to fee-for-service spending and permit Medicare to take advantage of many of the same forces private sector purchasers have successfully relied on to reduce their health care costs.

CONCLUSION

This concludes my formal statement, Mr. Chairman. I realize that I have covered a wide range of complex polices that ProPAC has considered over the past year, and I would be pleased to answer any questions you or members of the Committee may have.

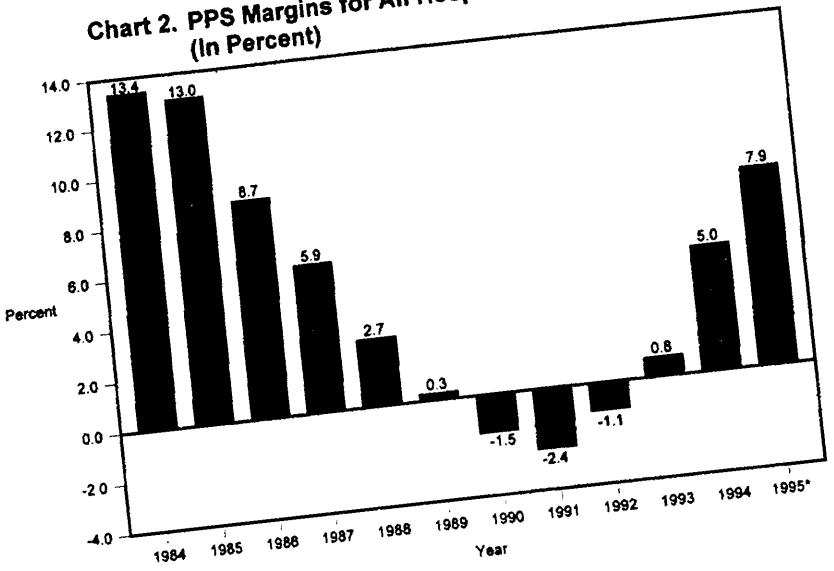
Chart 1. Annual Change in Medicare Operating Costs Per Discharge, First 12 Years of PPS (In Percent)



* Based on preliminary data and subject to revision.

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

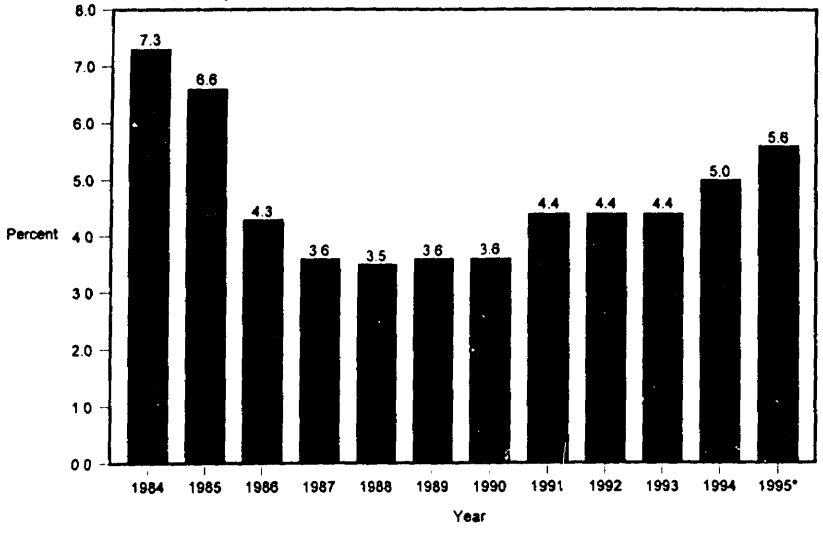
Chart 2. PPS Margins for All Hospitals, First 12 Years of PPS (In Percent)



* Based on preliminary data and subject to revision.

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Chart 3. Total Margins for All Hospitals, First 12 Years of PPS (In Percent)



* Based on preliminary data and subject to revision

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration

Chart 4. Medicare Part A Skilled Nursing Facility and Home Health Agency Payments, 1992-1996 (In Billions)

Year	Skilled Nursing Facility	Home Health Agency
1992	$ 4.2	$ 7.3
1993	6.0	9.6
1994	7.9	12.6
1995*	10.0	15.7
1996*	11.5	17.5
Average Annual Increase	28.8%	24.6%

* Estimated.

SOURCE: Health Care Financing Administration, Office of the Actuary.

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Chart 5. Medicare Risk Program Participation, 1990-1997

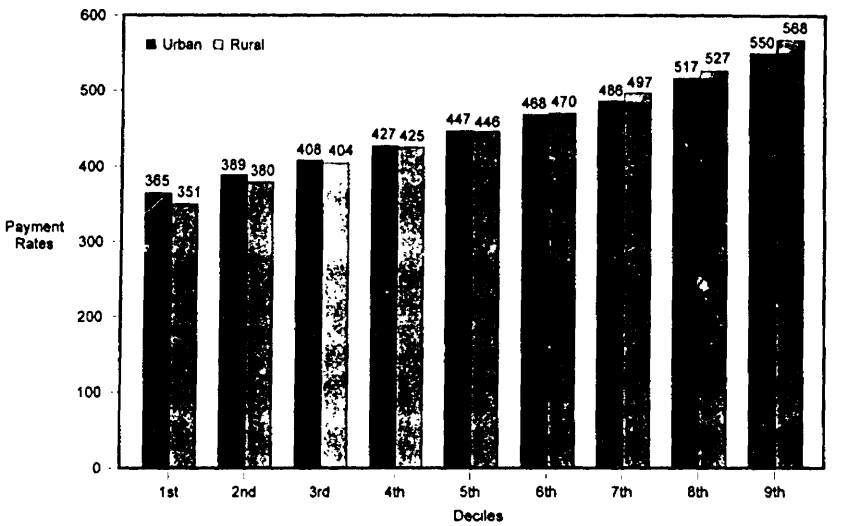
Year*	Enrollees: Number (In Millions)	Enrollees: As a Percentage of Total Medicare Enrollment	Contracts**
1990	1.2	3.5%	95
1991	1.3	3.7	85
1992	1.5	4.2	83
1993	1.7	4.7	90
1994	2.1	5.7	109
1995	2.9	7.7	154
1996	3.9	10.4	189
1997 (Jan)	4.2	11.0	248

* Enrollment data are as of September each year with the exception of 1997

** Data are as of January each year.

SOURCE: Health Care Financing Administration, Office of Managed Care.

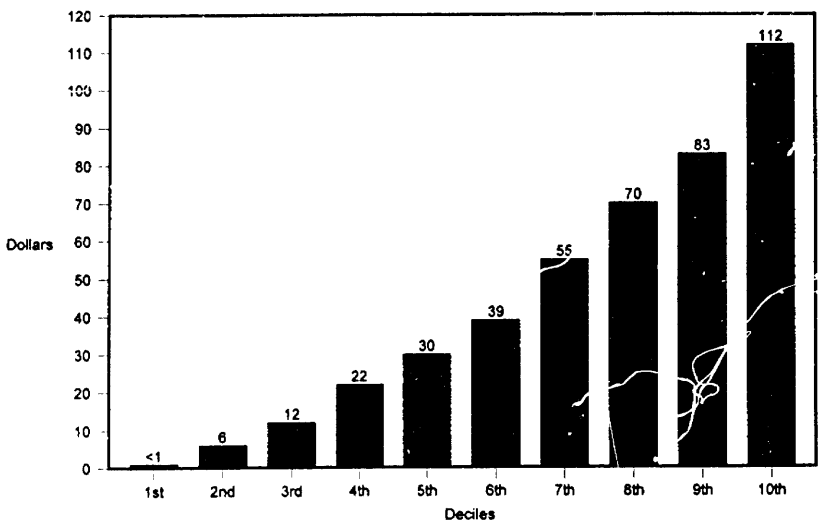
Chart 6. Standardized Medicare Risk Plan Aged Monthly Payment Rates for Urban and Rural Counties, 1997



Note: Payments are standardized by adjusting 70 percent of the rate by the applicable PPS hospital wage index

SOURCE: ProPAC analysis of 1997 risk plan payment data from the Health Care Financing Administration, Office of Managed Care

Chart 7. Standardized Value of Extra Benefits Offered by Risk Plans, Plan-Level Deciles, 1995



SOURCE ProPAC analysis of 1995 risk plan adjusted community rate proposals.

Chart 8. Characteristics of Medicare Risk Plans, by Risk Plan Payment Index, 1995

Decile	Average Plan Payment Index*	Average Standardized Value of Extra Benefits**
All	1.09	$43
10 (highest)	1.37	80
9	1.23	49
8	1.20	54
7	1.16	45
6	1.13	54
5	1.09	50
4	1.04	33
3	0.96	15
2	0.89	29
1 (lowest)	0.83	21

* Represents the level of payment relative to the national average. For example, a payment index of 1.37 means that payments are 37 percent greater than the national average.

** Amounts are standardized by adjusting 70 percent of the value by the applicable hospital wage index.

SOURCE: ProPAC analysis of data from the Health Care Financing Administration, Office of Managed Care and Bureau of Data Management and Strategy.

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QUESTIONS & ANSWERS FOR THE RECORD

Dr. Joseph Newhouse, Chairman
Prospective Payment Assessment Commission

Senator Jeffords: It is my understanding that in 1994 the national PPS margin was 6.0 percent. However, in Vermont, my hospitals tell me their PPS margin in that same year was -5.1 percent. Is it equitable to make a payment recommendation on the basis of national margins?

Dr. Newhouse: The Commission's update factor recommendation is based on a formula that includes an estimate of the expected increase in prices hospitals will pay for the goods and services they purchase, the added costs of new technology, increases in productivity and changes in the services they furnish, and changes in their mix of cases. The Commission reviews information on changes in hospital payments, costs, and margins as an indicator of the impact of its recommendations, but it does not develop its update recommendation based on margin information. Our data also indicate that PPS margins in Vermont are lower than in many other parts of the country. Since payments are based on a national formula with adjustments to reflect some local factors, this indicates that adjusted per case costs in Vermont are higher on average than in other parts of the country. Our data also show that total margins in Vermont are higher than the national average. These findings generally indicate that hospitals are able to obtain sufficient revenue from private payers to offset any losses from Medicare. They, therefore, do not have as strong an incentive to reduce their costs as many other hospitals. Consequently, their PPS margins are lower than those hospitals which did reduce their cost growth

Senator Jeffords: In your opinion, how much of the geographic variation in the AAPCC can be explained by differing utilization patterns?

Dr. Newhouse: Differences in the mix and amount of services furnished to enrollees in the fee-for-service program account for a substantial share of the variation. Prior work by ProPAC looking at the variation in Medicare spending per person at the state level also demonstrated large variation in utilization patterns. Of course, some of the variation in the amount of services also reflects a different mix of beneficiaries across counties. For example, studies have shown higher death rates with the associated costs of terminal illness in some counties relative to others.

Senator Jeffords: Even among high payment areas, there appears to be substantial variation. For example, there appears to be a $2,000 annual difference in plan payment between Miami and Los Angeles without much in the way of difference in benefits offered. What could explain that, in other words, where is that money going?

Dr. Newhouse: Unfortunately, the Medicare program does not collect the information that is necessary to answer your question completely. Our studies show that plans in areas with the highest payment rates do generally offer more extra benefits. Some of the difference may be explained by difference in the cost of labor and other goods across areas. It is also possible that some plans are enrolling a more complex mix of patients that are more costly to care for or some plans are providing more services to each enrollee. There also are likely to be differences in administrative costs and profits across areas.

Senator Jeffords: Please give me your recommendations regarding: mechanisms that would minimize the financial incentives for Medicare risk contractors to avoid enrolling older beneficiaries that have a higher likelihood of being diagnosed with high cost medical conditions; and ways to allow managed care organizations, in rural areas, to enter into Medicare risk contracts without incurring disproportionately high reinsurance premiums due to the small number of their enrollees.

Dr. Newhouse: The Medicare risk program must implement better methods to risk adjust payments, that is to provide higher payments for enrollees that are likely to be more costly. While there is still much work to be done, I believe the Medicare program should begin adding such risk adjustors now. The problems associated with risk plans entering more sparsely populated rural areas are much more difficult to deal with. As you are aware, in many rural areas there are no plans operating in the commercial market, and until plans find the commercial market attractive, it is unlikely that Medicare enrollees will have this option. A payment system that contained adjustments to reflect a sicker and more costly mix of patients would help. ProPAC also suggested that Medicare explore a system of partial capitation, where payments would be based in part on the capitation rate and in part on actual fee-for-service spending experience. Such an approach would help plans spread their risk. Expanding Medicare's risk program to include provider-service organizations may also increase the choices available to Medicare beneficiaries in rural areas.

Senator Jeffords: As more Americans move into managed care, and capitated payments become the norm, consumers want to be assured that they will receive quality health care services. My goal is that we should focus on insuring system wide quality and accountability and not to legislate standards for each disease or procedure. My question is, do you have any recommendations relating to the establishment of minimum standards for grievance procedures for managed care plans; and the use of uniform performance indicators to allow consumers to compare health plans and, thus, make informed choices on cost, patient satisfaction, benefits, and quality.

Dr. Newhouse: The Commission did not examine grievance procedures. In our March report, we support efforts to evaluate risk plans through the Health Plan Employer Data and Information Set and through satisfaction surveys. We also recommend that the Secretary continue to adapt and improve measurement tools to evaluate plan performance. We also recommend that all Medicare beneficiaries receive quality and satisfaction data for risk plans. We believe that cost and benefit definitions should be standardized so that beneficiaries can better compare plans.

Senator Mack: You have observed that hospital Medicare prospective payment margins dropped to a low of -2.4 percent in 1991 and then reversed and rose to an estimated 7.9 percent in 1995. Overall margins now may be the highest they have been for a decade. How much of this was caused by changes in Medicare guidelines, market basket inflation, management initiatives or managed care? Did Medicare manage this or did it just happen.

Dr. Newhouse: For many years, the Medicare program has constrained hospital payment increases. Until recently, hospitals were able to obtain sufficient revenue from private payers to maintain their relatively high level of cost growth. Private payers, many using managed care techniques, have begun to constrain payment increase to hospitals. Consequently, hospitals have no choice but to slow cost growth. Currently, the cost to furnish care to Medicare beneficiaries is actually falling. That is, in 1995 the cost was lower than the cost in 1994, even though Medicare payments increased. The result of declining costs and increasing payments is the high margins we have reported.

Senator Mack: You have recommended that the hospital operating update, the annual increase, for fiscal year 1998 should be zero. What evidence do you have that you won't recreate the situation of 1991 where there were minus margins. Is a zero update the right amount for all hospitals? What are your criteria? What does a one year freeze accomplish?

Dr. Newhouse: The major difference between 1991 and today is the financial pressure which private payers are placing on hospitals through slower growth in their payments. We are tracking hospital cost growth very carefully, and through November 1996 costs continue to rise at less 2 percent a year, while inflation is about 2.5 percent and Medicare payments are increasing about 4 percent. Consequently, we expect that PPS margins will rise from 7.9 percent in 1995 to 11.7 percent in 1997 and to 13.8 percent in 1998 under current law, if cost growth continues at the current level. We are continuing to monitor cost growth at monthly intervals, and if we see a substantial acceleration we will inform the Congress. Congress intended that the Medicare PPS be a national program with uniform payments, adjusted by local factors such as differences in wage rates. We, therefore, believe that the same update is appropriate for all hospitals. As your aware, however, Congress provides other special payment policies for certain groups of hospitals, such as teaching, disproportionate share, and sole community hospitals. In arriving at our update recommendation, we consider inflation in the price off goods and services hospitals purchase, the cost of new scientific and medical advances, changes in the complexity of cases, and productivity improvements. This year we especially noted the rapid decline in hospital length of stay and the movement of services

previously furnished at the end of a hospital admission to post-acute care sites, such as skilled nursing facilities and home health agencies. Our zero update recommendation is intended to bring the growth in Medicare payments more in line with the growth in hospital costs. As I noted, however, even with a zero update, it is likely that Medicare payment growth will be well above cost growth.

Senator Mack: You have said that current capital appreciation rates of approximately 16 percent are too high. That may be so, but what should be allowed for capital? How do you keep American hospitals equipped properly and even encourage them to acquire new technology and have a built-in reasonable amount for capital.

Dr. Newhouse: In 1997, Medicare capital payments jumped 22.6 percent. These reasons for this are complicated, but there is wide agreement that current payments are much higher than the Congress intended. Medicare is now in the middle of a transition from cost-based payment to a fully prospective capital payment system. Since Medicare will make a single payment for capital and operating costs when the transition is completed, the Commission believes that a single update factor should apply to both. ProPAC's update factor recommendation for operating and capital payments includes the added payment it believes is necessary for hospitals to continue to acquire new technology.

Senator Mack: Special payments to hospitals with a disproportionate share of low income patients is vitally important to many small hospitals throughout the country. What are you recommending that will improve the financial integrity of those hospitals that do serve the poor in their towns.

Dr. Newhouse: Medicare's current formula for distributing DSH payments favors urban and large hospitals. It is based on the share of Medicaid patient days and the share of days for Medicare patients receiving SSI cash benefits. The Commission's recommendation would treat all hospitals the same. We also recommend that the definition of low-income share be expanded to include uncompensated care. These policies, if enacted, would increase payments to rural and small DSH hospitals and treat urban and rural hospitals equally in terms of the low-income share.

Senator Mack: Please comment on why the savings anticipated from HMO enrollment in Medicare have not occurred. Why do HMO enrollees use fewer services overall and what are the analytically based changes in the risk payments that you would propose that will remedy this situation of overpayment and underuse.

Dr. Newhouse: Payments to Medicare HMO's are based on spending in the fee-for-service (FFS) program. There is evidence, however, that the patients enrolling in HMO's are generally healthier than those remaining in FFS, and healthier patients require fewer services. The payments to HMO's, however, are not adjusted to account for this more healthy mix of patients. Consequently, Medicare is overpaying the HMOs. This problem can be solved by

adding a risk adjustment to payments to account for differences in severity of illness and the need for services among Medicare beneficiaries.

Senator Moynihan: Could you explain the seeming contradiction between your recommendations to reduce Medicare reimbursements to teaching hospitals (in the form of reductions in direct and indirect medical education and disproportionate share payments) and your recommendation to establish more broad-based financing for medical education.

Dr. Newhouse: The Commission is not recommending a reduction in direct medical (DME) or disproportionate share (DSH) payments. We have recommended, however, that indirect medical education payments be reduced. The current IME formula results in payments to teaching hospitals that are much greater than the measured difference in the costs these hospitals incur to care for Medicare patients. We are also recommending that IME and DME payments no longer change in proportion to increases or decreases in a hospital's number of residents. The Commission believes that current policies inappropriately penalize hospitals that decide to reduce their number of residents and reward hospitals that increase the number of residents. Hospitals should make decisions regarding the appropriate number of residents with out the distorting incentives of Medicare's payment policies. We do not believe that these policies conflict with our support of broad-based funding. Currently, the Medicare program is the only payer at the national level that provides explicit support for teaching hospitals. We believe that this responsibility should be more widely shared.

PREPARED STATEMENT OF JONATHAN RATNER

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss recent Medicaid spending trends and their potential implications for future outlays. My comments are based on work that we have in progress at the request of the Chairmen of the Senate and House Budget Committees. Their request was prompted by an interest in what contributed to the precipitous drop in the annual growth rate of Medicaid spending from over 20 percent in the early 1990s to 3.3 percent in fiscal year 1996.

My remarks today focus on three issues: (1) the variation in Medicaid spending growth among the states, especially for the most recent 2-year period, that culminated in the 3.3-percent growth rate in fiscal year 1996; (2) key factors that contributed to the decrease from previous years' growth rates; and (3) the implications of these and other factors for Medicaid expenditures in the future. Our findings are based on our analysis of Medicaid expenditure data published by the Department of Health and Human Services' Health Care Financing Administration and our review of federal outlays as reported by the Department of the Treasury. We also contacted Medicaid officials in 18 states that represent a cross-section of state spending patterns over the past 2 years and that account for almost 70 percent of Medicaid expenditures.

In brief, we found no single pattern across all states that accounts for the recent dramatic decrease in the growth of Medicaid spending. Rather, a combination of factors–some affecting only certain states and others common to many states–explains the low 1996 growth rate. For example, several states saw substantial drops in their 1996 growth rates associated with circumstances such as a sharp reduction in very high levels of disproportionate share hospital (DSH) payments to conform with binding restrictions on such payments or the leveling off of their Medicaid enrollment following planned expansions in prior years. Such circumstances are unlikely to recur to dampen spending increases in future years. Moreover, the vast majority of states experienced declines in their growth rates that were moderate to limited. The experiences of these states reflect a number of factors at work, including a generally improved economy and state initiatives to limit expenditure growth, such as implementing managed care for primary and acute care services or alternative programs for long-term care. With an improved economy and declining unemployment, the number of people eligible for Medicaid decreased. In addition, a dramatic slowdown in price increases for medical services helped states control costs for certain services provided through Medicaid. While the magnitude of the effect of states' programmatic changes–such as managed care programs and long-term care alternatives–is less clear, there is evidence that they helped to restrain program costs. However, it is likely that the 3.3-percent growth rate is not indicative of the growth rate in the years ahead. Just as a number of factors converged to bring about the drop in the 1996 growth rate, so a variety of factors–including a downturn in the economy–could result in increased growth rates in subsequent years.

BACKGROUND

Medicaid, a federal grant-in-aid program that states administer, finances health care for about 37 million low-income people. With total federal and state expenditures of approximately $160 billion in 1996, Medicaid exerts considerable fiscal pressure on both state and federal budgets, accounting for roughly 20 percent and 6 percent of total expenditures, respectively.

For more than a decade, the growth rate in Medicaid expenditures nationally has been erratic. Between 1984 and 1987, the annual growth rates remained relatively stable, ranging between roughly 8 and 11 percent. Over the next 4 years, beginning in 1988, annual growth rates increased substantially, reaching 29 percent in 1992–an increase of over $26 billion for that year. From this peak, Medicaid's growth rates declined between 1993 and 1995 to approximately mid-1980 levels. Then, in fiscal year 1996, the growth rate fell to 3.3 percent.

NO SINGLE SPENDING TREND ACROSS STATES

The 3.3-percent growth in 1996 federal Medicaid outlays masks striking variation among the states. Growth rates ranged from a decrease of 16 percent to an increase of 25 percent. Such differences in program spending growth across states has been fairly typical. In addition, there are often some states that experience large changes in growth from one year to the next because of major changes in program structure or accounting variances that change the fiscal year in which a portion of expenditures are reported. To determine the stability of the growth rate among states, we compared states' growth rates in fiscal year 1995 with those in fiscal year 1996. Our analysis revealed that states could be placed in one of five categories, as shown in table 1. (See app. I for specific state growth rates.)

Table 1: Changes in Growth Rate of Federal Medicaid Outlays, Fiscal Years 1995 and 1996

Fiscal year 1996 growth rate compared with fiscal year 1995's	Number of states	Percentage of 1996 federal outlays	States
Decreased substantially	10	16	Colorado, Florida, Hawaii, Louisiana, North Carolina, Oregon, Rhode Island, South Carolina, Tennessee, Wyoming
Decreased moderately	20	48	Alabama, California, Idaho, Illinois, Iowa, Kansas, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Texas, Vermont, Washington
Changed minimally	16	32	Arizona, Arkansas, Connecticut, Delaware, District of Columbia, Georgia, Missouri, Montana, Nebraska, Nevada, New Jersey, New York, Utah, Virginia, West Virginia, Wisconsin
Increased moderately	3	2	Alaska, Maine, New Mexico
Increased substantially	2	2	Indiana, New Hampshire

Ten states that collectively account for 16 percent of 1996 federal outlays experienced substantial decreases in fiscal year 1996 growth compared with fiscal year 1995's. However, 80 percent of 1996 federal Medicaid outlays were in states that either experienced moderate decreases or minimal changes in their fiscal year 1996 growth. Although five states' fiscal year 1996 growth rates increased, those states did not have much impact on spending growth patterns because their combined share of Medicaid outlays is only 4 percent.

A CONVERGENCE OF FACTORS LED TO THE 3.3-PERCENT GROWTH RATE IN 1996

A number of factors have led to decreases in the growth rate in Medicaid spending in recent years. Some of these–such as the prior implementation of cost controls and a leveling off in the number of program eligibles following state-initiated expansions–continue to influence the growth rate in a handful of states. Other factors, such as improved economic conditions and changing program policies–for example, alternatives to institutional long-term care–also influenced many states' growth rates. The convergence of these factors resulted in the historically low 3.3-percent growth rate in fiscal year 1996 Medicaid spending.

States With Substantial Decreases in Growth Rates Affected by Several Nonrecurring Factors

The growth rate changes in those states that experienced large decreases in 1996 were largely attributable to three factors: substantial decreases in DSH funding, slowdowns in state-initiated eligibility expansions, and accelerated 1995 payments in reaction to block grant proposals.

In 1991 and 1993, the Congress acted to bring under control DSH payments, which had grown from less than $1 billion to $17 billion in just 2 years.[1] After new limits were enacted, DSH payments nationally declined in 1993, stabilized in 1994, and began to grow again in 1995. An exception to this pattern, however, Louisiana–a state that has had one of the largest DSH programs in the nation–still showed a substantial decrease in its 1996 growth rate as its DSH payments declined. The state's federal outlays decreased by 16 percent in 1996 because of a dramatic drop in DSH payments.

Recent slowdowns in state-initiated eligibility expansions also helped to effect substantial decreases in the growth rates in selected states. Over the past several years, some states implemented statewide managed care demonstration waiver programs to extend health care coverage to uninsured populations not previously eligible for Medicaid. Three states that experienced substantial decreases in their 1996 growth rates–Hawaii, Oregon, and Tennessee–undertook the bulk of their expansions in 1994. The expenditure increases related to these expansions continued into 1995 and began to level off in 1996. Tennessee actually experienced a drop in the number

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[1]DSH payments are intended to partially reimburse hospitals for the cost of providing care not covered by public or private insurance. A number of states, however, began to use the program to increase their federal Medicaid dollars in conjunction with certain creative financing mechanisms. To constrain these payments, DSH payments were limited at 12 percent of the Medicaid program.

of eligible beneficiaries in 1996, as formerly uninsured individuals covered by the program lost their eligibility because they did not pay the required premiums.

States' acceleration of 1996 payments into 1995 is another explanation sometimes given for the low 1996 growth rate.[2] In 1995, the Congress–as part of a block grant proposal–was considering legislation to establish aggregate Medicaid spending limits, which would be calculated using a base year. Officials from a few states told us that, in response to the anticipated block grant, they accelerated their Medicaid payments to increase their expenditures for fiscal year 1995–the year the Congress was considering for use as the base. For example, one state official with federal approval made a DSH payment at the end of fiscal year 1995 rather than at the beginning of fiscal year 1996. An official from another state, which had a moderate decrease in growth, told us that the state expedited decisions on audits of hospitals and nursing homes to speed payments due these providers.

Strong Economic Conditions Helped Moderate the Growth in Expenditures for Most States

Improved economic conditions, reflected in lower unemployment rates and slower increases in the cost of medical services, also have contributed to a moderation in the growth of Medicaid expenditures. Between 1993 and 1995, most states experienced a drop in their unemployment rates–some by roughly 2 percentage points. As we reported earlier, every percentage-point drop in the unemployment rate is typically associated with a 6-percent drop in Medicaid spending.[3] States told us that low unemployment rates had lowered the number of people on welfare and, therefore, in Medicaid.

In addition, growth in medical service prices has steadily been declining since the late 1980s. In 1990, the growth in the price of medical services was 9.0 percent; by 1995, it was cut in half to 4.5 percent. In 1996, it declined further to 3.5 percent. Declines in price inflation have an indirect impact on the Medicaid rates that states set for providers. Officials of several of the states we spoke with reported freezing provider payment rates in recent years, including rates for nursing facilities and hospitals. Such a freeze would not have been possible in periods with higher inflation because institutional providers can challenge state payment rates in court, arguing

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[2]Aggregate data show that federal outlays were flat in the first 6 months of 1996 and then grew 6 percent in the last 6 months.

[3]Medicaid: Restructuring Approaches Leave Many Questions (GAO/HEHS-95-103, Apr. 4, 1995).

they have not kept pace with inflation.[4] With inflation down, states can restrain payment rates with less concern about such challenges.

State Managed Care Programs and Long-Term Care Policies May Help Restrain Cost Growth

Several states that we contacted discussed recent program changes that may have had an effect on their Medicaid expenditures. Most prominently mentioned was the states' implementation of Medicaid managed care. However, the overall impact of managed care on Medicaid spending is uncertain because of state variations in program scope and objectives. States also mentioned initiatives to use alternative service delivery methods for long-term care. While these initiatives may have helped to bring Medicaid costs down, measuring their impact is difficult.

Although some states have been using managed care to serve portions of their Medicaid population for over 20 years, many of the states' programs have been voluntary and limited to certain geographic areas. In addition, these programs tend to target women and children rather than populations that may need more care and are more expensive to serve--such as people with disabilities and the elderly.[5] Only a few states have mandated enrollment statewide--fewer still have enrolled more expensive populations--and these programs are relatively new. Arizona, which has the most mature statewide mandatory program, has perhaps best proven the ability to realize cost savings in managed care, cost savings it achieved by devoting significant resources to its competitive bidding process.[6] However, in recently expanding its managed care program, Oregon chose to increase per capita payments to promote improved quality and access and to look to the future for any cost savings. Officials from Minnesota, which has a mature managed care program, and California, which is in the midst of a large expansion, told us that managed care has had no significant

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[4]The Boren Amendment, section 1902(a)(13)(A) of the Social Security Act, requires that states make payments to hospitals, nursing facilities, and intermediate care facilities for the mentally retarded that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities. Providers in a number of states have used the Boren Amendment to compel states to increase reimbursement rates for institutional services above the rates the states had been paying.

[5]Medicaid Managed Care: Serving the Disabled Challenges State Programs (GAO/HEHS-96-136, July 31, 1996).

[6]Arizona Medicaid: Competition Among Managed Care Plans Lowers Program Costs (GAO/HEHS-96-2, Oct. 4, 1995).

impact on the moderate decreases they experienced.[7] Given the varying objectives, the ability of managed care to help control state Medicaid costs and moderate spending growth over time is unclear.

Some states we contacted are trying to control long-term care costs, which, for fiscal year 1995, accounted for about 37 percent of Medicaid expenditures nationwide. They are limiting the number of nursing home beds and payment rates for nursing facility services while expanding home and community-based services, a less-expensive alternative to institutional care. For example, a New York official told us that the state is attempting to restrain its long-term care costs by changing its rate-setting for nursing facilities, establishing county expenditure targets to limit growth, and pursuing home- and community-based service options as alternatives to nursing facilities. Our previous work showed that such strategies can work toward controlling long-term care spending if controls on the volume of nursing home care and home- and community-based services are in place.[8]

POTENTIAL FOR HIGHER EXPENDITURE GROWTH IN FUTURE YEARS

Many of the factors that resulted in the 3.3-percent growth rate in 1996–such as DSH payments, unemployment rates, and program policy changes–will continue to influence the Medicaid growth rate in future years. However, there are indications that some of these components may contribute to higher–not lower–growth rates, while the effect of others is more uncertain.

Without new limits, DSH payments can be expected to grow at the rate of the overall program. While Louisiana's adjustments to its DSH payments resulted in a substantial reduction in its 1996 spending, other states' DSH spending began to grow moderately in 1995 as freezes imposed on additional DSH spending were removed.[9] Although DSH payments are not increasing as fast as they were in the early 1990s, these payments did grow 12.4 percent in 1995.

Even though the economy has been in a prolonged expansion, history indicates that the current robust economy will not last indefinitely. The unemployment rate

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[7]California considers its managed care program to be budget neutral, having no impact on spending one way or another.

[8]Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs (GAO/HEHS-94-167, Aug. 11, 1994).

[9]States whose DSH spending exceeded 12 percent of their total program spending in 1993 were not allowed to increase DSH spending until it fell below 12 percent of total current program spending.

cannot be expected to stay as low as it currently is, especially in states with rates below 4 percent. Furthermore, any increases in medical care price inflation will undoubtedly influence Medicaid reimbursement rates, especially to institutional providers.

While states have experienced some success in dealing with long-term care costs, the continued increase in the number of elderly people will inevitably lead to an increase in program costs. Alternative service delivery systems can moderate that growth but not eliminate it.

Other factors may dampen future spending growth, but by how much is unclear. The recently enacted welfare reform legislation makes people receiving cash assistance no longer automatically eligible for Medicaid. As a result, the number of Medicaid enrollees–and the costs of providing services–may decrease, since some Medicaid-eligible people may be discouraged from seeking eligibility and enrollment apart from the new welfare process. On the other hand, states may need to restructure their eligibility and enrollment systems to ensure that people who are eligible for Medicaid continue to participate in the program. Restructuring their systems will undoubtedly increase states' administrative costs. The net effect of these changes remains to be seen.

The potential for cost savings through managed care also remains unclear, as experience is limited and state objectives in switching to managed care have not always emphasized immediate cost-containment. Yet it is hoped that managed care will, over time, help constrain costs. While Arizona's Medicaid managed care program has been effective, cost savings were due primarily to considerable effort to promote competition among health plans. The challenge is whether the state can sustain this competition in the future.

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Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or members of the Committee might have at this time. Thank you.

For more information on this testimony, please call Kathryn G. Allen, Assistant Director, on (202) 512-7059. Other major contributors included William J. Scanlon, Lourdes R. Cho, Richard N. Jensen, Deborah A. Signer, and Karen M. Sloan.

STABILITY OF GROWTH RATE FOR FEDERAL MEDICAID OUTLAYS, FISCAL YEARS 1995 AND 1996

GAO developed a growth stability index that shows the direction and magnitude of change in the growth rates of federal outlays between fiscal years 1995 and 1996. An index of 1.0 indicates no change in the growth rates for the 2 years. An index greater than 1.0 indicates a decrease in the 1995-96 growth rates. For example, Colorado's index of 1.37 ranks it as having the largest decrease.

Table I.1: Growth Stability Index for Federal Medicaid Outlays by State, Fiscal Years 1995 and 1996

	Percentage growth, fiscal year 1995	Percentage growth, fiscal year 1996	Growth stability index	State ranking based on growth stability index
States and District of Columbia	**11.00**	**3.18[a]**	**1.08**	
Alabama	10.63	3.71	1.07	26
Alaska	2.54	17.60	0.87	49
Arizona	2.70	4.58	0.98	43
Arkansas	8.76	7.50	1.01	38
California	13.73	2.80	1.11	21
Colorado	30.84	-4.66	1.37	1
Connecticut	10.68	11.51	0.99	40
Delaware	24.47	19.65	1.04	35
District of Columbia	-0.51	-1.37	1.01	39
Florida	22.35	-4.28	1.28	4
Georgia	7.82	2.44	1.05	31
Hawaii	31.87	11.46	1.18	9
Idaho	12.99	5.46	1.07	24

APPENDIX I

Illinois	16.30	1.85	1.14	12
Indiana	-13.34	24.52	0.70	51
Iowa	11.46	-0.02	1.11	17
Kansas	12.67	-2.05	1.15	11
Kentucky	13.36	2.15	1.11	19
Louisiana	1.19	-15.96	1.20	8
Maine	-0.22	10.21	0.91	48
Maryland	15.56	3.36	1.12	16
Massachusetts	11.22	3.50	1.07	23
Michigan	7.86	1.46	1.06	27
Minnesota	13.48	2.52	1.11	20
Mississippi	16.54	3.34	1.13	15
Missouri	8.70	6.81	1.02	36
Montana	7.05	11.76	0.96	46
Nebraska	6.22	9.89	0.97	45
Nevada	20.88	15.52	1.05	32
New Hampshire	-21.73	0.95	0.78	50
New Jersey	10.16	5.54	1.04	33
New Mexico	13.80	21.30	0.94	47
New York	8.13	6.47	1.02	37
North Carolina	26.51	1.27	1.25	5
North Dakota	11.19	0.08	1.11	18
Ohio	10.94	4.43	1.06	28
Oklahoma	9.22	3.42	1.06	30
Oregon	38.37	4.26	1.33	3
Pennsylvania	7.50	1.62	1.06	29

Rhode Island	18.81	-10.97	1.33	2
South Carolina	16.72	0.71	1.16	10
South Dakota	13.18	-0.03	1.13	13
Tennessee	21.67	0.78	1.21	7
Texas	11.80	4.57	1.07	25
Utah	10.14	11.25	0.99	41
Vermont	18.23	7.40	1.10	22
Virginia	5.24	8.41	0.97	44
Washington	15.39	2.02	1.13	14
West Virginia	-3.19	-1.77	0.99	42
Wisconsin	7.55	3.17	1.04	34
Wyoming	20.88	-1.68	1.23	6

[a]Aggregate growth in federal outlays for Medicaid is 3.3 percent when outlays for territories are included in calculation.

Source: Federal outlays for Medicaid, U.S. Treasury.

RESPONSES OF MR. RATNER TO QUESTIONS FROM SENATOR MURKOWSKI

Question 1

The funding formula that is used to determine the federal matching payment is based on per capita income in individual states as it relates to per capita income in the United States. This formula has been historically unfair to Alaska.

Here's the reason: the Medicaid formula is based on per capita income in Alaska. At the same time, eligibility for Medicaid based on the federal poverty level, which is indexed by 25% in Alaska because of the high cost of living.

Bottom-line, this means that more people in Alaska are eligible for Medicaid programs, but the federal match isn't adjusted accordingly. Basically, the current federal formula gives us more Medicaid users and provides less money to pay for their services. It's a problem that can cripple a state budget.

Do you recognize this as unfair to states with a high cost of living, such as Alaska?

Answer to Question 1

It is true that federal poverty guidelines reflect a 25 percent adjustment for the higher cost-of-living in Alaska. If eligibility were based exclusively on this standard there would be more Medicaid users in Alaska compared to a federal poverty guideline that did not adjust for cost of living differences. However, these eligibility standards apply only to the mandated coverage of children and pregnant women made eligible after 1988. The vast majority of Medicaid spending is for the categorically and medically needy, whose eligibility is determined by state policy choices. Consequently, while federal poverty guidelines affect the number of Medicaid users in the program, state determined eligibility standards play a much larger role in determining the number of users served by the program.

Whether a cost-of-living adjustment would be appropriate depends on the Congressional intent underlying the matching formula. The legislative history of predecessor programs, from which the Medicaid formula was adapted, suggests that the use of state per capita income was intended, in part, to offset the higher financing burden of low-income states. That is, the legislative history suggests that the Congress wished to ensure that states are able to finance comparable Medicaid benefits with comparable state tax burdens. We have previously testified that this goal could be better advanced by adjusting state incomes for differences in the cost of health care services. An adjustment for health care cost differences would be more appropriate than a cost-of-living adjustment because Medicaid purchases health care services. In contrast, a cost-of-living adjustment would take into account many goods and services, such as housing, transportation and clothing, not funded under Medicaid.

If per capita income were adjusted for health care cost differences, it would also be appropriate to consider using a broader measure of states' capacity to fund program benefits from state resources. Previous GAO reports have identified several weaknesses in the use of per capita income for this purpose. The most significant short-coming is that it does not take into account income earned in-state by out-of-state residents, even though the state could tax this income. For example, dividends paid to out-of-state stockholders are taxable by the state but are not included in the per capita income of state residents. Per capita income therefore understates the relative funding capacity of states with higher proportions of income earned in-state by out-of-state residents. Consequently, if per capita income were adjusted for health care cost differences, it would also be appropriate to consider using a broader measure of state funding capacity, such as states' Total Taxable Resources, reported by the Department of the Treasury.

Question 2

Why is the cost of living of an individual state not factored into the Medicaid formula?

Question 3

Other federal formulas, such as the formula for the federal school lunch program, take into consideration an individual state's cost of living. Why is the cost-of-living not taken into consideration in the Medicaid formula?

Answers to Questions 2 and 3

The legislative history leading up to passage of the Medicaid program and its use of per capita income in the matching formula makes no mention of the cost-of-living issue. Consequently, one can only speculate as to why the issue was not considered. We note that the use of per capita income in health related programs goes back to the Hill-Burton Hospital Construction Act of 1946. Since that time, variants of the

Hill-Burton formula have been adapted for use in other programs. The current Medicaid formula is a Hill-Burton type formula adapted from the Medical Assistance to the Aged Program, a predecessor to the Medicaid program.

Question 4

The smallest federal Medicaid match is 50 percent. The highest federal match is 78.9 percent to the poorest state, Mississippi. As I have previously mentioned, Alaska has a 50 percent federal match based on the fact that it has the seventh highest per capita income in the United States ($17,961 based on 1993 data). The federal government adjustment for federal employees suggests that it costs 25 percent more to live in Alaska than in the lower 48.

Although Alaska's $17,961 per capita income suggests it is one of the richer states, when the 25 percent higher cost of living is factored in, the state looks far poorer.

Maine's per capita income is $14,855 and it ranks 38th of the 50 states. Therefore the federal share of Medicaid is 62 percent. However, when the cost of living in Maine is equalized with that of Alaska, it is fair to say that a citizen in Maine with $14,855 in income lives at the same level as a person in Alaska who has an income of $18,568 ($14,855 x 125%), which is higher than Alaska's per capita of $17,961.

Therefore, it would appear that the Federal share of Medicaid for Alaska should nearly equal that of Maine and therefore be a 62-38 split rather than 50-50. Would you agree with this analysis?

Answer to Question 4

If the objective is to provide all states with the capacity to finance comparable programs with comparable burdens on state taxpayers, several changes to the current matching formula would be appropriate, including: (1) using a comprehensive measure of state income to better reflect each state's capacity to fund Medicaid services from state resources, (2) taking into account the number of low-income individuals that would potentially be eligible to participate in the program, (3) adjusting state income for cross-state differences in the cost of health care so that incomes of comparable purchasing power are compared, and finally, (4) making an adjustment for states that have higher concentrations of the elderly and disabled for whom it is more expensive to provide care.

Since equalizing the burden of financing the state share of Medicaid spending depends on several factors, it is unclear whether Maine's matching percentage would be the appropriate comparison and, in particular, whether a 25% adjustment to Alaska's matching percentage would be appropriate.

STATEMENT

of the

AMERICAN COLLEGE OF SURGEONS

to the

SENATE COMMITTEE ON FINANCE

presented by

Seymour I. Schwartz, MD, FACS
Chairman, Board of Regents

RE: The President's FY 1998 Medicare Budget Proposal

March 5, 1997

Mr. Chairman and Members of the Committee, I am Seymour I. Schwartz, MD, FACS, Chairman of the Board of Regents of the American College of Surgeons, and Chairman of the Department of Surgery at the University of Rochester Medical Center. On behalf of the 62,000 Fellows of the College, I thank you for this opportunity to present our comments and recommendations regarding President Clinton's latest budget proposal.

Plainly stated, it is difficult for surgeons not to take offense at a number of proposals in the President's fiscal year (FY) 1998 budget. Furthermore, we view many of these proposals as fundamentally at odds with other positions and policies being championed by the Administration. Following are two examples.

The Administration has shown great concern for a woman's access to mammography, an important diagnostic tool for diseases of the breast. The Administration has also shown great concern about the problem of "drive-through" mastectomies. However, this same Administration is now advancing a variety of proposals that would substantially reduce payment for the surgeons

who treat women with diseases of the breast, such as cancers and other tumors.

President Clinton himself has shown great concern about patient access to organ transplantation, especially as it relates to the allocation of scarce organs, such as livers. In December, the Administration held three full days of hearings on the subject. And, in the budget, the President proposes to double the funding for the government's Division of Organ Transplantation in order to enhance organ donation. At the same time, however, the Administration is proposing Medicare policy changes that would significantly reduce payment to the surgical teams that actually perform these organ transplants.

I could continue with similar examples. But, instead, let me say more about some of the President's specific policy proposals.

The Medicare Volume Performance Standards and Conversion Factors

Under current law, there are different Medicare volume performance standards (MVPSs), or expenditure targets, for different categories of physicians' services--including a separate standard for surgical services. There are also separate dollar conversion factors for each service category. In the FY 1998 budget, the President proposes to adopt a single MVPS and conversion factor for all services. In addition, he proposes to use changes in the Gross Domestic Product (GDP) to determine the appropriate rate of growth in Medicare expenditures for the physicians' services required by elderly patients.

These changes would reduce Medicare expenditures by more than $5 billion over the next five years. From the information currently available, it appears that most of these savings would come from reducing payments for surgical services. In fact, adopting a single conversion factor,

as proposed by the Administration, would cut Medicare payments for all surgical services by about 13 percent.

With respect to the separate standards and conversion factors, the College believes that it is important to remember that these policies were adopted because government policymakers were concerned not only about pricing issues (that is, relative values), but also about service volume issues. They properly recognized that expenditures are a function of both price and volume. Many of those who complain about the effects of the MVPS on the fee schedule seem to forget the original rationale behind the concept. It seems to us that movement to a single standard would simply reduce the collective incentive to control service volume; it would reduce, not increase, physician accountability. Thus, if policymakers remain concerned about physician service volume, we believe it would be much more prudent to preserve the separate MVPSs.

Nevertheless, if the federal government continues to pursue the notion of a single MVPS and single dollar conversion factor, the College urges you to phase-in the change over at least a three-year period.

Of course, the length of the transition is not the only consideration. It will also be important to assure that the rate of any change is gradual, rather than abrupt. In other words, any attempt to implement the greatest portion of the change initially while providing a multiple year phase-in would be strenuously opposed by the College. We believe that our position is reasonable given the fact that gradual implementation of new payment policies has generally been a normal practice under Medicare, not only to cushion the impact on those who experience payment reductions, but also to minimize access problems for Medicare beneficiaries.

Also, we urge you not to lose sight of the fact that this significant reduction in the

conversion factor for surgical services would be implemented at the same time as new "resource-based" practice expense relative values are incorporated into the Medicare fee schedule. According to the estimates that the Health Care Financing Administration (HCFA) has made available, the combined impact of a single fee schedule conversion factor and new practice expense values could reduce total Medicare payments for coronary artery bypass and procedures to remove the kidney by 45 to 50 percent. It is difficult to imagine how payment reductions of this magnitude could be implemented so quickly without some impact on patient access to high-quality surgical care.

The College also is troubled by the proposal to use GDP in determining the appropriate utilization of physicians' services under Medicare. Used in this way, one could label the GDP as merely an "affordability factor." It obviously has nothing to do with Medicare beneficiary health care needs. It is not used to measure the expected demand for other individual categories of services in the economy, nor is it used to set prices or payment amounts for them. Rather, the GDP is a composite that flows from the entire panoply of economic developments in the nation--both positive and negative. Consequently, we find it difficult to understand why it should be considered a suitable adjustment factor for physicians' services under the Medicare program. We doubt that the Congress would be comfortable using the same approach to determine the appropriate level of expenditures for other government programs, such as Social Security or the national defense.

Of course, the College is not implying that the current formula for determining the MVPS is perfect. In fact, we continue to be concerned about several matters. First, under HCFA's most recent formulation, separate volume factors are used to determine volume performance standards

for each service category. We have pointed out the perverse incentives this provides--the greater the historic volume increase for a category of service, the higher its MVPS or expenditure target, all other things being equal. That is why we opposed HCFA's abandonment of a single, average volume calculation.

We also wish to take this opportunity to again voice our concern about the arbitrary performance adjustment factor--the so-called "minus four adjustment"--that is used in determining the current Medicare volume performance standards. This arbitrary adjustment factor certainly must be deleted from the MVPS methodology, since it produces expenditure targets that are unfair and impossible to meet. This is especially true for surgical services, since they comprise the category of physicians' services with the lowest historic rate of growth in volume and intensity. However, this issue does not, by itself, necessitate eliminating the separate standards.

Payment for Physicians as Assistants at Surgery

The Administration is also proposing to save $400 million over the next five years by adopting what is euphemistically called a "single fee for surgery." By this, the President means that the additional payment Medicare now makes for a physician assisting the principal surgeon in performing an operation would no longer be made. Instead, the payment amount for the operation would have to be split between the principal surgeon and the assistant at surgery. To make matters worse, this is being proposed at the same time that the Administration is advancing other legislative and regulatory proposals that would reduce payments for surgical services. For example, as noted earlier, the adoption of a single conversion factor would reduce Medicare payments for an operation by about 13 percent. The proposed adoption of a "single fee for

surgery" would require that 16 percent of this reduced amount go to the physician who is assisting at surgery, with the principal surgeon receiving the remainder. In other words, under these two proposals alone, a surgeon would end up being paid only 73 percent of what he or she receives today for performing the same operation.

What is particularly intolerable is that the Administration proposes a single fee for surgery without having made a clinical judgment about the medical needs of the patients involved. Instead, if the services of an assistant at surgery are needed, then it effectively becomes the principal surgeon's obligation to pay for them out of the funds he or she would be paid if it were possible to perform the operation without another physician's assistance. Why doesn't the Administration instead have the fortitude to identify those assistant at surgery services that are medically unnecessary and then deny payment for them? Why should Medicare be permitted to abandon its obligation to pay a fair amount for Medicare-covered services that its beneficiaries require?

With respect to assistants at surgery, the College has developed guidelines for determining when an assistant at surgery is required for a procedure. The factors that a principal surgeon should consider include:

- the degree to which the operation is complex and technically demanding, so that joint efforts of the principal surgeon and one or more assisting physicians contribute meaningfully to the successful treatment of the patient;
- the expected effect of the use of an assistant on the patient's mortality and morbidity, including related blood loss and duration of the operation; and
- the degree to which the patient's history indicates that there is a substantial risk of complications arising in the course of the operation that would require the services of an assistant at surgery to avoid the increased risk of mortality and morbidity.

The College has also tried to play a constructive role by identifying surgical procedures for which an assistant surgeon is "almost always," "almost never," or "sometimes" required. We just recently updated this information, in part to take into account the approval of new procedure codes by the American Medical Association's CPT Editorial Panel. (A copy of our December 1996 report accompanies this testimony.)

We strongly oppose the Administration's latest cost-cutting scheme. It is not only unfair, but dangerously imposes financial disincentives to the use of an assistant at surgery. It has been proposed in the past and rejected by Congress, and we believe it is being proposed again only to force you to find alternative savings. Further, no arbitrary list of exceptions to the "single fee for surgery policy will solve the problems inherent in this proposal. In fact, such a list is likely to be even more flawed than the existing policy denying payment for assistant at surgery services that are only rarely required for certain types of operations (that is, those for which Medicare claims for assistants at surgery are submitted less than 5 percent of the time). Furthermore, as the attached list shows, 100 procedures account for nearly four-fifths of amount that Medicare spends on assistants at surgery, and it is likely that most of these procedures would be included on any list of exceptions. It seems to us that, once again, we are confronting a poorly reasoned proposal in which the potential for cost savings is greatly outweighed by the potential adverse impact on quality of surgical care.

Of course, we remain concerned about current Medicare policy that arbitrarily denies payment for an assistant at surgery whenever claims indicate that nationwide utilization of such an assistant for a particular operation falls below 5 percent, no matter what an individual patient's medical condition or needs might be. This policy should be abandoned. It is the College's

strong view that the professional judgment of surgeons regarding the need for an assistant-at-surgery for a *specific* patient must be recognized, even for operations in which an assistant ordinarily may not be required.

The College would be pleased to work with policymakers to address any concerns they might have regarding the use of assistants at surgery as long as patient care is not compromised in the process.

High-Cost Hospital Medical Staff

The Administration proposes to reduce Medicare payments for so-called high-cost hospital medical staffs, something that is projected to produce $1.5 billion in Medicare savings over the next five years. This proposal is not new. In its 1994 *Annual Report to Congress*, the Physician Payment Review Commission concluded that such a "provision's disadvantages...outweigh its advantages." The Commission went on to note, among other things, that such a provision:

> ...may have unintended effects on physician behavior, including a shifting of admissions away from hospitals with the high-cost designation. The provision would also increase the cost and complexity [of] administering the Medicare program.

The College would add that such a provision would essentially convert a hospital's medical staff into an economic unit, something that is not typically the case today. It also focuses considerable energy on inpatient hospital care at a time when a very high proportion of services are being provided in other settings. We suspect that the hospital community would share the College's concerns about this provision.

Finally, we doubt very much that there is a fair way to apply this policy. In some cases, the physicians responsible for a hospital's medical staff being designated "high cost" for a given

year might simply take their patients elsewhere, leaving the remaining physicians on staff to bear the financial consequences, with potentially serious repercussions for the affected hospital. In fact, since many physicians--especially those in urban areas--have (or may easily obtain) admitting privileges at more than one hospital, a hospital that is designated "high cost" might suddenly discover that it no longer has a medical staff, let alone a "high cost" staff. That would be rather unfortunate for that hospital's nurses and other employees, as well as for the patients who routinely receive services there.

"Centers of Excellence"

The Administration proposes to expand what it calls the "Centers of Excellence' Demonstration, under which Medicare makes a bundled payment to participating entities covering both physician and facility services for selected conditions (such as coronary artery bypass operations). The College has a number of concerns regarding this proposal. However, for this hearing, we would simply like to request some "truth in advertising." The term "Centers of Excellence" is inappropriate and offensive. The institutions that HCFA selects to participate in this payment arrangement do not necessarily provide higher quality services than non-participating institutions. In fact, one of HCFA's principal requirements for participating entities is their willingness to grant Medicare a significant price discount. That explains why this initiative is estimated to save $100 million over the next five years.

Of course, the College strongly supports the concept of accreditation and the practice of designating true centers of excellence, but we are very concerned that use of this term under the current proposal will mislead patients into believing that the federal government has used

objective and clinically relevant criteria to determine that the quality of care provided in these centers is superior to the care provided by non-selected hospitals and surgeons. The College believes that it would be more accurate and appropriate to describe the hospitals selected for this project in terms that more clearly reflect their similarities to preferred provider organization (PPO) hospitals in the private sector. A more appropriate term that we have already suggested to HCFA is "Medicare demonstration participating centers." In any event, we believe that the term "Centers of Excellence" should be replaced by some less misleading term if Congress decides to give further consideration to the Administration's proposal.

Surgical Representation on the PPRC

A technical glitch will soon mean that surgeons will not be represented on the Physician Payment Review Commission (PPRC), the key body providing advice to the Congress about Medicare physician payment policies and other related matters. The term of the surgeon who currently serves on the Commission is about to end, and the body authorized by statute to nominate new members, the Office of Technology Assessment, has been abolished. Thus, in about a month, there will no longer be a surgeon on the PPRC and no ready means for one to be appointed--a state of affairs that is extremely troubling, given the fact that so many of the issues that the Commission will be expected to consider would have very important consequences for surgeons and their patients. The College urges the Congress to take immediate steps to correct this situation and to assure that at least one surgeon is represented on the PPRC at all times.

Graduate Medical Education and the Physician Workforce

Under current Medicare direct medical education payment policy, the program pays its full share of residency training for no more than the first five years of training, even for specialties that require a longer residency program, such as many surgical specialties. In addition, we know that many policymakers continue to believe there is a shortage of primary care physicians. In some cases, this belief has translated into policy proposals that are biased against specialty training programs--or even punitive in nature.

The President's budget includes a number of proposals that affect Medicare payments for graduate medical education. For any teaching hospital, it would impose a cap on the total number of residency positions and on the total number of positions devoted to non-primary care training. It would also count a resident's work in non-hospital settings for purposes of determining each hospital's Medicare indirect medical education payment adjustment. In addition, the budget proposes to allow direct medical education payments to be made to entities other than hospitals, but only in the case of primary care residents.

We are pleased to observe that the latest budget does *not* call for further reductions in the level of direct medical education payments for surgical residency positions. The College hopes that one day Medicare will pay its full share of the costs of all the residents needed to meet the physician workforce needs of the country, especially since it is obvious that generalist physicians cannot meet all of our nation's health care needs. Those specialties with the longest training periods are just as critical to the health care needs of our nation as those with the shortest residency training. Furthermore, the quality of programs that train our nation's medical and surgical specialists is as important as the quality of those that train our primary care physicians;

both types of programs should be funded for their full residency periods. All of this is particularly true for Medicare beneficiaries, whose health care problems frequently require the services of surgical and medical specialists.

The College does agree that the preponderance of the evidence indicates that there is an oversupply of physicians in general. For several years now, it has been the College's view that Congress should focus its attention on policies that are directly aimed at controlling the size and specialty mix of our nation's physician workforce, rather than on indirect efforts to achieve these goals through program financing mechanisms, such as arbitrarily reducing Medicare direct medical education payments for residents in their last few years of surgical training. Specifically, the College has agreed with proposals that would limit the total number of physicians being trained, perhaps to 110 percent of U.S. medical school graduates. We also agree that broad goals should be set regarding the number of generalists and specialists to be trained. We do believe strongly, however, that quality should be the major factor in determining which residency programs will be funded and how actual residency slots will be allocated among each specialty.

In the surgical specialties, the number of individuals being trained has been restrained by such quality considerations for many years In fact, the number of physicians trained in the surgical specialties has remained relatively constant for more than a decade. No surgical training program can add new residency positions unless patient mix and volume assure that specific training criteria are met. This limits both the number and the size of surgical training programs. In addition, smaller training programs with relatively few residents are held to the same high standards as larger programs.

Of course, there is a regulatory overtone to the idea of federal physician workforce

controls that may not appeal to some policymakers. However, while there is growing sentiment in the medical community that the number of residents should be constrained in some way, there is also a general belief that antitrust laws preclude physicians from establishing and imposing any limits on their own initiative. The residency review committees for the various specialties and the Accreditation Council on Graduate Medical Education believe that they do not have the authority or the antitrust immunity needed to impose such limits. A federal mandate to do so would address some of these concerns.

Finally, we see no obvious reason why the Administration's proposal to allow direct medical education payments to be made to entities other than hospitals should be limited to primary care residents. The truth is that residency training for all specialties is increasingly taking place in non-hospital settings.

Practice Expense Relative Values

Finally, the College would like to take this opportunity to comment on a pending regulatory initiative relating to Medicare physician payment--the adoption of new practice expense relative values, effective January 1, 1998, as required under current law. HCFA's current efforts to develop these new values are entirely unacceptable and are a cause for great concern among surgeons and other physicians throughout the country. We urge the Congress to put this entire process on hold immediately in order to provide adequate time for the issue to be thoroughly re-examined.

Data recently released by HCFA indicate that the new values could reduce aggregate Medicare payments to various surgical specialties by up to 44 percent while increasing payments

to other practitioner categories by as much as 54 percent, even if no changes are made in the fee schedule conversion factors. These are changes in total Medicare payments, not just in the portion of the fee currently associated with practice expenses. On a service-specific basis, here are just a few examples of the potential impact on surgical services:

- Medicare payments to the surgeon performing a heart transplant could decline by about 57 percent from what they are today.
- Medicare payments for coronary artery bypass operations could fall about 44 percent, while those for operations such as total hip replacement and brain surgery by nearly 40 percent.
- Payments for operations to treat colon cancer could fall by more than 25 percent, and those for a modified radical mastectomy by more than 17 percent.

Even as preliminary estimates, and even if they are only half-right, the magnitude and nature of the proposed reductions and redistribution are simply unacceptable, especially when the Administration is proposing a number of other policy changes that would simultaneously produce even further reductions in Medicare payments for surgical services.

In some cases, we estimate that the new relative values would result in Medicare paying *less than Medicaid* for many surgical services, a result that seems destined to create access problems for Medicare beneficiaries similar to those currently experienced by Medicaid recipients. On the other hand, Medicare could eventually pay *more than private insurers* for services provided by certain non-surgical practitioners, a result that seems inconsistent with Medicare's interest as a prudent purchaser of health care services.

In the College's view, the potential payment reductions are not the only indication that there are serious problems with the practice expense methodology. Consider the following:

The data being used are flawed. HCFA had to abandon one practice expense data

collection effort and now plans to rely on alternative data that were not collected for this purpose. If these existing data were adequate, why did the agency even attempt an expensive *de novo* data collection effort? Further, the College believes that the process used to determine direct practice expenses--the Clinical Practice Expert Panels (CPEPs)--has not produced valid or usable results. Only a relatively small number of physicians and non-physicians were involved in each CPEP, and their estimates appeared to be little better than educated guesses. In some cases, few, if any, of the CPEP members were even personally familiar with the more specialized and less frequently provided services that were examined. Moreover, since practice expenses are likely to vary considerably across the country, depending on the location, size and other characteristics of a physician's practice, even if one or more CPEP members were personally familiar with a particular physician service, it is not clear that their views would be truly representative.

Furthermore, it is doubtful that any single person within a physician practice would be personally knowledgeable about the total range of practice expenses involved. In the case of surgical procedures, expenses may be incurred because non-physician staff time is required to perform various patient-related tasks even when the surgeon is in the operating room. How, then, could HCFA and its contractor expect individual CPEP participants to provide valid estimates of all the practice expenses involved in providing a given service, especially a global surgical service that may involve care provided over a 90-day period? This is obviously a very different task than asking physicians to estimate the time and effort--that is, the work--that is involved when they *personally* provide *all* of a service.

To make matters worse, ***HCFA staff propose to delete certain direct practice expenses incurred by surgeons***--such as the salaries and fringe benefits provided to nurses and other

clinical personnel who accompany the surgeon to the hospital to assist in the care of patients--because the agency apparently believes these costs ought to be the responsibility of hospitals. That puts surgeons and their patients in an untenable position. These are real practice expenses. If necessary, some dollars should be shifted from Part A of the program to Part B in order to cover these costs.

Modest adjustments in the practice expense methodology would yield very different results, even if no changes are made in the conversion factors. For example, HCFA estimates that one of the options it is considering could reduce the total relative values for general surgery by 10 percent while another would reduce them by 19 percent--nearly twice as much. One option would reduce total relative values for vascular surgery by 17 percent while another would reduce them by 31 percent. For nephrology, one option would reduce total values by only 2 percent, but another would cut them by 27 percent. In the case of pathology, one approach would *increase* total relative values by 6 percent while another would *cut* them by 14 percent.

HCFA staff and most experts admit that it is not obvious how to decide between competing methodologies for determining practice expense relative values, especially the method for allocating indirect practice expenses (that is, overhead costs). The highly variable results that would be produced by various approaches make it unlikely that any of the options will gain broad acceptance by the many groups of physicians who hold an interest in the process. Further, HCFA staff already appear to have discarded one option--allocating indirect expenses based on physician work--that other researchers have used and that would produce far different results for at least some physician specialties

The practice expense methodology could seriously disadvantage rural physician

practices. Because of the size and the nature of their practices, surgeons and other physicians located in rural areas may simply not be able to achieve "average" efficiency targets for the use of equipment and staff that are assumed in calculating the new resource-based practice expense values.

Finally, on an even more fundamental level, the preliminary impact analysis confirms that ***a purely resource-based approach yields inappropriate results.*** The current resource-based methodology ignores the length of physician training (far longer for surgeons than for primary care physicians and non-MD practitioners), patient outcomes, the impact on patient quality of life of various services, patient preferences, and other factors that are typically used in valuing other products and services in the U.S. economy. The current methodology does not even specifically take into account the needs of the average *Medicare* patient--instead, the relative values were constructed with the average patient in mind, even if there are significant differences between the average patient and the average Medicare patient.

The College has repeatedly called attention to the limitations of the current payment methodology. As non-surgical examples of questionable results, the new "resource-based" practice expense values will apparently reduce the total values for physician visits to nursing home patients by up to 25 percent or more, which could have unfortunate consequences for Medicare beneficiaries residing in such nursing homes. Similarly, the new values will significantly reduce the total values for physician visits to patients' homes while increasing them for visits in the physician's own office. We doubt that this relative value shift will always be in patients' best interests.

In short, the College has concluded that the practice expense data and methodologies

available to HCFA at this time are fatally flawed and that the problems cannot be addressed in the time available. Further, we believe that at least part of the problem is that the agency was assigned a nearly impossible task, with too little time and money to do the job correctly. Therefore, at the very least, the current initiative must be set aside and the current deadline for adopting new practice expense values abandoned. Fortunately, setting aside the practice expense initiative in this way would have no federal budgetary consequences, because the effort was never intended to produce Medicare savings.

In closing, let me assure you that the College is prepared to work toward a reasonable policy that addresses policymakers' goals and concerns while assuring an outcome that preserves patient access to high-quality Medicare-covered physicians' services.

Conclusion

Mr. Chairman, we have all heard about the straw that broke the camel's back. On behalf of my surgical colleagues, I am obliged to point out that the anti-surgery proposals being advanced by the Administration make for a very big bundle of straw. The combined payment effect from adoption of a single conversion factor, refusal to pay fairly for medically necessary assistant at surgery services, and implementation of flawed practice expense values is simply too much. For example, if a single conversion factor, the new practice expense relative values recently released by HCFA, and the proposed assistant at surgery policy were adopted, their combined effect could reduce Medicare payment to the principal surgeon for a coronary artery bypass operation by about 60 percent!

To be quite frank, we sometimes get the feeling that Medicare would simply prefer to stop providing surgical services to its beneficiaries. We presume this also means that the Administration expects that Medicare beneficiaries requiring radical mastectomies, cataract extractions, kidney transplants, hip replacements, brain surgery, and a few thousand other types of operations, will soon be forced to obtain them from someone other than a qualified surgeon, or be offered some unproven alternative treatment by less-trained health care providers.

Thank you for this opportunity to share our views. I would now be pleased to answer any questions you may have.

1995 NCH Type of Service: Assistant at Surgery

CPT	DESCRIPTOR	1995 Alwd Chrg	% of Total	Cum %	1995 Alwd Freq	% of Total	Cum %
TOTAL		$265,887,725	100%		1,368,191	100%	
33533	CABG, arterial, single	$28,865,388	11%	11%	84,262	6%	6%
27447	Total knee replacement	$22,761,619	9%	19%	72,620	5%	11%
27130	Total hip replacement	$11,290,759	4%	24%	37,785	3%	14%
35301	Rechanneling of artery	$10,175,419	4%	27%	51,258	4%	18%
33512	CABG, vein, three	$7,659,932	3%	30%	18,640	1%	19%
33405	Replacement of aortic valve	$5,853,106	2%	33%	17,890	1%	21%
33513	CABG, vein, four	$5,815,950	2%	35%	13,070	1%	22%
44140	Partial removal of colon	$5,322,973	2%	37%	28,220	2%	24%
56340	Laparoscopic cholecystectomy	$4,516,093	2%	38%	35,718	3%	26%
27236	Repair of thigh fracture	$4,418,777	2%	40%	21,825	2%	28%
55845	Extensive prostate surgery	$4,374,730	2%	42%	12,805	1%	29%
33511	CABG, vein, two	$3,909,401	1%	43%	11,049	1%	30%
27244	Repair of thigh fracture	$3,765,553	1%	45%	19,165	1%	31%
33430	Replacement of mitral valve	$3,480,166	1%	46%	8,313	1%	32%
63047	Removal of spinal lamina	$3,454,979	1%	47%	14,764	1%	33%
56341	Laparoscopic cholecystectomy	$3,011,212	1%	48%	22,856	2%	34%
35081	Repair defect of artery	$2,755,318	1%	49%	9,940	1%	35%
33519	CABG, artery-vein, three	$2,712,872	1%	50%	28,667	2%	37%
58150	Total hysterectomy	$2,262,811	1%	51%	15,322	1%	38%
33514	CABG, vein, five	$2,216,001	1%	52%	4,715	0%	39%
44145	Partial removal of colon	$2,107,125	1%	53%	9,098	1%	39%
19240	Removal of breast	$2,094,456	1%	54%	13,059	1%	40%
35656	Artery bypass graft	$2,057,500	1%	54%	9,263	1%	41%
67038	Strip retinal membrane	$2,034,442	1%	55%	5,733	0%	41%
33518	CABG, artery-vein, two	$1,904,334	1%	56%	28,337	2%	43%
27134	Revise hip joint replacement	$1,796,656	1%	57%	4,594	0%	44%
33534	CABG, arterial, two	$1,780,799	1%	57%	4,666	0%	44%
32480	Partial removal of lung	$1,694,263	1%	58%	7,447	1%	45%
27487	Revise knee joint replace	$1,542,287	1%	59%	4,260	0%	45%
33521	CABG, artery-vein, four	$1,484,867	1%	59%	12,410	1%	46%
35646	Artery bypass graft	$1,474,760	1%	60%	4,398	0%	46%
33510	CABG, vein, single	$1,406,420	1%	60%	5,946	0%	47%
47600	Removal of gallbladder	$1,377,472	1%	61%	13,602	1%	48%
35102	Repair defect of artery	$1,372,825	1%	61%	4,447	0%	48%
50230	Removal of kidney	$1,370,411	1%	62%	5,272	0%	48%
63030	Low back disk surgery	$1,348,537	1%	62%	8,004	1%	49%
44120	Removal of small intestine	$1,346,349	1%	63%	9,917	1%	50%
33530	Coronary artery, bypass/reop	$1,321,767	0%	63%	13,133	1%	51%
63048	Removal of spinal lamina	$1,315,636	0%	64%	20,264	1%	52%
22842	Insert spine fixation device	$1,274,392	0%	64%	4,637	0%	52%
49505	Repair inguinal hernia	$1,263,098	0%	65%	17,697	1%	54%
44143	Partial removal of colon	$1,250,348	0%	65%	6,592	0%	54%
44005	Freeing of bowel adhesion	$1,218,177	0%	66%	8,991	1%	55%
58260	Vaginal hysterectomy	$1,166,790	0%	66%	8,340	1%	55%
44160	Removal of colon	$1,150,378	0%	66%	6,101	0%	56%
27125	Partial hip replacement	$1,116,103	0%	67%	5,278	0%	56%
23420	Repair of shoulder	$1,114,760	0%	67%	6,600	0%	57%
35556	Artery bypass graft	$1,065,371	0%	68%	4,346	0%	57%
35585	Vein bypass graft	$1,031,111	0%	68%	3,357	0%	57%
47605	Removal of gallbladder	$987,011	0%	68%	7,934	1%	58%
35566	Artery bypass graft	$969,882	0%	69%	3,285	0%	58%
67036	Removal of inner eye fluid	$863,888	0%	69%	3,097	0%	58%
35082	Repair artery rupture, aorta	$839,896	0%	69%	2,360	0%	59%

1995 NCH Type of Service, Assistant at Surgery

CPT	DESCRIPTOR	1995 Alwd Chrg	% of Total	Cum %	1995 Alwd Freq	% of Total	Cum %
TOTAL		$265,887,725	100%		1,368,191	100%	
57260	Repair of vagina	$773,085	0%	70%	9,548	1%	59%
66170	Glaucoma surgery	$749,778	0%	70%	4,161	0%	60%
36830	Artery-vein graft	$740,882	0%	70%	5,242	0%	60%
47610	Removal of gallbladder	$731,989	0%	71%	4,865	0%	60%
45110	Removal of rectum	$719,043	0%	71%	2,761	0%	61%
49560	Repair abdominal hernia	$712,945	0%	71%	8,549	1%	61%
27132	Total hip replacement	$674,107	0%	71%	2,036	0%	61%
67108	Repair detached retina	$670,306	0%	72%	2,054	0%	61%
22625		$666,968	0%	72%	2,793	0%	62%
22554	Neck spine fusion	$662,144	0%	72%	3,094	0%	62%
22612	Lumbar spine fusion	$661,718	0%	72%	2,822	0%	62%
49000	Exploration of abdomen	$648,814	0%	73%	6,524	0%	63%
27137	Revise hip joint replacement	$647,761	0%	73%	2,147	0%	63%
33516	CABG, vein, six+	$638,015	0%	73%	1,286	0%	63%
51595	Remove bladder; revise tract	$623,698	0%	73%	1,379	0%	63%
63042	Low back disk surgery	$598,747	0%	74%	2,459	0%	63%
67040	Laser treatment of retina	$593,067	0%	74%	1,957	0%	63%
61510	Removal of brain lesion	$541,062	0%	74%	1,562	0%	63%
51845	Repair bladder neck	$537,255	0%	74%	3,977	0%	64%
27486	Revise knee joint replace	$535,061	0%	74%	1,973	0%	64%
35583	Vein bypass graft	$531,527	0%	75%	2,035	0%	64%
65755	Corneal transplant	$525,968	0%	75%	1,958	0%	64%
61700	Inner skull vessel surgery	$505,676	0%	75%	1,149	0%	64%
63075	Neck spine disk surgery	$493,028	0%	75%	2,814	0%	64%
67107	Repair detached retina	$480,147	0%	75%	2,288	0%	65%
54405	Insert multi-comp prosthesis	$475,804	0%	76%	2,073	0%	65%
27590	Amputate leg at thigh	$463,299	0%	76%	3,580	0%	65%
23472	Reconstruct shoulder joint	$460,770	0%	76%	1,558	0%	65%
32500	Partial removal of lung	$460,684	0%	76%	2,951	0%	65%
23470	Reconstruct shoulder joint	$458,950	0%	76%	2,177	0%	65%
35661	Artery bypass graft	$454,160	0%	76%	2,530	0%	66%
19162	Remove breast tissue, nodes	$453,524	0%	77%	2,935	0%	66%
43324	Revise esophagus & stomach	$445,388	0%	77%	2,538	0%	66%
33860	Ascending aorta graft	$444,864	0%	77%	1,068	0%	66%
44150	Removal of colon	$442,815	0%	77%	1,887	0%	66%
51840	Attach bladder/urethra	$438,326	0%	77%	3,692	0%	66%
33535	CABG, arterial, three	$438,027	0%	77%	981	0%	67%
60500	Explore parathyroid glands	$426,413	0%	78%	2,337	0%	67%
35571	Artery bypass graft	$424,759	0%	78%	1,591	0%	67%
22650		$415,530	0%	78%	5,481	0%	67%
43632	Removal stomach, partial	$413,585	0%	78%	2,010	0%	67%
33522	CABG, artery-vein, five	$402,499	0%	78%	2,794	0%	68%
27138	Revise hip joint replacement	$397,195	0%	78%	1,328	0%	68%
50360	Transplantation of kidney	$383,791	0%	79%	1,075	0%	68%
33426	Repair of mitral valve	$383,090	0%	79%	1,375	0%	68%
33517	CABG, artery-vein, single	$379,924	0%	79%	11,034	1%	69%
44625	Repair bowel opening	$377,915	0%	79%	2,555	0%	69%
35141	Repair defect of artery	$373,033	0%	79%	2,250	0%	69%
61312	Open skull for drainage	$372,030	0%	79%	1,231	0%	69%
38770	Remove pelvis lymph nodes	$363,721	0%	79%	1,828	0%	69%
44320	Colostomy	$350,211	0%	79%	2,958	0%	69%
22845	Insert spine fixation device	$341,678	0%	80%	1,682	0%	70%
36832	Revise artery-vein fistula	$340,264	0%	80%	3,280	0%	70%

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

TESTIMONY
OF

DONNA E. SHALALA

SECRETARY
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Senate Finance Committee
Thursday, February 13, 1997

Mr. Chairman and members of the committee: Thank you for giving me the opportunity to testify today about the President's Fiscal Year 1998 Budget proposal. We in the Administration look forward to working closely with you as we move toward our shared goals of strengthening the Medicare trust fund and balancing the budget.

Someone once described America as "the only country deliberately founded on a good idea."

That good idea is "We the people," and it has emboldened our nation to face -- and overcome -- great challenges with courage and unity.

In the 1940s, we faced a broken Europe, but we summoned the will to fight and win -- and saved the world from tyranny.

In the 50s, we faced the terrible scourge of polio. But children contributed their dimes, and America's best scientists dedicated their lives to finding a vaccine. And we found one.

And, in the 1960s, we faced a Soviet Union that had taken the lead in the race for space. But, President Kennedy issued a challenge to land an American on the moon by the end of the decade. We did, and no country has done it since.

What do all of these triumphs have in common? They came during times of great social and political change. But with a deep sense of urgency, Americans put aside partisan differences, answered the call to unity, and achieved a critical national goal. Today, we must do the same.

Because today, we face another great challenge: At a time when we have fewer resources, a population that is rapidly aging, and a deficit that while much improved, still plagues us, we must come together again: This time to balance the budget and truly reform Medicare, Medicaid, and welfare, while still keeping our promises to the citizens we serve.

MEDICARE

For more than thirty years, Medicare has provided a blanket of health security for older Americans and people with disabilities. It has helped lift a generation of senior citizens out of poverty and into the middle class. It has helped change what it means to be old in America; what it means to be sick in America; what it means to be disabled in America. And it has often served as a fault line between a life of comfort and good health and a life of struggle and illness.

The gift that Medicare has given to those who came before us must be preserved for those who come after us -- for our children and our grandchildren, for every generation. That is our moral responsibility.

But you and I know that Medicare now faces several short-term and a long-term financing challenges that demand action. For nearly four years, we have been unable to come to a consensus on the best way to preserve Medicare and improve it for the future. The President has made it clear that he wants to work with the Congress to make this the year of bipartisan agreement on this vital program.

In this budget, the President has reached out to the congressional majority by offering a plan to meet them halfway. His Medicare proposals will extend the life of the Hospital Insurance Trust Fund into 2007, ten years from today. I have with me today a letter from the independent chief actuary of the Medicare program that verifies that fact. I will be happy to submit it for the record.

The President's plan contributes $100 billion to the five-year balanced budget, which corresponds to $138 billion over six years.

And we do that by maintaining a system that guarantees access to a defined set of services rather than creating a defined contribution per beneficiary.

These proposals are made in good faith and are based on sound policy. They make sense for both the Medicare program and its beneficiaries. Our savings are scoreable. I ask for your careful consideration of our proposals, and for your partnership in enacting them.

But Medicare reform is not and cannot be simply an exercise in number crunching. The actions we take this year to preserve the Medicare trust fund also must prepare Medicare for the future. Not many of us would drive cross country in a car that's more than 30 years old. Likewise, we can't move into the next century with a health insurance program built in 1965. That's why to preserve Medicare, we must modernize it. This modernization requires us to do six things:

First, we must make Medicare a more prudent purchaser of health care services.

Second, we must add new choices to compete with today's private market.

Third, we must strengthen our rural health care system.

Fourth, we must protect beneficiaries, by ensuring that beneficiaries receive higher quality health care.

Fifth, we must continue to root out waste, fraud, and abuse so that we spend our hard-earned tax dollars wisely and effectively.

And sixth, we must add new cost effective benefits to reflect developments in today's science.

Prudent Purchasing

Mr. Chairman, it is imperative that Medicare -- which is the largest purchaser of health care services in our nation -- be a more prudent purchaser. Unfortunately, in too many cases, because of limitations in the law, Medicare is now paying the highest price in the market for certain drugs, lab services and durable medical equipment when, given the volume of beneficiaries, we should be paying one of the lowest. From managed care premiums to medical devices, the reforms we propose will make sure that Medicare isn't paying retail while everyone else is paying wholesale.

These proposals are sound health policy and they require a shared burden. They will result in a slower rate of growth in Medicare spending and ensure that Medicare is paying a competitive price for the services it buys. The savings that these proposals generate are spread across all providers of health care and are focused, as they should be, on those areas where growth is the greatest.

Managed Care. Experts agree that Medicare's payment methodology for managed care, which was created in 1982, results in serious overpayments for services. For example, under contract to HCFA, Mathematica Policy Research, came to such a conclusion with its 1993 review of the Medicare Risk Program. Both the Physician Payment Review Commission and HCFA studies indicate that Medicare should be paying managed care plans at a rate between 88 and 90 percent of fee-for-service costs. At the same time, however, payments to many smaller, rural plans are too low and are failing to attract much market interest.

The President's budget includes reforms to move us to a better, more competitive system of paying for managed care. Through our Medicare Choices demonstration, we are working on risk adjusters to HMO payments to counter selection bias. We expect to have a proposal for a new risk adjusted payment methodology as early as 1999, with phase-in of new payments beginning as early as 2001.

We recommend three interim and important changes in Medicare payments for managed care plans. First, we propose to carve out from the payment those funds that are intended to cover the cost of direct and indirect graduate medical education and payments to disproportionate share hospitals. We will pay these funds directly to hospitals on behalf of managed care enrollees.

Second, we will gradually reduce the regional variation in payments to managed care plans and create a payment floor for plans in rural counties to encourage enrollment in managed care plans.

And, third, we will reduce the Medicare payment from 95 percent of the average adjusted per capita cost or AAPCC to 90 percent. However, to give plans a sufficient amount of time to adjust to these new payment levels, we would not begin this policy until 2000.

Hospital payments. We propose a series of Medicare hospital payment changes to safeguard the program and to reflect market changes. Under the President's budget, the hospital payment update will be reduced by one percentage point every year from fiscal year 1998 through 2002 to reflect increases in hospital productivity and efficiency.

The Prospective Payment Assessment Commission (ProPAC), created by Congress to offer advice on policies affecting Medicare payments to hospitals and other facilities, recently announced preliminary data showing that the majority of the nation's hospitals have record-setting Medicare margins. ProPAC believes that these margins are evidence that hospitals have become more efficient. Accordingly, ProPAC recommends that hospitals receive no update in their Medicare payments in FY 1998; this would be equivalent to "market basket -2.8 percent."

In light of its other hospital savings provisions, the Administration does not propose the deeper update reduction as recommended by ProPAC. Instead, the Administration spreads the hospital reductions across a number of different areas of hospital payment. When viewed as a whole, the Administration's hospital proposals balance the need to contain Medicare costs with ensuring access to quality care.

Home health care. Home health care is one of the fastest growing components of Medicare, with a projected average annual growth rate of 10.6 percent over the period FY 1997-2002. The average number of home health visits per user increased over 40 percent between FY 1992 and FY 1997. The average payment per visit also has increased, rising from $57 per visit in FY 1992 to an estimated $68 per visit by FY 1997.

We know that this growth has its roots in changes in medical practices and technology, in the expansion of the benefit, and in our current reimbursement system, which can contribute to overpayment and abusive practices. And we know that we must reduce the rate of growth in Medicare home health spending and keep it under control. And, that's what our reforms will help us do.

We will immediately revise our cost limits to establish a set of interim limits that will curb excessive spending and institute a new per-beneficiary payment limit for each home health agency.

We will implement a new prospective payment system for home health services in 1999. This system, which has been recommended by experts to control spending, will reduce incentives for overutilization.

We will eliminate periodic interim payments for home health agencies, which were originally established as an incentive for new agencies to serve Medicare patients. With 100 new agencies joining Medicare each month, this incentive clearly is no longer necessary.

In addition, we will pay for home health services based on where the service is delivered. Frankly, many agencies are taking advantage of a loophole by locating their billing offices in expensive urban areas to take advantage of higher prevailing payments, regardless of where services are actually rendered. We will close that loophole.

Along with our strategy to control home health spending, we propose to reassign payment for home health services that are not associated with post-hospital recovery from Part A to Part B. This reallocation is not counted in the overall $100 billion Medicare savings number that we submitted to the Congress. We would limit Part A home health coverage to the first 100 visits following a 3-day hospital stay, just as this part of the program covers 100 days of skilled nursing care following hospitalization. But, visits beyond 100, and those not following a 3-day hospital stay, would be paid under Part B, along with other outpatient services.

This return of non-post-hospital visits to Part B -- Medicare policy prior to 1980 -- makes the home health benefit consistent with the original intent of the Medicare statute and its division of services between Part A and Part B. It relieves the Part A trust fund of the responsibility for financing care that doesn't belong there, thereby significantly extending the life of the trust fund. And it achieves these goals without subjecting beneficiaries to increases in premiums and cost-sharing.

Beneficiary Centered Purchasing. To become a more prudent purchaser of other health services, our plan gives the Secretary payment authorities to secure better deals for Medicare and the citizens it serves. From setting payments based on competitive bidding to selectively paying centers of excellence a single rate for all services associated with a specific diagnosis, these -- and our other purchasing reforms -- will help us economize, modernize, and create a Medicare program that will not only survive, but thrive, to serve every generation.

New Choices

When it comes to health care for older Americans -- or any Americans for that matter -- there should be no conflicts between choice and quality. We need both. We are proud of our record of increasing choice for Medicare beneficiaries while continuing to protect the quality of care. Since 1993 the number of beneficiaries in managed care has increased by 108 percent and is rising at a rate of 80,000 per month. Today, approximately 13 percent of our Medicare beneficiaries -- about 5 million -- are enrolled in managed care plans.

The President's budget continues this progress by adding new choices to Medicare plans. We will include preferred provider organizations or PPOs, which offer patients a greater ability to choose their doctors and other providers. And we will offer beneficiaries the chance to enroll in provider sponsored organizations or PSOs, offered by hospitals and physicians under integrated arrangements that we hope will improve care and reduce cost.

At the same time, to promote real and informed choice among health plans, Medicare will establish coordinated annual open enrollment periods as well as additional enrollment opportunities to subscribe to managed care and Medigap plans.

To make sure that choice is real and that beneficiaries who choose managed care have an open door to go back to fee-for-service, if they so choose, we will prohibit Medigap insurers from imposing pre-existing condition waiting periods when beneficiaries initially enroll or any time they switch plans. In addition, Medicare will establish continuous Part B enrollment opportunities for beneficiaries.

Rural Health

The Administration continues to promote Medicare reforms that strengthen health care in rural America.

For example, our plan would expand the Rural Primary Care Hospital Program to all 50 states. It would update the payment for sole community hospitals, improve the rural referral center program, and reinstate the Medicare Dependent Hospital program to provide resources to those rural hospitals that need it most.

The reforms will create a national floor to better assure that managed care products can be offered in low payment areas, which are predominantly rural communities. In addition, the proposal includes a blended payment methodology, which combined with the national minimum floor, will dramatically reduce geographical variations in current payment rates.

Protect Beneficiaries

We believe we can balance the budget, preserve the Medicare Trust Fund and modernize Medicare for the 21st century, while still protecting our beneficiaries. And we *must* protect our beneficiaries.

The fact is, more than three-fourths of seniors have incomes of $25,000 or less. We believe that balance billing limits must protect all beneficiaries, regardless of which Medicare coverage option they choose.

Our plan proposes Medigap reforms to assure portability, protect against pre-existing condition limits, and provide equitable and affordable premium rates.

It keeps Part B premiums at 25 percent of program costs. This division of costs, first enacted in the Tax Equity and Fiscal Responsibility Act of 1982, has protected beneficiaries while ensuring that the cost of Part B is shared by those who use it. As noted, the plan creates an opportunity for continuous Medicare Part B enrollment.

For hospital outpatient services, it brings the patient co-insurance rate down from about 50 percent to the 20 percent charged for most other Part B services by 2007.

And, it ensures that managed care plans pay for emergency services when a "prudent layperson" would have reasonably believed they were necessary.

Quality Protection

We must also ensure that beneficiaries receive higher quality health care. We will institute a series of reforms to further improve the quality of care provided to all citizens who rely upon Medicare. We will adopt a new, integrated quality management system for Medicare and Medicaid. This will replace quality related requirements focusing on each provider entity individually. We will also collect and disclose more of our survey data on safety, quality of care, and program integrity so that citizens can have better comparative information on plans and providers. And we will replace the so-called 50-50 rule for managed care plans with more modern quality measures. Protecting and improving health, and increasing satisfaction with the care received are the goals of the program.

Fighting Fraud and Abuse

Modernizing Medicare for the 21st century also requires eliminating the fraud and abuse that robs our health care system and our taxpayers. Since I took office a little more

than four years ago, I have made this a top priority by setting a policy of "zero tolerance" for health care fraud and abuse.

Just two years ago, the President and I unveiled a pilot project called "Operation Restore Trust" to target our anti-fraud efforts to fight fraud and abuse in 5 key states. We have significantly increased the resources of our Inspector General and have strengthened our payment reviews using technology to prevent fraud, and to detect it when it occurs.

And, it's paid off. We estimate that every dollar we invest in our anti-fraud effort yields $10 dollars in savings for the American people. In fact, just last month, Inspector General June Brown reported that "Labscam," her investigation of payment fraud by independent clinical labs, could net the Medicare program millions in recoveries and penalties.

We intend to maintain and intensify these efforts. I will be submitting to Congress a fraud and abuse bill that will enable us to strengthen the identification and enrollment procedure to ensure that only legitimate providers bill Medicare. The President's Budget includes provisions to prevent home health agencies from using a loophole in the current reimbursement system to bill a higher urban rate for service provided in rural areas. We will require insurers to reject insurance coverage so that Medicare does not pay inappropriately for beneficiaries covered by private insurance. We would repeal the anti-kickback exemption for managed care plans, and the requirement that we provide advisory opinions on the anti-kickback statutes enacted last year and scored by the Congressional Budget Office as a considerable cost to the Medicare program. And we propose to reinstate the requirement that providers use reasonable diligence when submitting accurate claims to Medicare. Finally, we will strengthen our ombudsman function in the States, building a cadre of elderly volunteers.

New Benefits

The Medicare benefit package has remained relatively unchanged since 1965. But our science has not. From decades of research, we know that preventive services not only can save money but also can save lives. Now we're putting our money where our science is. I am very pleased by the bipartisan support for expansion of the Medicare benefit package. The President's plan will cover the following:

We expand the availability of annual mammograms for Medicare beneficiaries to eliminate economic barriers to mammography, . We also will waive the Part B deductible and coinsurance for both screening and diagnostic mammograms.

To save lives, we want to provide annual screening to detect signs of colon cancer.

Because better management of diabetes leads to better health, we include monitoring of blood glucose levels and outpatient self-management training for diabetics.

To improve access to adult vaccinations and help seniors avoid serious and sometimes deadly illnesses, we would increase provider payments for vaccines against pneumonia, influenza, and hepatitis B and waive patient cost-sharing for the hepatitis B vaccine.

And, finally, to offer some relief for the families who are primary caregivers of a relative with Alzheimer's disease and other dementias, we would provide a new respite care benefit of 32 hours per beneficiary per year.

MEDICAID

Mr. Chairman, I'd like, now, to turn to Medicaid. The President's budget strengthens the Medicaid program -- so that we can better reach the vulnerable Americans it is designed to serve. Our plan controls the costs of Medicaid and gives new flexibility to the states, without compromising the Federal guarantee of coverage for low-income children, pregnant women, frail senior citizens, and persons with disabilities.

We should all be proud that growth in Medicaid spending has declined significantly over the past two years. CBO's baseline projects five-year Medicaid spending to be more than $80 billion lower than projected just a year ago for the same period. The President's budget ensures that the success we have achieved with our State partners will continue.

Our plan saves, on net, about $9 billion over five years. Total savings are about $22 billion: roughly two-thirds from a reduction in disproportionate share hospital DSH payments and roughly one-third from the per capita cap. At the same time, the President's plan invests $13 billion in improvements to Medicaid including some of the health initiatives to expand coverage for children, changes to last year's welfare reform law, and new policies to help people with disabilities return to work.

Per Capita Cap

Let me take a minute to explain our per capita cap. Under the President's proposal, the Federal government will continue to match state Medicaid spending for each individual enrolled. In this way, there is absolutely no incentive for states to deny coverage to a needy individual or family.

Under the per capita cap, maximum Federal matching expenditures will then be established for each state based on per person spending, the number of beneficiaries, the types of beneficiaries, and the current Federal matching rate. The Federal government would only match expenditures up to a State's total allowable limit. States will have flexibility to use savings from one group to support expenditures for other groups or to expand benefits or coverage.

Not all Medicaid spending would be subject to the per capita cap. Spending for state fraud control units, DSH payments, Medicare premiums and cost sharing, payments to Indian Health Service and other Indian health providers, and the Vaccines for Children program would be excluded. Administrative costs would be included in the base year calculation.

Let me be clear: This per capita cap is neither a block grant nor a cost shift to the States -- it's a sensible way to make sure that the people who need Medicaid are able to receive it. When economic downturns occur, population growth and other factors cause Medicaid enrollment to expand, the Federal spending limit will increase as well. This budget keeps our promise of health care to our most vulnerable citizens, but it does so in a smart, responsible way.

State Flexibility

How will we help states keep spending within these per capita limits? The President's budget includes a series of reforms that increase state flexibility by throwing away mountains of red tape and regulations. For example:

We would repeal the Boren amendment for hospitals and nursing homes and establish a public notice process for determining those reimbursement rates.

We allow states to expand Medicaid coverage to new groups and to enroll beneficiaries in Managed Care without waivers.

We eliminate the requirement for cost-based payments for health clinics and create a new pool for supplemental payments to those clinics that may be adversely affected by this policy.

We replace the 75/25 enrollment composition rule for Medicaid managed care plans with new quality data standards.

We give States the option of extending Medicaid coverage to certain workers with disabilities, thus removing a potential barrier to employment faced by Americans with disabilities.

We eliminate the detailed requirements for state claims processing and information retrieval systems.

DSH Payment Reform

In addition to the per capita cap with enhanced state flexibility, federal DSH payments will be reduced and targeted to safety net hospitals and other essential community providers.

Medicaid DSH spending doubled each year from 1988 to 1993. Although this rapid growth has slowed -- thanks to bipartisan laws enacted in 1991 and 1993 to place stricter limits on growth in the DSH program -- today's DSH program is still too large, inconsistently distributed among States and is not always focused on safety net providers. Our proposal makes DSH a smaller, smarter program, better able to fulfill its original intent.

Covering Children

Mr. Chairman, I know that all of the members of this Committee agree that the tragedy of some 10 million American children without health insurance demands bipartisan action. The vast majority of these children live in families where parents work hard and play by the rules.

We believe that situation is unacceptable for a great nation. No working parent should have to live with the fear that his or her children will become sick or hurt one day -- and there will be nowhere to take them to ease the pain.

Our goal is to cut the number of uninsured children by up to 5 million over the next five years. And, the President's budget takes important steps to help us do just that.

First, the President's health insurance for the families of workers who are in-between jobs initiative, which provides up to six months of premium assistance, is expected to add another 700,000 children to the private-sector insurance rolls.

Second, we will make available to the states $750 million annually to support innovative programs designed to purchase insurance for an estimated one million uninsured children in families that receive neither Medicaid nor employer-sponsored insurance.

Third, we will give states the option to allow 12 months of continuous Medicaid coverage for all children who are eligible. By stopping the churning of children in and

out of Medicaid, we can provide stable coverage for children and better continuity of services. We estimate this change will help one million children annually.

Fourth, the Department will work closely with the states to enroll 1.6 million of the estimated three million children who are eligible for Medicaid today but who, for a variety of reasons, are not enrolled. We are committed to working with the nation's governors, communities, providers, and businesses to make this a reality.

And fifth, States will enroll an additional 250,000 low-income children in each of the next four years as part of the current law expansion of coverage to children between the ages of 14 and 18 under current law.

Mr. Chairman, let me say that we view these proposals as a package. My Department estimates they will dramatically reduce the number of uninsured children in America, thereby improving their health and their parents' peace of mind. And, they will create an affordable Medicaid program that fulfills the promises we have made to our most vulnerable citizens.

Welfare

Now let me turn to welfare reform. When the President signed the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, he made it clear that this was the beginning -- not the end -- of welfare reform. He made it clear that we all have a responsibility to come together and make this law work -- especially for our children. And, he made it clear that this was an opportunity for us to create a welfare system that requires work, promotes parental responsibility, and protects children.

I'm proud of the progress we've made together. Before welfare reform became law, we gave 43 states the flexibility they need to test innovative welfare strategies. Paternity establishments have gone up 50 percent since 1992. In 1996, we collected a record of over $12 billion in child support payments. And the tough new provisions in the welfare law are projected to increase child support collections by an additional $24 billion over 10 years.

The result? Because of the intensity of our efforts and because of the strength of our economy, welfare rolls have gone down by 2.5 million since the beginning of President Clinton's first term -- the largest drop in history. Moving people from welfare to work, enabling them to support their families and maintain their independence -- that's the goal upon which all of us have always agreed.

We are committed to combining all of the leadership, talent and resources possible to implement the new welfare law. The effort to make welfare reform a success is one in which many departments and agencies -- SSA, the Departments of Treasury, Labor, Transportation, HUD, and others -- have joined together.

Let me briefly give you a progress report on our implementation of the new Temporary Assistance for Needy Families (TANF) program. Although states have until July 1997 to implement the TANF program, we have already given the green light to 35 states (as of 2/10/97) to begin their reforms. HHS has provided guidance indicating that States have flexibility in designing their TANF programs, but at the same time emphasizing the importance of moving families from welfare to work and ensuring that Federal costs do not increase due to the potential loss of child support collections.

At the Federal level, we are challenging States to transform the very culture of the system from a welfare program to a work program. We must launch a national effort in every State and every community to make sure there are jobs for people making the transition from welfare to work. So they can leave the welfare rolls, they must have opportunities not only to find jobs, but to keep them.

As I indicated earlier, the hallmark of this welfare law is the broad flexibility it gives states to design innovative reforms that address their unique challenges. We are confident that States will use this considerable new flexibility and the President's new initiatives to strengthen their focus on work as well.

We will be monitoring state performance and, pursuant to the statute, ranking them accordingly. We will be identifying and studying the high performers and the low performers, tracking child poverty, and providing an overall assessment of the legislation's impact on children and families.

We will look closely at how states comply with some key statutory requirements, including child support enforcement, work participation rates, maintenance of effort, and data reporting.

We also will assume major new responsibilities for compiling and disseminating information. As the number of options continues to grow, states will need better information about these options, and the Congress will need better information to assess how effectively federal funds are used.

I know that several members of Congress have suggested a wait-and-see approach to the new welfare system. They advise that state implementation should be carefully reviewed before undertaking major policy changes to the TANF program. Our Department has proposed a number of technical and conforming changes to the TANF program that I believe maintain the spirit and intent of its policies.

Our Administration believes that welfare reform has always been -- and must always remain -- a bipartisan issue. But, just as we came together to make work and responsibility the law of the land, we believe it is time to come together again to ensure that the centerpiece of welfare reform remains a real effort designed to find work for everyone who is able to work.

Creating these opportunities will take a commitment from business and labor, from religious organizations and communities, from officials at the federal, state, and local levels. And, it will take the bipartisan Congressional spirit that brought us this far -- and must continue to carry us down the road to success.

That is why the President's FY 98 budget contains funds to help States and cities create new jobs, prepare individuals for them, and provide employers with incentives to create new job opportunities for long-term welfare recipients.

To help welfare recipients move from welfare to work, and to supplement TANF funds, the President proposes two new initiatives: A Welfare-to-Work Jobs Initiative to help States and cities create job opportunities for the hardest-to-employ welfare recipients and a greatly enhanced Work Opportunities Tax Credit to provide powerful new private-sector financial incentives to create jobs for long-term welfare recipients.

The Welfare-to-Work Jobs Initiative, which would be administered by the Department of Labor, would provide $3 billion in mandatory funding over three years for job placement and job creation to move a million recipients off the welfare rolls by the year 2000. We will encourage States and cities to use voucher-like arrangements as they deploy these funds to empower individuals with the tools and choices to help them get jobs and keep them.

Under the enriched Work Opportunities Tax Credit for hiring long-term welfare recipients, employers could claim a tax credit of 50 percent of the first $10,000 in wages paid to these hires.

Another major focus for the Administration is to change parts of the welfare reform law that have nothing to do with welfare reform. When the President signed the welfare reform bill he made clear his disappointment with the harsh provisions in the bill relating to benefits to immigrants. The President stated:

> "My Administration supports holding sponsors who bring immigrants into this country more responsible for their well-being. Legal immigrants and their children however, should not be penalized if they become disabled and require medical assistance through no fault of their own."

The President's FY 1998 budget makes good on his promise to correct provisions that were included to save money, and which burden States and punish children and the disabled who cannot work. Legal immigrants should have the same opportunities, and bear the same responsibilities, as other members of society. The welfare law denies most legal immigrants access to fundamental safety net programs unless they become citizens -- even though they are in the U.S. legally, are working and paying taxes and are responsible members of our communities.

The Administration has always supported making individuals who encourage their relatives to emigrate to the United States more responsible for the immigrant's well being. However, as a nation, we should not turn our backs on anyone who has lost their ability to earn a living due to injury, disease or illness. The Nation should protect legal immigrants and their families -- people admitted as permanent members of the American community -- when they suffer accidents or illnesses that prevent them from earning a living.

Consequently, the budget proposes to make legal immigrants who become disabled after entering the United States eligible for SSI and Medicaid. This proposal would allow 320,000 legal immigrants who experienced an accident or illness which resulted in disability after entering the U.S. to receive SSI and Medicaid benefits. We are pleased that the governors, in an NGA resolution last week, agreed - we must not balance the budget on the backs of States or legal immigrants.

The budget would lengthen the five year exemption from the ban for refugees to seven years in order to give them a more appropriate amount of time to naturalize. The United States admits refugees and asylees into this country on a humanitarian basis. Assistance for this population while they adjust to their new circumstances is a matter of simple decency. The budget also would delay the Food Stamp ban on legal immigrants until the end of FY 1997 in order to give immigrants more time to naturalize.

The budget would also provide poor children of legal immigrants the same Medicaid health care coverage low income citizen children receive. In addition, under our budget, disabled children who are currently eligible for Medicaid because they are receiving SSI benefits will be able to retain their Medicaid coverage -- even if they lose their SSI benefits as a result of the tightened definition of childhood disability. Under this proposal, the families of these needy disabled children will be assured that medical assistance will continue to be provided.

Finally, the Administration is proposing to restore some of the overly deep benefit cuts to the Food Stamp program. The proposal includes replacing the 3 month time limit for childless workers with a real work requirement which would not punish those looking for but unable to find work. Also changes would be made to help families with high

housing costs and to ensure that families' ability to purchase an adequate diet keeps up with inflation.

Overall, our proposals strengthen our commitment to a new welfare system focused on work and responsibility while addressing the concerns of State and local officials and restoring benefits to those who can't work - particularly children and the disabled. We must give all Americans a hand-up and get on with the real business before us; reforming our welfare system together.

Mr. Chairman, the budget I have discussed today discards tired old solutions and meets our challenges creatively and cooperatively. It balances the budget, without abandoning our values and commitments.

It makes tough choices and shows tough management.

Now we must act upon it.

Because, just like the past when we faced down diseases and tyranny, future generations will look back on today.

The question is, whether they will see a nation that put aside politics and came together to protect the health of its citizens in the 21st century.

The answer is up to us. Thank you.

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Modernizing Medicare

Prudent Purchasing

- Centers of Excellence
- Competitive bidding
- Global payment for selected services
- Inherent reasonableness authority
- Post-acute services payment reform

Improving Choices

- Expanded managed care options
- Annual open enrollment for Medigap and managed care plans
- Comparative information on all choices
- Medigap community rating
- Medigap pre-existing condition reform
- Standardized additional benefit packages
- Revised managed care payment

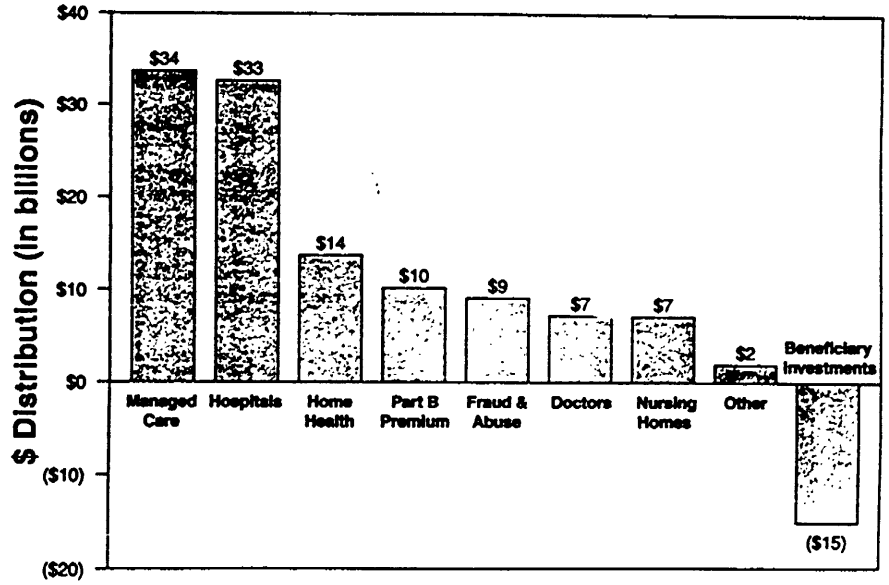
Beneficiary Protections

- Hospital outpatient coinsurance reform
- Part B late enrollment surcharge reform
- Improved financial protections for managed care enrollees

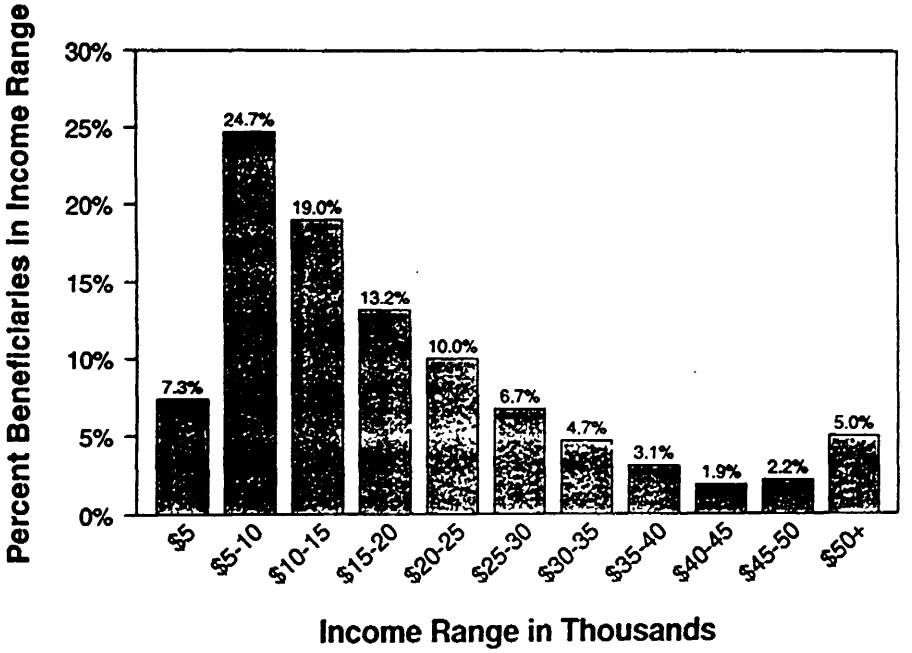
New Benefits

- Diabetes education
- Improved mammography benefits with no cost-sharing
- Colorectal cancer screening
- Increased payment for vaccines with no cost-sharing
- Respite benefit for Alzheimer's patients

1998 President's Budget Medicare Savings by Category (5-Year Totals, 1998-2002)

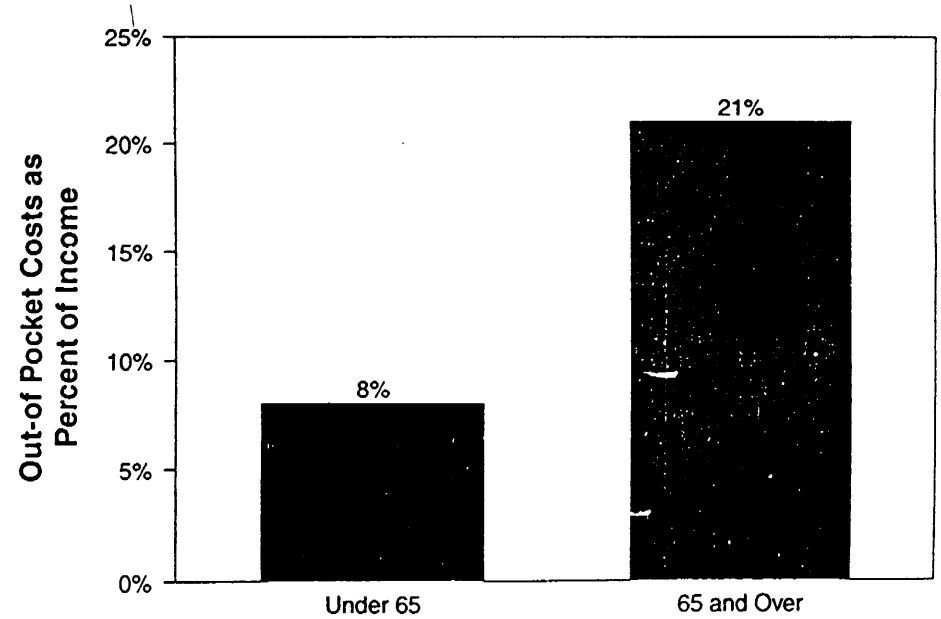


Almost 75 Percent of Medicare Beneficiaries Have Incomes Under $25,000



Source: HCFA Actuaries. Household Income Data.

Older Americans Spend Two and One-Half Times More of Their Income on Out-of-Pocket Costs Than the Non-Elderly



Source: AARP/Urban Institute

The President's Medicaid Proposal: Flexibility for States

Promote Managed Care

- Permits managed care without waivers
- Replaces certain Federal contracting rules and 75/25 rule with an improved quality assurance process

Increase Flexibility in Eligibility/Benefits

- Permits home and community-based care program without waivers
- Allows eligibility simplification

Eliminate Federal Provider Payment Rules

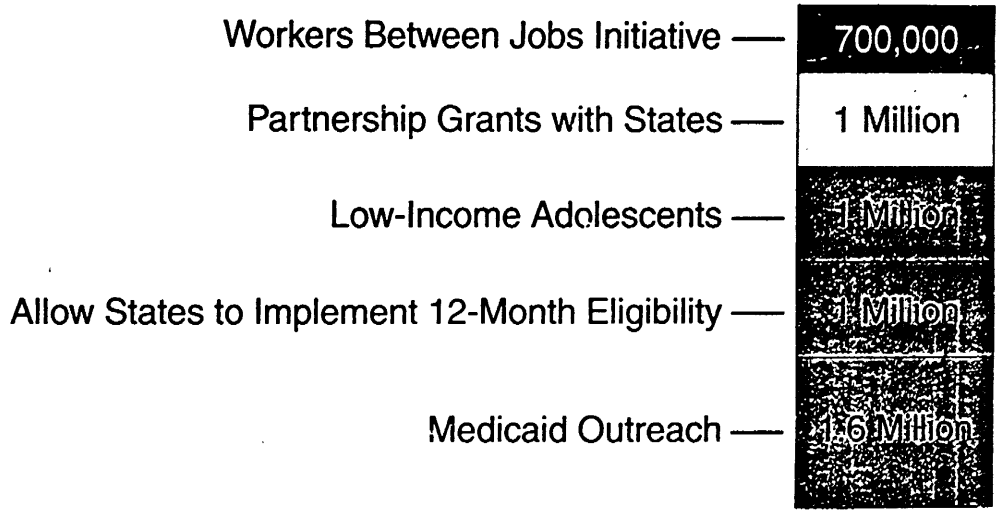
- Repeals Boren Amendment
- Eliminates cost-based payment for health centers (FQHCs/RHCs)
- Eliminates qualification requirements for certain physicians (Ob/Peds)

Streamline Administration

- Eliminates annual State reporting requirements for certain providers
- Simplifies computer system requirements

Children's Health Initiative

Potential Number of Children Covered by 2000



Total: ~5 Million

Department of Health and Human Services Estimates
1. Illustrative estimates of potential coverage. Assume all States and partners participate in program.
2. Estimates do not count for overlap between target populations.

MEDICARE FY98 LEGISLATIVE PROPOSALS
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BENEFICIARY IMPROVEMENTS

Beneficiary Improvements

Program Improvements
- o Definition of DME
- o PACE Demonstrations
- o Extend Social HMO for Three Years

Choice

Medicare Managed Care
- o Permit Enrollment of ESRD Beneficiaries
- o Limits on Charges for Out-of-Network Services
- o Coverage for Out-of-Area Dialysis Services
- o Clarification of Coverage for Emergency Services
- o Permit States with Programs Approved by the Secretary to Have Primary Oversight Responsibility
- o Modify Termination and Sanction Authority

Improved Quality

Accreditation
- o Modify the Deeming Provisions for Hospitals to Require that the JCAHO/AOA Demonstrate that All of the Applicable Hospital Conditions are Met or Exceeded and to Enhance Monitoring and Enforcement of Compliance
- o Permit the Secretary to Disclose Accreditation Survey Data from Accrediting Organizations for Purposes Other than Enforcement

Survey and Certification
- o Permit Collection of Fees from Entities Requesting Initial Participation in Medicare
- o Create Authority for an Integrated Quality Management System Across HCFA Programs (Medicare and Medicaid)

Managed Care
- o Deem Privately Accredited Plans to Meet Internal Quality Assurance Standards
- o Replace 50-50 Rule with Quality Measurement System

Nurse Aide Training
- o Permit Waiver of Prohibition of Nurse Aide Training and Competency Evaluation Programs in Certain Facilities and Clarify that the Trigger for Disapproval of

Nurse Aide or Home Health Aide Training and Competency Evaluation Program is Substandard Quality of Care (Medicare and Medicaid)

MODERNIZING MEDICARE

Prudent Purchasing

Post-Acute Payment Reform
- o Secretarial Authority to Create New Post Acute Care Payment System, and Collection of Assessment Data

Beneficiary Centered Purchasing
- o Centers of Excellence
- o Competitive Bidding Authority
- o Purchasing through Global Payments
- o Flexible Purchasing Authority
- o Inherent Reasonableness Authority

Contracting Reform
- o Reform contracting for FI's and Carriers

Improving Efficiency and Eliminating Overpayments

Hospitals
- o Hold-Harmless for DSH(technical)

Part B Issues
- o Replace "Reasonable Charge" Methodology (and "Reasonable Cost" Methodology for Ambulances) with Fee Schedules

FRAUD AND ABUSE
- o Clarify the Definition of "Homebound"
- o Provide Secretarial Authority to Make Payment Denials Based on Normative Service Standards
- o Requirement to Provide Diagnostic Information

MEDICAID FY 1998 PROPOSALS
INDEX
PROMOTING STATE FLEXIBILITY

Increase Flexibility in Provider Payment

- o Repeal Boren Amendment
- o Eliminate cost-based reimbursement for health clinics with one year delay

Increase flexibility in Eligibility:

- o Allow eligibility simplification and enrollment expansion
- o Guarantee eligibility for 12 months for children

Eliminate Unnecessary Administrative Requirements

- o Eliminate OB/Peds physician qualification requirements
- o Eliminate annual State reporting requirements for certain providers
- o Eliminate Federal Requirement for private health insurance purchasing
- o Simplify computer systems requirements
- o Eliminate unnecessary personnel requirements

Increase Flexibility regarding Managed Care:

- o Modify upper payment limit for capitation rates
- o Convert managed care waivers (1915(b)) to State Plan Amendments
- o Modify Quality Assurance with new data collection authority while eliminating 75/25 enrollment composition rule
- o Chang Threshold for Federal Review of Contracts
- o Allow nominal copayments for HMO enrollees

Increase Flexibility regarding Long-Term Care:

- o Convert Home and Community Based Waivers (1915(c)) to State Plan Amendments
- o Increase the Medicaid Federal financial participation rate from 75 percent to 85 for nursing home Survey and Certification activities
- o Permit waiver of prohibition of nurse aide training programs in certain facilities
- o Eliminate unnecessary repayment requirement for alternative remedies
- o Replace ineffective/duplicative Inspection of Care requirements in mental hospitals and ICFs/MR with survey and certification requirements
- o Create Alternative sanctions in ICFs/MR

SPECIAL POPULATIONS

- o Allow SSI beneficiaries who earn more than the 1619(b) thresholds to buy into Medicaid -- working disabled
- o Grant Programs for All inclusive Care for the Elderly (PACE) permanent provider status

IMPROVEMENTS RELATED TO WELFARE REFORM

Disabled beneficiaries

- o Retain Medicaid for current disabled children who lose SSI

Immigrants

- o Exempt disabled individuals from the ban on SSI cash assistance
- o Exempt the following groups from 5 year Medicaid ban and deeming: Disabled individuals and children
- o Extend the Exemption for Refugees/Asylees from 5 to 7 Years

STRENGTHENING FINANCIAL ACCOUNTABILITY

- o FMAP Commission
- o Strengthen MEQC system
- o Increase Federal Payment Cap for Puerto Rico
- o Increase Federal Payment to District of Columbia

FISCAL YEAR 1998 LEGISLATIVE PROPOSALS

PROPOSALS FOR BENEFICIARY IMPROVEMENTS, MODERNIZING MEDICARE, AND FRAUD AND ABUSE
(Proposals with no Budgetary Impact)
February 11, 1997

Beneficiary Improvements

Program Improvements

- **Definition of DME**

  Modify the definition of DME to include items needed "for essential community activities". The Secretary would have the authority to limit the benefit to assure the efficient provision of items needed by the beneficiary (e.g. through the use of prior authorization of equipment). Under current law, durable medical equipment (DME) is limited to those items appropriate for use in the home. This definition was developed in 1965, when Medicare only applied to the elderly, and beneficiaries who used DME were not expected to function outside the home. The expanded definition will encourage independent activity by disabled beneficiaries.

- **PACE Demonstrations**

  Grant full permanent provider status for Program of All-inclusive Care for the Elderly (PACE) demonstration sites that currently meet the PACE protocol. PACE has proven to be a successful model for a unique service delivery system for frail-elderly persons who live in the community.

- **Extend Social Health Maintenance Organization (SHMO) Demonstrations**

  Extend both the first and second generation of SHMO demonstrations until December 31, 2000. SHMOs enroll a cross-section of the elderly living in community and provide standard Medicare benefits, together with limited long-term care benefits. These congressionally-mandated demonstrations are currently set to expire on December 31, 1997. A three-year extension would provide additional time to evaluate this delivery model.

Choice

Medicare Managed Care

- **Permit Enrollment of ESRD Beneficiaries**

  Permit beneficiaries with ESRD to enroll in a managed care plan. Currently, while beneficiaries who develop ESRD can stay enrolled in a plan, beneficiaries with ESRD are prohibited from enrolling. ESRD beneficiaries should not have their coverage options limited because of their health status.

- **Limits on Charges for Out-of-Network Services**

  Expand current limits on charges to plans by non-contracting entities for authorized services. Limits which now apply in the case of inpatient hospital, SNF, physician and dialysis services would apply in regard to all services for which there is a fee schedule or limit under fee-for-service Medicare. Apply these same limits to unauthorized, out-of-network services. Providers should not have a windfall payment as a result of providing an authorized or unauthorized service to a Medicare beneficiary enrolled in a managed care plan. Beneficiaries who decide to receive unauthorized services should have the same protections as beneficiaries who remain in fee-for-service Medicare.

- **Coverage for Out-of-Area Dialysis Services**

  Require plans to pay for out-of-area dialysis services when an enrollee is temporarily out of the plan's service area. Under current law, plans are only obligated to pay for out-of-area services in two instances: emergency care and urgent care. Since services such as dialysis are foreseeable, plans have no obligation to pay for them. As a result, managed care enrollees with ESRD are effectively barred from ever leaving their home town.

- **Clarification of Coverage for Emergency Services**

  Clarify the obligation of managed care plans to pay for emergency services provided to their plan's enrollees (whether through the plan or by a non-plan provider) by defining "emergency services" as services that a "prudent layperson" would, from his or her perspective, reasonably believe were needed immediately to prevent serious harm to his or her health. This clarification of Medicare policy will be helpful to states as they determine what requirements should apply in regard to emergency services provided to commercial managed care enrollees.

- **Permit States with Programs Approved by the Secretary to Have Primary Oversight Responsibility**

  Authorize States, with programs approved by the Secretary, to certify whether a plan is eligible to contract with Medicare and to monitor certain aspects of plan performance. Such certification and monitoring would be subject to Federal standards. The Secretary would retain final authority in regard to contracting and compliance actions. User fees would be collected from plans for both the certification and monitoring activities. Effective 1/1/98. The proposal would eliminate certain duplication of effort that exists between States' traditional licencing role and HCFA oversight of managed care contractors.

- **Modify Termination and Sanction Authority**

  Authorize the Secretary to terminate a contract prior to a hearing in cases where the health and safety of Medicare beneficiaries are at-risk. Delete requirement for corrective action plans and for hearing and appeals prior to imposing intermediate sanctions. Conform sanctions options add by the existing sanction authority. When the health and safety of beneficiaries is at risk, HCFA should not be required to hold a hearing prior to terminating a contract. In regard to intermediate sanctions, HCFA already provides plans with the opportunity to respond to findings that the plan has committed an act subject to an intermediate sanction. Requiring a hearing and an appeal in all instances however, would unnecessarily hinder enforcement actions. .

Improved Quality

Accreditation

- **Modify the "Deemed Status" Provisions for Hospitals to Require that the JCAHO Demonstrate that All of the Applicable Hospital Conditions are Met or Exceeded and to Enhance Monitoring and Enforcement of Compliance**

  This would require the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) to demonstrate that, under its accreditation process and standards, accredited hospitals meet or exceed all federal health and safety standards (called the Medicare "conditions of participation"). Further, the JCAHO would be required to enforce compliance with the standards and monitor those entities that are found out of compliance. Under current law, hospitals that receive JCAHO accreditation are automatically deemed to have met Medicare conditions of participation and the Secretary has no statutory authority to require the JCAHO to monitor compliance. The Omnibus Consolidated Rescissions and Appropriations Act of 1996 raised the standards for deemed status of other (non-hospital) providers by authorizing the Secretary to grant Medicare deemed status to providers if the accrediting body has demonstrated to the

Secretary that a provider category meets or exceeds all of the Medicare conditions and requirements. This proposal would bring hospital "deemed status" requirements in line with deeming requirements for other providers.

- **Permit the Secretary to Disclose Accreditation Survey Data from Accrediting Organizations for Purposes Other than Enforcement**

  This would broaden the instances when the Secretary may disclose accreditation survey information to include instances where the Secretary deems disclosure to be in the interests of beneficiary safety, quality of care, and program integrity. Under current law, the Secretary may not publicly disclose any accreditation survey result unless the information relates to an enforcement action taken by the Secretary. Such limited authority restricts the Secretary from fully safeguarding quality.

Survey and Certification

- **Permit Collection of Fees from Entities Requesting Initial Participation in Medicare**

  This would permit the Secretary to charge entities (including dually-participating Medicare/Medicaid providers but excluding clinical labs under CLIA) a fee for the initial survey required for participation in the Medicare program. Under this new authority, HCFA would charge fees through its agreements with State survey agencies. As HCFA's agents, States would collect and retain these fees and apply them to their survey costs. HCFA's survey and certification budget has been held constant since 1993, while the number of entities seeking to enter the Medicare program has grown dramatically each year. This under-funding has forced HCFA to prioritize State survey workloads and has resulted in extensive delays of initial certification surveys. This proposal would allow a greater number of providers to enter the Medicare program in a timely fashion, thereby enhancing beneficiary access to, and choice of, providers. In addition, program certification allows providers to derive a financial benefit from participating in Medicare and Medicaid. Charging for initial program participation surveys is consistent with the fee-based approach for other government services.

- **Create Authority for an Integrated Quality Management System Across HCFA Programs (Medicare and Medicaid)**

  This proposal would provide for a uniform authority for all Medicare and Medicaid quality management activities. A re-engineered, integrated quality management approach would include, but not be limited to: authorities for data collection, quality conditions, enforcement, publication of provider-level data, user fees, deeming flexibility, and designated accountability. Prior to full implementation of an integrated quality management system, HCFA would test out various models through demonstrations. For the last five years, HCFA has been building the foundations of a truly re-engineered

approach to survey and certification activities, which creates a new conceptual framework and reshapes many operational features of the current system and breaks through current limitations. HCFA would like to test this re-engineering concept through a demonstration.

Managed Care

- **Privately Accredited Plans Deemed to Meet Internal Quality Assurance Standards**

  Authorize the Secretary to deem plans with private accreditation as meeting internal quality assurance requirement. This proposal, without reducing Federal standards, would eliminate certain duplication of effort that exists between private accreditating organizations' review of plans internal quality assurance programs and HCFA's own efforts.

- **Replace 50/50 Rule with Quality Measurement System**

  Eliminate the current requirement that managed care plans maintain a level of commercial enrollment at least equal to public program enrollment, once the Secretary, in consultation with the consumers and the industry, develops a system for quality measurement. Authorize the Secretary to terminate plans that do not meet standards under the quality measurement system. Until the quality measurement system is in place, expand the Secretary's waiver authority for 50/50 (e.g., plans with good track records). The Administration believes that the 50/50 rule should be retained until an adequate quality measurement system is in place. This system, once in place, should drive contracting decisions.

Nurse Aide Training

- **Permit Waiver of Prohibition of Nurse Aide Training and Competency Evaluation Programs in Certain Facilities and Clarify that the Trigger for Disapproval of Nurse Aide or Home Health Aide Training and Competency Evaluation Programs is Substandard Quality of Care (Medicare and Medicaid)**

  This would allow States to waive the prohibition on nurse aide training and competency evaluation programs offered in (but not by) a SNF or Medicaid NF if the State: (1) determines that there is no other such program offered within a reasonable distance of the facility; (2) assures, through an oversight effort, that an adequate environment exists for operating the program in the facility; and (3) provides notice of such determination and assurances to the State long-term care ombudsman. The proposal would also make clear that a survey finding substandard quality of care, rather than the mere occurrence of an extended or partial extended survey is what triggers the sanction of the training program. The current prohibition on nurse aide training and competency evaluation programs causes a special problem for rural nursing home where a community college or other training

facility may be inaccessible to nurse aides. This proposal would safeguard the availability of nursing homes which might otherwise stop participation in Medicare and Medicaid as a result of losing a training program's approval. This proposal is also a part of the Vice-President's "Reinventing Government" initiative. A clarification of the circumstances under which a program must be sanctioned is needed because the fact that an extended or partial extended survey is conducted is not, in itself, an indication that substandard quality of care exists in the SNF, NF, or HHA.

STRUCTURAL REFORM -- MODERNIZING MEDICARE

Prudent Purchasing

Post-Acute Payment Reform

- **Secretarial Authority to Create Integrated Post Acute Care Payment System, and to Collect Assessment Data**

  This would signal the Administration's intention to develop, in the future, a fully integrated payment system for all post-acute care services (including SNFs, HHAs, rehabilitation and long-term care hospitals). It would give the Secretary the authority to implement, through regulations, a single payment system that includes (at a minimum) a case-mix adjustment mechanism predicated on a standard core patient assessment instrument; equitable payment among provider types; budget neutrality to post-acute payments in some base year; and geographic adjustments. The uniform payment system would be built upon the prospective payment system for home health and an expanded PPS for SNF that more appropriately reflects costs across all post-acute inpatient settings, including the higher intensity of service in rehabilitation and long-term care hospitals. It would authorize the Secretary to collect any and all data, on a national basis, that would be necessary to implement such a system. There is considerable overlap in the types of services provided and the types of beneficiaries that are treated in each of the post-acute settings. Despite this overlap, Medicare's current payment and coverage rules vary by setting and may create perverse incentives to treat patients in one setting rather than another in order to maximize reimbursement. A "site-neutral" integrated post-acute care payment would help to ensure that beneficiaries receive high quality care in the appropriate settings. This system would ensure that reimbursement is sufficient for all patient types, including high intensity patients who in the current environment are cared for in rehabilitation hospitals. In addition, any transfers among settings occur only when medically appropriate and not in an effort to generate additional revenues. A consistent patient classification system would allow meaningful comparisons of the diagnoses, severity, and functional limitations of patients in all these settings; permit case-mix adjustment for payment purposes; and permit greater coordination of care. ProPAC has cited the perverse incentives that currently operate under separate and distinct payment methods for post-acute care services.

Beneficiary-Centered Purchasing

In general, provide the Secretary with authority to pay on the basis of special arrangements as opposed to statutorily-determined, administered prices. This proposal has five components which are fully described below: Centers of Excellence; Competitive Bidding; Global Payments; Flexible Purchasing Authority; and Inherent Reasonableness Authority. Two years after enactment, and annually thereafter for the next three years, the Secretary would report to Congress by March 1st on the use of these new authorities, including the impacts on program expenditures and on the access and quality of services received by beneficiaries.

+ **Centers of Excellence** - Authorize the Secretary to pay selected facilities a single rate for all services (including potentially post-acute services) associated with a surgical procedure or hospital admission related to a medical condition, specified by the Secretary (The Secretary would be required by January 1, 1999 to establish Centers of Excellence for CABG surgery, other cardiac procedures and for hip and knee replacements across the country). Selected facilities would have to meet special quality standards. The single rate paid to a Center would have to represent a savings to the program. There would be no requirement for beneficiaries to receive services at Centers. However, Centers would be allowed, subject to approval by the Secretary, to provide additional services (such as private room) or other incentives (waiver of cost-sharing) to attract beneficiaries.

+ **Competitive Bidding Authority** - Authorize the Secretary to set payment rates for Part B services (excluding physician services) specified by the Secretary based on competitive bidding. The items included in a bidding process and the geographic areas selected for bidding would be determined by the Secretary based on the availability of entities able to furnish the item or services and the potential for achieving savings. Bids would be accepted from entities only if they met quality standards specified by the Secretary. The Secretary would have the authority to exclude suppliers whose bid was above the cut off bid determined sufficient to maintain access. Automatic reductions in rates for would be triggered for clinical laboratory services and DMEPOS (excluding oxygen services) if by 2001 a 20 percent reduction had not been achieved.

+ **Purchasing Through Global Payments** - Authorize the Secretary to selectively contract with providers and suppliers to receive global payments for a package of services directed at a specific condition or need of an individual (e.g. diabetes, congestive heart failure, frail elderly, cognitively or functionally impaired, need for DME). The Secretary would select providers on the basis of their ability to provide high quality services efficiently, to improve coordination of care (e.g. disease management, case management), and to offer additional benefits to beneficiaries (e.g. prescription drugs, respite, nutritional counseling, adaptive and assistive

equipment, transportation.) Within the global payment, providers would have flexibility in how services are provided, and they may, subject to approval by the Secretary, offer additional, non-covered benefits financed through the global payment. The global rate would have to represent a savings to the program. Beneficiaries would voluntarily elect on a month-to-month basis to participate in such arrangements and during that period would be "locked-in" for the services covered under the arrangement.

+ **Flexible Purchasing Authority** - Authorize the Secretary, after rulemaking, to negotiate alternative administrative arrangements with providers, suppliers and physicians who agree to provide price discounts to Medicare. These discounts could be based on current fee schedules or payment rates or could involve alternative payment methods. The alternative administrative arrangements could not include any changes to quality standards or conditions of participation. The Secretary would have the authority to permit sharing of these savings with beneficiaries who use these entities - - for example, through a reduced deductible in the case of hospital services or lower coinsurance payments in the case of other services.

+ **Inherent Reasonableness Authority** - Restore Medicare's carriers authority to make "inherent reasonableness" payment changes for durable medical equipment, prosthetics and orthotics (DMEPOS) as well as surgical dressings.

Medicare's statutory framework was based on a Blue Cross/Blue Shield model from the 60's. Although payment methodologies have improved over time, current payment authority is too rigid for the fee-for-service program to meet the challenges of the 21st century. Each component of this initiative represents an approach that has been used successfully by the private sector, other government program or under Medicare's demonstration authority.

Contracting Reform

o **Reform Contracting for FIs and Carriers**

This proposal would end the requirement that all Medicare contractors perform all Medicare administrative activities, and would allow Medicare to contract with entities other than insurance companies. New contractors would be awarded contracts using the same competitive requirements that apply throughout the government. The proposal would give HCFA the tools to take advantage of innovations and efficiencies in the private sector when it comes to beneficiary and provider services, and claims processing. It builds on the Medicare Integrity Program contracting changes established in HIPAA.

Improving Efficiency and Eliminating Overpayments

Hospitals

- **Hold-Harmless for DSH**

  Freeze hospital-specific disproportionate share hospital (DSH) adjustments at current levels, for a period of 2 years. Require the Secretary to submit a legislative proposal to Congress by 18 months after enactment for revised qualifying criteria and payment methodology for hospitals that incur higher Medicare costs because they serve a disproportionate share of low-income patients. Without action by FY 2000, the old (current) formula would be reinstated. The current formula for identifying DSH hospitals relies on counting the number of days the hospital serves Medicare/SSI beneficiaries (as a proportion of total Medicare days) and the number of days it serves Medicaid beneficiaries (as a proportion of total days). The resulting "DSH percentage" is plugged into a formula that computes the increase in Medicare payments for DSH hospitals.

  However, this measure is becoming increasingly unreliable. The recently enacted welfare reform law will have an impact both on the number of people eligible for SSI and the number of people eligible for Medicaid but mot necessarily on the number of low-income individuals seeking hospital care. Furthermore, as the number of uninsured Americans increases, the reliability of this measure to reflect the a hospital's level of uncompensated care decreases. Concurrently, HCFA has lost a series of court cases on the DSH formula, resulting in varying definitions of "eligible Medicaid days" across the country. By freezing the current DSH levels for the next two years, the level of support for DSH hospitals will be sustained while the Secretary develops a proposal to refine the DSH criteria and adjustment.

Part B Issues

- **Replace "Reasonable Charge" Methodology (and "Reasonable Cost" Methodology for Ambulances) with Fee Schedules**

  Create fee schedules, on a budget neutral basis, for the few Part B services still paid according to "reasonable charge" methodology (the most significant services affected would be ambulances, and enteral and parenteral nutrition). Specify that ambulance services provided by hospitals or "under arrangements" would also be covered by the new ambulance fee schedule, with adjustments allowed for certain "core services" that may have higher costs. This proposal will make the payment methodology consistent for all Part B services and improve administrative efficiency. Including hospital based ambulance services under the fee schedule will remove incentives for independent suppliers to evade fee schedule limits by establishing costlier arrangements with hospitals.

FRAUD AND ABUSE

- **Clarify the Definition of "Homebound"**

  This would redefine the "homebound" definition by adding several calendar month benchmarks to emphasize that home health coverage is only available to those who are truly unable to leave the home. The current definition of "confined to the home" is vague and over broad. It allows for considerable discretion in interpretation and fraud and abuse. Financial reviews show that Medicare routinely reimburses care to beneficiaries who are not truly homebound. Without a more concrete definition, this eligibility requirement is very difficult to enforce. The March 1996 GAO report cites the problematic homebound definition as contributing to excessive spending and fraud and abuse.

- **Provide Secretarial Authority to Make Payment Denials Based on Normative Service Standards**

  This proposal would allow the HHS Secretary to establish normative numbers of visits for specific conditions or situations. For example, HCFA could establish a normative number of aide visits for a particular condition, and deny payment for those visits that exceed this standard. Allowing the Secretary to establish more objective criteria will help HCFA gain more control over excessive utilization. A March 1996 GAO report criticizes current statutory coverage criteria as leaving too much room for interpretation and inviting fraud and abuse.

- **Requirement to Provide Diagnostic Information**

  Extend to non-physician practitioners, the current requirement that physicians provide diagnostic information on all claims for services that they provide. Also require physicians and non-physician practitioners to provide information to document medical necessity for items or services ordered by the physician or practitioner, when such documentation is required by the Medicare contractor as a condition for payment for the item or service. Diagnostic information is needed by Medicare's contractors to determine the medical necessity of physician services and for use in quality/outcome research. Given the need for this data, there is no reason to exclude non-physician practitioners from the current requirement to include diagnostic codes on claims forms. Also, in regard to non-physician services and DMEPOS items, suppliers providing the services and items ordered by physicians or non-physician practitioners have reported having difficulty obtaining diagnostic information required by Medicare's contractors. This proposal will clarify that the ordering physician or non-physician practitioners is required to provide such information.

MEDICAID FY 1998 PROPOSALS

STATE FLEXIBILITY AND NEW INVESTMENTS

PROMOTING STATE FLEXIBILITY

Increase Flexibility in Provider Payment

- **Repeal Boren Amendment**

  Repeal the Boren amendment for hospitals and nursing homes, while establishing a clear and simple public notice process for rate setting for both hospitals and nursing homes.

  Modify the process for determining payment rates for hospitals, nursing facilities and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) to add a public notification process that provides an opportunity for review and comment, which should result in more mutually agreeable rates.

- **Eliminate cost-based reimbursement for health clinics**

  Federal requirements that most Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) be paid based on costs would be removed beginning in 1999; and a capped, temporary funding pool would be established to help these facilities during the transition.

Increase Flexibility in Program Eligibility

- **Allow Budget Neutral eligibility simplification and enrollment expansion**

  Enable States to expand or simplify eligibility to cover individuals up to 150 percent of the Federal poverty level through a simplified and expedited procedure. Current rules would be retained to the extent they are needed to ensure coverage for those who do not meet the eligibility criteria of the new option. Federal spending would be restrained by the per capita cap for current eligibles and such expansions would be approved only if they were demonstrated to be cost neutral (i.e. no credit for persons who were not otherwise Medicaid eligible in the determination of cap number).

  This proposal enables States to expand to new groups that are not eligible under current law without a Federal waiver. Administration would be streamlined and simplified in that States would be able to use the same eligibility rules for everyone eligible under the new percent-of-poverty option in place of the current plethora of different rules for different groups. Integrity of Federal spending limits would be maintained by the cost neutrality requirement.

- **Guarantee eligibility for 12 months for children**

  This proposal would permit States to provide 12-month continuous Medicaid eligibility for children ages 1 and older. (Continuous coverage was enacted for infants by OBRA 90.)

  This proposal would provide stable health care coverage for children -- particularly children in families with incomes close to the eligibility income limits, who often lose eligibility for a month due to an extra pay period within a month. This proposal would also reduce State administrative burden by requiring fewer eligibility determinations.

Eliminate Unnecessary Administrative Requirements

- **Eliminate OB/Peds physician qualification requirements**

  Federal requirements related to payment for obstetrical and pediatric services would be repealed. States would only have to certify providers serving pregnant women and children based on their State licensure requirements

  The minimum provider qualification requirements under current law do not effectively address quality of care. In addition, current law fails to recognize all bodies of specialty certification, so certain providers are precluded from participation in Medicaid (e.g., foreign medical graduates). Congress amended the law in 1996 to include providers certified by the American Osteopathic Association and emergency room physicians.

- **Eliminate annual State reporting requirements for certain providers**

  States would no longer have to submit reports regarding payment rates and beneficiary access to obstetricians and pediatricians.

  Current law assumes that access is linked to payment rates. However, the State-reported data do not reveal much regarding the link between payment rates and access.

- **Eliminate Federal requirements on private health insurance purchasing**

  Eliminate requirement that States pay for private health insurance premiums for Medicaid beneficiaries where cost-effective.

  The current law provision is not necessary. States have an inherent incentive to move Medicaid beneficiaries into private health insurance where it is cost-effective. The proposed per capita spending limits increase this incentive. The current, detailed, one-size-fits-all Federal rules hinder States from designing programs that most effectively suit local circumstances.

- **Simplify computer systems requirements**

  Eliminate detailed Federal standards for computer systems design. State systems would be held to general performance parameters for electronic claims processing and information retrieval systems.

  Current detailed requirements for system design were developed for an earlier time in which technology was primitive and detailed Federal rules were necessary to move States closer to what was then state-of-the-art. This is no longer the case. It is now sufficient to require States merely to show that their State-designed system meets performance standards established under an outcome-oriented measurement process.

- **Reduce unnecessary personnel requirements**

  We would work with States and State employees to replace the current, excessively detailed, and ineffective Federal rules regarding administrative issues that are properly under the purview of States, such as personnel standards, and training of sub-professional staff.

Increase Flexibility Regarding Managed Care

- **Modify upper payment limit for capitation rates**

  Modify upper payment limit and actuarial soundness standards for capitation rates to better reflect historical managed care costs by requiring actuarial review of the rates.

  The current Medicaid upper payment limit for managed care contracts (i.e., 100% of fee-for-service) is not an accurate payment measurement for Medicaid managed care plans. It does not reflect historical managed care costs and States claim it is inadequate to attract plans to participate. This proposal would modify the definition of the UPL to more accurately reflect Medicaid spending. It would also modify actuarial soundness standards.

- **Convert managed care waivers [1915(b)(1)] to State Plan Amendments**

  Permit mandatory enrollment in managed care without federal waivers. States would be able to require enrollment in managed care without applying for a freedom of choice waiver [1915(b)(1)]. States would be allowed to establish mandate enrollment managed care programs through a State plan amendment. Qualified IHS, tribal, and urban Indian organization providers would be guaranteed the right to participate in State managed care networks.

  This proposal would provide States greater flexibility in administering their State Medicaid programs by eliminating the freedom-of-choice waiver application process. States would not have to submit applications for implementation or renewal. The Administration is pursuing strategies to assure quality in Medicaid managed care that are more effective and less burdensome than the assurances added through the waiver process. Guaranteeing urban Indian organization providers the right to participate in State Medicaid managed

care networks integrates ITUs into managed care delivery systems and recognizes their unique health delivery role.

- **Modify Quality Assurance with new data collection authority while eliminating 75/25 enrollment composition rule**

  Replace the current enrollment composition rule with a new quality data monitoring system under a beneficiary purchasing strategy with new data collection authority.

  As part of the continuous effort to ensure Medicaid managed care beneficiaries receive quality care, HCFA proposes to implement a "beneficiary-centered purchasing" (BCP) strategy. BCP will replace certain current federal managed care contract requirements. The current enrollment composition rule (i.e., 75/25 rule) requires that no more than 75 percent of the enrollment can be Medicare and Medicaid beneficiaries. The current requirement is a process-related, ineffective proxy for quality. This requirement would be replaced with a quality monitoring system based on standardized performance measures.

  HCFA, in collaboration with States, would define and prioritize a new standard set of program performance indicators, including a new quality monitoring system. These measures would be used to quantify and compare plans' quality of care, provide purchasers and beneficiaries with the means to hold plans accountable, and provide HCFA with comparable data to compare the performance of State programs to effectively hold States accountable as well.

  This proposal would enhance the Secretary's ability to ensure that beneficiaries' interests are being protected as enrollment in managed care increases, and to detect and correct possible abuses by managed care plans. A more outcome oriented quality review process is vital to the Federal and State oversight of managed care plans to ensure that Medicaid beneficiaries are receiving the highest quality care possible. Data would be vital to the success of such an effort.

- **Change threshold for federal review of contracts**

  Raise the threshold for the federal review of managed care contracts from the current $100,000 threshold to $1 million contract amount (or base threshold for federal review on lives covered by plan).

  This proposal would provide greater State flexibility in management and oversight of Medicaid managed care programs. It would also reduce the number the of managed care plan contracts requiring HCFA review and approval.

- **Nominal copayments for HMO enrollees**

  Permit States to impose nominal copayments on HMO enrollees.

  This proposal would bring policy on Medicaid copayments for HMO enrollees more in line with Medicaid copayments that a State may elect to impose in fee-for service settings. It would also allow HMOs to treat Medicaid enrollees in a manner similar to how they treat non-Medicaid enrollees. However, impact on beneficiaries would not be harmful since copayments, if imposed, would still have to be nominal.

Increase Flexibility Regarding Long-Term Care

- **Convert Home and Community Based Waivers (1915(c)) to State Plan Amendments**

  Give States the option to create a home and community-based services program without a Federal waiver, through a State plan amendment. This proposal would benefit States and beneficiaries by eliminating the constant and costly necessity of renewing the waivers, while ensuring a high level of care.

- **Increase the Medicaid Federal financial participation rate from 75 percent to 85 for nursing home Survey and Certification activities**

  Raise the Medicaid Federal financial participation (FFP) rate to 85 percent.

  Federal funding is important to maintain both quality standards established by OBRA 87 and resulting enforcement activities. Increasing the Medicaid federal financial participation percentage to 85 percent would encourage States to increase total spending on nursing home survey and certification activities.

- **Permit waiver of prohibition of nurse aide training and competency evaluation programs in certain facilities. Clarify that the trigger for disapproval of nurse aide or home health aide training and competency evaluation programs is substandard quality of care (Medicare and Medicaid).**

  This would allow States to waive the prohibition on nurse aide training and competency evaluation programs offered in (but not by) a SNF or Medicaid NF if the State: (1) determines that there is no other such program offered within a reasonable distance of the facility; (2) assures, through an oversight effort, that an adequate environment exists for operating the program in the facility; and (3) provides notice of such determination and assurances to the State long-term care ombudsman. The proposal would also make clear that a survey finding substandard quality of care, rather than the mere occurrence of an extended or partial extended survey is what triggers the sanction of the training program.

  The current prohibition on nurse aide training and competency evaluation programs causes a special problem for rural nursing home where a community college or other training facility may be inaccessible to nurse aides. This proposal would safeguard the availability of nursing homes which might otherwise stop participation in Medicare and Medicaid as a

result of losing a training program's approval. This proposal is also a part of the Vice-President's Reinventing Government initiative. A clarification of the circumstances under which a program must be sanctioned is needed because the fact that an extended or partial extended survey is conducted is not, in itself, an indication that substandard quality of care exists in the SNF, NF, or HHA.

- **Eliminate repayment requirement for alternative remedies for nursing home sanctions**

  Eliminate the requirement for repayment of federal funds received if a State chooses to use alternative remedies to correct deficiencies rather than termination of program participation.

  This proposal would allow States to promote compliance by employing alternative remedies on nursing facilities. This provision for alternative remedies gives States the flexibility for more creative implementation of the enforcement regulations.

- **Delete Inspection of Care requirements in mental hospitals and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)**

  Eliminate the duplicative requirement for Inspection of Care (IOC) reviews in mental hospitals and ICFs/MR. The survey and certification reviews that currently take place in mental hospitals and ICFs/MR would remain in place.

  Inspection of Care (IOC) reviews were originally designed to ensure that Medicaid recipients were not being forgotten in long term care facilities. The current survey process has been improved through a new outcome-oriented process that protects recipients in mental hospitals and ICFs/MR from improper treatment. Consequently, IOC reviews are no longer needed and are, in fact, in direct conflict with the revised ICF/MR survey protocol. The current requirement for two reviews (IOC and the ICF/MR survey) has become duplicative. If the IOC were eliminated, the ICF/MR survey and certification process would remain in place.

- **Alternative sanctions in Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)**

  Provide for alternative sanctions in ICFs/MR that already are available for nursing homes. Alternative sanctions that currently are available in nursing homes include: directed in-service training, directed plan of correction, denial of payment for new admissions, civil monetary penalties and temporary management.

  Sanctions other than immediate termination were established for nursing homes under the OBRA-87 legislation, but not for ICFs/MR. This proposal would extend the alternative sanction option to ICFs/MR.

SPECIAL POPULATIONS

- **Allow SSI beneficiaries who earn more than the 1619(b) thresholds to buy into Medicaid**

  This proposal would give States the option of creating a new eligibility category for disabled persons to encourage them to work beyond the 1619(b) income thresholds. SSI beneficiaries who become eligible for this new category would contribute to the cost of the program by paying a premium. Premium levels would be on a sliding scale, based on the individual's income as determined by the States.

  Despite existing work incentives in SSI, fewer than ½ of 1 percent of beneficiaries return to substantial gainful employment annually. The fear of losing medical benefits has been identified as one of the most significant barriers to disabled beneficiaries returning to work or working for the first time. Under this proposal, Medicaid would be used to extend access to coverage for the working disabled who no longer qualify for health care benefits under current law.

- **Grant Programs for All inclusive Care for the Elderly (PACE) permanent provider status**

  Grant full permanent provider status for Program of All-inclusive Care for the Elderly (PACE) demonstration sites that currently meet the PACE protocol. PACE has proven to be a successful model for a unique service delivery system for frail elderly persons who live in the community.

IMPROVEMENTS RELATED TO WELFARE REFORM

Disabled Beneficiaries

- **Retain Medicaid for current disabled children who lose SSI**

  Medicaid would be retained for children currently receiving Medicaid who lose their Supplemental Security Income (SSI) benefits because of changes in the definition of disability.

  Most of these children would requalify for Medicaid by meeting another eligibility category either by meeting other SSI disability listings or other Medicaid categories for non-disabled low-income children. Those who do not, and who would be grandfathered under this proposal, continue to have relatively extensive health and developmental needs which would not be met if these children lost their Medicaid coverage.

Immigrants

- **Exempt certain disabled individuals from the ban on SSI cash assistance**

This proposal exempts immigrants who become disabled after entering this country from the recently enacted ban on SSI cash assistance for "qualified aliens", and ensures that they would retain their Medicaid benefits. The exemption would apply to immigrants who were already here on the date of enactment as well as to new arrivals.

This proposal allows States to continue providing SSI and Medicaid benefits to immigrants who become disabled and who would otherwise be cut off due to welfare reform. It protects those who can no longer be expected to work due to circumstances beyond their control.

- **Exempt immigrant children and certain disabled immigrants from the Medicaid bans and deeming requirements**

This proposal would exempt immigrant children and immigrants who are disabled after entering this country from the bans on Medicaid benefits for current and future immigrants. Immigrant children and immigrants disabled after entry would also be exempt from the new deeming requirements that mandate that the income and resources of an immigrant's sponsor be counted when determining Medicaid eligibility.

These proposals assist the most vulnerable groups of immigrants for whom lack of access to medical care may produce long-term negative consequences and whose medical care may result from an unexpected injury or illness that occurs after their arrival.

- **Extend the Exemption for Refugees/Asylees from 5 to 7 Years**

This proposal would extend the exemption from Medicaid bans and deeming requirements for refugees and asylees by an additional 2 years for a total of 7 years.

Protection of refugees and asylees has been a consistent feature of U.S. immigration policy. Refugees and asylees often face challenges that other immigrants do not because of persecution. Extending the exemption for an additional two years allows for these unique circumstances and possible difficulties these individuals may have in becoming self-sufficient. In addition, more recent populations have included larger numbers of elderly individuals, who may take a longer time to adjust to new circumstances.

STRENGTHENING FINANCIAL ACCOUNTABILITY

- **Establish a Federal Payment Commission**

  Establish a commission to review equity among the States in Medicaid financing formula (FMAP), as well as the base year and growth rates in the per capita spending limits.

  The formula for determining the Federal and State contribution to the Medicaid program, which is based on per capita income in a State, has long been criticized as failing to adequately reflect State variations in their ability to raise revenues and in magnitude of State need. An impartial commission could make recommendations for a more refined formula. Similarly, once the per capita cap has an established track record, an impartial commission would make recommendations for further improvements to improve equity across States.

- **Strengthen Medicaid Eligibility Quality Control (MEQC)**

  Modify and strengthen Medicaid Eligibility Quality Control (MEQC) system. Under a per capita cap limit on spending where Federal funding is tied to the number of beneficiaries in a State, it would become more important than ever to ensure Federal matching payments are provided to States only for their spending on people who actually meet the State's eligibility criteria. The current MEQC system is the appropriate tool for this task, but it must be modified to accommodate and measure population components of the per capita cap. States would have a reasonable error tolerance limit of three percent of enrollments, which is similar to the current tolerance limit.

- **Increase Federal Payment Cap for Puerto Rico**

  Increase the Federal Medicaid payment cap for Puerto Rico by $30 M, $40 M, $50 M, $60 M, and $70 M over current law for FY 1998-2002 respectively.

  Federal matching for the Puerto Rico has always been capped, but at amounts determined by Congress unrelated to impartial measures of need in the Puerto Rico or their ability to contribute a share of program costs. Beginning after 1994, Federal payments are increased every year by the medical component of the CPI, but continue not to take population factors into account. Given underlying eligibility structure in Puerto Rico it would not be appropriate to apply per beneficiary Federal spending limits to Puerto Rico. Nevertheless, some adjustment for population is called for in Puerto Rico, which has had a demonstrated need for Medicaid funding beyond its cap for a number of years.

- **Increase Federal payment to District of Columbia**

  Increase the Federal payment to the District of Columbia by changing the Federal matching rate from 50 percent to 70 percent.

  This proposal would change the District's share of the costs of health care services under Medicaid from 50 percent to 30 percent. This equals the maximum amount that the District, as a local government, could be required to contribute if it were located within a State.

Mr. Chairman, I am pleased to submit for the record the 10-year budget estimates of the President's Medicare proposals. You may note that the five-year savings total is somewhat higher than previously announced. That is because a few technical changes were made to our package after budget numbers were transmited, including changes to respond to CBO's different baseline assumptions. These changes took the package as scored by OMB up to $106 billion. CBO, however, scored this revised package as saving $82 billion over five years. In any case, these changes do not change the basic thrust of our proposals. As we have discussed previously, the 20- and 30-year estimates you requested will be provided sometime in May, after our actuaries have completed work on the 1997 Medicare Trustees Report.

The President's FY 1998 Budget: Medicare Savings and Investment Proposals a/

(FY, $'s in billions, positive numbers are savings, negative numbers are costs, sums may not add due to rounding)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	98-02	98-03	98-07
PART A PROPOSALS													
Managed Care	1.3	3.4	6.7	8.5	10.1	11.4	12.9	14.6	16.4	18.1	30.0	41.4	103.6
Hospitals													
Reduce Hospital PPS Update	0.7	1.4	2.2	3.1	4.0	4.4	4.8	4.9	5.1	5.4	11.4	15.7	35.8
Extend PPS Capital Reduction from OBRA 1990	1.2	1.2	1.3	1.3	1.4	1.4	1.5	1.6	1.6	1.7	6.4	7.8	14.2
Reduce PPS-Exempt Update w/ Rebasing	0.3	0.4	0.6	0.8	1.0	1.1	1.2	1.3	1.4	1.6	3.2	4.3	9.9
Reduce PPS-Exempt Capital Payments	0.1	0.2	0.2	0.2	0.2	0.0	0.0	0.0	0.0	0.0	0.8	0.8	0.8
Reform Base Puerto Rico Payment	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	-0.1	-0.1
Moratorium on Long-Term Care Hospitals	0.0	0.0	0.1	0.1	0.1	0.2	0.2	0.2	0.3	0.3	0.4	0.5	1.5
Expand Centers of Excellence	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.3	0.5
Lower IME	0.2	0.4	0.7	0.9	2.0	2.3	2.5	2.7	2.9	3.1	4.2	6.5	17.6
GME Reform	0.2	0.4	0.7	0.9	1.2	1.5	1.9	2.3	2.7	3.1	3.4	5.0	14.9
Eliminate Add-Ons for Outliers	0.5	0.5	0.5	0.6	0.6	0.6	0.7	0.7	0.8	0.8	2.6	3.3	6.2
PPS Redefined Discharges	0.7	0.8	0.8	0.9	1.0	1.0	1.1	1.2	1.2	1.3	4.1	5.2	10.0
SCH Rebasing	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.6	-0.7	-1.2
RPCH Expansion	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	-0.1	-0.2
Medicare Dependent Hospitals	0.0	0.0	-0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	-0.1	-0.1
Direct Pay of GME/IME/DSH Removed from AAPCC	-1.1	-1.9	-2.1	-2.6	-3.0	-3.5	-3.9	-4.4	-5.0	-5.7	-10.7	-14.2	-33.2
Interactions Among Hospital Proposals	0.0	0.0	-0.1	-0.2	-0.4	-0.5	-0.7	-0.8	-0.9	-1.0	-0.7	-1.3	-4.6
Home Health													
Extend Savings from OBRA 1993 Freeze	0.1	0.3	0.3	0.3	0.3	0.4	0.4	0.4	0.4	0.5	1.3	1.6	3.3
HH Interim System	0.9	1.3	1.5	1.8	2.1	2.4	2.8	3.1	3.4	3.7	7.7	10.2	23.1
HH PPS	0.0	0.0	1.5	1.6	1.7	1.8	2.0	2.1	2.2	2.4	4.7	6.5	15.2
Part A Benes Who Choose Not to Enroll in Part B b/	0.0	0.4	0.7	0.8	0.7	0.7	0.8	1.1	1.1	1.2	2.6	3.3	7.4
Fraud and Abuse													
Clarify and Enhance MSP Authority	0.1	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.4	0.4	1.0	1.3	2.6
Extend Expiring MSP Provisions	0.0	0.7	0.9	1.1	1.3	1.5	1.7	1.8	2.0	2.1	4.0	5.5	13.0
Revise HIPAA Provisions	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.2	0.3	0.5
Pay Home Health at Location of Service	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4	0.5	0.9
Eliminate Home Health PIP	0.0	0.0	0.6	0.1	0.1	0.1	0.1	0.1	0.1	0.1	1.0	1.1	1.4
Require SNF Consolidated Billing	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.3	-0.4	-0.8
Skilled Nursing Facilities													
Extend Savings from OBRA 1993 Freeze	0.0	0.2	0.3	0.4	0.4	0.4	0.4	0.5	0.5	0.5	1.3	1.7	3.6
Establish SNF PPS	0.0	0.9	1.5	1.7	1.7	1.8	2.0	2.3	2.5	2.7	5.8	7.6	17.1
Beneficiary Investments													
Colorectal Screening	-0.1	-0.2	-0.2	-0.3	-0.3	-0.4	-0.4	-0.4	-0.4	-0.4	-1.1	-1.4	-3.0
HI Premium Free Working Disabled	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	-0.1	-0.1
Part A Premium Offset	-0.2	-0.2	-0.3	-0.4	-0.4	-0.5	-0.5	-0.6	-0.6	-0.7	-1.5	-2.0	-4.4
TOTAL PART A	4.9	10.1	18.6	21.8	25.9	28.5	31.5	34.8	38.0	41.4	81.3	109.8	255.4

PART B PROPOSALS													
Managed Care	-01	02	11	17	21	17	15	18	19	22	51	68	142
Hospitals													
Outpatient PPS c/	00	18	18	21	25	37	34	41	50	58	82	119	302
Outpatient GME Reform	00	00	00	00	00	00	00	00	00	00	-00	00	01
Expand Centers of Excellence	00	00	00	00	00	00	00	00	00	00	01	01	02
Physicians and Other Practitioners													
Single Conversion Factor, Reform Update	01	08	15	21	28	36	45	55	68	82	73	109	358
Single Fee For Surgery	00	01	01	01	01	01	01	02	02	02	04	06	12
Incentives for In-Hospital MD Services	00	00	03	05	07	09	09	10	11	12	15	24	67
Direct Payment to PA, NP, CNS	-01	-01	-01	-01	-02	-02	-02	-02	-02	-02	-06	-08	-17
Pay Acquisition Costs for Drugs	01	02	02	02	02	02	02	02	02	03	08	10	20
Increase Access to Chiropractors	00	00	00	-01	-01	-01	-01	-01	-01	-01	-02	-02	-05
Interaction among Physician Proposals	00	00	00	-01	-01	-01	-01	-02	-02	-03	-02	-03	-11
Fraud and Abuse													
Clarify and Enhance MSP Authority	01	01	01	02	02	02	02	02	03	03	06	08	18
Extend Expiring MSP Provisions	00	03	04	05	06	08	09	10	12	13	19	26	71
Require SNF Consolidated Billing	01	01	01	01	01	01	01	01	01	01	03	03	06
Revise HIPAA Provisions	00	00	00	00	00	00	00	00	00	00	01	01	02
Other Providers													
Competitive Bid	00	00	00	05	08	09	10	11	12	13	14	23	70
Reduce ASC Update	00	00	01	01	01	02	02	02	03	03	03	05	15
Reform Lab Payments	00	00	00	00	00	00	00	00	00	00	01	01	02

Part B Premium													
Extend 25% Premium Beyond 1998	0 0	1 0	2 5	4 1	5 9	8 1	11 0	14 0	17 3	21 0	13 6	21 7	84 9
Premium Offset	0 0	-0 3	-0 7	-1 2	1 4	0 9	-0 6	-0 7	-0 7	-0 7	-3 5	-4 4	-7 2
Beneficiary Investments													
Waive Mammography Costsharing	0 0	-0 1	-0 1	-0 1	0 1	0 1	-0 1	-0 1	-0 1	-0 1	-0 3	0 3	0 0
Annual Mammogram	0 0	-0 1	-0 1	-0 1	0 1	-0 1	0 1	-0 1	-0 1	-0 1	-0 4	-0 5	-0 8
Respite Care	-0 3	-0 3	-0 3	-0 3	-0 4	-0 4	-0 4	-0 4	-0 4	-0 4	-1 7	-2 0	-3 6
Colorectal Screening	0 0	-0 1	-0 1	-0 2	-0 2	-0 3	-0 3	-0 3	-0 3	-0 4	-0 7	-0 9	-2 2
Diabetic Screening	-0 2	-0 3	-0 3	-0 3	-0 3	-0 4	-0 4	-0 4	-0 4	-0 4	-1 5	-1 8	-3 3
Blood Glucose Monitor Strips	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 1	0 1	0 2
HI Premium Free Working Disabled	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0
Preventive Injections	0 0	-0 1	-0 1	-0 1	-0 1	-0 1	-0 1	-0 1	-0 2	-0 2	-0 4	-0 5	-1 1
Actuarially Determined Premium Surcharge	-0 1	-0 2	-0 2	-0 2	-0 2	-0 2	-0 3	-0 3	-0 3	-0 3	-0 8	-1 0	-2 2
Appropriate Outpatient Coinsurance c/	0 0	-1 1	-1 3	-1 8	2 6	-6 6	8 5	-10 2	-12 4	-14 7	-6 8	-13 4	-59 2
TOTAL PART B	-0 4	2 0	4 9	7 8	10 6	11 2	13 2	16 7	20 2	24 3	24 9	36 1	110 5
NET SAVINGS FROM TOTAL PACKAGE	4 5	12 1	23 5	29 5	36 5	39 7	44 7	51 5	58 2	65 8	106 1	145 8	365 9

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	98-02	98-03	98-07
Home Health Reallocation													
Part A Home Health Spending Reallocated d/	14 4	15 6	15 8	17 3	18 9	20 5	22 2	24 0	25 8	27 8	82 0	102 4	202 1

Footnotes

a/ The President's FY 1998 Budget submitted in February was scored by OMB at $100 billion over 5 years. A few technical changes were made to this package after budget numbers were transmitted, including changes to respond to CBO's different baseline assumptions. These changes took the package as scored by OMB up to $106 billion. CBO, however, scored this revised package as saving $82 billion over 5 years.

b/ Includes interactions with other MMA proposals.

c/ The net budget impact of the Outpatient PPS proposal is equal to the Federal costs of appropriate outpatient coinsurance ($59.2 billion) net of the Federal savings of OPD PPS ($30.2 billion) or $28.0 billion over 10 years. In addition, there is a net budget impact of OPD PPS on managed care equal to $9.8 billion over 10 years.

d/ These figures represent the total amount of the home health transferred from Part A including the impacts on both the fee for service and managed care sectors. The line in the savings table titled Part A beneficiaries who choose not to Enroll in Part B represents the fee for service effect. The managed care effects [illegible] Part A savings figures.

Senator Rockefeller's Questions:

Q1. Your proposal would not eliminate the 50/50 rule until the Secretary develops a new system of quality measurement. What would you anticipate is the time frame for when you would be ready with these new quality standards?

A1. The answer to this question is as follows:

- The Administration's bill proposed to replace the 50/50 rule with a quality performance measurement system. In the interim, the Secretary would have additional authority to waive the 50/50 rule (e.g., for plans with good track records) including broad, general waiver authority.

- The bill would require that a proposed rule for this quality performance measurement system be published by July 1998. The 50/50 rule would not be repealed until the final rule for the system is published.

- HCFA currently has several initiatives that address quality and performance improvement that will help us to develop a state-of-the-art quality measurement system that would replace the 50/50 rule.

- These initiatives include --

  - **HEDIS.** Medicare managed care plans are required to report on performance measures from the Health Plan Employer Data and Information Set 3.0 (HEDIS 3.0) including measures specific to the Medicare population.

  - **MEDICARE CAHPS.** Medicare managed care plans also are required to participate in an independently administered Medicare beneficiary satisfaction survey, the Medicare version of the Consumer Assessments of Health Plans Study (Medicare CAHPS).

    The HEDIS 3.0 and Medicare CAHPS requirements were effective January 1, 1997. Data reported from HEDIS 3.0 and Medicare CAHPS will be used to help Medicare beneficiaries choose among plans; to serve as a monitoring tool for HCFA and the Peer Review Organizations (PROs); and to facilitate internal quality improvement of plans.

  - **FAcct.** The Foundation for Accountability (FAcct) is a new non-profit organization dedicated to helping purchasers and consumers obtain the patient-oriented quality information they need to make better decisions about health plans and providers. HCFA is one of the Federal liaisons to the FAcct Board of Trustees, which is comprised of public and private sector purchasers. FAcct

is dedicated to the proposition that the health care marketplace will function best if consumers make quality-oriented decisions. This will be achieved by providing consumers usable information on quality. Specifically, FAcct endorses and promotes a common set of patient-oriented measures of health care quality.

Together, HCFA and AHCPR have played major roles in the development of FAcct quality measures for depression, breast cancer and diabetes. HCFA and the Assistant Secretary for Planning and Evaluation also recently contracted with the RAND Corporation, a non-profit research organization, to refine and test three sets of outcome measures for implementation in 1998.

- **MMCQIP**. The Medicare Managed Care Quality Improvement Project (MMCQIP) is designed to enhance HCFA's ability to assess how well the ambulatory care process in managed care is meeting the needs of beneficiaries. At this time, we are evaluating the care received by Medicare managed care plan enrollees diagnosed with diabetes mellitus, and the incidence of screening mammography in a sample of enrolled beneficiaries. The Peer Review Organizations in five states (California, Florida, New York, Pennsylvania and Minnesota) and 23 Medicare-contracting HMOs are collaborating on MMCQIP.

- **Medicare Choices Demonstration/Encounter Data**. An important component of this demonstration is improvement in our comprehensive quality monitoring system. Under the Choices project, we will be developing and testing quality/outcomes and risk adjustment measurements systems that use encounter data (health care services received by enrollees); all participating plans will be required to provide 100 percent encounter data. We have contracted with the RAND Corporation to assist us in designing such a system, which will be refined further using the "Choices" data.

- QISMC. The objective of the Quality Improvement System for Managed Care (QISMC) project is to design a new approach to the oversight of the quality improvement activities of managed care plans that serve Medicare and Medicaid beneficiaries. QISMC will define and elaborate HCFA's expectations with regard to plans' quality improvement, with a particular focus on demonstrable, measurable improvement.

Q2. I would also be very interested in comments from HHS on the quality standards that Senator Frist and I have specified in our PSO legislation. Are there any deficiencies in our quality standards, and if there are, I would appreciate specific ideas for improving them.

A2. In general, the quality standards that you and Senator Frist have included in your PSO

legislation (S. 146) are consistent with the current standards that we apply to HMOs. However, we have concerns that your bill will place many of the standards that are now in regulations or manuals in statute, with unforeseeable consequences for how easily such standards can be revised to reflect future changes in the fields of quality improvement and performance measurement. Your bill would also require more than is currently required of other plan types with regard to making performance on outcome measures available to beneficiaries. HCFA has plans to make such information available in the future.

Senator Baucus' Questions:

Q1. As you know, many rural hospitals in Montana are operating under a demonstration project called the Montana Medical Assistance Facility (MAF), which has been very successful. Does the Administration have details yet on what type of limited-service hospital program they propose? Will it be similar to the MAF? Please expand on the other rural health provisions in the President's budget.

A1. The FY 1998 budget includes a limited-service hospital provision which expands the current Rural Primary Care Hospital program (RPCH) to all fifty states so that rural areas across the country could benefit from these services. This program incorporates many of the best features of the current RPCH and MAF programs. It broadens the current definition of eligible hospitals by increasing the size limitation for RPCHs to allow up to 15 inpatient beds. It also deletes the provision requiring that a RPCH had to have met the hospital requirements before applying for designation, and allows RPCHs to utilize all of their beds (up to a maximum of 15) as swing-beds if they have a swing-bed agreement. In addition, based on the MAF experience the limited service hospitals created under this provision would have an increased length of stay limitation of 96 hours, and expanded options for referral relationships and eliminating the Essential Access Community Hospital (EACH) designation while grandfathering current EACHs. All Montana Medical Assistance Facilities would be grandfathered as RPCHs. Other rural health provisions included in the budget include:

Revised managed care payment methodology. The payment methodology for HMOs would be modified so that those serving Medicare beneficiaries in rural areas would receive the greater of either a minimum payment amount ($350 in 1998) or a blend of their local rate and a national rate. The increasing payment rates in rural areas, combined with provisions in the President's Budget which allow Medicare to contract with provider sponsored organizations (PSOs) could encourage more managed care plans to enter rural markets and should result in increased availability of managed care in rural areas.

Sole Community Hospital Rebasing. Sole Community Hospitals (SCHs) are currently paid based on the highest of three base years: a 1982 hospital-specific rate; a 1987 hospital-specific rate; or the Federal rate. The Budget would add a fourth option for a base year which would consist of the average of 1994 and 1995 hospital-specific costs. This option would provide more updated payment rates for SCHs whose costs have significantly changed in recent years and would still allow hospitals to retain their more advantageous 1982 or 1987 hospital-specific rates.

Medicare Dependent Hospital Reinstatement. This would reinstate the Medicare Dependent Hospital program (MDH) for rural hospitals beginning with cost reporting periods on or after October 1, 1998. To be eligible, rural hospitals must have fewer than 100 beds and a Medicare share of inpatient days or discharges of 60 percent or more. This program was established under the Omnibus Budget Reconciliation Act of 1989, but lapsed September 1, 1994.

Rural Referral Centers. Rural Referral Centers (RRCs) designated as such on September 30, 1994 would continue to be designated as RRCs for FY 1995 and subsequent years. In addition, the budget would establish a tiered approach to exemption from the 108 percent threshold requirements for wage index reclassification for hospitals between 100 and 108 percent of the average wages in the rural area in which the RRC is located, thus facilitating their ability to be reclassified.

Graduate Medical Education. Medicare would have the authority to pay federally qualified health centers (FQHCs) and rural health clinics (RHCs) directly for certain graduate medical education (GME) expenses. Currently, Medicare only has authority to pay hospitals for GME expenses. To be eligible for these payments, FQHCs and RHCs would have to participate in an accredited GME program and pay the residents' salaries for time spent in the clinic setting.

Payments for Midlevel Practitioners. This provision would provide for direct payment by Medicare to physician assistants, nurse practitioners, and clinical nurse specialists in home and ambulatory settings in which a facility or provider fee is not billed. This will help attract and retain necessary allied health professionals to medically underserved areas.

Q2. Many Medicare reform proposals rely on managed care as a way to make the program more efficient. But as you know, there's not a lot of managed care in Montana. Moreover the Administration has compiled many reports concluding that healthier people tend to join HMOs. I'm worried that as more Medicare recipients move into managed care, seniors in Montana will have no choice but fee-for-service. And if favorable selection occurs in Medicare managed care, the Fee-For-Service program may become expensive to the Federal Government and the target for more cuts. Could you please elaborate on how the Clinton would address the flaw in Medicare's Payment methodology for managed care?

A2. There is widespread agreement that under the current methodology, Medicare overpays HMOs because, on average, beneficiaries in HMOs are healthier than the average Medicare beneficiary, a phenomenon known as "favorable selection." Research indicates that if HMO enrollees were receiving care under fee-for-service Medicare, Medicare's costs would be between 87.6 and 89.9 percent of costs of an average-fee-for-service beneficiary. Under the current methodology Medicare pays 95 percent of projected fee-for-service costs.

The General Accounting Office, the Physician Payment Review Commission (PPRC), and the Prospective Payment Assessment Commission (ProPAC) among others recommend changes to address this matter. The President's budget envisions a two-step approach to adjusting managed care plan payments for favorable selection. First, in 2000, the President has proposed to reduce payments from 95 percent to 90 percent of projected fee-for-service costs. Second, we are developing a new payment methodology that incorporates health status adjusters. Under risk adjusters that we will be testing under our demonstration authority, payment would be significantly increased for sicker enrollees and reduced for healthy enrollees. Thus, incentives to enroll only healthy beneficiaries and to avoid enrolling

beneficiaries with health problems would be significantly reduced. For example, under one approach:

- For a 70-year old woman in poor health (with conditions like bladder cancer, cardiomyopathy and asthma), Medicare's payment would be almost 3 times the payment under a model similar to the current AAPCC (adjusted average per capita cost) methodology ($11,318 vs. $4,007).

- However, Medicare's payment for a 70-year old woman in good health would be about one-half the payment under the AAPCC-like model ($1,948 vs. $4,007).

We hope to have a proposal ready for Congressional action as early a 1999, with phase-in beginning as early as 2001.

The President's budget also includes provisions that would enable Provider-Sponsored Organizations (PSOs) and Preferred Provider Organizations (PPOs) to contract to enroll Medicare beneficiaries. We believe that increasing the types of entities that can contract to provide comprehensive services to Medicare beneficiaries should make managed care more widely available. In particular, many believe that the creation of a PSO option in Medicare will increase the availability of managed care in rural areas.

Senator Breaux's Questions:

Q1. What kind of long-term structuring of the Medicare system will the Administration propose to get us beyond 2007 when the real problems begin?

A1. The President's Budget proposal extends the life of the Hospital Insurance Trust Fund through the next ten years, without increasing costs to beneficiaries. Enacting the President's plan will extend Trust Fund solvency immediately and give Congress and the Administration time to develop and consider options for long-term solvency. Many groups, including the Medicare Trustees, have recommended the establishment of a national advisory group to help develop recommendations to address the long-term financing problem.

Q2. In addition to moving home health and skilled nursing facilities to a prospective payment system, what can the Administration do to prevent spiraling costs in other parts of Medicare?

A2. The Administration has a two-pronged strategy: first, to increase the number of Medicare beneficiaries enrolled with capitated risk plans and to increase the range and types of plan choices available to Medicare beneficiaries; and second, to be a more prudent purchaser in paying for services in fee-for-service Medicare.

The Administration can make more choices among capitated plans available to Medicare beneficiaries and increase the attractiveness of enrollment in settings where there are incentives to control the volume of services. The range of choice should include point-of-service HMOs, preferred provider plans, and physician hospital organizations as included in the President's budget plan. In addition, the Administration is exploring alternative ways to pay Medicare risk plans such as competitive bidding and risk adjustment strategies which are being explored in the Medicare Choices and our Competitive Bidding Demonstrations.

The Administration's goal with respect to reforming Medicare fee-for-service payment policies is to make Medicare an accountable purchaser of health care services by introducing ideas that have worked in the private sector, such as high cost case management and competitive bidding for lab services and durable medical equipment. To that end, Medicare payment policies are moving away from cost-based reimbursement. In addition to expanding prospective payment systems to include other providers, the Administration intends to develop an integrated prospective payment system for all post-acute care settings, including SNF, HH, and rehabilitation and long-term care hospitals.

In addition, we are proposing to re-define a hospital transfer to include transfers to other post-acute inpatient settings such as rehabilitation and long-term care (LTC) hospitals and SNFs. This will allow us to re-capture savings from changes in medical practice that have increased the use of post-acute care. These changes have resulted in Medicare paying twice for care that, in the past, would have been provided in the hospital; now we pay once in the hospital and again in the post-acute setting.

Furthermore, we are currently conducting demonstrations to test competitive bidding for durable medical equipment (DME) and competitive pricing for managed care contracts. The President's budget proposal would give HCFA permanent authority to implement competitive bidding for DME.

Senator Kerrey's Questions:

Q1. Please provide background information on your income-distribution statistics for the elderly. For example, what income sources are included in these figures? Do these statistics include all income available to the elderly, including Supplemental Security Income payments?

A1. More than three-quarters of elderly Medicare beneficiaries reported incomes of $25,000 or less, with 29 percent reporting incomes less than $10,000. In determining these figures, we define income to include all sources. Income represents total gross income, and includes pensions, Social Security Railroad Retirement, SSI and disability payments; the cash value of food stamps and public assistance payments; capital gains, annuities, VA and Workers' Compensation benefits; interest, dividends, and work-related income. We collect data on the income of the beneficiary, and spouse, if applicable.

Q2. I am extremely concerned about the impact your per capita cap proposal will have on States with high per capita growth rates like Nebraska. How will these States be able to live within the cap on Federal matching payments? How will States be able to cope with older, sicker beneficiaries-- particularly as the costs of care for these individuals continue to increase without regard to the growth rates that the cap would apply to Federal matching payments?

A2. Over the five year period of the President's budget, Medicaid spending in each State will be able to grow at an average of 5 percent based on 1996 spending. This growth rate is close to the annual growth rate CBO is projecting for private insurance on a per person basis.

Each State's aggregate cap would reflect the sum of per capita costs for the four categories: seniors, people with disabilities, adults and children. Each State would have a single total limit, so a State such as Nebraska with increased costs in a certain category, could use savings from one group to support expenditures for other groups or to expand benefits or coverage.

If enrollment in these categories increases, the total and Federal limit would increase automatically because the aggregate limit is calculated on a per-person basis. If enrollment shifts to more expensive populations such as seniors, then the total limit would increase automatically.

This analysis may be affected by policy changes negotiated in upcoming bipartisan budget talks.

Q3. How will States like Nebraska, which currently have little managed care in sparsely populated rural areas, be able to find sufficient savings to manage under limits to Federal matching payments?

A3. The President's plan includes a provision to help foster managed care in rural areas by allowing States to restrict beneficiary choice of a plan as long as the beneficiary has choice of providers within a given plan. In addition, the President's plan improves State's flexibility to better manage their Medicaid programs. Under the President's plan, States would have greater flexibility with respect to provider payments, program eligibility, long-term care, and administrative requirements. Under the President's plan States would be allowed to target DSH payment to a range of essential community providers; to move populations into managed care; to move populations needing long-term care from nursing homes to home and community-based care. Furthermore, the President's plan repeals the "Boren amendment" for hospitals and nursing homes and mandatory cost-based reimbursement for health clinics. We believe this additional flexibility will help States reduce costs and operate more efficient Medicaid managed care programs.

Q4. Can you provide more detail on your proposal to reduce disproportionate share hospital (DSH) payments? What impact will this proposal have on low DSH states? On high DSH states?

A4. The Administration's policy, as presented in the President's budget request, essentially freezes DSH spending in 1998 at 1995 levels, with a gradual decline to $8 billion in spending for FYs 2000-2002. These DSH savings are achieved by taking an equal percentage reduction off of States' 1995 DSH spending levels, up to an "upper limit." If a State's DSH spending is greater than 12 percent of total Medicaid spending in that State (High DSH States), the equal percentage reduction is subtracted from the first 12 percent rather than the full DSH spending amount. This "upper limit" maintains the policy balance struck by Congress in the DSH provisions it enacted in 1991 and 1993, which recognized that some States' Medicaid programs are particularly dependent on DSH spending. Low DSH States would take the reductions from their actual DSH 1995 spending. This "upper limit" policy ensures that the few States with high DSH spending are not bearing a disproportionate share of the impact of the savings policy.

The Administration has always said that DSH dollars should be targeted to the providers that need them most: those hospitals and other providers that disproportionately serve a high volume of Medicaid patients, the uninsured, and low-income people. Our policy this year is no different. We support better targeting of DSH funds and look forward to working with Congress and interested parties to do this.

To respond to the special needs of critical safety net providers, the President's plan includes a temporary fund of about $1.4 billion to help cover the cost of care delivered in Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). Also, there is a critical safety net provider pool of about $1 billion to assist States and safety net providers who are disproportionately affected by Medicaid savings policies. These provider pools are funded by Medicaid savings. We believe these supplemental funds are necessary to help providers during the transition to a per capita cap, particularly in view of our proposal to end the requirement that States reimburse FQHCs and RHCs on a cost basis. This proposal would

become effective in FY 1999.

This analysis may be affected by policy changes negotiated in upcoming bipartisan budget talks.

Q5. You state that you will implement new quality data standards for Medicaid managed care plans. How will this data be used? Will you have any standards beyond data collection such as minimum plan performance standards or requirements for state-level quality assurance programs?

A5. We are developing new quality data standards as part of the President's 1998 Budget bill. The new quality data standards, developed in conjunction with States, would be used to measure plan and state performance with respect to Medicaid managed care. States would be required to provide HCFA with quality assurance plans which could include a number of elements such as a grievance process; a comparative report card of health plan performance; and reporting of encounter data.

Under the quality assurance plan, a number of indicators or performance standards would be monitored and assessed annually by States. Plans would be required to meet a range of "benchmarks" or "thresholds" that could be established for a given indicator, such as immunization rates, C-section rates, and low birth weight rates. The success of providers in meeting these quantifiable performance goals would affect the contractual relationship between the health plan and the State Medicaid program.

By requiring all States and all Medicaid managed care plans to report data on a core set of performance measures, HCFA can evaluate and compare Medicaid managed care plans within and across States. The new quality data standards would provide a better means for holding plans and States accountable for services provided under their Medicaid managed care programs.

Q6. In your testimony, you reference a new quality management system for Medicare and Medicaid and the use of "modern quality measures." Can you be more specific about what kind of quality information will be available to Medicare HMO enrollees? Will quality performance be a condition of contracting with the Medicare program?

A6. The Administration's bill proposed to replace the 50/50 rule with a state-of-the-art quality performance measurement system. In the interim, the Secretary would have additional authority to waive the 50/50 rule (e.g., for plans with good track records) including broad, general waiver authority.

- The bill would require that a proposed rule for this quality performance measurement system be published by July 1998. The 50/50 rule would not be repealed until the final rule for the system is published.

- HCFA currently has several initiatives that address quality and performance improvement that will help us to develop this state-of-the-art quality measurement system.

- These initiatives include --

  - **HEDIS.** Medicare managed care plans are required to report on performance measures from the Health Plan Employer Data and Information Set 3.0 (HEDIS 3.0) including measures specific to the Medicare population.

  - **MEDICARE CAHPS.** Medicare managed care plans are also required to participate in an independently-administered Medicare beneficiary satisfaction survey, the Medicare version of the Consumer Assessments of Health Plans Study (Medicare CAHPS).

    The HEDIS 3.0 and Medicare CAHPS requirements were effective January 1, 1997. Data reported from HEDIS 3.0 and Medicare CAHPS will be used to help Medicare beneficiaries choose among plans; to serve as a monitoring tool for HCFA and the Peer Review Organizations (PROs); and to facilitate internal quality improvement of plans.

  - **FAcct.** The Foundation for Accountability (FAcct) is a new non-profit organization dedicated to helping purchasers and consumers obtain the patient-oriented quality information they need to make better decisions about health plans and providers. HCFA is one of the Federal liaisons to the FAcct Board of Trustees, which is comprised of public and private sector purchasers. FAcct is dedicated to the proposition that the health care marketplace will function best if consumers make quality-oriented decisions; this will be achieved by providing consumers patient-oriented quality information. Specifically, FAcct endorses and promotes a common set of patient-oriented measures of health care quality.

Together, HCFA and AHCPR have played major roles in the development of FAcct quality measures for depression, breast cancer and diabetes. HCFA and the Assistant Secretary for Planning and Evaluation also recently contracted with the RAND Corporation, a non-profit research organization, to refine and test three sets of outcome measures for implementation in 1998.

  - **MMCQIP.** The Medicare Managed Care Quality Improvement Project (MMCQIP) is designed to enhance HCFA's ability to assess how well the ambulatory care process in managed care is meeting the needs of beneficiaries. At this time, we are evaluating the care received by Medicare managed care plan enrollees diagnosed with diabetes mellitus, and the incidence of screening

mammography in a sample of enrolled beneficiaries. The PROs in five states (California, Florida, New York, Pennsylvania and Minnesota) and 23 Medicare-contracting HMOs are collaborating on MMCQIP.

- **Medicare Choices Demonstration/Encounter Data**. An important component of this demonstration is improvement in our comprehensive quality monitoring system. Under the Choices project, we will be developing and testing quality/outcomes and risk adjustment .neasurements systems that use encounter data (health care services received by enrollees); all participating plans will be required to provide 100 percent encounter data. We have contracted with the RAND Corporation to assist us in designing such a system, which will be refined further using the "Choices" data.

- **QISMC**. The objective of the Quality Improvement System for Managed Care (QISMC) project is to design a new approach to the oversight of the quality improvement activities of managed care plans that serve Medicare and Medicaid beneficiaries. QISMC will define and elaborate HCFA's expectations with regard to plans' quality improvement, with a particular focus on demonstrable, measurable improvement.

- Before contracting with an HMO, HCFA conducts an on-site review including a review of the plan's quality assurance systems. Once a contract has been awarded, HCFA regularly monitors plans to ensure that quality care is delivered to beneficiaries. In addition, HCFA plans to utilize the performance measurements provided through Medicare HEDIS and CAPHS described above in its monitoring efforts.

Under the President's budget, plans that do not meet the requirements of the quality measurement system would be subject to termination.

Senator Murkowski's Question:

Q1: What assurances can I get from HCFA that the President recognizes this program as a vital and efficient program for Alaskans?

A1: The President's budget proposal to cap the number of residents on a hospital-specific basis is intended to stop the growth in the number of residents nationwide. However, we realize that because of the geographic maldistribution of physicians, particularly in rural areas, certain exceptions to this cap would be appropriate. We would not want this cap to inhibit creative solutions to recruiting physicians to underserved areas, which is why the Administration is currently working on a limited exceptions policy for the resident cap. We would be happy to work with your staff to ensure that this policy meets the needs of the Alaska residency program.

Senator Hatch's Questions:

Q1. The President's FY 1998 Budget proposes to reduce reimbursement for prescription drugs prescribed in a physician's office and reimbursed by Medicare. What is your rationale for this new policy?

A1. While Medicare does not have an expansive outpatient drug benefit, it does cover outpatient injectable drugs that are furnished by a physician and certain drugs that are administered with durable medical equipment. In 1992, the Medicare-allowed charges for these drugs were $680 million. In 1995, allowed charges were $1.8 billion, an increase of over 250 percent in only three years.

Medicare pays the "average wholesale price" (AWP) for covered drugs. However, the AWP is not the average price actually charged by wholesalers to their customers. Rather, it is a "sticker" price set by drug manufacturers and published in several commercial catalogs. As a result, the HHS Inspector General estimates that Medicare currently pays 15 to 30 percent more because the physician is marking up the drug when the manufacturer charges the patient less than the average wholesale price. We believe that physicians should be paid for their professional services and not derive a profit from drugs furnished incident to their professional services. Also, the current payment rules for drugs allow an increase in the AWP even if the cost to the physician remains constant. This creates an incentive for physicians to furnish the most profitable drugs. Our proposal would remove this incentive so that the decision to furnish a particular drug is more directly based on medical considerations.

Q2. How would this new policy work? How would HCFA determine acquisition costs? How would HCFA determine the median national cost that is to be the cap for payment on each drug? How will this program be administered and what will be the costs in dollars and FTEs?

A2. Effective January 1, 1998, the Administration's proposal would eliminate the mark-up for drugs by basing Medicare's payment on the provider's acquisition cost of the drug. Effective January 1, 2000, payments for a particular drug would not be allowed to exceed the national median cost of that drug.

Under the proposed policy, physicians would report their acquisition cost for each drug on the claim submitted for reimbursement. Physicians, rather than HCFA, would determine their acquisition cost. The median limit would be implemented based on actual costs reported for each drug for 12-month periods beginning July 1, 1998. Median limits have been implemented for other Part B services (e.g., clinical diagnostic laboratory services and durable medical equipment). Carriers report the data to HCFA and the median is calculated for each code in HCFA Central Office. The median for each code is then furnished to all carriers to be used as part of the payment screens developed for the following January. We do not have dollar or FTE estimates for the costs of administering this policy, but since HCFA has

experience administering median caps, any administrative costs involved are likely to be very small.

Q3. The proposal indicates that Medicare will pay the acquisition cost for these drugs. Will the physician receive any other payment to cover costs of acquiring, storing or associated costs of dispensing the drug, as under the Medicaid program?

A3. These kinds of expenses are paid through the practice expense component of the physician fee schedule.

Q4. What is your assessment of the effect that this new policy will have on physician treatment and/or prescribing practices, and the effect that this will have on patients? How do you plan to monitor this effect in the future?

A4. We do not believe that this policy will have any negative effect on physician treatment or prescribing practices. This policy would pay physicians their costs for acquiring drugs but eliminate their mark-ups in furnishing them to beneficiaries. As we indicated, we believe that this policy would remove the current incentive to furnish the most profitable drugs, so that the decision to furnish a particular drug will be based on medical considerations.

Q5a. In the year 2007, what do you expect will be the percentage of Medicare beneficiaries enrolled in a managed care system?

A5a. HCFA's Office of the Actuary projects that in 2007, under current law 23 percent of Medicare beneficiaries would be enrolled in managed care plans, and under the Administration's proposal, 26% of beneficiaries would be enrolled in managed care plans.

Q5b. Does the Department have any data now, or is the Department prepared to look into the issue, as to the number of seniors who, for whatever reason, decide to opt out of a Medicare managed care plan? Can the Department provide the Committee data on the extent of opt-outs from managed care systems as well as the reasons for these decisions? Are there any data on the prior coverage of seniors who opt for Medicare HMOs (e.g., other Medicare HMOs, Medicare fee-for-service, or new Medicare enrollees?)

A5b. The Health Care Financing Administration (HCFA) collects data on disenrollments from Medicare managed care plans. Currently, HCFA uses plan-specific disenrollment data internally for monitoring purposes. A high disenrollment rate or a sudden surge in a plan's disenrollment may identify access, education, or quality problems, and will lead to an appropriate investigation. HCFA is in the process of reviewing different methods for analyzing disenrollment rates that may be helpful to consumers.

Research on disenrollment trends indicates that reasons for disenrollment are complex and that many beneficiaries reenroll in another HMO. Studies which have examined these issues

include:

(1) *Disenrollment Experience in the Medicare HMO and CMP Risk Programs (1993).* Mathematica found that almost one-third of Medicare beneficiaries disenroll within two years of enrolling in a Medicare HMO and that of beneficiaries who disenrolled, roughly one-third joined another HMO. Mathematica concluded that high disenrollment rates may indicate that beneficies perceive quality-of-care problems or that there is competition between plans for Medicare enrollments.

(2) *Factors Associated with Disenrollment from Medicare HMOs (1992).* This study conducted by Brandeis University found that 30 percent of disenrollments were solely associated with change-related experiences such as financially motivated switches to another HMO, household moves, physician contracting changes, or terminations of HMO contracts. About 20 percent of disenrollments were due to either perceived access restrictions or misunderstandings about HMO procedures and operations. The remainder of disenrollees were motivated by a mix of both kinds of reasons for disenrollment.

(3) *Disenrollment of Medicare Cancer Patients from HMOs (1994).* This HCFA and NCI article concluded that a pattern of high disenrollment among cancer patients diagnosed before enrolling and low disenrollment among cancer patients diagnosed after enrolling suggests that factors other than encouragement by the HMO may be responsible for the decision to disenroll. Low disenrollment among persons diagnosed with cancer after enrollment may be due to a reluctance to break provider ties formed during the initial course of therapy and high disenrollment among persons diagnosed before enrollment may have several causes related to a low level of commitment to managed care.

(4) *Beneficiary Perspectives of Medicare Risk HMOs (1995).* The Office of the Inspector General found that disenrollees reported a much greater decline in health status during their HMO stay and were much more likely to blame their HMO care for their declining health status.

(5) *Biased Selection and HMOs: Analysis of the 1989-1994 Experience (1995).* A Physician Payment Review Commission (PPRC) study found that beneficiaries who disenrolled from managed care plans used more services after disenrollment than beneficiaries in Medicare fee-for-service. PPRC also found that beneficiaries who stayed in managed care had lower medical expenditures than fee-for-service beneficiaries.

(6) PPRC and PROPAC have also published some recent Reports to Congress that included analyses of disenrollment trends. An October 1995 Joint PPRC and

PROPAC Report to Congress concluded that aggregate disenrollments have been stable over a number of years and that plans with highest disenrollment are newer, for-profit IPAs. A June 1996 PROPAC Report to Congress reported that the proportion of first time enrollees who disenroll within three months of enrollment has been declining and that returns to fee-for-service are declining.

HCFA has not analyzed the prior utilization or enrollment experience of Medicare managed care enrollees. As mentioned earlier in this response, we review disenrollment data received from plans to determine trends that might reflect issues with the plan's quality of care.

A recent field test of HCFA's upcoming beneficiary satisfaction survey found that there was no relationship between prior experience in a managed care plans and the enrollees' level of satisfaction. Therefore, the survey does not include questions about Medicare managed care enrollees' previous enrollment status.

As managed care increases in the commercial sector, we anticipate that more and more newly-eligible beneficiaries will go directly into managed care. To make this transition easier, HCFA has established a workgroup to determine if any barriers exist to newly-eligible retirees who wish to enroll in Medicare managed care plans.

Q6a. I understand that you are proposing to submit to Congress separate legislation that will include, among other things, a repeal of the advisory opinions provision as well as a repeal of the anti-kickback clarification for managed care plans. Would you explain your intentions on this?

A6a. Yes, the President's budget proposes the repeal of three HIPAA provisions.

First, we would like the broad new exception to the anti-kickback statute when providers are at "substantial financial risk" eliminated. These terms are undefined and somewhat broad. CBO assigned a considerable cost to this provision because it could be easily abused by those wishing to profit from referrals.

Second, we would like the requirement eliminated that advisory opinions be issued in response to specific requests as to how certain business arrangements may or may not be considered to violate the anti-kickback laws. This provision would severely hamper the government's ability to prosecute fraud and would be impractical because it is difficult, if not impossible, to determine intent based on the submission of the requestor.

Third, we would like the reasonable diligence standard reinstated. HIPAA eliminated the current standard for use of reasonable diligence and made providers subject to civil monetary penalties only if they acted with deliberate ignorance or reckless disregard. This is a very difficult standard to prove in court and would permit providers with patterns of improper submission of claims to unsanctioned.

Q6b. With respect to the anti-fraud provisions in the Kennedy-Kassebaum bill would you give me a status report on the implementation of those provisions?

A6b. First, HIPAA established the Fraud and Abuse Control Program to be coordinated by the HHS-OIG and the Attorney General to fight Medicare, Medicaid, and private sector health care fraud. To implement the Control Program, the OIG has recently initiated Operation Restore Trust Plus (ORT Plus). ORT Plus will institutionalize the lessons learned, expand the geographical and program areas covered, and improve on the results of the two-year ORT demonstration project. The ORT Plus team includes the OIG, HCFA, and AoA. (HRSA will also establish the national data bank to receive and report final adverse actions against health providers). Other governmental groups participating include DoJ, Medicare claims processing contractors, State agencies, Medicaid fraud control units, and ombudsmen. ORT Plus will use a coordinated team approach to develop and coordinate various anti-fraud and abuse activities. It will emphasize:

- new ways of manipulating data in targeting program areas and providers;
- covering all health care provider sectors but focusing on selected ones;
- targeting specific providers;
- identifying systemic problems and solutions;
- soliciting the help of beneficiaries in detecting fraud and abuse;
- encouraging the participation of providers to uncover and prevent fraud;
- publicizing the activities as a deterrent to potential wrongdoers; and
- conducting continuous follow-up to ensure problem resolution.

Second, HIPAA established the Medicare Integrity Program (MIP) to carry out Medicare payment integrity activities that are funded from the HI Trust Fund. HCFA has specific contracting authority for this purpose. Current fiscal intermediaries and carriers cannot duplicate activities under both a Medicare and a MIP contract.

MIP activities. These include review of provider activities, medical, utilization and fraud review, cost report audits, MSP determinations, provider and beneficiary education regarding payment integrity, and developing and updating a list of DME which are subject to prior authorization.

Regulations. Although not required, we are currently in the process of drafting a Notice of Proposed Rule Making to implement the MIP. These regulations will identify the characteristics of entities who can compete for contracts and

more clearly define when a conflict of interest exists.

Implementation. Maintaining good payment safeguard activities is not possible if we attempt implementation as a "big bang." We must coordinate with the introduction of the Medicare Transaction System (MTS), a new state-of-the-art consolidated claims processing system which will be implemented over a two-year period. Implementation of MIP requires (1) separation of benefit integrity activities from claims processing (including activities such as prepayment editing); (2) reduction of the number of contractors performing such activities and, thus, an increase in the workload of individual contractors; and (3) introduction of new contractors who may not have experience with Medicare. These are major changes and require thoughtful planning, experience, and incremental implementation. We are developing a "risk mitigation" plan to ensure that the Medicare program is fully protected during the course of implementation. We anticipate that as work on payment safeguards continues, features of the specific plan will evolve to reflect new thinking.

Third, the OIG has recently published the advisory opinion regulation. Several requests for advisory opinions on the Medicare and Medicaid exclusion provisions, civil money penalties, and on the criminal provisions have been submitted. However, these requests were returned to the senders because they did not meet the standards of the regulation.

Q7. Can you give me the status of Utah's 1115 waiver? Any idea when it will be approved?

A7. The latest round of discussions with Utah has centered on budget neutrality issues. HCFA made a counter offer to Utah on February 13, 1997, and we are awaiting the State's response. We also have programmatic issues such as the cost-sharing requirements that still need to be worked out, making it difficult to say exactly when to expect approval for the waiver.

Q8. The President's budget proposes deep cuts in payments to Medicare HMOs. Clearly these cuts will have an effect on the willingness of plan sponsors to expand to new areas or increase benefits. Has the Administration attempted to quantify the impact of these cuts on projected Medicare enrollment?

A8. While overall payments to managed care plans under the President's budget would be less than they would have been under current law, this is true for all providers as we reduce Medicare program growth.

Under the President's plan:

- Relative to 1997 rates, plans in three-fourths of counties would receive

increased rates in 1998 and 1999; no county would have its rate reduced in those two years.

- Including payments for teaching and disproportionate share hospitals made on behalf of HMO enrollees, all counties would receive an increase in 1998 and 1999.
- Two-thirds of counties get an increase in 2000, and the largest decrease in that year is only 3.37 percent.
- In 2001 and beyond, all counties get an increase in payments.

Under both current law and proposed law, the Department projects increased growth in Medicare managed care enrollment in the coming years. We project somewhat faster growth under the President's budget proposals because of the increased managed care options that would be made available to beneficiaries. Specifically, the President's budget includes provisions that would enable Provider-Sponsored Organizations (PSOs) and Preferred Provider Organizations (PPOs) to contract to enroll Medicare beneficiaries and would create annual open-enrollment periods for Medigap coverage. We project that in 2002 about 23 percent of the Medicare population will be enrolled in a managed care plan if the President's proposals are enacted. We project enrollment of Medicare beneficiaries in 2002 at about 19 percent under current law.

Q9. Many current Medicare HMO enrollees receive additional plan benefits, such as no deductibles and coverage of drug, dental, and vision expenses. Has the Administration attempted to quantify the impact of the proposed cuts on the ability of HMO plan sponsors to continue to offer these kind of expanded benefits? What effect will the changes have on plan enrollees?

A9. It is, of course, not possible to predict precisely the effect of changes to the payment methodology on plan and beneficiary decision making. We believe that the operation of market forces, the fact that the budget would not dramatically change rates, and the fact that plans can reduce their administrative costs and profits, will minimize the number of plans that actually reduce benefits.

- No county would receive a decrease in rates during the 5-year budget window, except in the year 2000. In 2000, almost 2/3 of counties (64 percent) would receive increases: the other counties would receive either no increase or a decrease no greater than 3.37 percent.

- Since the beginning of the risk contracting program, market competition has been the driving force in determining the level at which plans establish their premium (if any) and additional benefits. In recent years, individual plans entering a market with a zero premium product, or plans choosing to reduce or eliminate their premium, have caused competing plans to follow suit rather than risk loss of market share.

- The budget would increase competition in two ways:

  - **More Managed Care Choices** - Provider Sponsored Organizations (PSOs) and Preferred Provider Organizations (PPOs) would be able to offer plans to Medicare beneficiaries and compete directly with HMOs.

  - **Medigap Reforms** - If beneficiaries are given real freedom of choice, managed care plans will have to become more competitive with FFS Medigap options, and preserve their ability to attract and hold beneficiaries. This is especially true for individuals who would otherwise be forced to remain in FFS coverage due to the concern that they could not pass the underwriting after the initial six-month open enrollment period (when they turn 65 or become eligible for the first time for Medicare). Medigap reforms would also expand coverage options for beneficiaries. Given how few individuals hold Medigap coverage with drug benefits, managed care plans can be competitive even for beneficiaries who might believe they are better off in FFS coverage. Additionally, vision and dental coverage is nonexistent in FFS plans, which has the effect of increasing the competitiveness of managed care plans.

- Plans can reduce their administrative costs and profits rather than reduce benefits. Part of Medicare's payment to plans is for the plan's administrative costs, including marketing costs and plan profits. In 1996, administrative costs ranged from less than 5 percent of total benefit costs to over 40 percent. Also in 1996, over 40 percent of plans showed administrative cost amounts in excess of 20 percent of benefit costs.

Q10. Background materials provided to us by your agency refer to an additional "significant structural reforms that will bring Medicare into the 21st century" and to "market-oriented reforms to assure quality and make the program more efficient" (page 13). Can you offer any details on these additional reform proposals?

A10. [Attachment A10]

Q11. The President's budget proposes to implement a per diem SNF prospective payment system beginning in FY 1998. An important element of this program will be the development of a reliable "case mix" adjuster to tie SNF payments to the intensity of medical services required by Medicare eligible patients in a particular facility. How far along is HCFA in developing such a mechanism?

A11. HCFA currently has a reliable, operable case mix mechanism. HCFA has developed and implemented a case mix prospective payment system as part of the Multi-state Nursing Home Case Mix and Quality Demonstration. The case mix mechanism in

use is Resource Utilization Groups III (RUGs III); a 44 group resident classification system that is based on the Minimum Data Set (MDS) resident assessment instrument which all nursing homes are required to complete under OBRA '87. This case mix system has been in use for over two years in the six state demonstration and has been validated by several studies. HCFA is in the process of refining RUGs III through collection of new staff time data from a number of additional states (including New York, Florida and California) and doing other research that will be completed this year. In addition, many of the operational components necessary to implement a RUGs III system (e.g., vendor software, billing codes, claims pricer) have already been developed.

Q11a. Does HCFA intend to seek comments from industry and other outside sources?

A11a. HCFA has and will continue to seek comments from the industry and other outside sources. HCFA has had numerous academic and industry technical advisory panels as part of the development phase of the demonstration. In addition, HCFA has been regularly meeting with a number of industry groups to seek input on the case mix and other features of the payment system.

Q12. The President's budget proposes a prospective payment system (PPS) for home health services beginning in FY 1999. Documents provided by HHS state that the PPS is intended to be "budget neutral" after a 15 percent reduction from FY 1998 levels. Are you confident that needed home health services can be maintained in the face of so drastic a one-year reduction?

A12. It is necessary, when implementing a new prospective payment system, to establish a base period in which the system is budget-neutral. After the prospective rates have been established, it is then possible, in later years, to adjust them upward or downward to account for factors such as inflation, case mix "creep," forecasting errors, and additional expenditure controls. The base expenditure level, to which a PPS is made budget neutral, is critical for achieving necessary program savings.

We are confident that the cost and utilization experience of the country's HHAs in FY 1998 will be high enough that a 15 percent expenditure reduction immediately prior to the transition to PPS rates will have no adverse impact on the availability of home health services. This confidence comes from the steady growth in home health utilization and costs that we have experienced over the last decade or so. For example, the number of home health visits per user has grown steadily each year and *tripled* from 1986 to 1996. Medicare outlays per user are also growing steadily each year; spending between 1986 and 1996 represents a 285 percent increase. Charges per visit -- after adjustment by either the consumer price index or the HCFA market-basket index of home health input prices -- did not contribute significantly to the rise in HHA expenditures. While we are aware that much of this growth is due to changes in case mix, medical advances, consumer demand, and other forces, these factors do not account for all of the growth.

There is no question that some of this explosive growth in Medicare expenditures reflects generous profit margins for the providers. For many, home health care has become a lucrative business. We are confident that while a reduction in costs and expenditures across the industry will affect profit margins, it will not have an adverse impact on beneficiaries.

Q13. The President's budget proposes to transfer the costs of home health services which do not follow a hospital stay, or which occur after 100 visits following a hospital stay, to the Part B program. How long does the Administration propose to keep a moratorium in effect on Part B coinsurance and deductibles for such services?

A13. Our policy does not establish a time-limited moratorium. It reflects a principle that Medicare beneficiaries should not have to bear higher out-of-pocket expenses.

Q14. The President's budget does not propose to extend the freeze of SNF and home health cost limits. However, it proposes to recapture the savings that would have occurred in both programs had the freeze remained in place. How would this work?

A14. Actually, the President's budget proposes to recapture the savings that would have occurred had the update to the cost limits for FY 96 and subsequent years excluded inflation associated with FY 1994 and FY 1995 (the OBRA '93 mandated freeze years). These savings are achieved through the update methodology associated with the President's proposal for a SNF prospective payment system. Specifically, the historical cost data used for the development of the prospective payment rates will be trended forward to the first effective year of the payment system by an inflation factor. This factor will established at a level appropriate to provide the necessary savings.

HHA Cost Limits: Our proposal would preserve the savings the program recognized from the statutorily mandated freeze in updates to the HHA cost limits. We have proposed neither an extension of the freeze nor a retroactive "recapture" of outlays that have occurred since the freeze expired. Rather, our proposal would merely not recognize, on a *prospective* basis, inflationary increases in home health costs for the freeze period that would otherwise be reflected in the HHA cost limits. This would be accomplished by the simple expedient of excluding the inflation that occurred during the period the freeze was in force from that used in calculating the level of the limits in future periods.

Q15. The President's budget proposes to base payments for home health services on rates which apply where the service is performed rather than where it is billed. How will this work? Will it require payment to be based on the patient's place of residence or the location of the nearest branch office of the home health agency?

A15. We propose this change because the HHA per visit payment limitation under current law is based on the geographic location of the parent agency regardless of the location where the home health service is rendered. Some HHAs establish branches so that they can provide services in a rural or lower cost area and take advantage of the application of the higher cost limitations corresponding to the geographic location of the parent HHA.

The payment incentive to establish branches in rural areas appears to stimulate the growth of branches and promotes inappropriate payments to parent HHAs located in urban areas with rural branch offices. It also provides an unfair competitive advantage to urban agencies providing services in an area already served by a rural agency. Our proposal would require payment based on the county in which the beneficiary resides, i.e., payment would be based on where the services are rendered, not where the services are billed, thereby creating a level playing field for all agencies.

Q16a. The President's budget would require consolidated billing for Medicare services provided to patients of skilled nursing facilities beginning in FY 1998. Can you provide more detail on how this proposal would affect the way that services are currently provided to SNF patients?

A16a. From the patient's perspective, the most immediate impact would be that a beneficiary in a covered Part A stay would no longer be liable for cost-sharing expenses under Part B. This is because our proposal would require the SNF to include in its Part A bill the services that a beneficiary receives from an outside supplier, rather than allowing the supplier to submit bills for its services directly to Part B (which would entail payment of any applicable deductibles and coinsurance by the beneficiary). We also anticipate that establishing the SNF itself as the single point of billing responsibility for all services will ultimately serve to promote greater continuity of patient care and greater accountability since there will be a single point through which all bills for services must pass.

Q16b. Information you provided to the Committee appears to suggest that most, but not all, services would be subject to consolidated billing requirements. Which services would not be subject to the requirement and why?

A16b. A similar comprehensive Medicare billing requirement for hospitals (42 U.S.C. 1395y(a)(14)), which has been in effect for well over a decade, specifically exempts the services of certain types of medical practitioners (e.g., physicians, certified nurse-midwives, qualified psychologists, certified registered nurse anesthetists) that are not regarded as falling within the scope of the hospital benefit. Existing law (42 U.S.C. 1395x(h), in the material following paragraph (7)) defines the SNF benefit, in part, as excluding those types of services that would not be covered under the inpatient hospital benefit when furnished to a hospital inpatient. Accordingly, our SNF consolidated billing proposal would incorporate similar exceptions for medical practitioners, in order to

maintain consistency with long-standing hospital policy.

Q16c. Why is the proposal scored as a net cost increase to the program?

A16c. The proposal's scoring as a net cost increase reflects the projected short-term impact of reduced Part B cost-sharing payments from beneficiaries, since beneficiaries (as discussed previously) will no longer be responsible for paying Part B deductibles or coinsurance for outside services that are incorporated into the SNF's Part A bill. In the long run, we anticipate that these costs will be largely offset by the diminished potential for fraudulent and duplicative billing as well as the greater administrative efficiencies that are inherent in consolidating the responsibility for Medicare billing in a single source.

Q16d. When will specific legislative language be available for this proposal?

A16d. The budget bill was given to Congress on March 27.

Q17. The President's budget envisions an interim cost control system for home health payments beginning in FY 1998 -- presumably as a transition to a full prospective payment system in FY 1999. Can you provide additional details on how this interim system will work?

Our interim system addresses the single greatest problem we currently face with the Medicare home health benefit -- excessive utilization. The interim system would establish a ceiling on annual expenditures per beneficiary. This ceiling would be based on utilization in 1994, a year in which visits per beneficiary had already increased *153 percent* from 1989. Hence, such a ceiling provides more than adequate assurance that beneficiaries will have access to the medically necessary care they require, while providing agencies with an incentive to curtail excessive service delivery.

The interim system has the very attractive feature of administrative simplicity. This system uses currently available information that is routinely reported by all HHAs. It places no administrative burden on agencies, and a minimal burden (and cost) on our fiscal intermediaries. In contrast, some other current proposals would impose a massive administrative burden, in that agencies would be required to retroactively collect and report data that some (and possibly many) agencies will not have collected or kept. The administrative burden on our contractors to review and verify this data is far beyond any resources they have.

Because this interim system is based on each agency's individual utilization, it automatically takes into account the different medical needs of the beneficiaries that comprise each HHA's case mix. Since the ceiling is based on an annual average, it also provides agencies almost unlimited flexibility in changing both the type and number of visits provided to individual beneficiaries. Therefore, it avoids the massive disruption in service delivery that would be the inevitable consequence of the premature

implementation of a "prospective" payment system that relies on a system of adjusting for case mix that is unable to account for *90 percent* of the difference in cost per case.

Finally, this system will produce demonstrable, scorable savings for the Trust Fund. Both our actuaries and CBO are in substantial agreement on the reduction in outlays the interim system would generate. Given the alternatives available in the next two years, we find this system, with its guarantee of no disruption to either the industry or the beneficiaries, to be the only available and viable solution to the problems currently facing the Medicare home health benefit.

Q18. Published reports on the President's budget indicate that HHS will propose a new definition of "homebound." Is this true? If so, how will the definition change?

A18. We are proposing to clarify the "homebound" definition by adding several calendar month benchmarks to emphasize that home health coverage is only available to those who are truly homebound. The current definition of "confined to the home" uses terms such as "infrequent" and "short duration" that are vague and allow for considerable discretion in interpretation and encourage fraud and abuse. The March 1996 GAO report cites the problematic homebound definition as contributing to excessive spending and fraud and abuse.

The current provisions state that while an individual does not have to be bedridden to be considered "confined to the home," the condition of the individual should be such that there exists a normal inability to leave the home, that leaving the home requires a considerable and taxing effort by the individual, and that absences from the home are for an "infrequent" or of relatively "short duration," or attributable to the need to receive medical treatment. We would elaborate on this long-established policy by requiring that the beneficiary must have a condition due to an illness or injury that restricts the beneficiary's ability to leave the home for more than an average of 16 hours per calendar month for purposes other than to receive medical treatment that cannot be provided in the home. We would define "infrequent" to be an average of 5 or fewer absences per calendar month, excluding absences to receive medical treatment that cannot be furnished in the home. We would define "short duration" to be an absence from the home of 3 or fewer hours, on average per absence, within a calendar month excluding absences to receive medical treatment that cannot be furnished in the home. Medical treatment would also be defined to be any services that are furnished by the physician or furnished based on and in conformance with the physician's order; by or under the supervision of a licensed health professional; and for the purpose of diagnosis or treatment of an illness or injury. These clarifications are contained in our current instructions to fiscal intermediaries. Codifying them in the statute would make it easier for us to enforce the homebound definition.

Q19. Some of the information you have provided to us appears to indicate that payments to Medicare HMOs in high cost areas will be frozen for two years. Will this freeze preserve the entire current payment, including portions which are attributable to the GME, IME, and DSH programs?

A19. Under the President's proposal for setting rates for managed care plans, the rate in each county would be the greater of: (1) a minimum rate, in 1998 equal to the lesser of $350 or 150 percent of the 1997 rate, (2) a local/national blend, or (3) a minimum percentage increase, of 0 percent in 1998 and 1999, and 2 percent thereafter (sometimes called a hold harmless provision). Under the hold harmless provision, no county's rate would be reduced below its 1997 level (which includes IME/GME/DSH payments) in 1998 and 1999.

The President has also proposed that IME/GME/DSH payments be made directly to teaching and DSH hospitals for managed care enrollees, rather than incorporating amounts attributable to IME/GME/DSH into the county rates, as they are under current law. Both the Prospective Payment Assessment Commission and the Physician Payment Review Commission have recommended this policy change. In order to make these payments directly for managed care enrollees, the payment amounts attributable to GME/IME/DSH would be pulled out of the local component of the blend amount in all counties in 1998 and 1999.

While rates in counties subject to the hold harmless provision would not decline, their rates are lower than they would have been under current law since no update is received. The national update factor is 6.8 percent in 1998 and 5 percent in 1999 and is provided only to county rates based on the blend or the minimum payment amount. To the extent that the savings from the zero updates to hold harmless counties in 1998 and 1999 are not sufficient to cover the costs of the IME/GME/DSH carve out, county rates subject to the blended rates are adjusted by a budget neutrality factor. In 1998 and 1999, this budget neutrality adjustment would reduce the increase in the blended rates by 1.4 percent and 2 percent respectively. The budget neutrality adjustment is determined each year and only impacts on the rates for that year. After IME/GME/DSH payments are carved out of the local rates, the budget neutrality adjustment is negligible or positive.

Q20. The President's budget once again proposes to utilize competitive bidding for certain Medicare services and supplies. How have you addressed the administrative complexities and concerns about ensuring access to quality services and supplies which have caused such efforts to be delayed or abandoned in the past?

A20. The President's budget would permit the Secretary to establish payments for all Part B services and items (excluding physician services) based on a competitive bidding process.

- The Secretary could not contract with any bidder unless the Secretary finds that the entity meets quality standards specified by the Secretary.

- Prohibitions in regard to proposed competitive bidding demonstrations have been imposed by previous Congresses, not by this Administration.

- Given the widespread use of competitive bidding by other purchasers of health care services (e.g., Medicaid, Veterans' Administration, Department of Defense, managed care plans), we believe that we could both assure access and maintain quality.

Q21. I understand that the Office of the Inspector General has begun an audit of physicians at teaching hospitals. This audit is presumed to be intended to identify instances where teaching physicians have fraudulently billed the government for physician services.

I am concerned that the OIG may not be separating instances of true fraudulent billing from honest billing errors--and in the process is needlessly scaring a lot of very fine teaching institutions which are already undergoing some tough times. In addition, I am concerned about aggressive use of the False Claims Act, which may not be the way to go for some of these cases.

Can you give us the status of these "PATH" audits? I hope this is something you are taking a personal interest in, because I believe it has big implications for academic medicine.

A21: The OIG is identifying substantial billing problems at teaching hospitals. The OIG found noncompliance with a Medicare rule regarding physician services provided by residents, yet billed by teaching physicians, and improperly "upcoding" the level of service provided. (Upcoding means billing Medicare for a service that has a higher reimbursement level than the service that was actually provided.) The original review resulted in recovery and fines of more than $30 million. It became apparent from OIG work at additional hospitals that this was a somewhat widespread problem. The OIG then established a review protocol to be used by other hospitals and physician group practices to assess their own liability for this improper billing practice. This initiative is referred to as "PATH," an acronym for "physicians at teaching hospitals." Active participation includes arrangement, at the hospital's or group's expense, for an independent review conducted by a third party, using the OIG protocol. This provides an alternative to having the OIG conduct all the reviews and thereby leverages its audit impact. A number of voluntary settlements are expected from these reviews. The first settlement using this protocol resulted in an agreement to pay $11.9 million. The OIG carefully evaluates each case on its own merits and considers whether improper billings

were made in error. The OIG coordinates with the appropriate Assistant United States Attorney (AUSA) who assesses the facts in each review to determine whether appropriate legal intervention is warranted. The AUSA's are part of the PATH process from the beginning of each review.

Q22. Another area of concern is with respect to your initiative to assist children who currently are without health insurance. I want to get a better understanding of the problem and would appreciate your comments specifically about your proposal to enroll 1.6 million of the estimated three million children who are eligible for Medicaid today, but who are not enrolled. Exactly who are these children? Can you give us some demographic information on these children? Are they the very young or are they teenagers? And why are they not enrolled? How do you intend to get them enrolled?

A22. All of these questions are pertinent to any success in enrolling the targeted population. We do not have demographic data on these children. We speculate that these children tend to be healthier -- otherwise they would have entered the system at some point, identified as Medicaid eligible and enrolled in the program.

We also speculate that these children are older rather than younger -- again due to the lack of interaction with the health care delivery system -- younger children have greater utilization rates due to well child visits, immunizations for school, etc. The Department is using existing surveys to develop more information on this issue.

As for why these children are not enrolled, again we can only speculate. We believe a large portion of these children reside in households where there is either no access to employer-sponsored insurance or no dependent coverage and the parents are unaware of their child's Medicaid eligibility status.

All of these questions need to be addressed in order to have any success in enrolling these children. We intend to work with the States to identify these children and the barriers to Medicaid enrollment. We intend to build upon current State and Federal outreach activities -- using best practices implemented by States and strengthening current Federal program relationships (e.g., Head Start and Medicaid).

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ATTACHMENT A10

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The President's FY 1998 Budget: Medicare Structural Reforms in the President's Budget

The President's Budget modernizes Medicare and brings it into the 21st century through a number of major structural changes.

FEE-FOR-SERVICE PAYMENT REFORM

- **Building on the success of prospective payment for inpatient hospital, the President's Budget would move to prospective payment systems for:**

  - **Skilled nursing facilities (SNFs).** Driven primarily by increases in intensity of services, SNF care is one of the fastest growing Medicare benefits. The budget would establish a per-diem SNF prospective payment system beginning in 1998, which would reimburse for all costs (routine, ancillary, and capital).

  - **Home health services.** Medicare's current reimbursement system does not help control volume, contributing to the increasingly high expenditures in this area. The President's budget implements a prospective payment system in 1999, which pays home health agencies based on characteristics of the patients, not on how many services agencies provide. In the mean time, while the prospective payment system is being developed the President's budget improves the current system to reduce overutilization.

  - **Hospital outpatient departments (OPDs).**

    Implements prospective payment system. OPDs are still paid, in part, on a cost basis. The President's budget would move to a prospective payment system for these services starting in 1999, which for the first time, would create incentives for efficiencies not present in a cost-based system.

    Addresses the current inequity in coinsurance for hospital outpatient fees. There is a significant flaw in the reimbursement methodology for OPDs involving the calculation of beneficiary coinsurance. Since coinsurance is a function of hospital charges and since charges are significantly greater than Medicare's payment rates, beneficiaries pay nearly a 50-percent copayment for outpatient department services, as oppose to the 20-percent rate beneficiaries typically pay for other Part B services. The President's proposal assures that by 2007, coinsurance will be reduced to the traditional 20-percent level.

IMPLEMENT SUCCESSFUL PURCHASING APPROACHES

- **Adopts approaches to purchasing health care services that have proved successful in other areas.** The following approaches to purchasing health care services have been used successfully by the private sector and other Federal and State purchasers and have been tested under Medicare's demonstration authority.

    - **Centers of Excellence.** Since 1991, the Health Care Financing Administration has been conducting a demonstration that pays facilities a single flat fee to provide all diagnostic and physician services associated with coronary artery bypass graft (CABG) surgery. Medicare has achieved an average of 12 percent savings for the CABG. Using this proposal would make the "centers of excellence" a permanent part of Medicare expanding it to include other heart procedures, knee surgery, and hip replacement surgery.

    - **Competitive Bidding.** To help implement more competitive strategies in managing payment for durable medical equipment, laboratories, and other items and supplies, the President's proposal would establish competitive bidding for these items.

    - **Purchasing Through Global Payments.** This enables the Secretary to selectively contract with providers and suppliers to receive global payments for a package of services for a specific condition or need of an individual. Providers would be selected on the basis of their ability to provide high quality services, to improve coordination of care, and to offer additional benefits. Beneficiaries would voluntarily elect on a month-to-month basis to participate in such an arrangement.

    - **Flexible Purchasing Authority.** This authorizes the Secretary to negotiate alternative administrative arrangements, excluding changes in quality standards or conditions of participation, with providers who agree to provide price discounts to Medicare. Savings from these arrangements could be given directly to the beneficiaries who use them, e.g. through reduced deductibles and copays.

MANAGED CARE PAYMENT REFORMS

The President's Budget would reform the payment methodology for managed care plans.

- **Addresses flaws in payment methodology for managed care.** The reforms will create a national floor to better assure that managed care products can be offered in low payment areas, which are predominantly in rural communities. In addition, the proposal includes a blended payment methodology, which combined with the national minimum floor, will reduce geographical variation in current payment rates.

- **Carves out GME, IME, and DSH payments from managed care.** Eliminates medical education and disproportionate share hospital payments from the HMO reimbursement formula and provides this money directly to teaching and disproportionate share hospitals for managed care enrollees.

- **Adjusts payment rates to reduce Medicare's current overpayment to managed care plans.** Currently, this overpayment exists because managed care enrollees are typically healthier than Medicare beneficiaries who remain in fee-for-service. This is a temporary adjustment until we implement a risk-adjusted payment system which is expected to be in place by no later than 2002.

NEW CHOICES FOR BENEFICIARIES

- **Establishes new private health plan options.** The budget increases the number of plans -- including Preferred Provider Organizations and Provider Sponsored Organizations -- available to seniors and people with disabilities. These options will meet strong quality standards and include consumer protections. The plans would be required to compete on cost and quality, not on the health status of enrollees.

- **Replaces 50/50 rule with quality measurement system.** The Secretary, in consultation with consumers and the industry, will develop a system for quality measurement. Once this system is in place, the current requirement for managed care plans to maintain a level of private enrollment at least equal to the public program enrollment will be eliminated.

- **Provides beneficiaries with comparative information to help them choose the plan that best meets their needs.** Similar to information provided under FEHBP, this proposal would enable beneficiaries to examine and compare all of the information about their coverage options.

- **Develops a process with the National Association of Insurance Commissioners to better standardize benefits.** This proposal creates a process to standardize some of the additional benefits provided by managed care plans and revises standard Medigap packages so that Medicare beneficiaries can make an "apples to apples" comparison when evaluating their coverage options.

- **Guarantees that beneficiaries can enroll in community-rated Medigap plans annually without being subject to preexisting condition exclusions.** These new Medigap protections would make it possible for beneficiaries to switch back from a managed care plan to traditional Medicare without being underwritten by insurers for private supplemental insurance coverage. This should encourage more beneficiaries to choose managed care plans because they would be assured that they could always go back to fee-for-service.

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NATIONAL RURAL HEALTH ASSOCIATION
Testimony Before the Senate Finance Committee, United States Senate

Tim Size
NRHA President-elect
March 5, 1997

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Mr. Chairman and Members of the Committee:

Good morning. I appreciate the opportunity to share the views of the National Rural Health Association (NRHA) on President Clinton's Medicare Part A proposals contained in his Fiscal Year 1998 budget. My name is Tim Size. I am the Executive Director of the Rural Wisconsin Health Cooperative in Sauk City, Wisconsin, and the president-elect of the National Rural Health Association.

It is difficult for us to have a detailed reaction to the President's budget proposal at this time because there are not many details currently available on exactly how the President would reach the general goals outlined in the Medicare reforms. With Medicare and rural health, the meat of the matter is usually found in the fine print.

Nonetheless, the NRHA and rural communities will strongly oppose an across-the-board Medicare freeze or reduction as long as:

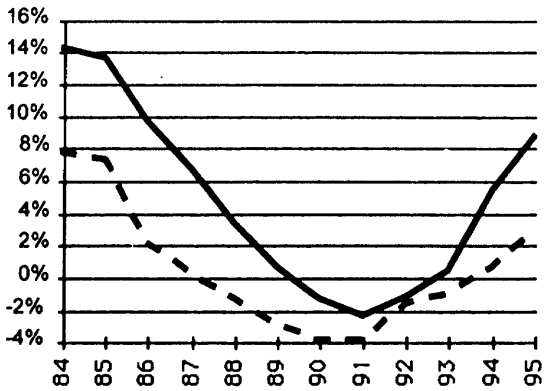
(1) rural beneficiaries have lower utilization rates, same tax rates;
(2) rural hospitals have lower reimbursement for the same work;
(3) rural hospitals have lower Medicare operating margins as a class; and
(4) rural hospitals serve disproportionately more Medicare patients.

A Twelve Year History Of Inequitable Payments

In the first year following the implementation of Medicare's Prospective Payment System (PPS), urban hospitals enjoyed an average operating margin of 14% due to Medicare PPS inpatients, while rural hospitals received 8%. Over the following years Medicare margins fell, and the difference between urban and rural hospitals substantially narrowed. In 1990 through 1992, both groups averaged negative operating margins (Medicare revenues less than costs).

Since 1992, the margin for both urban and rural hospitals has improved, but urban hospital margins much more so—preliminary figures for 1995 show urban hospitals are again 6% higher than the average for rural hospitals. Some are quick to say that these numbers reflect superior management; however, when you look at total margins that include inpatient Medicare and all other activities, rural hospitals are doing as well as urban hospitals. What we have here is more a problem of the effect of discriminatory Medicare reimbursement against the class of rural hospitals, not as some would argue, rural not managing as well as urban.

Medicare Hospital PPS (Inpatient)
Margins, 1984-1995



Source: ProPAC 6/96 & 1/97
Graphic: RWHC 1/16/97

Rural Hospital Issues

Reductions in hospital updates: PPS hospitals will be reduced by 1% per year. PPS-exempt will receive a 1.5% reduction per year. Capital payments for PPS hospitals will receive a 15.7% reduction while PPS-exempt hospitals will receive a reduction of 85% of their capital costs. As Medicare spending is considered, it is critical to understand how significantly disadvantaged rural hospitals already are by the current system. **Across the board cuts that fail to recognize the Medicare payment inequities that discriminate against rural communities are destructive of rural health and the maintenance of local access to appropriate care.**

Sole Community Hospital program "improvement": Because President Clinton does not offer any details on exactly how this program will be improved, it is difficult to have a specific reaction. However, the Sole Community Hospital program is a crucial part of the rural health care delivery system and we support continuation and potential improvement of the program.

Medicare Dependent Hospitals: Rural hospitals with a high Medicare patient load often struggle to remain open. The MDH program expired on April 1, 1993. Because of the

potential impact Medicare reform will have on hospitals, the NRHA supports reinstatement of the program with the following recommendations:

1) Reduce the eligibility percentage for Medicare discharges from the current 60 percent to 50 percent;

2) Include the current audited base year as an option in addition to the 1982 or 1987 updated hospital specific rate base; and

3) Allow the same capital-related payments as those allowed for sole community providers.

EACH/RPCH program: The president's budget proposes to "expand" the current Rural Primary Care Hospital program. We agree with the idea of expanding this program but would take it one step further by recommending a more comprehensive Limited Service Hospital program that would grandfather in all current limited service hospital program such as the EACH/RPCH, Montana Assistance Facilities, and others and include them under one new limited hospital designation. Legislation recently introduced by Senators' Rockefeller, Baucus and Grassley moves in that direction. I have submitted for the record a white paper prepared by the NRHA that contains more detailed recommendations on this issue.

Disproportionate Share Hospital (DSH) payments: In conjunction with a per capita cap on Medicaid spending, President Clinton proposes to reduce DSH payments, eliminate increased IME and DSH payments attributable to outlier payments, and remove $11 billion in DSH, IME and GME payments from Medicare payments to HMOs and give them directly to hospitals. In Fiscal Year 1996, 98 percent of DSH payments went to urban hospitals. We agree with the Prospective Payment Commission's recent recommendation that DSH payments should be concentrated among hospitals with the highest shares of poor patients. "The same general approach for distributing payments should apply to all PPS hospitals. ProPAC believes with a change in the measure should also come one common threshold shared by both urban and rural hospitals."

Payment Rates For Rural Managed Care

Average Adjusted Per Capita Cap (AAPCC): The president is proposing a $350 payment floor (as of 1998) and a 70-30 regional/national blend by the year 2002. The NRHA supports a regional/national blend closer to 50-50 in conjunction with a payment floor of 85% of the national input-price adjusted capitation rate. Eliminating wide geographic variations that currently exist will encourage managed care participation in

rural areas. While managed care is not a panacea, it is important to be on a level playing field so that those wishing to participate in these types of plans can have access to them. As there are currently practically no rural Medicare HMOs there is insufficient data to support reducing in rural counties overall payment to HMO's by 5% as proposed in the Clinton budget; without addressing the equity issue, rural areas (low payment areas) will again be further disadvantaged. **Rural communities are placed in an untenable steel vice when federal policy aims to move Medicare into managed care while at the same time federal policy has the effect of prohibiting the development of rural Medicare managed care.**

Other Key Issues

Fail-safe trigger: Not much has been said about the potential effects of the fail-safe mechanism in the Clinton budget proposal. The president proposes a trigger mechanism that would cut federal programs across-the-board 2.25% in fiscal year 2001 and 2002 if the budget is not balanced. Although the measure is just a "back up" as I believe Secretary Shalala said before your committee previously, the possibility of additional across-the-board cuts would affect rural health care providers significantly. Many times when we talk about cuts to this program or that program, it is not taken into consideration the cumulative effect of these cuts on any particular sector of health care. Rural providers are at a significant risk for devastating effects of cumulative cuts because the communities they serve rely so heavily on the Medicare fee-for-service system and Medicaid.

Graduate Medical Education (GME): The GME issue is very important to rural health providers. The current system of distributing these funds, primarily through Medicare, is flawed. The NRHA supports a payment system that supports national and regional workforce needs. In the interest of time, I am submitting for the record a white paper that details the history of this program and the NRHA's recommendations how it can be improved.

I want to thank the Committee for the opportunity to share our views on these very important issues. Please use the NRHA as a resource as debate continues on how to reform the Medicare system. We are aware of the recently introduced legislation by Finance Committee members to establish a Medicare Commission and believe it is crucial that there is rural representation on such a commission in order to assess the impact of potential reforms on the 25% of Americans that reside in rural areas.

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FUNDING OF GRADUATE MEDICAL EDUCATION

An Issue Paper Prepared by the National Rural Health Association—May 1996

The current mechanisms in place to fund graduate medical education (GME) primarily through Medicare are fundamentally flawed. They were created decades ago and designed to meet objectives that are no longer relevant. For example, while once a physician shortage was projected, a surplus is now anticipated. Since initiation, furthermore, public funding for GME has evolved into a system so arcane as to approach incomprehensibility. Finally, when we look at the current geographic distribution of physicians and their specialty mix, it is clear that the current system has not served the needs of rural communities well. Accordingly, the National Rural Health Association (NRHA) believes that the Medicare payment system to support GME should be altered in ways that support national and regional work force needs.

This paper briefly reviews the current payment methodology and then offers what the NRHA believes are the key elements that must be included in any alternative funding mechanism. The Council on Graduate Medical Education (COGME) *Seventh Report*, issued in June 1995, will serve as a starting point. The *Sixth Report*, issued in September 1995, addresses the impact of managed care on GME and makes many of the same recommendations. This approach is taken because the prodigious work done by COGME since its creation in 1986 is essentially sound and the conclusions drawn are generally consistent with the interests of the NRHA and its members.

HISTORY

For decades, Medicare has funded GME through two mechanisms, Direct Medical Education (DME) payments and Indirect Medical Education (IME) payments. Both

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payments are add-ons to the reimbursement teaching hospitals receive for care of Medicare beneficiaries and are driven by the number of residents in the hospital and the number of Medicare beneficiaries served. The DME payments are to defray resident salaries, faculty salaries and other costs directly generated by the GME program. The IME payments are designed to offset the increased costs associated with having teaching programs in the hospital, such as the extra tests trainees are believed to order. These amounts are complexly determined and differ for different teaching hospitals.

Historically, DME rates have been increased annually based on rises in the Consumer Price Index, though increases in support for residents not in primary care (family practice, general internal medicine, general pediatrics, and obstetrics and gynecology) were eliminated in 1994. In addition, since 1994, residents who are beyond the initial training for board eligibility are counted as 0.5 full-time equivalent (FTE). In most states, similar mechanisms are in place to support GME through the Medicaid program. A perceived shortage of physicians to serve the Medicare population was the initial rationale for public funding of GME. Similar thinking animated Veterans Affairs Medical Center (VAMC) support for GME and other health professions training programs.

The dollars spent through these mechanisms are not trivial. The estimated total expenditures for DME for Fiscal Year (FY) 1995 will be $1.8 billion. The analogous figure for IME is $4.5 billion. Expenditures through Medicaid are in excess of $1 billion, while approximately 10 percent of all GME positions are funded by the VAMC. It is also important to note that, with regard to Medicare funding, support for house staff has functioned essentially as a teaching hospital entitlement. That is, so long as training programs receive Accreditation Council on Graduate Medical Education (ACGME) approval, hospitals hosting those programs receive DME and IME payments for as many residents and in whatever specialties they choose to hire. As regards funding through Medicaid, there is variability among the states, but generally an entitlement model also applies. VAMC funding functions entirely differently using a centrally managed process that allocates training funds based on a budget. Individual facilities must have ACGME approval and apply for positions competitively, either as freestanding VAMC residency programs or as affiliated programs with medical or osteopathic schools or other consortia.

The core problems with this system for funding GME spring from the fact that it has never been correlated with work force needs. Residency training programs have grown up to meet the service needs of hospitals. This, in turn, has lead to a grossly disproportionate distribution of training positions such that almost no one is currently trained in the rural communities where they are needed. Thus, while the health care system has moved in the direction of managed care leading to a shift in work force need from individuals trained primarily in hospital-based specialty care to persons skilled in ambulatory primary care, the GME funding system is ill equipped to meet those needs.

The current system is thus flawed for the following reasons.

- Because it is hospital based, it tends to encourage training of the sorts of doctors found in hospitals—specialists. It is hospitals that receive the funds and, in most cases, hire the residents.
- Because it is hospital based, trainees learn how to work in hospitals. In most cases, time spent in outpatient settings is not supported through these reimbursement mechanisms and, hence, is discouraged.
- In some locations, what began as primarily a mechanism for funding hospital-based education has become primarily a mechanism for funding hospital-based indigent care. In some urban areas, poor patients are totally dependent on residents in teaching hospitals for their care.

COGME RECOMMENDATIONS AND NRHA PERSPECTIVES

In the 10 years since its founding, COGME has studied GME and issued recommendations for its reform and improvement. A recurrent theme has been the need to better correlate expenditure of public funds for GME with societal needs. Specifically, based on its study of work force needs, a shift in training support from hospital-based specialties to ambulatory-based primary care is indicated.

In its *Seventh Report*, COGME offers two categories of recommendations. The first five deal with Health Care Financing Administration (HCFA) support for GME

through Medicare, while the latter four address the Public Health Service (PHS). Each is reviewed below and the NRHA's perspective is offered.

Recommendations Regarding HCFA

1. **Funding for International Medical Graduates (IMGs).**

Much of COGME's work has been devoted to study of physician work force needs as regard specialty distribution and absolute number. Particularly in light of the growth in managed care, there are convincing data to suggest that we face a quantifiable oversupply of specialists and potentially an undersupply of generalists if the current resident numbers and specialty mix continue.

Looking first at absolute numbers, over the past decade, the number of resident positions has grown steadily, while the number of U.S. allopathic and osteopathic graduates has remained essentially constant. As a consequence, by 1994, 22 percent of the nation's house staff were international medical graduates (IMGs), 75 percent of whom, based on historical trends, will establish practice here. The projected physician surplus thus can be attributed largely to this increase in IMG postgraduate trainees who enter practice in the United States.

COGME argues that public funds should support the training of physicians in proportion to societal need. Accordingly, COGME recommends that public funding of GME positions through the IME and DME mechanisms be continued at current levels for graduates of U.S. medical and osteopathic schools, but that funding for IMGs be reduced over time to 25 percent of 1995 funding levels, thus effectively reducing the number of residents in training supported by Medicare to approximately 110 percent of U.S. graduates. The American Association of Medical Colleges (AAMC) also has recently taken the position that public funding of GME should be limite *l* to 100 percent of U.S. allopathic and osteopathic graduates as a way of correcting the projected oversupply of physicians. Similar recommendations have been made by The Pew Charitable Trusts, the Institute of Medicine (IOM) and the Prospective Payment Assessment Commission (ProPAC).

While the NRHA is sensitive to the problem of physician oversupply and its attendant inflation of health care costs, the issue of IMGs bears careful study. Many rural communities are being served by IMGs willing to locate in places that have not been successful at recruiting or retaining U.S. medical graduates. The J-1 visa waiver program also has been successfully used to address critical shortage areas. If this source of providers to rural communities is to be cut off, alternative mechanisms that encourage rural practice must be identified. Possibilities include expansion of the National Health Service Corps (NHSC) scholarship and/or loan repayment programs at the state and federal levels and employment of GME funds to enhance and expand programs for the training of primary care oriented physician assistants or nurse practitioners, particularly in rural training sites. The NRHA is not convinced that the market alone will correct these geographic provider disparities.

The NRHA agrees with the principle regarding expenditure of public funds, and is convinced by the data suggesting that specialists will be in significant oversupply if current trends continue. The association supports, with some reservations, the gradual reduction in support for IMGs. However, before such a program is implemented, the impact on rural communities in both the short and long terms must be carefully studied and, should potential negative consequences be identified, remedies put in place. Such remedies should include expansion of the NHSC and/or use of GME funds to support training of primary care providers in rural primary care training sites.

2. Changing the Specialty Mix.

COGME's research suggests that, not only are we training too many physicians, we also are training the wrong kind and in the wrong places. Accordingly, COGME recommends that DME and IME funding be allowed for resident training in non-hospital settings such as physicians' offices, community health centers and managed care organizations. Public funding for GME would thus follow the resident to the outpatient setting, eliminating a major barrier for training in such facilities.

COGME also recommends differential weighting of DME and IME depending on the specialty of the resident such that trainees in the first three years of training in family practice, general internal medicine and general pediatrics would be weighted at 125 percent with a complementary reduction of funding for other specialties based on a weighting of 75 percent. Furthermore, all positions after initial board eligibility or five years, whichever is shorter, would be weighted at 50 percent, offering a significant barrier to subspecialty training.

The NRHA supports these recommendations with the following suggested improvements.

- *To encourage utilization of training sites in rural and other areas with underserved populations, the IME and DME weights should be adjusted to 150 percent for primary care and 100 percent for all other specialties when training occurs in such settings.*
- *Because, in some states, medical and pediatric graduates have gravitated to rural practice in proportions that exceed general pediatrics, we suggest the inclusion of medicine and pediatrics as primary care disciplines.*
- *The NRHA suggests careful monitoring of provider needs and practice patterns to allow modifications in policies and incentives as needed to ensure that today's solutions do not create tomorrow's shortages.*

3. **Transitional Payments.**

COGME acknowledges that, because of the existing payment mechanism, some urban hospitals have become dependent on IMGs and other residents to provide essential services to poor people. Accordingly, COGME recommends establishment of a transition program to allow these institutions to find alternative methods of care delivery. Possible mechanisms include support for physician assistant or nurse practitioner training programs, or increased loan repayment opportunities through the NHSC that are targeted to urban teaching hospitals.

The NRHA supports the development of transition strategies that avoid inflicting undue hardship on IMG dependent institutions that maintain their commitment to providing services to disadvantaged populations.

4. Medicare Managed Care.

When Medicare beneficiaries are enrolled in managed care organizations, the capitation payment that the provider receives, the Average Adjusted Per Capita Cost (AAPCC), includes the IME and DME adjustments. Many of these organizations, however, do not provide GME. COGME, therefore, recommends that this component of the AAPCC be removed and reallocated to support GME in whatever settings it occurs.

The NRHA supports the separate identification of the GME components of the AAPCC and the use of these funds to support GME.

5. Consortia.

In its earlier *Fourth Report*, COGME recommended the creation of a National Physician Work Force Commission to monitor physician supply and recommend broad outlines for resident line allocation. Educational consortia, organized around medical or osteopathic schools were the recommended vehicle for implementation of the resulting strategies. This recommendation was based, the NRHA believes, on the assumption that broad-based national reform of the health care system was likely and that a National Physician Work Force Commission might be part of it. The *Seventh Report* makes a more modest proposal, suggesting that "both the accrediting bodies and HCFA...encourage the development of...education consortia or training networks to determine the number and specialty mix of residents, to facilitate the more appropriate utilization of training settings, and to receive and distribute GME funds to whoever (sic) bears the training costs.... Demonstration projects could be utilized to develop such a consortium approach."

The NRHA supports the concept of consortia, but believes that basic principles regarding allocation of resources for GME can be correlated at this time to guide support for demonstration projects. Specifically, allocation of Medicare funding for resident lines among states ought not to be tied to the current distribution, driven as it is by inpatient, tertiary care in urban hospitals. This mechanism has led to a grossly disproportionate geographic distribution of residents. The long-term objective of GME payment reform must be to allocate training opportunities in a manner that more closely approximates population distribution. As regards the nature of consortia, the NRHA concurs with COGME's April 25, 1994, letter clarifying its concept of consortia as outlined in the Fourth Report *and suggesting flexibility in consortium administration. The NRHA believes that there may be circumstances in which rural-based training can be better served by entities other than academic medical centers and, therefore, concurs with the principle of flexibility in consortium structure. The NRHA also recommends that funding for demonstration projects be geographically dispersed according to general population distribution and not according to current resident position distribution.*

Recommendations Regarding PHS

While the bulk of public funding for GME comes through HCFA and the Medicare Trust Fund, PHS also has historically provided support for the enterprise, albeit at much lower levels. The funding streams differ markedly in that, while HCFA funds are tied directly to patient care delivery in teaching hospitals, PHS funds have come primarily through grants and scholarships to institutions or training programs. Also, PHS funds have been targeted for specific policy objectives while HCFA funding, as has been seen, is outcome neutral. COGME reviewed the performance of PHS programs, finding that useful policy outcomes have been achieved through this mechanism and citing the growth in family practice residency and clerkship experiences in institutions receiving PHS funds through Title VII, the Health Professions Training Act. While its mission is to provide service to underserved

populations, the NHSC, funded through Title III, also has supported health professions education through its scholarship and loan repayment programs. Finally, through the Agency for Health Care Policy Research (AHCPR), PHS funds research on primary care, treatment effectiveness and other topics.

6. **Reauthorization.**

COGME recommends reauthorization at pre-recision levels for the NHSC, the Title VII programs and funding for AHCPR, based on their general success in increasing the number of generalist practitioners, minorities in clinical practice and access for underserved populations.

The NRHA supports these programs and concurs with this recommendation.

7. **Consolidation.**

Both President Clinton's 1996 budget and the Senate's Health Professions Education Consolidation and Reauthorization Act of 1995 envision consolidation of a variety of currently separately authorized programs under a single authority with the goal of simplifying administration and allowing greater cross-disciplinary cooperation. Under these proposals the NHSC would be included in Title VII.

With regard to Title VII programs, the NRHA is generally supportive of the concept of consolidation to allow greater flexibility in utilization of PHS funds to support the goals of increasing primary care provider production and improving work force distribution. The NRHA suggests, however, that guarantees be included to ensure that discipline-specific funding remains at current levels or is proportionate. The NRHA is concerned that smaller disciplines not be dismissed in favor of disciplines with larger constituencies.

8. **Outcomes.**

COGME recommends that unified outcome criteria and evaluation strategies be required of Title VII-funded programs with funding favoring programs with a

record of success at placing graduates in primary care practice in rural and underserved areas.

The NRHA concurs with this recommendation, with the caveat that new programs, specifically targeted at training based in rural communities, should be favorably considered, even though such new programs will, by definition, lack a track record.

9. **Reauthorization of COGME**

COGME is reauthorized in both President Clinton's budget and in the Health Professions Education Consolidation and Reauthorization Act.

The NRHA supports the reauthorization of COGME, believing that it has served the common interest and continues to do so.

Additional Points

All-Payer Support for GME

The NRHA believes that GME is a societal good for which all who benefit should pay. It is no longer reasonable, if ever it was, that Medicare be the primary provider of funding for GME. Accordingly, the NRHA supports an all-payer system for funding both direct and indirect support of GME as a policy objective. This was a recommendation of COGME's *Fourth Report* and remains pertinent.

Subsidy for Teaching Hospitals

The increased costs of care delivered in teaching hospitals associated with severity of illness, acuity and the like must, as COGME recommended in its *Fourth Report*, be funded independently of the number of resident positions because these factors are a consequence of the broad mission of the academic medical center, not just of its residency training programs. Tertiary care is the province of the academic medical center because of the faculty, not the residents. The NRHA believes, therefore, that support for teaching hospitals by all payers should be a policy

objective. Current proposals for a Medical Education Trust Fund may be the appropriate mechanism to achieve this objective, provided it is supported not just by Medicare, but by all payers. The NRHA believes it is critically important, however, that funding of these service delivery aspects of the academic medical center be separated from the training mission and that funds for training be driven by issues of work force composition and geographic distribution. ■

NATIONAL RURAL HEALTH ASSOCIATION

THE NEED FOR A NATIONAL LIMITED-SERVICE HOSPITAL PROGRAM

An Issue Paper Prepared by the National Rural Health Association—November 1996

WHY DO WE NEED A NATIONAL LIMITED-SERVICE RURAL HOSPITAL PROGRAM?

Rural communities continue to struggle to maintain adequate access to quality health care services. Factors such as demographic changes, shortages of physicians, changes in medical practice, and economic stagnation have led to the closure of hundreds of rural hospitals over the past decade. Those that remain are often in financial difficulty and struggle to maintain adequate facilities and services. According to the Prospective Payment Assessment Commission (ProPAC), non-metropolitan hospitals, as a group, have lost money on their Medicare patients for the past six years (ProPAC, 1995), despite changes in Medicare payment policy designed to assist these facilities. The smallest rural hospitals (those with fewer than 50 beds), which serve disproportionate numbers of Medicare beneficiaries and are, therefore, particularly dependent on Medicare revenue, are those in the most precarious financial position. Although about one-half receive local tax support to subsidize operations, ProPAC reports that total revenues still lag behind costs for 39 percent of these facilities (ProPAC, 1994).

The closure of hospitals that have been more than 20 miles away from the next nearest acute-care facility have created undue access problems for the residents they served, especially for elderly and poor residents (Adams & Wright, 1985; Hogan, 1988). In addition to an increase in barriers to access, closure of local rural hospitals often leads to the provision of more expensive care in urban hospitals that absorb the resulting unmet health care needs (Langwell, et al., 1985; Kleinman & Makuc, 1983;

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Rosenbach & Dayhoff, 1995; Wright, 1985). *Hospital closure can ultimately result in the exodus of physicians and other health care personnel, the closure of primary care services, and the reduction of emergency medical capacity.*

One of the first casualties of rural hospital closure is emergency medical services (EMS) with care available at increasingly greater distances. Rural EMS response is complicated by low population densities, long distances to hospital emergency rooms, poor quality back roads, mountainous terrain, and severe winter travel. Often the major occupations of rural areas are among the most hazardous (e.g., farming, mining and logging) with accident rates many times the national average (Pratt, 1990).

There also is evidence that rural hospitals are crucial to attracting and retaining physicians and that communities without a nearby hospital have greater problems with physician supply than other communities (Langwell, et al., 1985; Wright, 1985). Like hospitalization, the use of ambulatory services is directly related to travel distance and time, particularly for low-income families and the frail elderly (Kleinman & Makuc, 1983).

Given these findings, it is apparent that some rural communities can no longer support a full-service hospital, but residents of these communities will lack adequate access to care if the local hospital closes. Some of these communities would be better served by an alternative model that preserves access to emergency services and primary care and offers a level of acute-care services appropriate to the needs of the community and the capabilities of the facility and its staff. A limited-service hospital model would combine improved reimbursement with cost savings from relaxed operating requirements to help ensure financial viability. In communities that have difficulty recruiting doctors, services at these facilities could be provided by a non-physician practitioner, under the remote supervision of a physician.

Models for the creating of a national limited-service rural hospital program already exist at the federal level in the Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) program and the Montana Medical Assistance Facility (MAF) demonstration (Note 1). Both of these programs have been in operation for a number of years, but participation has been limited to a small number of states (Note 2). A substantial number of hospitals in these states, however, have examined

conversion to limited-service hospitals and an ever-increasing number have chosen to participate in the EACH/RPCH and MAF programs (Note 3).

Both the EACH/RPCH and MAF programs have been extensively studied and evaluated by both independent and government researchers (e.g., Campion, 1995; Campion & Dickey, 1995; Campion, et al., 1993; Christianson, Moscovice, & Tao, 1990; Christianson, Moscovice, Wellever, & Wingert, 1990; Felt & Wright, 1992, 1993; Gaumer, et al., 1993; General Accounting Office, 1995; Office of the Inspector General, 1993a, 1993b). Based on these studies and on program operating experience, there is a general consensus among participants on the most effective aspects of the limited-service models that could be combined into a successful national program. Such a program would not represent an effort to reform the operations of all rural hospitals or to consolidate Medicare rural hospital payment methodologies, nor would it be a panacea for all rural hospitals that face financial or other difficulties. Program experience has shown that limited hospital programs effectively address hospital and community issues in some cases, but not others. The viability of conversion varies from facility to facility, depending on factors such as the cost structure of the hospital and utilization patterns in a community. Issues that are not directly health care related, such as community acceptance, also are critical and are unique to each rural community. It is clear, however, that limited-service rural hospitals occupy a constructive niche for rural delivery system reform and offer a viable alternative to full-service hospitals and preserving access to cost-effective quality health care services.

CURRENT LIMITED-SERVICE RURAL HOSPITAL PROGRAMS

Policy-makers in several states have responded to the need to preserve access to essential health care services in rural areas by developing new models of health services delivery that improve the viability of providers by easing regulations and removing some of the bias of public payment systems against small-volume providers. Developed in Montana in 1987, the MAF demonstration was the first of these models to be implemented. Finding the model promising, the Health Care Financing Administration (HCFA) supported experimentation with limited-service rural

hospitals by funding a multi-year demonstration of MAF and issuing waivers that accepted the Montana MAF licensure rules in lieu of the Medicare Hospital Conditions of Participation and reimbursing MAFs for Medicare services on the basis of reasonable cost. The MAF quickly became a model for other state and federal limited-service rural hospital programs (Christianson, et al., 1990).

Some of the limited-service rural hospital models adopted in the years between 1987 and 1990 are essentially reproductions of the MAF model (e.g., models created in Florida, Kentucky and Wyoming). Although states are at liberty to license any new institutional provider types they choose, the Medicare and Medicaid programs will pay only for services delivered in certified facilities governed by Medicare conditions of participation. Because limited-service rural hospitals are hospitals of a particular type, they are subject to the Medicare conditions of participation for hospitals. If the state licensure rules are less stringent than the conditions of participation for hospitals, limited-service hospitals need to obtain a waiver from the HCFA to receive payment for services provided to Medicare and Medicaid patients. The waiver authority granted by Congress to the HCFA to conduct the MAF demonstration project, however, was specific to that project only. Even if the HCFA wanted to, it does not have the authority to grant waivers for any additional state-sponsored limited-service hospital programs. Because rural facilities rely heavily on payments from Medicare and Medicaid, policy-makers in states with MAF-like models have decided that it is not practical to implement a model that is not reimbursed by Medicare or Medicaid.

The hospital licensure rules of most states are close or identical to the Medicare conditions of participation. A few states, however, have state licensure rules that are more stringent than the Medicare conditions of participation for hospitals. In these states, it is possible to implement a limited-service rural hospital model without a waiver. To date, only one state has created such a model, the Alternative Rural Hospital Model (ARHM) in California. The state offered its rural hospitals a measure of regulatory relief by creating a category of licensure that would roll back state requirements for hospitals to the level of the federal requirements. Although the ARHM does lessen the regulatory burdens of some California rural hospitals, it is not as effective as the MAF in removing regulatory barriers to ensure access to needed health

services. The licensure rules simply put ARHMs on a par with rural hospitals in most other states (Wellever & Rosenberg, 1993).

In 1989, Congress created the Rural Primary Care Hospital (RPCH) program, a limited-service rural hospital modeled on the MAF. Unlike MAFs, however, RPCHs were to operate in the context of a rural health network with a larger, more sophisticated hospital known as an Essential Access Community Hospital (EACH). Care provided in RPCHs is a covered service of Medicare; accordingly, RPCHs have their own conditions of participation, eliminating the need for waivers to receive payment. When Congress developed the RPCH model, it also created a grant program to implement it. RPCH certification by the HCFA was limited to facilities in the seven states that received grant funding (California, Colorado, Kansas, New York, North Carolina, South Dakota and West Virginia). The program has not been expanded to other states despite positive evaluations of the MAF and RPCH models and high degrees of interest in alternative models by rural health policy-makers in other states.

Both the MAF and the RPCH have been the subject of independent program evaluations sponsored by the HCFA. (These evaluations were conducted by Abt Associates and Mathematica Policy Research Inc.) Although MAF was evaluated somewhat more favorably than RPCH, both models were judged to have reversed the deterioration of health services in the communities they serve, expanded the supply of practitioners and services, improved the financial position of the facilities, and fostered the integration of community services to improve continuity and avoid duplication. In addition to the HCFA-sponsored evaluations, the MAF project has been evaluated positively by the Office of the Inspector General of the Department of Health and Human Services (DHHS), by the General Accounting Office (GAO) and by others (Felt & Wright, 1992, 1993; Gaumer & Geller, 1993). The MAF and RPCH models also have gained the approval of knowledgeable rural health practitioners and researchers: The MAF demonstration program was selected the 1994 Outstanding Rural Health Program by the National Rural Health Association (NRHA) and the Kansas EACH/RPCH program won the same award in 1995.

Many states that are interested in participating in limited-service rural hospital programs are excluded from doing so. One the one hand, they are prohibited from

taking state action to implement state models by the need for a federal waiver. On the other hand, they are excluded from participating in the federal program by an unjustified cap on the number of states that may participate in the EACH/RPCH program. The number of states that would participate in a national program is not known, but some indication of interest in limited-service rural hospital models may be gleaned from the following: 21 states applied for EACH/RPCH program grants; the MAF program office has responded to inquiries about the program to people in 35 states; nine states attempted alternative models before it became clear that they could not be implemented without waivers.

Responding to the need for a national limited-service rural hospital program, in 1995 Congress proposed two new models. One model was similar to MAFs and RPCHs; the other model resembled a free-standing emergency room. Neither model was incorporated into law.

The effort by Congress in 1995 to create a national limited-service hospital program highlighted several issues of concern to the NRHA. First, it appears that Congress is willing to respond to the growing consensus for the need for a national limited-service rural hospital model, but in the absence of rural advocates speaking with one clear voice, Congress will design its own model. Many in the rural health community have experience with limited-service rural hospitals; they know what works and what does not work. Those familiar with MAFs and RPCHs should draw on their experiences to design a national model that meets the needs of rural providers and the communities they serve. Second, there is not a need for multiple limited-service rural hospital programs. A single program can be designed to meet the particular needs of different states. The existence of multiple limited-service rural hospital programs in a legislative bill may work to the disadvantage of rural areas. If multiple programs were passed, they might add to the complexity of operating the programs at the federal level, resulting in a less flexible administration. There is a clear need to build on the experiences of the past and to develop a single national limited-service rural hospital model that is flexible enough to accommodate the unique circumstances of the various states.

CRITERIA FOR A NATIONAL LIMITED-SERVICE RURAL HOSPITAL PROGRAM

Program components of existing and proposed limited-service hospital programs have been incorporated below to produce a single model that is flexible enough to reflect different state circumstances and provides for appropriate federal oversight. The program criteria described below include facility size, service limitation, geographic location, reimbursement and networking.

Number of Beds.

Criteria—The limited-service rural hospital may have up to 15 acute-care inpatient beds. The entire component of acute-care beds also may be licensed as swing beds.

Currently, RPCH facilities are limited to six acute-care beds. At the start of the EACH/RPCH program, RPCHs that participated in the swing-bed program were permitted by regulation to operate up to 12 beds. Congress amended the authorizing statute in 1994 to eliminate this option and limit RPCHs to six acute-care beds. MAFs have no bed size limit, but there are currently no MAFs with more than 10 beds. To provide for maximum flexibility and differences in size and scope of services of rural hospitals around the country, a 15-bed limit should be adopted, thus making the program more acceptable to rural areas in the more densely populated eastern part of the country.

Service Limitation.

Criteria—Within a limited-service rural hospital, inpatient care cannot exceed 96 hours, except in circumstances where the peer review organization (PRO) or equivalent organization may, on request, waive the 96-hour restriction on a case-by-case basis.

Currently, RPCHs must maintain a yearly average length of stay of 72 hours (at the start of the program, the authorizing legislation established an absolute limit of 72 hours; the requirement was subsequently changed in statute to a 72-hour average length of stay). Inpatient stays in MAFs are limited to 96 hours. While less flexible than an

average length of stay, an absolute limit eliminates the perverse incentives that could arise if a facility approaches the end of the year above the average length of stay target. The 96-hour limit in MAFs is widely accepted by both clinical and administrative staff and is easy to administer and monitor.

Geographic Limitation.

Criteria—The limited-service rural hospital should be located no less than 20 miles from another hospital.

The primary purpose for developing this program is to ensure access to essential health services for rural areas. Again, there needs to be criteria that maintain some basic standard, but allow for flexibility and consideration of different geographic locations of these facilities.

Reimbursement.

Criteria—The reimbursement for limited-service rural hospitals should be based on reasonable costs (not subject to the lesser-of-cost-or-charges) including the cost of professional services and should allow for the inclusion of costs for networking with other providers.

Currently, RPCHs participating in the EACH program are subject to an interim payment methodology based on the first year's cost after certification. Congress specified that a prospective payment system for RPCHs be developed by the HCFA, but to date this payment methodology has not been developed. This leaves a certain amount of ambiguity for existing RPCHs. MAFs are reimbursed based on a facility-wide, cost-based reimbursement methodology that has proven easy to administer and has been positively evaluated by the GAO and the Office of the Inspector General.

Networking.

Criteria—Limited-service rural hospitals would be required to have formal agreements with at least one hospital and other appropriate providers for such services as patient referral and transfer, communication systems, the provision of emergency and non-emergency transportation, and back-up medical and emergency services.

Experience with the EACH and MAF programs highlights the importance of networking these facilities with other providers to strengthen the services of the facility and linkages to the health care delivery system. Limited-service rural hospitals should be at liberty to select the facilities with which they network. Where possible, limited-service rural hospitals should be encouraged to participate in health care networks that extend beyond these affiliation relationships. Integration into multi-provider networks offers an expanded resource base upon which to draw to meet patient and organizational needs. The scope of services that can be potentially provided by a limited-service rural hospital can be greatly enhanced by the provider network to which it belongs. Currently licensed RPCHs and MAFs facilities would need to be incorporated into the new program.

CONCLUSION

Limited-service hospitals are effective in maintaining access to cost-effect, quality health care services in rural communities that can no longer support a full-service hospital. Existing limited-service hospital programs have provided a positive alternative to hospital closure and the loss of emergency, acute care and other services, especially in remote rural areas and communities with high numbers of elderly or poor residents. The need for such an alternative is apparent in the high level of interest in the existing models exhibited by states and providers across the nation. In addition, approximately 40 hospitals have converted to MAF or RPCH status in the states that participate in these programs and many others are either examining participation or are in the process of conversion. These providers and communities are responding to the various benefits that the continued presence of a health care facility provides to the community, including important factors, such as economic development and employment, that are not directly health related.

However, because federal law does not recognize limited-service hospitals as a type of provider that may be reimbursed by the Medicare program (unless, as in California, they continue to meet Medicare conditions of participation), states have been restricted in taking positive action to develop their own limited-service hospital

programs. As a result, viable models operate only in seven states—six of the states that participate in the EACH/RPCH program and Montana, which participates in a HCFA-sponsored demonstration project. Clearly, community hospitals in other states could benefit from a limited-service hospital alternative and would use such an option if it were available.

Several years of experience with the MAF demonstration and the EACH/RPCH program provide sound guidance on the desirable features of a national limited-service rural hospital program. The program should be uniform in its basic features, yet flexible enough to allow it to be adapted to the unique circumstances of each participating community and provider. A single national model, as proposed in this issue paper, offers both flexibility and administrative simplicity, particularly at the federal level. While not intended to supplant other federal programs or offer a panacea for all rural providers, a national limited-service hospital program will provide many rural communities with the tools to positively address the potential closure of the community hospital and preserve local access to needed health care services. Limited-service rural hospitals occupy a viable niche in the delivery system and can clearly play a valuable role in the health care of rural America. ■

NOTES

1. Many states also have created their own limited-service hospital models, but most of these are not eligible for Medicare reimbursement and have not been implemented (Wellever & Rosenberg, 1993).
2. The EACH/RPCH program is limited by statute to seven states, which were selected by the Health Care Financing Administration (HCFA) through a competitive grant award process. Participating states are California, Colorado, Kansas, New York, North Carolina, South Dakota and West Virginia. The MAF demonstration is a state program in Montana and operates under legislative authority granted only for this project.
3. As of October 1996, approximately 40 hospitals have converted to RPCH or MAF status.

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Questions for the Record
Senator Bob Kerrey
Senate Finance Committee Hearing
President's Medicare Budget Proposal
March 5, 1997

For the National Rural Health Association:

1. I understand that the National Rural Health Association generally supports the President's proposal to adopt a national payment floor of $350 per member per month for Medicare managed care contracts.

- Can you explain why you prefer a more aggressive blend of national and regional averages compared to the President's proposal? (50/50 versus 70/30) Which regions would benefit from your approach versus the President's?

- Why is an artificially high payment rate necessary to induce managed care companies to enter into Medicare managed care contracts in rural areas?

- What effect do you think this proposal, or any other that increases managed care payment rates in rural areas, will have on rural health delivery systems? What would happen without this type of support?

- Besides low payment rates, what other barriers exist that inhibit the expansion of Medicare managed care to rural areas?

2. You state that rural providers are at particular risk from cuts in provider payment rates because the communities they serve are heavily dependent on Medicare and Medicaid for health insurance coverage. What proportion of rural residents are covered by these programs? What proportion of rural hospitals' revenues are derived from Medicare and Medicaid payments? What impact would these cuts have on rural communities?

3. Yesterday we heard testimony from the CBO that, in their eyes, the President's budget proposal would result in a $69 billion deficit in 2002 -- thus requiring implementation of the fail-safe trigger of across-the-board cuts in federal programs. How would this fail-safe affect rural communities?

NATIONAL RURAL HEALTH ASSOCIATION

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Response to Questions Submitted for the Record by Senator Bob Kerry
Senate Finance Committee Hearing
March 5, 1997

Tim Size, President Elect
National Rural Health Association
April 24, 1997

1) The National Rural Health Association (NRHA) supports using a percentage to establish a national Adjusted Average Per Capita Cost (AAPCC) payment floor versus a specific dollar figure as contained in the President's FY 1998 Budget. By using a percentage, you allow the payment floor to grow in relation to the national AAPCC over a defined number of years. This provides a safety net for communities that could continue to have significantly lower capitation payments despite the implementation of a national/regional blend.

The NRHA supports a more aggressive blend that will increase capitation payments in rural areas. More equitable rates will attract Managed Care Organizations (MCOs) to offer competitive benefit packages to Medicare beneficiaries in these counties and regions. The more aggressive the blend, the more quickly MCOs will be able to penetrate these markets and offer comparable benefits packages as those being offered in higher payment areas.

Increases in capitation payments for Medicare managed care will expand choice, access, and benefits for rural beneficiaries. Without equalizing the AAPCC payments in rural counties, Medicare beneficiaries would be denied the same opportunities and benefits that individuals are receiving in large, metropolitan areas – taking into account that beneficiaries have equally contributed to the Medicare system.

The NRHA supports mechanisms to ensure that enhanced funding received by MCOs as a result of changes in the capitation payments be utilized to provide additional preventive and other services which will improve the health status of beneficiaries and to support and improve the rural health care infrastructure, including the utilization of appropriate local services and eliminating geographical inequities in provider payment.

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2) 15.8 percent of the rural population was covered by Medicare in 1994 – compared to 12.2 percent of the population in urban areas (Source: Rural Research Policy Institute). According to the 1990 U.S. Census, 14.7 percent of the rural population was over the age of 65 and 5.6 percent of the rural population was disabled persons between the ages of 16 and 64.

16 percent of the rural population fell below the poverty level and were Medicaid eligible in 1994. Of the16 percent eligible for Medicaid in rural areas, 44 percent actually enrolled in the Medicaid program. As a percentage of the entire rural population in 1994, 12.7 percent participated in the Medicaid program (Source: Economic Research Service – USDA March 1995 Current Population Survey).

In 1995, government sources, including Medicare, Medicaid, and other public programs, accounted for 52.1 percent of net patient revenues received by rural hospitals. 42.1 percent of rural community hospitals net patient revenues came from the Medicare program and 11 percent c ume from Medicaid. The costs of uncompensated care, which includes both bad debt and charity care, amounted to 5.7 percent of rural hospital expenses. (Source: Calculated by American Hospital Association using data from1995 Annual Survey of Hospitals).

3) A combination of the reductions in hospital payments in the President's FY 1998 Budget, along with an additional 2.25 percent reduction would result in financial instability and closure for many rural hospitals and health care providers. While many larger, urban hospitals are seeing increased profit margins, many rural and frontier hospitals are being forced to control costs by limiting access to some services. Any additional cuts to providers must recognized the barriers and challenges being experienced in the rural health care delivery system, and must not perpetuate geographic differentials and other inequities in reimbursement of rural providers.

PREPARED STATEMENT OF PAUL N. VAN DE WATER

Mr. Chairman and Members of the Committee, I am pleased to be with you this morning to present the Congressional Budget Office's (CBO's) analysis of the President's budget. My statement will give an overview of our findings and provide more details about CBO's estimates of the President's proposals for Medicare, Medicaid, and other programs in the Committee's jurisdiction.

OVERVIEW OF THE BUDGET

As he did last year, the President has submitted a budget that is intended to eliminate the deficit by 2002. To help ensure that this goal is reached, the President has proposed two sets of policies: one that would produce a $17 billion surplus under the Administration's economic and technical estimating assumptions, and an alternative set that would reach budgetary balance in 2002 under CBO's more cautious assumptions.

Using CBO's economic and technical estimating assumptions, the President's basic budgetary proposals would fall short of balance in 2002 by $69 billion. The alternative Administration policies are designed to fill the $69 billion deficit hole estimated by CBO. Under those alternative policies, some proposed tax cuts would sunset after 2000, and most spending programs would be cut across-the-board in 2001 and 2002 from the levels proposed by the President.

CBO Estimates of the President's Basic Policies

If current budgetary policies remain unchanged, CBO projects that the federal deficit will rise from the $107 billion posted last year to $188 billion by 2002. Balancing the budget in 2002, however, would lower interest rates and produce other changes in the economy that would yield a fiscal dividend of an estimated $34 billion in 2002. Under CBO's projections that include that fiscal dividend, $153 billion in policy savings in 2002 would be needed to produce a balanced budget that year. Those projections provide the starting point for CBO's analysis of the President's budget, since the budget is intended to eliminate the deficit over the next five years.

CBO estimates that the President's basic policies would save $84 billion in 2002 and produce a deficit of $69 billion (see Table 1). Over the 1998-2002 period, the President's policies would reduce the deficit by a total of $133 billion. Reductions in projected spending for Medicare and Medicaid account for $89 billion, or two-thirds of the proposed savings.

TABLE 1. CBO ESTIMATE OF THE EFFECT ON THE DEFICIT OF THE PRESIDENT'S BASIC BUDGETARY POLICIES (By fiscal year, in billions of dollars)

	1997	1998	1999	2000	2001	2002	Total 1998-2002
CBO Revised Deficit Projections, Including Fiscal Dividend[a]	115	121	145	159	142	153	n.a.
Effect on the Deficit of the President's Budgetary Policies							
Revenues[b]							
Reductions	1	21	21	22	27	28	120
Increases	-1	-11	-16	-17	-18	-19	-81
Subtotal	c	10	5	5	10	9	39
Outlays							
Discretionary	c	9	-3	-13	-29	-42	-79
Mandatory							
Medicare	0	-3	-10	-18	-22	-29	-82
Medicaid	c	2	2	-1	-4	-6	-7
Health Insurance	0	3	3	3	4	1	14
Supplemental Security Income	c	2	2	2	2	2	9
Food Stamps	c	1	1	1	1	1	5
Education and training	0	2	2	3	2	c	9
Spectrum auctions	0	0	-3	-4	-6	-12	-24
Other	c	-2	-2	-2	-2	-5	-13
Subtotal	c	5	-6	-17	-26	-46	-90
Total Policies	1	23	-3	-24	-46	-79	-129
Debt service	c	1	1	c	-2	-5	-4
Total Effect on the Deficit	1	24	-2	-24	-47	-84	-133
Deficit Under the President's Budgetary Policies as Estimated by CBO	116	145	142	135	95	69	n.a.

SOURCE: Congressional Budget Office.

NOTES: Estimates contained in this table exclude alternative policies to eliminate the deficit gap under CBO asssumptions.
n.a. = not applicable.

a. Deficit under CBO's revised projections that assumes both balanced budget economic assumptions and discretionary spending that increases with inflation, subject to the statutory cap for 1998.

b. The revenue estimates differ somewhat from those published by the Joint Committee on Taxation (JCT). CBO has used Administration estimates for two proposals that JCT was unable to estimate because they are not yet specified—a new aviation fee system and a District of Columbia tax-incentive program. CBO's estimates also include additional fee proposals and exclude a proposal that would only affect outlays. In addition, they assume that tax cuts specified in statutory language to sunset in 2000 are extended permanently

c Less than $500 million.

CBO's estimated deficit of $69 billion in 2002 contrasts with the surplus of $17 billion that the Administration estimates (see Table 2). About 70 percent, or $60 billion, of that $86 billion discrepancy stems from differences in deficit estimates under current policies, largely because of different economic assumptions. Reestimates of the effects of the President's proposed policy changes account for the remaining $27 billion difference. Most of that reestimate is the result of different estimates of the President's Medicare proposals and the proposed auction of additional portions of the electromagnetic spectrum.

TABLE 2. CBO REESTIMATE OF THE PRESIDENT'S BASIC BUDGETARY POLICIES
(By fiscal year, in billions of dollars)

	1997	1998	1999	2000	2001	2002
Deficit Under the President's Basic Budgetary Policies as Estimated by the Administration	126	121	117	87	36	-17
Baseline Reestimates						
Economic Differences						
Revenues	8	17	25	35	40	46
Outlays	a	3	10	12	12	15
Subtotal	8	20	35	47	52	61
Technical Differences						
Revenues	-11	-11	-15	-13	-14	-15
Outlays	-10	-5	-5	-9	-a	-14
Subtotal	-21	-6	-20	-4	-14	-2
Total, Baseline Differences	-13	15	15	43	38	60
Policy Reestimates						
Revenues	1	3	4	1	4	5
Outlays						
Discretionary	1	1	5	-1	7	1
Mandatory						
Medicare	0	2	1	4	6	6
Medicaid	a	a	1	a	a	a
Spectrum auctions	-2	4	-1	a	1	11
Other	2	-1	1	1	3	5
Subtotal	a	5	2	5	10	21
Total, Policy Differences	3	10	10	5	21	27
Total Differences	-10	25	25	48	59	86
Deficit Under the President's Basic Budgetary Policies as Estimated by CBO	116	145	142	135	95	69

SOURCE: Congressional Budget Office.

NOTE: Estimates contained in this table exclude alternative policies to eliminate the deficit gap under CBO assumptions.

a. Less than $500 million.

CBO Estimates of the President's Alternative Policies

The President's budget briefly mentions an alternative set of policies that are designed to eliminate the deficit in 2002 under CBO's current economic and technical estimating assumptions. That alternative set of policies includes all of the President's basic policies plus additional ones that would be in effect only if CBO's assumptions are used in the budget process.

If CBO's assumptions are used for budget planning, the President would allow most of his tax cuts to sunset at the end of calendar year 2000. The Joint Committee on Taxation estimates that ending those tax cuts would increase revenues by $24 billion in 2002 (see Table 3).

TABLE 3. ESTIMATE OF THE PRESIDENT'S ALTERNATIVE POLICIES TO ELIMINATE THE DEFICIT HOLE UNDER CBO ASSUMPTIONS (By fiscal year, in billions of dollars)

	2001	2002
Revenues	-3	-24
Outlays		
Discretionary	-14	-20
Mandatory		
Medicare	0	-6
Medicaid	0	-3
Fee to broadcasters	0	-9
Cost-of-living adjustments[a]	0	-3
Other	0	-1
Subtotal	0	-23
Total Policies	-17	-67
Debt Service	b	-2
Total Effect on the Deficit	-17	-69

SOURCE: Congressional Budget Office.

a. Exempts the cost-of-living adjustment of Social Security beneficiaries.

b. Less than $500 million.

On the outlay side of the budget, the President's alternative policies include a 2.25 percent across-the-board cut that would reduce Medicare spending in 2002 by $6 billion, Medicaid by $3 billion, and other nonexempt mandatory spending by $1 billion. Except for Social Security, cost-of-living adjustments in 2002 would be limited to 0.46 percent instead of the 3 percent projected under current law. Television broadcasters would be assessed a fee to make up any difference between the actual proceeds of the proposed auction of the analog broadcast spectrum and the amount assumed in the budget. The remaining gap would be filled by an across-the-board reduction in discretionary spending in 2001 and 2002. CBO estimates that the required cut would be about 4 percent rather than the 2.25 percent estimated by the Administration.

MEDICARE

Under current policies, CBO projects that gross mandatory spending for Medicare-primarily for medical benefits-will increase from $209 billion in 1997 to $314 billion in 2002, an average annual increase of 8.5 percent (see Table 4). Net mandatory spending, which takes into account premiums paid by Medicare beneficiaries, will increase at an average annual rate of 8.8 percent. CBO's baseline projections of Medicare spending are virtually the same as those of the Administration.

TABLE 4. CBO ESTIMATE OF THE PRESIDENT'S MEDICARE PROPOSALS
(By fiscal year, in billions of dollars)

	1997	1998	1999	2000	2001	2002	Total, 1998-2002	Average Annual Rate of Growth, 1997-2002 (Percent)
CBO Baseline								
Benefit Payments[a]	208.8	227.0	248.2	273.0	285.6	313.7	1,375.4	8.5
Premiums	-20.2	-21.4	-22.4	-23.4	-24.5	-25.6	-117.4	4.8
Total[b]	188.6	205.5	225.7	249.5	261.1	288.1	1,230.0	8.8
Proposed Changes								
Benefit Payments								
Payments to fee-for-service providers	0	-3.0	-7.6	-11.4	-14.2	-16.7	-52.9	n.a.
Payments to health maintenance organizations	0	-0.9	-2.9	-6.7	-8.2	-11.1	-29.9	n.a.
Additional benefits	0	1.2	3.0	3.8	4.5	5.0	17.5	n.a.
Other changes[c]	0	-0.2	-1.9	-2.0	-2.1	-2.3	-8.5	n.a.
Subtotal	0	-2.9	-9.4	-16.3	-20.1	-25.1	-73.8	n.a.
Premiums	0	0.2	-0.6	-1.4	-2.2	-3.8	-7.8	n.a.
Total	0	-2.8	-10.0	-17.7	-22.3	-28.8	-81.6	n.a.
CBO Estimate of the President's Proposal								
Benefit Payments[a]	208.8	224.0	238.8	256.7	265.5	288.7	1,273.7	6.7
Premiums	-20.2	-21.2	-23.0	-24.8	-26.7	-29.4	-125.2	7.7
Total[b]	188.6	202.8	215.7	231.8	238.8	259.3	1,148.5	6.6
Memoranda:								
SMI Premium Under Current Law	$43.80	$45.80	$47.10	$48.50	$50.00	$51.50	n.a.	n.a.
SMI Premium Under Proposal	$43.80	$45.80	$49.50	$52.50	$55.90	$61.20	n.a.	n.a.

SOURCE: Congressional Budget Office.

NOTES: Numbers may not add to totals because of rounding; estimates exclude Administration's alternative policies; n.a. = not applicable.

a. Includes mandatory administrative expenses.
b. Excludes discretionary administrative expenses.
c. Primarily the extension of secondary payer provisions.

Although the growth in Medicare spending has slowed since the late 1980s and early 1990s, it will continue to outpace the growth in the resources that finance the program. Without changes in law, outlays for Hospital Insurance (HI) benefits will increase more rapidly than payroll taxes, and the HI trust fund will be depleted by the end of 2001. Similarly, Supplementary Medical Insurance (SMI) benefits will absorb an increasing share of general revenues.

The budget contains many proposals intended to reduce the growth of spending in Medicare. Those savings proposals would reduce Medicare outlays by $99 billion over the 1998-2002 period. At the same time, the Administration is proposing to expand some benefits, which would cost $17 billion. On balance, CBO estimates that the President's basic proposals would reduce Medicare spending by $82 billion over five years and would slow the growth of net Medicare spending to 6.6 percent a year.

In contrast to CBO's figure of $82 billion, the Administration estimates that its basic Medicare proposals would save $100 billion over the 1998-2002 period-a difference of $19 billion. CBO estimates that the President's proposed benefit expansions would cost $4 billion more and that the proposed reductions would save $15 billion less than the Administration assumes. CBO's estimate of reductions in payments to fee-for-service providers is $11 billion smaller than the Administration's, and its estimate of savings in payments to managed care plans is $4 billion less.

Payments to Fee-for-Service Providers

Over half of the savings in the President's plan would stem from curtailing payments to providers of health care services in Medicare's fee-for-service sector. The budget would limit increases in payments to hospitals for both inpatient and outpatient care, capital payments, and graduate medical education. It would also establish new prospective payment mechanisms for skilled nursing facilities and providers of home health care to slow the growth of spending in those sectors.

The growth in aggregate payments to physicians would be limited to the rate of growth in national income. In addition, new competitive payment mechanisms for laboratory services and suppliers of durable medical equipment would be established. The budget would ensure that those mechanisms reduced payment rates by at least 20 percent. Overall, payments to fee-for-service providers would be reduced by an estimated $53 billion over the 1998-2002 period.

Payments to Health Maintenance Organizations

The President's proposals would reduce payments to risk-based health maintenance organizations (HMOs) by $30 billion compared with current-law levels. Because payments to HMOs are linked to spending in the fee-for-service sector, much of that reduction would come from slowing the growth in payments to fee-for-service providers. In addition, the budget proposes to reduce the HMO payment rate from 95 percent to 90 percent of Medicare's adjusted average per capita cost (AAPCC) beginning in 2000.

The Administration would remove payments for disproportionate share hospitals (DSH) and graduate medical education from the AAPCC. That change would reduce average payment rates by an additional 5 percent. Removing those special payments from the AAPCCs would have little net budgetary impact, however, because the funds would be returned directly to DSH and teaching hospitals based on the number of HMO enrollees they served. (Those direct payments are included under payments to fee-for-service providers in Table 4.)

The Administration's proposal would narrow the gap between counties with high and low payment rates by phasing in a blend of local and price-adjusted national rates by 2002, and by setting a minimum payment rate of $350 per month. It would also ensure that no county's payment rate in 1998 and 1999 was reduced from its level in the previous year. The proposal includes a computation for budget neutrality intended to ensure that the hold-harmless provision and the $350 floor on payment rates would not increase HMO payments overall. The Administration would update the new payment rates by the growth in national Medicare spending per capita, with a minimum update of 2 percent a year beginning in 2000.

The Administration's proposal also contains several features intended to make HMOs more attractive to beneficiaries. It would allow Medicare to contract with additional types of plans (including preferred provider organizations and provider-sponsored networks), establish an annual open-enrollment period, provide beneficiaries with standardized comparative materials about plans, and guarantee that Medigap coverage would be available at community rates for beneficiaries choosing to disenroll from a Medicare HMO.

CBO estimates that the Administration's proposal would not significantly increase or decrease enrollment in managed care plans. Some elements of the proposal-such as using a coordinated enrollment period and contracting with new types of plans-would tend to expand the managed care program. But enhancing the benefits package in fee-for-service Medicare and reducing HMO payments relative to those in the fee-for-service sector would discourage enrollment.

Additional Benefits

The Administration proposes several improvements in Medicare's package of fee-for-service benefits. It would reduce the coinsurance rate for services provided in hospital outpatient departments, expand the range of services covered by Medicare, and reduce the late-enrollment penalty for people who do not enroll in the SMI program upon turning 65.

The largest expansion of benefits is a provision that would reduce the effective coinsurance rate paid by beneficiaries for services provided in hospital outpatient departments. Under current law, the coinsurance rate is much higher than the 20

percent rate applied to other SMI benefits because it is based on hospital charges rather than on Medicare's allowed payments. As part of its proposal to restructure payments for hospital outpatient services, the Administration proposes to phase in a reduction in the coinsurance rate for services provided in hospital outpatient departments from the nearly 50 percent projected under current law in 1998 to 20 percent by 2007. That provision would cost $7 billion over the 1998-2002 period and more than $10 billion a year by 2007 when fully phased in.

Most of the new services that would be covered are preventive in nature. The Administration would cover screening for colorectal cancer, annual mammography (with no cost sharing), glucose monitors, test strips, and education for diabetics. Respite care of up to 32 hours a year would be provided for the families of Medicare beneficiaries with Alzheimer's disease or other severe mental impairments. Those new benefits would increase Medicare spending-net of any savings attributable to avoided illness-by $7½ billion over the 1998-2002 period.

The Administration's proposal to reduce the penalty for late enrollment would increase Medicare benefits by $3 billion over the 1998-2002 period. Under current law, people who do not enroll in the SMI program upon turning 65 pay a premium that is 10 percent higher for each year that they delay enrollment and are not covered by a group health insurance plan. This proposal would encourage people to enroll in the program who would not have done so otherwise. Medicare's costs would increase because the additional premiums would cover only 25 percent of the additional benefits.

Other Changes in Spending

The Administration would achieve $8½ billion in savings over five years from reductions in spending that do not fall neatly into one of the previous categories. More than $7 billion of that amount would stem from extending three provisions of the Omnibus Budget Reconciliation Act of 1993 that make Medicare the secondary payer for certain beneficiaries who are also covered by employment-based or other health insurance.

Premiums

Premiums paid by beneficiaries now cover 25 percent of spending for Supplementary Medical Insurance. Under current law, however, SMI premiums may increase by no more than the Social Security cost-of-living adjustment after 1998, and the share of costs covered by premiums will then begin to shrink by about 1 percentage point a year. The Administration would maintain the share of SMI spending covered by premiums at 25 percent after 1998. In conjunction with other proposals in the budget, this change would increase receipts by $8 billion over the 1998-2002 period. Premium receipts would grow by 8 percent a year, up from 5 percent a year under current law. In 2002, the projected SMI monthly premium would be $61.20 under the Administration's proposal, compared with $51.50 projected under current law.

Status of the HI Trust Fund

The Administration proposes to transfer spending for certain home health visits from the HI program to the SMI program. The transfer would have no impact on total Medicare spending, but it would help preserve the solvency of the HI trust fund. CBO estimates that the Administration's policies would maintain a positive balance in the HI trust fund through at least the end of 2007.

Under the Administration's proposal, the HI program would retain responsibility for the first 100 visits in an episode of home health care following a hospital stay of at least three days. SMI would pay for all other home health visits-about 65 percent of the total. Home health visits would not be subject to coinsurance or the SMI deductible and would not affect the SMI premium. After taking account of the proposal to reduce payments to home health providers, the Administration would shift about $86 billion in spending from HI to SMI over the 1998-2002 period.

MEDICAID

CBO projects that federal outlays for Medicaid will grow from $99 billion in 1997 to $144 billion in 2002 under current law-an average annual increase of just under 8 percent (see Table 5). Medical assistance payments, the largest component of spending, are projected to rise from about $84 billion to $123 billion by 2002.

TABLE 5. CBO ESTIMATE OF THE PRESIDENT'S MEDICAID PROPOSALS
(By fiscal year, in billions of dollars)

	1997	1998	1999	2000	2001	2002	Total, 1998-2002	Average Annual Rate of Growth, 1997-2002 (Percent)
CBO Baseline								
Federal Outlays	98.6	105.3	113.6	122.9	132.8	143.8	618.4	7.8
Proposed Changes								
Savings Proposals								
Per capita cap[a]	0	0	-0.2	-1.5	-2.9	-4.7	-9.3	n.a.
Reductions in DSH payments[b]	0	-0.3	-2.1	-3.8	-4.7	-5.6	-16.6	n.a.
Supplemental payments[c]	0	0	1.0	0.8	0.6	0.4	2.8	n.a.
Subtotal	0	-0.3	-1.3	-4.6	-7.0	-9.9	-23.1	n.a.
New Initiatives								
Children's health	0	1.0	1.1	1.1	1.2	1.3	5.7	n.a.
Retain benefits for disabled children	d	0.1	0.2	0.2	0.2	0.2	1.0	n.a.
Retain benefits for certain aliens	0.1	0.9	1.0	1.1	1.3	1.6	5.8	n.a.
Payments to the District of Columbia	0	0.1	0.2	0.2	0.2	0.2	0.9	n.a.
Other proposals	0	d	0.4	0.5	0.6	0.8	2.2	n.a.
Subtotal	0.1	2.1	2.8	3.1	3.5	4.1	15.6	n.a.
Total	0.1	1.8	1.5	-1.5	-3.5	-5.8	-7.5	n.a.
CBO Estimate of the President's Proposal								
Federal Outlays	98.8	107.1	115.2	121.4	129.3	138.0	610.9	7.0

SOURCE: Congressional Budget Office.

NOTES: DSH = disproportionate share hospital; numbers may not add to totals because of rounding; estimates exclude Administration's alternative policies; n.a. = not applicable.

a. Assumes a per capita growth rate equal to the growth of gross domestic product per capita plus 2 percentage points in 1997 and 1998, 1.5 percentage points in 1999, and 0.5 percentage points in 2000 and thereafter.
b. Assumes DSH payments would be limited to $10 billion in 1998, $9 billion in 1999, and $8 billion in 2000 and thereafter.
c. Assumes that supplemental payments for federally qualified health centers, rural health clinics, and other purposes would total $2.8 billion.
d. Less than $50 million.

The President's basic budget includes proposals that would produce budgetary savings in Medicaid, as well as several measures that would increase Medicaid spending. The net effect of those policies is to reduce Medicaid spending by $7½ billion over the 1998-2002 period compared with current law. In addition, the budget makes a number of proposals that would increase the flexibility of states in administering the Medicaid program. Although CBO's baseline projections for Medicaid are slightly higher than those of the Administration, CBO and the Administration have similar estimates of the President's proposed changes in policy.

Savings Proposals

The President's budget would achieve savings in Medicaid by placing caps on federal payments to states for each beneficiary and by limiting the growth in those caps to slightly more than the rate of economic growth per person. Separate caps would be established for the four main groups of people eligible for Medicaid-the

aged, disabled, children, and other low-income adults-but states whose average spending for one group was below the cap could apply the savings to other groups. CBO estimates that the per capita caps would save $9 billion over the 1998-2002 period, with most of the savings occurring in the last two years.

The President also proposes to limit Medicaid's payments to disproportionate share hospitals to $10 billion in 1998, $9 billion in 1999, and $8 billion in 2000 and thereafter. That change would save $17 billion over the 1998-2002 period compared with current law. The savings would be partly offset by almost $3 billion in supplemental payments for federally qualified health centers, rural health clinics, and other purposes.

New Initiatives

Several provisions of the Administration's budget would expand Medicaid spending. First, the budget would cover additional children by allowing states to guarantee at least 12 months of continuous eligibility when a child becomes eligible for Medicaid. It would also increase Medicaid enrollment among children who are already eligible for benefits as a by-product of giving states grants to expand children's health coverage. CBO estimates that those changes would cost $6 billion over the 1998-2002 period. Second, the budget proposes to repeal provisions in last year's welfare reform law that removed certain legal aliens and disabled children from the Medicaid rolls. Reinstating those beneficiaries would cost $7 billion over five years. Finally, other changes in Medicaid-including the effects on Medicaid of the Administration's proposals for Medicare-would cost $3 billion.

OTHER HEALTH INSURANCE PROPOSALS

The President's budget would create three new federal grants to states for the purpose of expanding health insurance coverage. First, the budget would provide nearly $10 billion over the 1998-2001 period for programs providing health insurance to certain unemployed workers and their families. The budget includes no funding for those grants in 2002. Second, grants of $750 million a year would be made available to expand health insurance coverage among children. As noted above, CBO estimates that the resulting outreach efforts would also generate additional costs for the Medicaid program. Finally, $25 million a year would be devoted to helping establish health insurance purchasing cooperatives. In total, those three grants would cost $14 billion over the next five years.

WELFARE PROGRAMS

The President proposes to modify portions of last year's welfare reform law and to provide additional support to people who are making the transition from welfare to work.

Legal Aliens

The budget's proposed changes to welfare reform would exempt aliens who became disabled after entering the United States from the new restrictions on Supplemental Security Income (SSI) and Medicaid benefits. In addition, the President proposes to extend from five to seven years the period that refugees and asylees may receive SSI benefits after admission to the United States. Because of the difficulty in establishing the onset of disability for immigrants and because determining disability for the aged is problematic, CBO estimates that nearly all aliens who would otherwise be barred from SSI disability benefits and two-thirds of the aged would be able to secure eligibility for SSI benefits under this proposal. The two proposals would increase SSI spending by $9 billion over the 1997-2002 period.

Welfare-to-Work Proposals

The Administration's welfare-to-work proposals would increase federal spending by $3 billion and reduce revenues by $1 billion over the next five years. The Administration is requesting mandatory appropriations of $0.8 billion in 1998, $1.0 billion in 1999, and $1.2 billion in 2000 for state and local governments to help long-term welfare recipients obtain jobs. The Administration would extend the Work Opportunity Tax Credit and expand its coverage to include credits for employers who hire able-bodied individuals age 18 to 50 who would be affected by the new work requirements in the Food Stamp program. It would also create a new credit for employers who hire long-term welfare recipients.

RESPONSES OF MR. VAN DE WATER TO A QUESTION FROM SENATOR KERREY

LONG-TERM BUDGET PROJECTIONS

Question:

Using the spending cuts and program changes included in the Administration's budget proposal, when would CBO estimate that mandatory programs will absorb 100 percent of the federal budget? When would this effect occur under the current baseline projections?

Answer:

CBO projects that, under current budgetary policies, entitlement spending and interest on the debt will consume all federal revenues by 2015 or 2020. CBO has not prepared similar projections for the Administration's budget proposal, because the Administration has not fully specified its policies for the long term.

RESPONSES OF MR. VAN DE WATER TO A QUESTION FROM SENATOR BAUCUS

LIMITED-SERVICE HOSPITAL PROGRAM

Question:

The President's budget contains a provision that creates a limited-service hospital program. This proposal is almost identical to a demonstration project in Montana, the Medical Assistance Facility (MAF). Has that specific provision been scored yet by CBO?

Answer:

The President's 1998 budget includes a provision to modify and expand the Rural Primary Care Hospital (RPCH) component of Medicare's Essential Access Community Hospital (EACH) program. The Congressional Budget Office (CBO) estimates that this provision would increase Medicare outlays by $20 million in fiscal year 1998 and by $100 million over the 1998-2002 period.

The EACH program was established to encourage the development of rural health networks in which limited-service RPCHs are affiliated with a full-service EACH. The EACH program is currently limited to seven states. The Secretary of Health and Human Services may also designate 15 facilities in other states as RPCHs. An RPCH is an operating or recently closed rural hospital that becomes a freestanding skilled nursing facility with a hospital outpatient department. The RPCH is permitted to maintain up to six acute care inpatient beds and to keep inpatients for up to 72 hours. Medicare makes payments to RPCHs on a per diem basis for the reasonable cost of inpatient services.

The President's proposal would expand the RPCH program nationwide. It would permit RPCHs to maintain up to 15 acute care inpatient beds and to keep inpatients for up to 96 hours. It would also drop the requirement that the rural facility be an operating or recently closed hospital. Facilities in Medicare's Montana Medical Assistance Facility (MAF) demonstration (which expires on July 1, 1997) would be considered RPCHs.

CBO based its estimate of the proposal on data from the Health Care Financing Administration and on a report by the General Accounting Office on the MAF program. CBO concluded that the proposal would increase Medicare outlays, primarily because a relatively large number of patients would eventually be transferred from limited-service hospitals to full-service hospitals that are reimbursed under Medicare's prospective payment system. In addition, the greater availability of inpatient facilities would increase the use of health care services.

RESPONSE OF MR. VAN DE WATER TO A QUESTION FROM SENATOR MURKOWSKI REGARDING MEDICAID FUNDING FORMULAS

The Congressional Budget Office does not make policy recommendations and cannot comment on the appropriateness of the current Medicaid funding formula.

Physician
Payment
Review
Commission

STATEMENT BEFORE

Committee on Finance
U.S. Senate

on

Physician Payment Review Commission's 1997 Annual Report to Congress

February 27, 1997

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Gail R. Wilensky, Ph.D.
Chair

Mr. Chairman and members of the Finance Committee, I am pleased to be here today to discuss aspects of the Physician Payment Review Commission's 1997 *Annual Report to Congress* that are of interest to this committee. Although the report will not be released until March 31st, the Commission met last week to finalize its major conclusions and recommendations. As staff finish working on our 11th annual report, I am happy to share with you some of its highlights.

Reflecting the Commission's mandate, the 1997 annual report considers a wide range of issues affecting Medicare, Medicaid, and the broader health system. Throughout, we have looked to see how these public programs can benefit from the tremendous changes that are occurring in how Americans pay for and receive health care. The number of individuals covered by traditional indemnity insurance is shrinking. Managed-care plans are evolving toward more integrated systems and closer relationships with their provider networks, while physicians and hospitals are joining together in new types of organizations. In response to rising premiums, leading corporate purchasers of health care are changing the way they pay for health services, potentially affecting both the costs and quality of care.

Medicare can learn from these experiences. In fact, as commercial managed-care penetration grows and managed-care enrollees age into Medicare, it is inevitable that more and more beneficiaries will select this option within Medicare. Moreover, changes can be made in the traditional program that can help contain costs and improve quality. The challenge is to develop reforms that ensure both Medicare's financial solvency and beneficiary access to timely, appropriate health care services.

Expansion of managed care and introduction of new private health plan options for Medicare beneficiaries present both opportunities and challenges. It is important to keep in mind, however, that Medicare differs from other payers in several important ways. First, Medicare managed-care enrollment, while growing, still lags substantially behind commercial enrollment (Figure 1). Second, although managed-care growth in the private sector has been associated with reduced cost growth, under current policy, this is not the case for Medicare. In fact, some studies suggest that managed care growth *increases* program outlays. Third, the private market encompasses a broader range of plan options than Medicare currently permits, but most individuals with employer-based insurance have only a limited number of plans to choose from. Fourth, as a public program, Medicare may face certain obstacles in quickly adopting and implementing techniques for managing care that have been used by other payers.

In developing a work plan, conducting analyses, and discussing policy alternatives, the Commission has been working closely with congressional committees and staff to ensure that we can help inform your deliberations. My comments today begin with some brief background information about Medicare managed care and the issues that will arise as managed-care choices expand. Then I would like to highlight four topics detailed in the Commission's report that are most immediate on the congressional agenda:

- improving payment policy under Medicare's managed-care program,
- addressing the critical issue of risk adjustment,

- determining the rules under which provider-sponsored organizations (PSOs) may participate in Medicare, and
- implementing resource-based practice expense relative values under the Medicare Fee Schedule.

MEDICARE MANAGED CARE: PLAN PARTICIPATION AND BENEFICIARY ENROLLMENT

As you know, Medicare managed care is growing. By the end of 1996, about 13 percent of Medicare beneficiaries were enrolled in some form of managed care, compared to 5 percent in 1990. Participation by beneficiaries varies widely, with over 20 percent of urban beneficiaries enrolled in managed care, compared to about 1 percent of rural beneficiaries. Although predominantly an urban phenomenon, enrollment rates differ across urban areas. Over half of beneficiaries in Riverside, CA, are in risk plans, for example, while virtually none are in Atlanta and Detroit (Figure 2).

Most plans participate in Medicare through the risk-contracting program. Under a risk contract, plans commit to providing Medicare-covered services to beneficiaries for a fixed monthly payment from the program. There were 241 risk contracts in effect at the end of 1996; 17 more have been added in the last two months (Figure 3).

Current policy allows only health maintenance organizations (HMOs) to be offered to Medicare beneficiaries (some of which offer point-of-service coverage). The Health Care Financing

Administration's (HCFA) Medicare Choices demonstration, however, is testing the development of other types of managed-care products, such as preferred provider organizations and provider-sponsored organizations.

The availability of risk plans varies widely across the nation. In most urban areas, beneficiaries can choose among several plans, while 80 percent of rural beneficiaries have no plan available. Overall, about two-thirds of beneficiaries are served by at least one risk plan; 25 percent have access to more than four plans (Figure 4).

IMPROVING MEDICARE MANAGED-CARE PAYMENT POLICY

The debate on Medicare managed care always eventually turns to payment. Changes in payment policy could serve any of several goals: reducing program spending, encouraging managed-care enrollment by making the program more attractive to plans in certain markets, improving equity by reducing the variation in benefits offered by risk-plans in different areas of the country, or structuring payment policies so that the government remains neutral about the health plan choices beneficiaries make. The challenge facing policymakers is to develop an approach to paying plans that is fair, reduces cost growth, and ensures that beneficiaries have access to appropriate care at a cost they can afford.

Before moving to the different options, I would like to first sketch out how Medicare now pays managed-care plans and the problems associated with current policy which the Commission and others have identified. Then, I will talk about the options for addressing these problems (including those included in the Balanced Budget Act passed in the last Congress and the President's recent budget proposal) as well the Commission's recommendations concerning implementation of these options.

Current Policy Affecting Risk-Plan Payment, Benefits and Premiums

As a result of current policies and local competitive pressures, there is wide geographic variation in Medicare payments to risk-plans, in the benefits available to beneficiaries, and in the premiums that they pay. For example, there is a three-fold difference between the lowest and highest county payment rates (Figure 5). Over 50 percent of 1997 county rates, however, are between $340 and $440. Currently, more than three-quarters of risk plans offer additional eye and ear care, and over half provide prescription drug coverage (Figure 6). By the end of 1996, two-thirds of plans provided benefits beyond those covered by Medicare at no additional charge to enrollees (Figure 7).

Setting Payments and Benefits. Payments, benefits, and premiums are the result of two separate administrative processes, as well as of local competitive pressures.

Process for Setting Plan Payments. Payments are set to reflect local fee-for-service costs. Actual per capita spending is adjusted for differences in the characteristics of local populations that affect

their use of health services. This measure, known as the AAPCC, is the expected local cost of caring for a typical beneficiary. Each county's payment is set at 95 percent of the AAPCC. Plans are paid this rate with an adjustment for enrollee characteristics.

In setting both the local rate and the payment to a plan, adjustments are made to reflect the characteristics that affect beneficiaries' use of health care. The same five risk adjusters are used in both steps: age, sex, welfare status, institutional status, and working status.

This two-step process of setting a local rate for a typical beneficiary in each county and then adjusting payments to plans based on actual enrollment was designed with two purposes. First, expected spending on managed care should equal that in fee for service less the 5 percent savings. Second, plans should be fairly compensated for the relative risks of their enrollees.

Process for Establishing Required and Optional Benefits. The benefits and premiums that risk plans offer to beneficiaries are set in a second process. Plans submit adjusted community rate (ACR) proposals in which they estimate the cost of providing Medicare-covered services to enrollees based on the costs of serving their commercial population. If the Medicare capitation payment is higher than these estimated costs, then the plan must return the difference to Medicare or to beneficiaries in the form of additional benefits. In practice, all plans opt to provide additional benefits to beneficiaries. The Commission estimates that in 1995, enrollees received additional benefits because of the ACR requirement worth about $42 per month for which they paid no additional premium.

To be competitive, plans may also offer even more benefits than those required to meet the ACR requirement. The ACR proposal establishes the maximum premium that plans can charge for these optional benefits, but plans can choose to waive all or part of this premium. In 1995, enrollees also received optional benefits worth about $45 per month for which they paid an average premium of $18 per month.

Concerns about Current Policy

The wide geographic variation and volatility in spending for traditional Medicare results in large differences in the AAPCC across counties. These differences may contribute to the uneven pattern of Medicare managed-care enrollment that I described earlier. And they account, at least in part, for the wide and seemingly arbitrary variation in additional benefits that Medicare beneficiaries receive from risk plans in different markets.

Several factors that could be addressed in legislation contribute to this geographic variation. The most important of these are:

- **Inadequacies of current demographic risk adjusters.** Inadequate risk adjustment results in increased Medicare spending in two distinct ways. First, local rates may overstate the likely cost of a typical beneficiary because the AAPCC reflects only beneficiaries in fee-for-service. If these beneficiaries are less healthy than those in managed care and their poorer health is not captured by the current demographic adjusters, then expected fee-for-service

payments are overstated. In fact, the Commission's analysis shows that new managed-care enrollees have significantly lower health care costs than those who remain in fee for service (Figure 8).

Second, in addition to the local rate being biased, inadequate risk adjustment results in overpayments to plans for their particular enrollees. Risk adjusters currently used in the Medicare program explain only a small portion of the variation in health costs among Medicare beneficiaries. More accurate risk adjustment would result in lower payments to plans reflecting their relatively healthier enrollment. Commission analyses of new enrollees suggest that currently available improved methods would capture at least half of the true risk selection in Medicare managed-care plans.

As I will explain in a moment, the Commission plans to make a series of recommendations concerning risk adjustment in its upcoming 1997 annual report to the Congress. Better risk adjusters would make the AAPCC a more accurate reflection of expected outlays for a typical beneficiary and would reduce some of the variation in payments.

- **Inclusion of earmarked funds.** Medicare makes payments to hospitals for graduate medical education and for serving a disproportionate share (DSH) of low-income patients. Including these special funds in AAPCC-based rates contributes to geographic variation in managed-care payments. It also raises the question of whether these payments should be passed along to all risk-plans, since they are meant to compensate hospitals for special circumstances beyond the costs of caring for Medicare patients.

The Commission has recommended that these funds could be removed from the AAPCC. A related issue is whether teaching and DSH hospitals should receive additional compensation for seeing managed-care enrollees or whether managed-care plans should be compensated an additional amount for teaching or serving low-income patients. The Commission recommends that mechanisms be developed to ensure that hospitals, plans, and other entities involved in training are paid fairly for these costs.

- **Geographic basis of rates.** Use of counties, which are relatively small geographic units, in setting payments leads to more variation and volatility than may be appropriate. Variation and volatility reflect differences in practice patterns, differences in the health status of local populations, and, at least in some cases, small numbers of beneficiaries. Areas larger than counties would help address these problems and may be more consistent with the notion that managed-care plans serve markets, not counties. Using larger areas, however, loses information about the variation in health status at the county level that contributes to the accuracy of payment. For these reasons, any changes to geographic areas should be accompanied by implementation of better risk adjusters.

It is important to recognize that even if all of these technical issues were resolved, under current policy, savings from managed-care enrollment cannot exceed 5 percent. Because managed-care payments increase in lock-step with Medicare fee-for-service expenditures, cost increases in fee for service drive cost increases throughout the program. To expand managed-care without increasing

outlays may require breaking the link between managed-care payments and fee-for-service expenditures.

Proposals for Change

Over the past two years, the Congress and the Administration have been considering how to set Medicare capitated rates that are fair to plans and allow the program to benefit from managed-care efficiencies. Proposals to improve risk-plan payment policies were included in the Balanced Budget Act passed during the 104th Congress. Proposals supported by the Administration last year and more recently put forward in the President's fiscal year 1998 budget proposal have many similarities. All of these proposals included provisions previously recommended by the Commission.

There are basically three different ways to reduce the variation in risk-plan payment rates. These approaches could be implemented to achieve budget savings, or could be budget-neutral, focused solely on reallocating payments across areas.

The first approach is to improve the AAPCC. Improving risk adjustment, removing earmarked funds, and changing the geographic basis of the local rate would all result in better estimates of patient care costs, which would differ less across areas. All of these modifications are among the changes the Commission will be recommending in its report to Congress this year. It also recommends that, once graduate medical education costs are removed from the AAPCC, separate mechanisms should be developed to ensure that hospitals, managed-care organizations, and other

training entities are paid fairly for those costs when they are involved in appropriate training activities.

A second approach is to unlink risk payments from local spending, using current rates as a starting point for new rates. A variety of strategies could be used to set rates which have less geographic variation than those now based on the AAPCC. These include blending current local rates with national rates, trimming rates through floors and ceilings, and setting new ways to update local rates. Since these approaches begin with the AAPCC, the Commission recommends that if they are adopted, that they be adopted in tandem with the improvements in the AAPCC that I just mentioned.

Finally, current policy could be discarded altogether in favor of market-driven competitive solutions. Local market characteristics could be used to set rates, either through some form of competitive bidding or a defined federal contribution for both fee-for-service and risk beneficiaries. This approach would work only in markets with sufficient local competition. It could be adapted to markets with little managed-care penetration if payments are based on the cost experience of both managed-care and fee-for-service beneficiaries. The Commission has recommended that HCFA continue to test such alternative methods for setting payments, including competitive bidding, partial capitation, and reinsurance.

THE IMPORTANCE OF RISK ADJUSTMENT

Regardless of how payment rates are set, as long as Medicare beneficiaries can choose among

options, improved risk adjustment will be essential. Otherwise, plans will not be fairly paid for enrollees with better or worse-than-average health status (for example, those with chronic conditions or functional disabilities). Without improvements in risk adjustment, plans will continue to have an incentive to avoid enrolling patients who will be expensive to care for.

The Commission recommends that improved risk adjustment be implemented immediately. Although available approaches are not perfect, they would do a better job than the demographic factors currently used. As a first step, the Commission recommends that Medicare begin to phase-in risk-adjusted payment changes using administrative data. For example, our analyses and those of others would support an approach of paying less for new managed-care enrollees who have lower-than-average per capita costs. (New enrollees now account for 55 percent of Medicare managed-care enrollees, up from 43 percent in 1993.) Since risk adjustment methods typically underpredict the true variation in costs and selection, improvements such as paying less for new enrollees do not risk over adjusting (that is paying too little) for individuals with certain characteristics.

Because there are substantial differences among plans in the proportion of new enrollees, this approach would be preferable to an across-the-board cut which would particularly hurt those plans with a large proportion of long-time enrollees (Figure 9). The President's budget proposes such a cut, setting local rates at 90 percent of the AAPCC, instead of the 95 percent under current policy. Although this would mitigate the budget impact of risk selection against the fee for service program, it would not adjust for risk selection among managed-care plans and so would not reduce plans' incentives to avoid enrolling costly beneficiaries.

Steps could also be taken immediately to improve the availability of data useful for risk adjustment. For example, hospitals are now required to submit "no-pay" bills to HCFA for hospitalized managed-care enrollees but many do not do so. The potential use of these data for risk adjustment increases the importance of enforcing this requirement.

Use of administrative data for risk adjustment is an important first step. Over the longer term, however, the data and infrastructure required to support risk adjustment should be developed and implemented. This includes obtaining data that more accurately capture risk (such as those obtained from surveys of beneficiaries or encounter data collected by plans and their contracting providers), further development of risk adjustment models, and implementation of adjusted payment rates.

EFFECTS OF CHANGES IN MANAGED-CARE PAYMENT POLICY

The effect of any payment changes on total Medicare payments, plans, and beneficiaries will ultimately depend upon how they are implemented, how much payment levels change, and how plans and beneficiaries respond. The effect of payment floors, blended rates, and other approaches to reducing inappropriate variation in risk plan payments will differ, depending upon the exact combination of policies and the sequence in which they are calculated.

The effects of changes on plan participation and beneficiary enrollment are also uncertain. If plans and beneficiaries are sensitive to payment rates, then rate changes could lead to participation

increases in areas with increased rates and declines in those where rates drop. But if plans and beneficiaries are relatively insensitive to risk-plan payment rates, then we might not see such effects.

Unfortunately, there is little information that could guide us in predicting how plans and beneficiaries will react to payment changes. Researchers have been examining this question but their conclusions have been mixed. One recent analysis indicated that plan entry into the risk program is highly sensitive to the local payment rate. Another published study found that beneficiary enrollment rates are much more sensitive to factors such as local managed-care penetration in the commercial market than to local Medicare rates.

If risk payments differ from per capita fee-for-service outlays, then more detailed information about beneficiaries' enrollment behavior will be required in order to make accurate budget projections. In particular, it will be important to understand how beneficiaries of different risk categories select between managed care and fee for service. The Commission has concluded that any changes in payment policy should be designed and phased in so as to reduce disruptive effects on beneficiaries and plans.

Finally, it is critical to remember that expansion of Medicare managed care raises issues beyond setting payments to plans. The Commission this year is reiterating recommendations with regard to the process through which beneficiaries learn about their choices, enrollment and disenrollment policies, and enrollee grievance procedures. These recommendations were described more fully in its *Annual Report to Congress 1996*.

PROVIDER-SPONSORED ORGANIZATIONS

Another important issue considered in the Commission's annual report is how Medicare should treat provider-sponsored organizations if the risk-contracting program is opened to new forms of plans. Under the Balanced Budget Act passed by the last Congress, provider-sponsored organizations would have been allowed to contract directly with Medicare. Since then, HCFA has given the green light to several PSOs as part of its Medicare Choices demonstration project.

Considering a broader role for PSOs in Medicare raises questions about how plan standards should be applied and how to protect consumers from the consequences of plan insolvency. In its 1996 annual report, the Commission looked broadly at how plan standards should be applied to different types of health plans; in this report, it focuses specifically on their application to PSOs.

PSOs are loosely defined as health care delivery systems created through the formal affiliation of providers. These range from a physician-hospital organization (PHO) where providers own their practices to an integrated system that owns the practice assets and in which revenues flow through the organization to the providers. PSOs typically play any of three roles in the market: contracting with licensed HMOs and other plans to provide services, frequently on a capitated basis; contracting directly with self-funded employer plans; and competing directly with other health plans.

The states now regulate insurers and HMOs to assure quality and protect consumers. A key decision for both state and federal policymakers is whether to regulate PSOs under the same rules that apply

to HMOs. A similar debate took place in the early 1970s concerning how HMOs should be regulated. Initially, rules were developed to encourage growth of HMOs. But after some well-publicized failures, many consumer-protection rules were tightened.

States are currently taking three different approaches when deciding whether and how to license PSOs: (1) applying existing laws and regulations to them, (2) developing specific regulations for overseeing PSOs and (3) creating a new regulatory category applying to all entities accepting risk, regardless of the name.

A particular concern for policymakers is how to protect consumers from the consequences of plan insolvency. In deciding whether HMO standards apply to PSOs, several issues must be resolved, including whether solvency standards should be lower than for HMOs, and the extent to which health care delivery assets (facilities and equipment) could be used to satisfy solvency requirements.

States also require plans to protect consumers from the adverse consequences of plan failure. For example, plans are usually required to have insolvency insurance, to continue to cover services in the event of failure, and are not permitted to hold consumers liable for additional costs as a result of insolvency. These measures appear equally appropriate for PSOs as for other types of plans.

In 1995, different versions of Medicare restructuring legislation anticipated a need for special treatment for PSOs by waiving state licensure requirements and applying federal solvency standards. Since then the environment has changed. New PSOs have emerged in many markets, states are

revising their laws, and the National Association of Insurance Commissioners is developing new regulatory approaches that could be adopted by the states.

In the Commission's view, the key principle is that PSOs participating in Medicare should be required to meet the same standards as all other plans. It is less clear whether this principle is best implemented by requiring that PSOs be licensed at the state level, as required of other risk contractors, or by substituting federal certification for state licensure for PSOs and all other Medicare risk plans. The Commission also endorses the need fo the design and enforcement of standards, for example, to ensure that solvency rules are not biased toward one type of plan or another. It also recommends that market developments be monitored to see that unreasonable barriers to market entry are not created.

In its discussion of quality standards, the Commission has recommended that the enrollment composition rule (that is, the requirement that at least 50 percent of a plan's enrollees must be from the private sector) should be dropped in favor of an enhanced quality monitoring system. Once this rule is dropped, PSOs and other plans will have the option of operating as Medicare-only plans.

IMPLEMENTATION OF RESOURCE-BASED PRACTICE EXPENSE

With the completion of the transition in 1996, the Medicare Fee Schedule is now the sole basis for Medicare payments to physicians. Important refinements to the fee schedule are still taking place,

however, improving the accuracy with which it measures the relative resources required to provide each service.

The most controversial of these continues to be the development of resource-based practice expense relative values, required by legislation passed in 1994 to be implemented in 1998. The Commission has always considered the current charge-based values to be inconsistent with the goals and intent of a resource-based fee schedule. And its research demonstrated that it is feasible to develop resource-based values for practice expense.

The current controversy concerns two issues: the accuracy of the values HCFA and its contractors are developing, and the anticipated size of the payment changes projected to occur. With respect to the accuracy of the values, a number of specialty societies have questioned HCFA's data and methods for developing values. They argue that acceptable values cannot be derived in time under the current schedule and are thus calling for a delay in the implementation of new values.

The Commission disagrees. No new information will be available to HCFA with another year that would produce "better" relative values. In fact, enough is known about the direction and magnitude of changing to a resource-based method that it makes sense to proceed. This is the approach that was taken even before the fee schedule was implemented when payments cuts were mandated for those "overvalued procedures" predicted to be cut under a resource-based approach. Further delay in implementing new practice expense values is unwarranted, given how much time has already passed since implementation of the fee schedule with its flawed charge-based practice expense values.

Any inaccuracies in relative values could be resolved in a refinement process similar to those used to refine physician work values. The Commission recommends that HCFA develop a process to refine initial values with input from interested parties. Announcement of this process should be made when proposed practice expense values are released for public comment.

With respect to concerns that some physicians will experience more extreme payment reductions than they had anticipated, the Commission has long maintained that new values be phased in over a three years, rather than all at once as required by current law. This is because substantial changes in payment for individual services risk significant disruption if implemented in a single step. HCFA's Practicing Physicians Advisory Council recently concurred in this recommendation. A three-year transition would also would help mitigate the effect of any errors before they are corrected in the refinement process. If the implementation of new values is delayed contrary to the Commission's recommendations, the duration of the phase-in should be shortened accordingly. Providers who will experience large payment reductions can use the delay to prepare for changes so a full three-year phase-in would not be necessary.

Finally, there are concerns about whether HCFA will apply a volume offset to maintain budget neutrality when implementing the new values. When the fee schedule was first implemented, HCFA's actuaries assumed that physicians experiencing payment declines would increase services to offset half of their lost revenues. To account for this volume offset, the conversion factor was lowered, resulting in lower increases in physician fees than had been anticipated. The Commission recommended then that the volume offset should have been symmetrical: that is, it should have been

structured to recognize that physicians experiencing payment gains may reduce the number of services they provide.

In implementing new practice expense values, HCFA should consider three issues: whether physicians actually responded to fee changes as the volume offset anticipated, whether an offset should be symmetric, and whether increased penetration of managed care has affected physicians' ability to increase service volumes in response to payment reductions.

OTHER ISSUES ADDRESSED IN THE COMMISSION'S ANNUAL REPORT

I have focused today on just a few of the issues the Commission considers in its 1997 report. With respect to managed care, it is important to recognize that payment policy is only one of the factors that will determine its future within Medicare and its impact on the federal budget, beneficiaries, and providers. Other critical areas raised by the Commission include consumer protection, use of quality and performance measures, and access to care, particularly for vulnerable populations. We will be making a variety of recommendations about these topics that I hope will provide the Congress some guidance. Given that many state Medicaid programs have already moved a substantial proportion of their beneficiaries into managed care, the Commission also examines the lessons that Medicare might learn from these experiences.

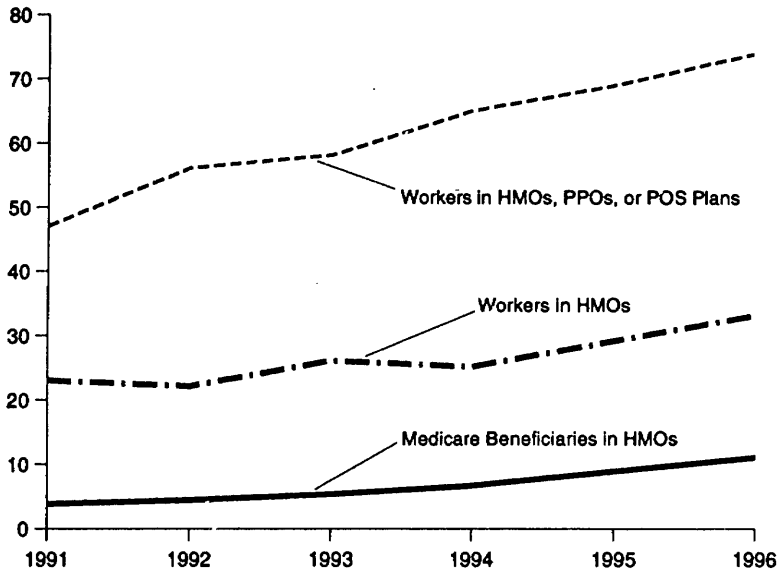
The report also considers the future of the traditional fee-for-service program with chapters on design of expenditure targets and limits, access to care and beneficiary financial liability, and other payment issues concerning the Medicare Fee Schedule.

Finally, the report considers a number of more specific issues of interest to this Committee. These include:

- the implications of changing Medicare's methods of financing graduate medical education by creation of a trust fund,
- the potential impact of program changes on dual eligibles (those individuals who are both Medicare and Medicaid beneficiaries,
- the effect of secondary insurance on Medicare spending and Medicare beneficiaries, and
- design issues associated with adoption of a premium contribution system for the Medicare program.

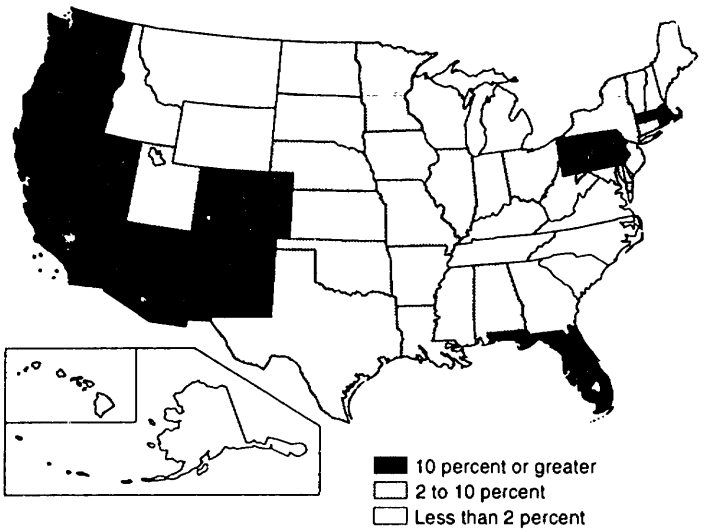
I would be glad to provide information about these issues to the Committee.

Figure 1. Trends in Managed-care Enrollment, 1991-1996



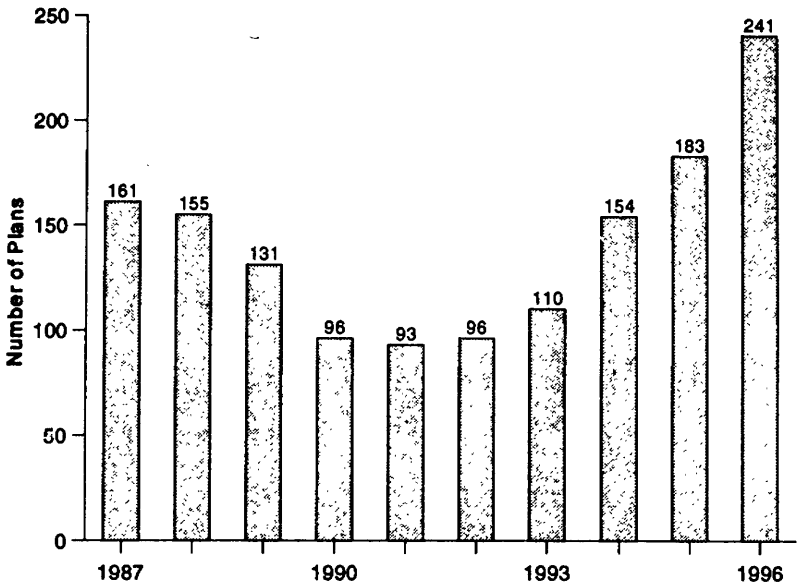
NOTE: Data for workers refers to workers in firms of 200 employees or more
SOURCE: PPRC analysis of data from HCFA and KPMG

Figure 2. Percent of Medicare Beneficiaries Enrolled in Risk Plans, by State, December 1996



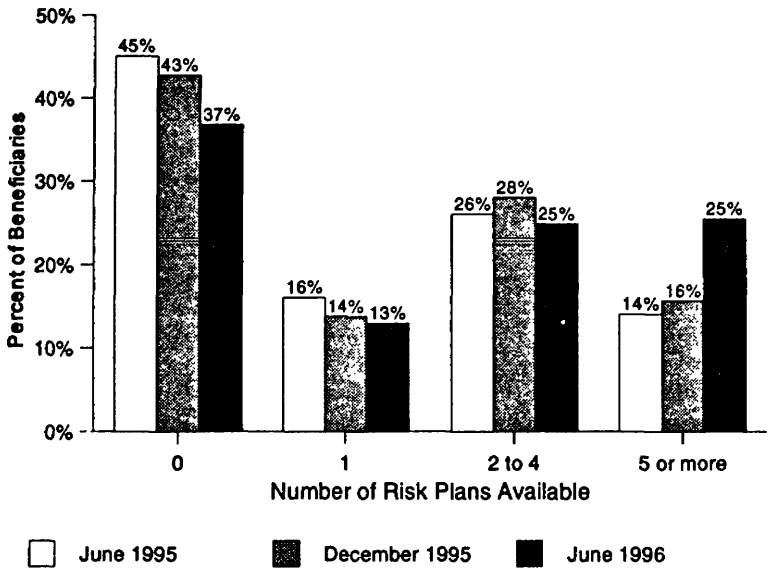
SOURCE PPRC analysis of Medicare Managed Care Contract Report, December 1996.

Figure 3. Number of Risk Plans Participating in Medicare, 1987-1996



NOTE: All data are for December.
SOURCE: Health Care Financing Review, 1996 Statistical Supplement; Medicare Managed Care Contract Report, December 1996.

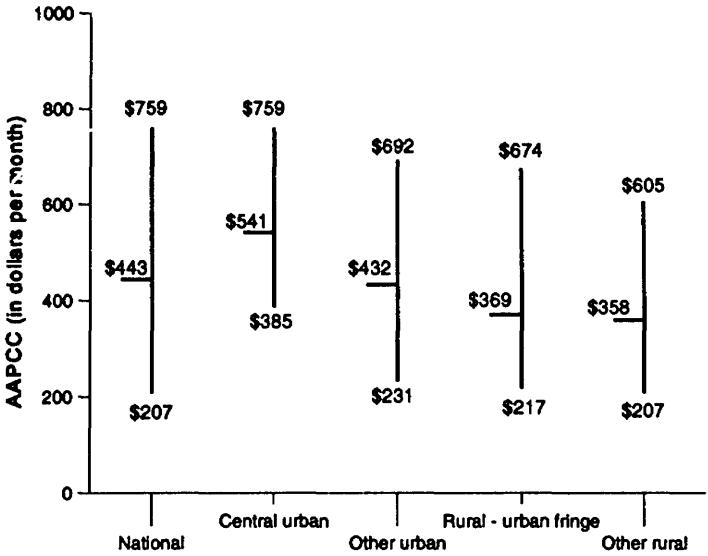
Figure 4. Distribution of Medicare Beneficiaries, by Number of Risk Plans Available in Their Area, 1995-1996



NOTE: Area is defined as the zip codes in a risk plan's service area.
SOURCE: PPRC analysis of HCFA data.

Figure 5. Spread of County AAPCCs by Location, 1996

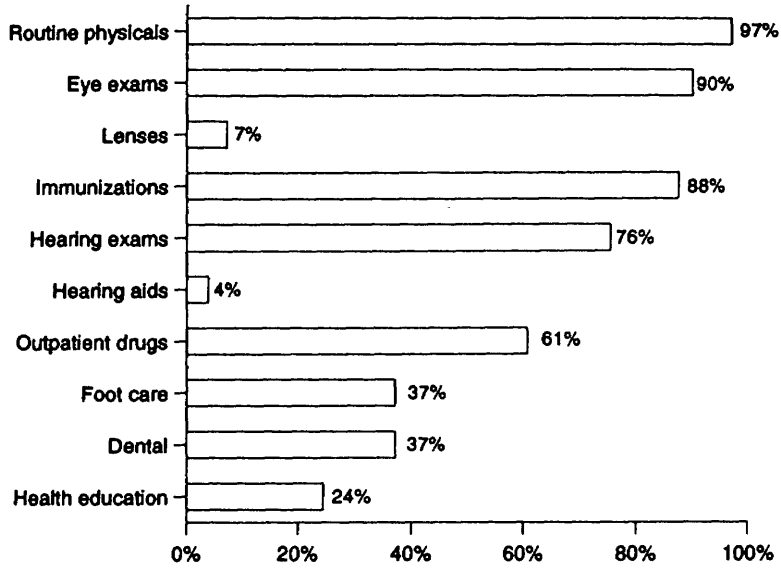
Minimum, Maximum, and Mean weighted by beneficiaries



NOTE: Three AAPCCs are presented for each category: the lowest and highest AAPCC among the counties and the mean weighted by the number of beneficiaries per county. Loving County, Texas, was excluded because it had an extremely high AAPCC ($887) but a very small population. Its AAPCC dropped 40 percent for 1997.

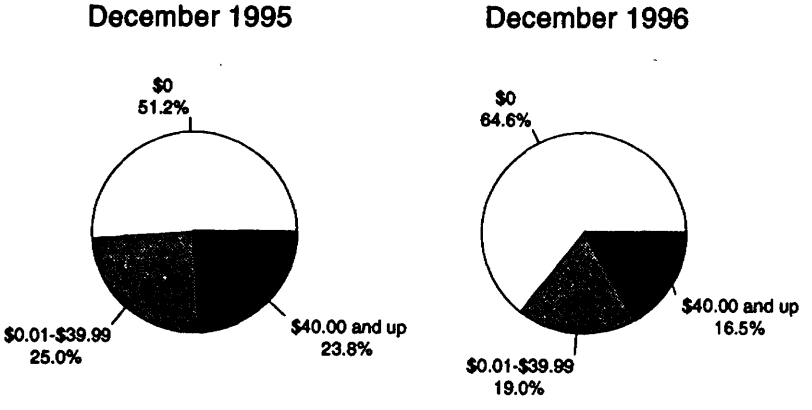
SOURCE: PPRC analysis of HCFA data.

Figure 6. Percentage of Medicare Risk Plans Offering Additional Benefits in Their Basic Option Package, December 1996



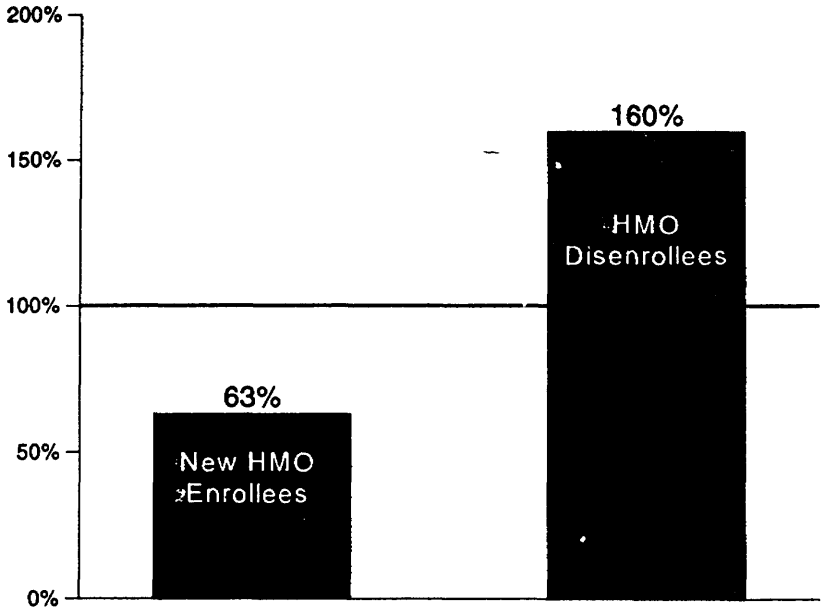
SOURCE: Medicare Managed Care Contract Report, December 1996.

Figure 7. Distribution of Medicare Risk Plans by Premiums Charged, 1995-1996



SOURCE: Medicare Managed Care Contract Reports.

Figure 8. Costs as Percentage of Average Medicare Spending per Beneficiary



SOURCE: PPRC analysis of 1989-1994 Medicare claims and denominator files, 5 percent sample of beneficiaries.

Figure 9. Length of HMO Enrollment for Medicare Enrollees in Five Large Risk Contracts, June 1994

Length of Enrollment In Years	PERCENT OF ALL ENROLLEES					
	Plan A	Plan B	Plan C	Plan D	Plan E	Total for Top 5
Under 1	11%	22%	14%	7%	18%	15%
1 - 2 years	12%	23%	11%	6%	17%	14%
2 - 3 years	8%	13%	11%	5%	11%	10%
3 - 4 years	6%	8%	12%	5%	10%	8%
4 - 5 years	5%	6%	10%	6%	7%	7%
6 or more	59%	28%	41%	71%	38%	47%

SOURCE: PPRC Analysis of Medicare 5 Percent Enrollee Data Base (EDB) file.

NOTE: Age-ins are individuals who enrolled in the HMO in their first month of Medicare eligibility. Age-ins were placed in the "6 or more" category.

GAO United States
General Accounting Office
Washington, D.C. 20548

Health, Education and Human Services Division

B-259614

October 2, 1995

The Honorable Max Baucus
United States Senate

Dear Senator Baucus:

One of the issues before the Congress as it considers modifications to the Medicare program is controlling costs while maintaining access to basic hospital and physician services. One model intended to preserve access to basic services in rural areas is medical assistance facilities (MAF), which are limited-service hospitals located only in Montana. Following the closure of numerous rural hospitals in Montana, the state legislature created the MAF provider category in 1987. In 1990, the Congress authorized Medicare to pay for MAF services provided to Medicare beneficiaries on the basis of reasonable cost. In 1993, the Congress extended this authorization until July 1, 1997.

The MAF program was meant to preserve access to basic emergency care, outpatient services, and limited inpatient care in areas where full-service hospitals had closed or were at risk of closure. MAFs must be located in frontier counties[1] or be more than 35 miles from another hospital. MAFs were not intended to provide surgical services (although they are not prohibited from doing so), and inpatient stays are limited to 96 hours. Montana established special licensure rules to allow mid-level practitioners (physician assistants and nurse practitioners) to provide care at MAFs under the supervision of a physician, who is not required to be collocated with the MAF.

Currently, seven MAFs exist in Montana, primarily in the eastern portion of the state. Each MAF shares space, personnel, and utilities with a nursing home. The MAFs each have an emergency room, outpatient clinic, and a 2- to 10-bed inpatient unit.

[1]Under the Montana law, a frontier county is one with a population density of fewer than six persons per square mile.

B-259614

You asked us to develop information on cases treated and services performed at MAFs, the relative cost to Medicare for inpatient services at MAFs and at acute-care hospitals, and the number of hospitals that might qualify if the program was expanded nationwide.

To address your questions, we obtained Medicare cost and claims data for five of the seven MAFs operating in Montana.[2] We compared the cost of treating Medicare inpatients[3] at MAFs with the cost of treating the same conditions at acute-care hospitals, most of which are paid through Medicare's prospective payment system (PPS). We also obtained Medicare data on outpatient and related professional services performed at MAFs. The cost and claims data covered 172 Medicare inpatient stays and over 8,200 outpatient services at MAFs for various time periods from December 1990 through 1994. Details of our analysis and a description of our methodology appear in enclosure 5. We conducted our work between October 1994 and July 1995, in accordance with generally accepted government auditing standards.

In summary, MAFs primarily serve patients with urgent, but uncomplicated, conditions or stabilize patients who have more complicated needs before transferring them to full-service hospitals. Medicare costs for patients served by MAFs were on average lower than if the patients had been treated at regular hospitals. MAFs also serve as primary (and, in some areas, the only) providers of emergency and routine outpatient services for area residents. In 1990, researchers from the University of Minnesota estimated that about 510 hospitals nationwide would meet Montana's qualifying criteria for MAFs.

CASES TREATED AND SERVICES FURNISHED BY MAFs

All but 1 of the 172 inpatient admissions to MAFs were emergency admissions, which involved treatment for a wide range of medical conditions. The 172 patients were assigned to 67 different medical diagnosis-related groups

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[2]No cost or claims data were available for the two most recently certified MAFs.

[3]For the period of time for which we obtained data, Medicare patients were 68 percent of all MAF discharges, Medicaid patients were 3 percent, and other categories made up the remaining 29 percent.

(DRG).[4] The three medical conditions most commonly treated by the MAFs were pneumonia (22 cases), inflammation of the digestive canal (15 cases), and heart failure and shock (12 cases), which together accounted for 28 percent of the 172 cases. Conditions classified as respiratory, cardiac, digestive, and "diabetes and other metabolic conditions" accounted for 100 of the cases (58 percent) and 30 of the DRGs treated at MAFs. (A summary of inpatient DRGs treated at MAFs appears in enclosure 1.)

In addition to providing inpatient care, MAFs provide local primary care for many Medicare beneficiaries. From 1991 to 1994, the 5 MAFs we studied submitted over 8,200 outpatient Medicare claims[5] covering more than 23,000 primary care and diagnostic procedures. About 92 percent of the outpatient procedures were for specimen collection for laboratory tests, the laboratory tests themselves, diagnostic radiology services, and physician services. The MAFs also provided emergency care for injuries such as fractures, open wounds, contusions, strains and sprains, and burns. (The outpatient procedures performed by MAFs from 1991 to 1994 are summarized in enclosure 2.)

PAYMENTS TO MAFs LOWER THAN PPS RATES

Costs of inpatient care for the 172 Medicare-covered stays compared favorably with the amount Medicare would have paid if those patients had been treated at PPS hospitals. While costs varied among the MAFs, overall costs at the five MAFs were about $75,300 less than the amount Medicare would have paid rural PPS hospitals for treating the same conditions between December 1990 and June 1994. As table 1 shows, overall costs for treatment at the five MAFs were about $132,100 less than the amount Medicare would have paid for treating the same conditions at urban hospitals.[6] (Enclosure 3 includes more detail on our cost analysis, and

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[4]DRGs are used to classify inpatients into groups that determine the rate of payment under PPS.

[5]In addition, the physician and physician assistants affiliated with 1 MAF submitted 122 claims for services directly to Medicare, including 35 claims for outpatient services and 87 for hospital visits.

[6]We used the rate for Billings, Montana, because hospitals in that city received all of the patients who transferred from MAFs to urban acute-care hospitals.

enclosure 5 describes our methodology for estimating MAF costs and PPS payments.)

Table 1: Net Increase (Decrease) in Medicare Costs for 172 MAF Patients Compared With Estimated PPS Payments

	Net difference of estimated MAF costs compared with PPS payments to rural and urban hospitals	
MAF	Rural hospitals	Urban hospitals
Dahl Memorial Healthcare Center	$(22,200)	$(34,000)
Garfield County Health Center	(16,400)	(20,400)
McCone County Hospital	(64,600)	(83,000)
Prairie Community Hospital	6,000	(5,000)
Roosevelt Memorial Hospital	21,900	10,300
Total net payments	$(75,300)	$(132,100)

During the period covered by our review, 18 of the 172 inpatients (about 10.5 percent) were transferred from a MAF to an acute-care hospital. During fiscal years 1991 through 1993, about 4.3 percent of all Medicare inpatients at rural hospitals in Montana were transferred to another hospital. We think it is reasonable that the percentage of MAF patients transferred is higher than the percentage transferred from rural hospitals for the following reason: One function of a MAF is to stabilize patients and prepare them for transfer to a facility if treatment beyond the scope of MAF services is needed. An official with the peer review organization for Montana and Wyoming suggested the following two reasons why the transfer rate for MAFs may be higher than that for other rural hospitals:

-- patients admitted for observation are transferred after a few hours because their symptoms worsen or they need surgery or

-- patients reach the 96-hour limit on length of stay and must be transferred.

Medicare claims data support these explanations. Of the 18 transfer patients, 10 were transferred within 24 hours of being admitted to the MAF and 4 had been in the MAF for 96 hours.

Regardless of what kind of hospital makes the transfer, all transfers result in higher cost to Medicare because two facilities receive payment for the same patient. Under PPS, the transferring hospital receives a per-diem payment determined by dividing the PPS payment by the mean length of stay associated with the patient's DRG. The hospital from which the patient is finally discharged receives the full PPS payment for the patient's DRG. When patients are transferred from MAFs, the MAF receives cost-based reimbursement for the patient, and the hospital from which the patient is finally discharged receives the full PPS payment. We estimate that the costs of treating the 18 transfer cases at the MAFs were about $7,900 greater than the amount Medicare would have paid an acute-care hospital in per diem payments if the patient had first gone to an acute-care hospital for the same length of time. Considering the additional costs associated with transfers reduces our estimate of total MAF savings over PPS payments to about $67,400 when compared with payments to rural hospitals and to about $124,200 when compared with payments to the hospitals in Billings. (Additional information on transfer cases is provided in enclosure 4, and our methodology for estimating costs for transfer patients is described in enclosure 5.)

POTENTIAL NUMBER OF MAFs NATIONWIDE

Available data suggest that the number of hospitals nationwide that could convert to MAFs is relatively small. Two types of limited service hospitals are currently recognized by Medicare: MAFs in Montana and rural primary care hospitals (RPCH),[7] which are currently authorized only in California, Colorado, Kansas, New York, North Carolina,

[7]RPCHs are one provider type under the Essential Access Community Hospital program, which was created by the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239, Dec. 19, 1989). A RPCH is limited to six inpatient beds, and inpatient care is limited to an average of 72 hours.

South Dakota, and West Virginia. In a 1990 study,[8] researchers associated with the University of Minnesota estimated that a total of about 510 hospitals would meet either the frontier or distance criteria Montana uses as a qualifying condition for MAFs.[9] The researchers also estimated that, at most, about 370 rural hospitals might convert to a RPCH. But given a variety of factors, the researchers estimated that no more than 100 to 150 rural hospitals across the country would ultimately convert to either a MAF or a RPCH.

AGENCY COMMENTS

The Health Care Financing Administration reviewed a draft of this letter and provided some technical comments, which we incorporated where appropriate.

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This letter was prepared under the direction of Thomas Dowdal, Assistant Director. Please contact Mr. Dowdal at (202) 512-6588 or me at (202) 512-7119 if you have any questions. Other analysts who made major contributions to this letter include Robert Sayers, Suzanne Rubins, Roger Hultgren, and Jerry Baugher.

Sincerely yours,

Sarah F. Jaggar
Director, Health Financing
and Public Health Issues

Enclosures - 5

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[8]Jon B. Christianson, Ira S. Moscovice, and Guoyu Tao, Final Report, Medical Assistance Facility Certification Criteria, Division of Health Services Research and Policy, School of Public Health, University of Minnesota (Oct. 1990).

[9]About 200 hospitals would qualify as MAFs under the distance criterion, about 120 would qualify because they were located in frontier counties, and about 190 would qualify under both criteria.

ENCLOSURE 1 ENCLOSURE 1

SUMMARY OF INPATIENT MAF CASES REVIEWED

	Cases		DRGs	
DRG category	Number	Percent	Number	Percent
Respiratory system conditions	41	24	8	12
Cardiac conditions	24	14	9	13
Digestive system conditions	25	15	9	13
Diabetes and other metabolic conditions	10	6	4	6
Other medical conditions	72	42	37	55
Total	172	100[a]	67	100[a]

[a]Numbers do not add to total because of rounding.

ENCLOSURE 2 ENCLOSURE 2

SUMMARY OF OUTPATIENT PROCEDURES PERFORMED AT FIVE MAFs, 1991-94

Type of procedure	Number of procedures[a]	Percent
Laboratory tests	15,637	68
Specimen collection for laboratory tests	2,492	11
Diagnostic radiology	1,706	7
Physician services[b]	1,400	6
Other	1,890	8
Total	23,125	100

[a]The summary of procedures does not include billings by the physician and physician assistants at one MAF, who billed Medicare directly for their services. Between October 1994 and February 1995, they submitted 122 claims, which included 35 claims for outpatient services and 87 claims for hospital visits.

[b]Includes 19 services coded as minor surgical procedures.

ENCLOSURE 3 ENCLOSURE 3

COMPARISON OF MAF COSTS PER DISCHARGE TO PPS PAYMENTS FOR SIMILAR CASES

	MAF				
	Dahl Memorial Healthcare Center	Garfield County Health Center	McCone County Hospital	Prairie Community Hospital	Roosevelt Memorial Hospital
Number of cases	36	13	53	38	32
Time period covered	5/17/91 to 6/30/94	10/1/92 to 9/30/93	12/18/90 to 6/30/94	1/1/92 to 6/30/94	5/1/93 to 4/30/94
Estimated average MAF cost per case	$1,785	$ 976	$1,249	$2,389	$3,363
Estimated PPS payment per case for rural hospitals	2,403	2,237	2,467	2,230	2,678
Amount by which estimated MAF cost per case was greater (or smaller) than rural PPS payment	(618)	(1,261)	(1,218)	159	685
Estimated PPS payment per case for urban hospitals located in Billings, Montana	2,729	2,542	2,816	2,520	3,042
Amount by which estimated MAF cost per case was greater (or smaller) than urban PPS payment	(944)	(1,566)	(1,567)	(131)	321

ENCLOSURE 4 ENCLOSURE 4

SUMMARY OF MAF TRANSFER CASES

Acute-care hospital to which MAF patients were transferred	Location	Number of patients
Community Memorial Hospital	Sidney, MT	1
Deaconess Hospital	Billings, MT	4
Fallon County Medical Complex	Baker, MT	1[a]
Glendive Community Hospital	Glendive, MT	4
Holy Rosary Hospital	Miles City, MT	3
Mercy Hospital	Williston, ND	1
St. Vincent's Hospital	Billings, MT	3
Trinity Hospital	Wolf Point, MT	1[b]
Total		18

[a]This patient was subsequently transferred to Holy Rosary Hospital, Miles City, Montana.

[b]This patient was subsequently transferred to St. Vincent's Hospital, Billings, Montana.

ENCLOSURE 5 ENCLOSURE 5

OBJECTIVES, SCOPE, AND METHODOLOGY

Our objectives were to develop information on the cases treated and services performed at medical assistance facilities, the relative cost of providing inpatient health care services to Medicare beneficiaries at MAFs and at acute-care hospitals, and the number of hospitals nationwide that might qualify as limited service facilities if such an option were made available.

We did not compare MAF outpatient costs to such costs at other hospitals or to Medicare payments to other types of suppliers, such as clinical laboratories. However, the MAFs are often the only providers of these services in their areas.

We obtained automated cost data for five MAFs from three files maintained by the Health Care Financing Administration:

-- Hospital Cost Report Information System (HCRIS), which includes selected data from hospital cost reports;

-- Medicare Provider Analysis and Review (MEDPAR), for data on the diagnoses and length of stay associated with Medicare patients admitted to MAFs; and

-- the standard analytical file, for data on outpatient services provided to Medicare beneficiaries.

We estimated the costs for each MAF Medicare inpatient stay. We then compared those costs with the amount Medicare would have paid an acute-care hospital under the prospective payment system for the same diagnosis-related groups at hospitals in rural Montana and the urban hospitals in Billings, Montana. We also compared the amount Medicare would have paid a PPS hospital and a MAF that transferred a patient to an acute-care hospital.

ESTIMATING MAF INPATIENT COSTS

Because the MAFs in our analysis were certified at different times and had varying cost reporting years, the cost report information we obtained covers different time periods for each facility, as identified in table 5.1.

Table 5.1: Number of Cost Reports and Inpatient Claims Data Available for Five MAFs Reviewed

MAF	Location	Certification date	Number of cost reports available in HCRIS	Number of inpatient claims in MEDPAR
Dahl Memorial Healthcare Center	Ekalaka	May 17, 1991	4	36
Garfield County Health Center	Jordan	May 17, 1991	1	13
McCone County Hospital	Circle	Dec. 18, 1990	4	53
Prairie Community Hospital	Terry	Jan. 1, 1992	3	38
Roosevelt Memorial Hospital	Culbertson	Nov. 20, 1992	1	32
Total				172

We calculated Medicare inpatient operating costs for each MAF's cost reporting period, excluding capital costs.[10] We then computed the average daily cost for Medicare patients for each cost reporting period at each facility by dividing operating costs by the number of Medicare days. We estimated the cost of treating each MAF patient by multiplying the facility's daily Medicare cost by the number of days each patient was an inpatient.

[10]We excluded capital costs because they are not reimbursed through DRG-based PPS payments.

ESTIMATING PPS REIMBURSEMENT RATES

We calculated the PPS reimbursement rates for the 172 MAF inpatients in our analysis for hospitals located in rural Montana and Billings, Montana.[11] We identified each patient's DRG from the MEDPAR file and estimated the amount Medicare would have paid for each of the 172 MAF discharges in a rural and urban PPS hospital, using PPS payment rates in effect during fiscal years 1991 through 1993. Our estimate of PPS payments does not include adjustments for teaching status or disproportionate share of low-income patients, either or both of which a particular hospital might receive.

INPATIENTS WHO TRANSFERRED FROM MAFs TO PPS HOSPITALS

Eighteen patients were treated at a MAF then transferred to a PPS hospital. We estimated Medicare's cost of treating those patients at the MAF as we did for all patients, that is, by multiplying the MAF's daily Medicare cost by the number of days the patient was at the MAF prior to transfer.

PPS hospitals are reimbursed for the care provided to a patient who transfers to another hospital according to a per-diem rate. This rate is obtained by dividing the PPS payment by the mean length of stay expected for the patient's DRG (this number is published annually with the DRG relative weights).

We calculated the per-diem PPS rate for each of the 18 transfer cases and multiplied that amount by the number of days each patient stayed at the MAF prior to transfer. The result of this calculation was the estimated payment that PPS hospitals would have received had the patient been treated at a PPS hospital for the same number of days that the patient was at the MAF.

Our estimate of the cost of treating the patients at the MAF before transferring them was the difference between the estimated cost of the case at the MAF and the estimated cost of treating the patient at a PPS hospital before transfer.

(106425)

[11]PPS hospitals in Billings are paid urban rates.

Bringing lifetimes of experience and leadership to serve all generations.

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

on

THE PRESIDENT'S FY '98 MEDICARE BUDGET

Presented by

JANE BAUMGARTEN

AARP Board Member

before the

Committee on Finance

of the

United States Senate

Washington, D.C.

March 5, 1997

For further information contact:
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Good morning Mr. Chairman and members of the Committee. I am Jane Baumgarten from North Bend, Oregon. I am a member of the American Association of Retired Persons (AARP) Board of Directors and I am pleased to have the opportunity to share our views on the President's FY1998 Medicare budget.

The Medicare program is at a critical juncture. The Trustees' projection of Part A Trust Fund insolvency by 2001 is a signal that action must be taken this year to further protect the program. The President and Congress were close last year to reaching consensus on a Medicare budget number. AARP believes agreement on short-term improvements is essential in 1997 and we encourage you to work diligently towards this goal. Thirty-eight million Americans and their families depend on Medicare's guarantee of affordable health care coverage -- critical protection they are not willing to sacrifice to partisan politics.

As we have stated for the last two years, AARP believes that by following a two-step approach to reforming Medicare, we can protect the program and make it even stronger for the next generation of retirees. The first step is, of course, to achieve the budget savings necessary to keep the Hospital Insurance (HI) Trust Fund financially stable for the short-term. Our testimony today focuses on some of the specific proposals in the President's FY1998 budget.

The second and more challenging step requires a broad public debate followed by enactment of policy changes to enable Medicare to remain strong for the next generation of beneficiaries who will begin to retire in 2011. To meet the needs of the next generation, changes in Medicare will be necessary. The retirement of the "baby boom" generation will challenge the program as never before. Therefore, as soon as we can put the short-term debate of 1997 behind us, we must begin the task of public education and debate about the trade-offs that will be necessary in the program over the longer term. This debate should be thorough, but it must also lead fairly promptly to the next round of Congressional decisions to ensure that the next generation of retirees can depend on the economic and health security that Medicare has provided to elderly and disabled Americans thus far.

The President's Medicare Budget Proposal

The President's FY1998 budget proposes to reduce overall Medicare spending by $100 billion over five years through reductions in provider payments and increases in beneficiary premiums.

AARP is pleased that the President's budget recognizes the impact of out-of-pocket costs on beneficiaries. The average non-institutionalized older person already spends 21% of his/her family income on health care, compared to 8% spent by those under 65

-- a fact that is even more significant considering that the median household income of older Americans is only about half that of persons under the age of 65.

Older Americans are willing to share the responsibility of preserving and strengthening Medicare. They look to policymakers to do this in a way that does not create unmanageable financial burdens for beneficiaries, or that undermines Medicare's guarantee of quality, affordable and dependable health insurance coverage.

Let me turn now to a discussion of some of the specific provisions of the President's budget which we believe will have the greatest impact on Medicare beneficiaries.

In his budget the President proposes to introduce prospective payment systems in two of the program's fastest growing benefits -- home health and skilled nursing facility care.

As Americans grow older and hospital care is more limited, it is inevitable and appropriate that the demand for both of these benefits will grow. There is, however, evidence that the cost growth of these services varies from one region of the country to another for no apparent reason. In some cases, this may be an indicator of inappropriate or abusive practices.

Prospective Payment in Home Health Care

The President's proposal for a prospective payment system (PPS) in home health is probably the direction the program should ultimately take. In general, AARP is supportive of this step. However, we also believe that considerable research and refinement are still necessary before implementation in order to assure that a PPS system in home health effectively assures quality of care.

We also have concerns about the proposed interim payment limits to be used during the period that additional research is conducted prior to the implementation of a full PPS for Medicare Home Health services. A payment system based on an episode of care is untested, lacks an adequate case-mix adjuster, and could include incentives to arbitrarily cut off benefits. Certainly, a prompt appeals mechanism would need to be made available as part of such a system. Even then, the system should not be fully phased-in until a reliable case-mix adjuster can be developed. Quality of care under such a system should also be closely monitored.

Clarifying the Definition of Homebound

The President has also proposed to "clarify" the definition of the "homebound" criteria for purposes of determining eligibility for Medicare home health services.
In effect, the proposal would mean that individuals who use adult day care services to stay out of expensive nursing homes or to provide relief to caregivers would be denied Medicare home health benefits, regardless of the extent of their sickness or disability.

This provision would produce no scorable savings, but could increase the likelihood of premature institutionalization. In our view, it is bad policy and we strongly urge that the provision be deleted or reworked.

Home Health Transfer

In order to significantly extend Part A solvency without requiring additional provider or beneficiary reductions, the President's budget proposes to transfer a portion of home health care coverage from Part A to Part B. The first 100 visits of home health following a 3-day hospitalization would continue to be reimbursed under Part A. All visits after the first 100, and those not following a hospital stay, would be shifted to Part B. While shifting part of home health from Part A to Part B would contribute significantly to extending Medicare Part A solvency without jeopardizing access or quality, it doesn't address the overall problem of Medicare cost growth. It also raises a number of important financing questions.

For example, in and of itself, shifting a significant part of the home health benefit to Part B would make it more likely in the future that these services would be included in the calculation of the beneficiary premium or subject to the 20% coinsurance. If home health costs were included in the Part B premium, preliminary estimates indicate that beneficiaries would pay about $8.50 more per month in 1998 even after the spending reductions from implementation of home health PPS are factored in. By the year 2002, beneficiaries would pay an additional $11 per month on top of the 25% premium included in the President's budget. Because home health expenditures are growing faster than other Part B services, the rate of increase in the Part B premium in future years would also rise. This could prove unaffordable for some beneficiaries -- particularly lower income beneficiaries between 120% and 150% of poverty.

AARP is also very concerned about the potential for establishing home health coinsurance. The nature of the home health benefit has changed over the last decade. More chronically ill beneficiaries now use this benefit and many, particularly older, frailer and sicker women, use more than 100 visits. If coinsurance were imposed, it could create a serious barrier to this kind of critical care for beneficiaries requiring services over an extended period.

We also believe that the impact of such a shift on the approximately 2 million beneficiaries who do not voluntarily enroll in Part B could be significant and we urge that this be explored. Finally moving home health to Part B doesn't address the overall problem of Medicare cost growth. Rather, it only addresses the short-term problem of Part A solvency.

We urge Congress and the Administration to see how much can be saved from more traditional spending reductions before adopting this shift. If the budget falls short of the goal to extend Part A solvency for at least several years beyond the current insolvency date of 2001, then it would be appropriate to consider this home health

proposal as a necessary and prudent step to allow sufficient time for longer term reforms to be debated and implemented.

Part B Premium

The President's proposal would maintain the beneficiary Part B premium -- currently scheduled to revert back to the Social Security Cost of Living Adjustment (COLA) after 1998 -- at 25% of program costs.

AARP believes that there is merit to a fixed contribution that asks all Medicare beneficiaries to contribute a portion of Medicare Part B costs. However, we believe that any change that increases beneficiary out-of-pocket costs must be viewed in the context of the larger budget package and other potential changes in beneficiaries' out-of-pocket costs and income. We also believe that low-income beneficiaries should continue to be protected against higher out-of-pocket costs. Our estimates indicate that maintaining the premium at 25% of Part B program costs could yield a premium that is nearly $10 higher in 2002 than it would be based on underlying law. While most older Americans would be able to afford this increase, others could not without the help of the Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) programs that currently pay the monthly cost-sharing and premium for many poor and near-poor older Americans.

The Administration's budget does not include an additional premium for higher income individuals; but despite the fact that only a small percentage of beneficiaries fall into the "high income" category, both the President and the leadership in the Congress have expressed interest in this proposal. Therefore, AARP believes that it is important to state our position on this issue.

Some have argued that those older Americans who are better off than others should no longer be "subsidized" by the federal government. What this argument doesn't recognize, however, is that higher-income older persons routinely pay more in income taxes. Moreover, during their working years, they generally paid more in payroll taxes. In addition, the removal of the wage cap for Medicare means higher income individuals are now paying even more into the system.

Fairness and equity are important here. Higher-income workers benefit from government health care "subsidies" through the significant tax write-offs their employers receive for providing health insurance and through the tax break individuals receive directly for benefits not considered as taxable income. In the interest of fairness, AARP believes that if higher-income older persons are asked to pay more for the cost of Medicare, then this policy should apply across generations and to all higher income individuals.

Hospital Outpatient Coinsurance

For most Medicare Part B services, the coinsurance beneficiaries pay is limited to 20 percent of the amount Medicare approves. But when it comes to hospital outpatient surgery, radiology, and diagnostic services, beneficiaries pay significantly more in coinsurance.

In fact, most beneficiaries now pay about 50 percent in coinsurance. And, in some cases, beneficiaries are actually paying more in coinsurance than Medicare pays for the service.

This occurs because of a "glitch" in the law that allows hospitals to base coinsurance on what they charge, rather the amount Medicare determines is a reasonable amount for a service. Since there is no limit on what a hospital may charge for a service, hospitals are shifting costs onto beneficiaries.

For example, a hospital may charge $3,500 for outpatient cataract surgery. Medicare may determine that $1,500 is the more appropriate charge for this service, so it bases its reimbursement on the $1,500 figure. The typical 20% coinsurance would be $300 for this $1500 service. But, because of the glitch in the law, the beneficiary's coinsurance is actually 20 percent of the amount the hospital charged -- $3,500 -- even though Medicare determined that this amount was far above what it would reimburse for the service. Thus, in this case, the beneficiary pays $700 in coinsurance -- more than twice the amount that he/she would pay if the 20% coinsurance were calculated the same way for outpatient care as it is for all other Part B services.

The irony is that many beneficiaries are led to believe that services performed in hospital outpatient departments are more cost-effective than inpatient care -- but then they end up paying a 50 percent coinsurance rather than the standard 20 percent.

Because of the increasing number of beneficiaries who receive services in hospital outpatient departments, the inequity in the coinsurance has become a widespread problem. As hospitals continue to raise their charges, the amount that beneficiaries will pay in coinsurance will skyrocket. The Health Care Financing Administration (HCFA), the agency that administers Medicare, projects that over the next four years beneficiaries could end up paying 70 percent in coinsurance.

Some argue that this really is not a direct out-of-pocket cost because most Medicare beneficiaries have Medigap coverage. While it is true that most beneficiaries have some form of supplemental coverage, the high coinsurance is still a direct out-of-pocket expense since most of it is passed directly on to the beneficiary in the form of higher premiums. In fact, a portion of the increase in 1996 premiums for some supplemental plans was directly attributable to rising outpatient costs. High outpatient costs are, of course, even more burdensome for the many lower-income beneficiaries who don't have Medigap or qualify for QMB protection and are forced to pay the entire amount.

The President's budget would begin to correct this problem by phasing coinsurance down to the standard 20 percent of Medicare's approved payment by 2007. However, since the proposed phase-down would not begin until 1999, we believe it is critical that the level of coinsurance currently paid by beneficiaries not increase beyond the 1997 percentage. We also believe that the phase-down of beneficiary coinsurance should commence on schedule even if the implementation of the new outpatient PPS is delayed.

Reduce Medicare's Reimbursement to Managed Care Plans

The President's proposal includes various changes in Medicare's reimbursement to managed care plans, including: a gradual 5% reduction of Medicare's payment of plans from 95% to 90% of the Adjusted Average Per Capita Cost (AAPCC); a freeze in AAPCC rates; the creation of a payment floor; and a carve-out of the Graduate Medical Education (GME) and Disproportionate Share Hospital (DSH) payments.

AARP shares the Administration's concern regarding the need to improve the appropriateness of Medicare payments to managed care plans. To the extent that plans are being overpaid for healthy enrollees, valuable financial resources are being misdirected. These resources need to be retargeted so that Medicare can cost-effectively provide high quality health care to all of its beneficiaries and appropriate payments to managed care plans for all beneficiaries, including those who are less healthy.

Managed care plans claim that the proposed reductions will force them to eliminate additional beneficiary services, such as prescription drugs, and to raise premiums. It is difficult to evaluate what the impact of the proposed payment changes will be, and whether the claims of managed care plans are accurate, because of gaps in data. AARP believes that it is up to plans to respond with actual data demonstrating their costs.

If plans do, in fact, react by instituting or raising premiums, or reducing benefits, beneficiaries could suffer. In addition, some beneficiaries who would otherwise choose to enroll in managed care might remain in the traditional Medicare program. However, plans could choose to absorb reduced revenues rather than shift the costs to consumers -- particularly in highly competitive markets. In this case, most of the burden of the payment decrease would fall on the plan.

More importantly, an across-the-board cut does nothing to address the absence of a reliable risk adjuster in the AAPCC. This means that plans will continue to have incentives to enroll the healthiest beneficiaries while avoiding those who are the sickest.

Hence, it is critically important that Medicare develop an accurate means of paying for managed care, including adequate risk adjustments. We urge the Administration to improve the current risk adjustment methods in the AAPCC. For example, research has shown that the use of health status and prior use adjusters could improve the

current risk adjustment and save the program money. Even in the absence of a perfect risk adjuster, steps such as these should be taken now to help limit incentives for adverse selection.

While the number of Medicare beneficiaries electing to enroll in managed care plans is growing, a significant number of beneficiaries find that fee-for-service is the better -- or perhaps only -- option for them, and choose to remain in the traditional program. Therefore, AARP believes that reform of the Medicare program must include ensuring that the traditional program remains an attractive and affordable option for beneficiaries. Any efforts to expand the range of Medicare coverage options should move in tandem with efforts to improve the operation and design of the traditional fee-for-service option.

Provider Service Organizations (PSOs)/ Provider Service Networks (PSNs)

The President's proposal expands Medicare's managed care options beyond HMOs to include PSO/PSNs that adhere to certain quality and consumer protection standards. The specific legislative language with respect to the standards has not yet been released by the Administration.

These "new" organizations typically consist of a physician group or groups in conjunction with one or more hospitals. They subcontract to larger HMOs or contract directly with self-funded employers. They generally cover a smaller service area than an HMO, and have fewer capital financial resources. Some argue that they should be made available to Medicare beneficiaries to broaden choice, and that they may be able to give an individual more personalized community-based care than a large HMO.

AARP believes that offering beneficiaries additional coverage choices is a good thing -- as long as those new coverage options also provide beneficiaries with the quality and consumer protection standards they are guaranteed under other Medicare coverage options.

While some have suggested that PSOs and PSNs should have different standards, and some have even argued for exemptions from standards that other plans have to abide by, we believe strong standards must be maintained. For example, if a PSO/PSN becomes bankrupt, the beneficiary and/or the entire Medicare program suffers. Therefore, strong solvency standards must be required.

Similarly, the Medicare program should not be expanded to offer choices that require beneficiaries to give up Medicare consumer protections, such as quality review and external appeals.

AARP is pleased that the President's proposal appears to extend balance billing protection to beneficiaries who choose the new PSO/PSN option. It is our view that

beneficiaries who choose any new Medicare coverage option should have the same protection against physician balance billing that they do under the traditional Medicare program.

Medicare Respite Benefit

The President's proposal establishes a modest Part B respite benefit for the caregivers of individuals with Alzheimer's disease. Costs of this benefit would be excluded from the Part B premium.

AARP is pleased that the Administration recognizes the enormous burdens on caregivers of persons needing long-term care and has proposed a modest down-payment to address the problem. The proposal is very modest, however, and at least initially would have only limited impact. Ideally, a respite benefit should not be limited only to caring for those with Alzheimer's disease. Eligibility should be based on a broader definition of functional and cognitive impairment (e.g., dependencies in 2 out of 5 Activities of Daily Living).

Expanding Medicare's Coverage of Preventive Care Services

The President's proposal broadens Medicare's coverage to include colorectal screening, diabetes management and annual mammograms without coinsurance. The budget also calls for an increase in the reimbursement rates for the three covered vaccines.

The President's proposal broadens access to important preventive benefits in two ways: 1) by adding coverage for key benefits not currently covered by Medicare; and 2) by eliminating coinsurance for mammograms and increasing reimbursement for vaccines to prevent any financial barriers to these services. The proposal also brings the Medicare program more in line with the kinds of preventive services offered in private sector health coverage.

Annual Open Enrollment/Medigap Portability

The President has asked Congress for authority to require Medicare managed care plans and Medicare Supplemental insurers to participate in an annual "open season." During this time, any Medicare beneficiary, regardless of health status, could enroll in any Medicare managed care plan or supplemental (Medigap) insurance. The purpose is to provide "portability" between Medicare fee-for-service and managed care.

With the exception of a 6-month period when the individual first enrolls in Medicare, there is no Medigap portability -- although managed care plans are required to accept beneficiaries regardless of health history or condition. As a result, under current law, beneficiaries are sometimes unwilling to try managed care for fear that they will be unable to obtain a Medigap policy if they choose to return to fee-for-service. A

different version of this proposal, that is pending before Congress, would essentially allow a 12-month window to re-enroll in Medigap after trying out managed care.

The President's proposal to require Medigap insurers to "take all comers" has merit and would certainly help foster true choices for Medicare beneficiaries. However, it should be carried one step further, if the goal is realistic choice. Medigap plans should be required to community rate premiums. Increasingly, insurers are pricing their policies through an age-rating process, in which an insured is charged a higher rate the older he or she gets. The practical result is that an older beneficiary may not be able to afford to reinstate a Medigap policy, so the choice is not really there. If equal choices are the goal, then Medigap insurers, just as Medicare managed care plans, must not be permitted to age-rate.

The coordinated open enrollment, along with the competitive pricing, comparative information, and independent broker elements of the President's proposal are all part of research projects being undertaken by the Office of Research and Demonstrations. These are promising ideas, but have yet to be fully evaluated. Before these policies are extended to the full Medicare program, Congress should give careful attention to the pros and cons as well as the possible refinements in these proposals.

Fraud and Abuse Initiatives

The President's proposal seeks to eliminate fraud and abuse in home health care by ensuring that home health agencies are reimbursed based on the location of the service -- not the location of the billing office -- and by allowing the Secretary of Health and Human Services (HHS) to deny payments for excessive home health use.

Basing home health care payments on the area of service and not on where the billing office is located won't completely solve the problem, but should help to reduce the incentive to commit fraud (as well as reduce Medicare program expenditures). Giving the Secretary authority to deny excessive home health payments to a particular provider could also help minimize abuse but it could also result in payments for legitimate services being denied -- especially in the case of individuals with a chronic conditions who need extensive home health care services.

The proposal would also repeal provisions Congress enacted last year that weakened fraud and abuse enforcement. This includes the repeal of the "clarification of intent" provision enacted last year which put a higher burden of proof on law enforcement authorities to determine, for instance, if a provider intentionally filed false claims.

The President also proposes to repeal a requirement that the Secretary of HHS issue advisory opinions on a case-by-case basis on whether a provider's business is in violation of the Medicare anti-kickback statute. As with the "clarification of intent" provision, the advisory opinion requirement also created a higher burden of proof in

prosecuting suspected providers and undermined the authority of the Justice Department.

AARP supports repeal of the provisions enacted last year that weakened anti-fraud and abuse enforcement efforts. Both the "clarification of intent" provision and the advisory opinion requirement hindered anti-fraud and abuse efforts, and in the case of the advisory opinions, added an unnecessary layer of bureaucracy and additional cost to an already strapped Medicare program.

AARP believes that these initiatives are modest but significant steps toward reducing the costly burden fraud and abuse place on the Medicare program, but they by no means solves the problem. The current cost of fraud and abuse in the Medicare program is estimated to be as high as 20% of the annual cost of the program. Though it would be impossible to completely eliminate fraud and abuse -- unscrupulous providers will inevitably find a way to defraud the system -- significant advances in reducing health care fraud can be made, especially in the areas of durable medical equipment and skilled nursing facility care. More can and should be done.

Conclusion

AARP urges Congress to come to agreement promptly on a budget package that achieves solvency of the Medicare Part A Trust Fund in a fair and equitable manner. Ultimately, AARP will judge a budget package on whether the sacrifices asked of older Americans -- both as part of and separate from the Medicare program -- are fair.

AARP looks forward to working with this Committee and with other Members of Congress as the budget debate progresses.

COMMUNICATIONS

STATEMENT OF THE AMERICAN ASSOCIATION OF EYE AND EAR HOSPITALS, ET AL.

March 4, 1997

Honorable William V. Roth
Chairman
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 10510

Dear Senator Roth:

On behalf of our nation's hospitals and integrated delivery systems, we welcome the opportunity to work with the Senate Committee on Finance to develop a Medicare reform plan which balances the need to: (1) assure the long term viability of the Hospital Insurance Trust Fund; (2) secure proportional contributions to balancing the Federal budget while ensuring that our nation's hospitals and health systems remain capable of providing quality care and rising to the new economic and delivery system demands which result from the new health care market. We ask that this letter be included in the hearing record of March 5, 1997 on the President's fiscal year 1998 budget proposal.

As hearings begin to review the Medicare program and the various proposals that are before the Senate, we are concerned that recent reports of high aggregate Medicare PPS profit margins may lead some to conclude that a large share of the reductions can be borne easily by hospitals and health systems. That is not the case, and we urge you to review the Prospective Payment Assessment Commission's (ProPAC) report in its entirety and not just rely on the information that has been reported in the media.

In the aggregate, government payment sources pay less than the cost of providing care - according to ProPAC Medicare pays 97 percent of a hospital's total costs for treating Medicare patients, while Medicaid pays even less. One out of five hospitals receive more than two-thirds of their revenues from Medicare and Medicaid, and forty percent of hospitals lose money treating Medicare beneficiaries. Approximately 10 percent of all hospitals had negative total margins for the last three years in a row.

We trust the Finance Committee will not be tempted to make policy based solely on ProPAC's findings dealing with inpatient margins alone. Hospitals provide much more than inpatient services, and the entire set of Medicare activity within the hospital should be reviewed.

The success of any plan to reform the Medicare program will depend, to a large part, on the ability of our nation's hospitals and health systems to assume a leading role in the delivery of high quality health services in their community. Accordingly, we look forward to working with you to arrive at the correct solutions to the impending Medicare solvency crisis.

Sincerely,

American Association of Eye and Ear Hospitals
American Hospital Association
American Osteopathic Healthcare Association
Association of American Medical Colleges
Catholic Health Association
Federation of American Health Systems
InterHealth
National Association of Public Hospitals and Health Systems
Premier, Inc.
VHA Inc.

STATEMENT OF THE HEALTH INDUSTRY DISTRIBUTORS ASSOCIATION (HIDA)

The following statement is submitted to the Senate Committee on Finance on 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 virtually every hospital, physician office, nursing home, clinic, and other healthcare sites in the country, and to a growing number of home care patients.

The President's FY 1998 budget proposal includes a number of provisions designed to restructure the Medicare Program. Many of these provisions would directly impact HIDA Members. This statement will focus on three such proposals: competitive bidding, nursing facility consolidated billing, and strengthened fraud and abuse prevention programs.

Competitive Bidding

The Administration's FY 98 budget proposes to offer the Department of Health and Human Services (HHS) broad authority to put all Part B covered items and services (excluding physician services) up for competitive bid. Under this proposal, the supplier(s) with the winning bid would be given control over the market for a certain item of durable medical equipment, prosthetic, orthotics and supplies (DMEPOS) in a specified geographic area. HIDA understands the Administration's desire to encourage the prudent purchasing of health care services. However, we feel that this undue reliance on the implementation of competitive acquisition is based upon faulty assumptions and will ultimately prove to be detrimental to Medicare beneficiaries.

Comparisons to the VA: Supporters of competitive bidding routinely compare Medicare's reimbursement for DMEPOS with payments made by the Department of Veterans Affairs (VA). This comparison ignores the fact that the VA and the Medicare Program have radically different purchase, distribution, delivery and payment structures. The VA operates 172 hospital medical centers (VAMCs), and arranges contract purchases with prices based on a projected very large volume over several years. Each VAMC has the ability to negotiate a price on a product because they can guarantee to order in bulk over the course of the contract. Individuals and nursing facilities do not have this ability because they do not purchase in bulk. In addition, the VA negotiates directly with manufacturers and not with outside providers. Thus, any comparison to the Medicare program is inappropriate.

Under the Medicare program, no individual beneficiary or supplier has the leverage to negotiate the prices that each VA hospital can. Medicare does not purchase any product, but rather reimburses for products and allied services purchased in very small quantities on behalf of individual beneficiaries. Further, each transaction completed by the VA involves one payment and one invoice regardless of the amount of supplies. In contrast, the Medicare program requires a separate invoice for each beneficiary and a separate payment transaction. In addition, the claim filing expenses incurred under Medicare for each beneficiary are expensive and are not incurred under the VA program.

Comparisons to the Retail Market: Administration officials also use comparisons between retail transactions and Medicare reimbursements to bolster their arguments in favor of competitive bidding. This comparison is also specious. In a retail transaction, a consumer purchases an item and the transaction is completed. No other services are provided to the consumer. As long as the individual has enough finances to cover the transaction, the sale is concluded.

In contrast, before a Medicare beneficiary can receive a Part B covered product, a physician must determine the resident's medical necessity. A Medicare - approved provider then supplies the product and allied services. The beneficiary receives the product in compliance with the appropriate medical treatment protocol. The Medicare reimbursement amount includes payment for this bundled package of product and services.

Once a beneficiary receives the product and services, it takes time to receive reimbursement. The supplier must procure and submit written documentation of the beneficiary's medical need for the item to a Durable Medical Equipment Provider (DMERC), properly submit the claim to the DMERC, and wait a minimum of 30-70 additional days for reimbursement.

It is important to recognize that not all transactions will be reimbursed by Medicare. In fact, even though a physician prescribes certain items, many claims are denied by Medicare because the beneficiary does not meet Medicare's strict medical necessity requirements for the item or the paperwork does not sufficiently document the beneficiary's medical need. In these cases, the supplier then must appeal the denial, seek reimbursement directly from the beneficiary (which may or may not be appropriate

depending on the particular facts of the case), or take the loss. This is a time consuming process which requires resources that simply do not occur in a typical retail transaction.

Competitive Bidding Is Anti-Competitive: Although the term 'competitive bidding' may sound attractive, this proposal would actually stifle the existing true market competition that encourages the provision of high quality medical services to Medicare beneficiaries. The President's proposal would require Medicare to contract with a very limited number of suppliers in any geographic area - thereby eliminating competition. HIDA strongly opposes the Administration's competitive bidding proposal for the following reasons:

- Loss of Quality and Service: Competitive bidding schemes will not work for Medicare because the allied services are as important to beneficiaries as product quality. For instance, home oxygen equipment can not be drop-shipped to consumers - therapeutic support services are crucial to positive health outcomes. History shows that once an artificially low bid is awarded and the contract holder faces budget pressures, the first thing the provider eliminates is support services - such as 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 and require costly re-hospitalizations.

- Access and Choice: Competitive bidding will radically reduce the number of providers of Medicare services, thereby harming consumer access (especially in rural areas) and eliminate beneficiaries' statutory right to choose their provider.

- States Have Rejected Competitive Bidding: Competitive bidding for home medical equipment (HME) and home oxygen services has been tried and rejected in Ohio, Montana, and South Dakota. These states cited increased administrative costs and serious management problems as reasons for dropping competitive bidding. Each state also experienced an actual reduction in competition among providers and reduced access to provider support services.

- HCFA Unlikely to Administer an Effective Program: All historical evidence indicates that it is virtually impossible for HCFA to design and administer a competitive bidding program without damaging the market, compromising healthcare, and increasing costs.

In conclusion, competitive bidding strategies are inappropriate for DMEPOS services. Although the term sounds attractive, this proposal is actually anti-competitive. In addition, competitive bidding may threaten the delivery of important support services, and will likely decrease beneficiary access and choice.

Nursing Facility Consolidated Billing

The Administration's FY 1998 budget package contains a legislative proposal prohibiting any entity other than a nursing facility from billing Medicare for medical supplies and services provided to nursing facility residents. This "consolidated billing proposal" does not distinguish between reimbursements for services covered by Medicare Part A vs. Part B.

HIDA supports consolidated billing for nursing facility residents who are covered by Medicare Part A. We understand that Part A consolidated billing is needed to gather the information that the Health Care Financing Administration (HCFA) needs to develop a nursing facility prospective payment system. However, HIDA believes that nursing facilities should retain their ability to fully utilize the services of outside suppliers of medically necessary Part B services when the resident is not covered under the 100-day Part A stay. This choice is more efficient and economical for many nursing facilities.

Outside suppliers provide nursing facilities with a number of services that promote positive health outcomes. Value-added services provided by medical suppliers including storage, inventory management, clinical services (e.g., respiratory therapy, nutritional assessments, support for wound care protocols), billing and collection, and outcomes support. Many nursing facilities do not have the administrative staffing, physical space, or other resources to ensure that adequate quantities of the appropriate products are available to meet each patient's needs, especially since some patients require products on an emergency basis or have frequently changing needs. As a result, beneficiaries could be denied access to the wide range of high quality, medically necessary products that are currently available.

The Health Industry Distributors Association opposes consolidated billing for nursing facility residents who are not covered by Medicare Part A because:

- Concerns Relating To Fraudulent Billing Are Not Applicable After The 100 Day Part A Stay. It is argued that consolidated billing is needed to eliminate the opportunity for fraudulent simultaneous "double billing" of Medicare Part A and Part B. These concerns can be addressed through Part A consolidated billing - simultaneous billing of Part A and Part B is not feasible for residents who are not covered by Part A. In addition, the new Durable Medical Equipment Regional Carriers (DMERCs) have instituted tight controls over the Part B benefit. With full time Medical Directors developing and implementing strict guidelines defining medical necessity and utilization of medical supplies, the DMERCs have been highly effective in combating fraudulent billing practices. Therefore, irregularities in the Part B billings of outside suppliers providing services to nursing facility residents are readily apparent under the current system.

- Consolidated Billing Would Impose New Cost Burdens On Nursing Facilities: By requiring fully consolidated billing, even when beneficiaries are not under a Part A stay, many nursing facilities that previously utilized outside suppliers to provide their residents with medically necessary supplies and services would be required to provide these services themselves, to directly bill for these supplies and services, and to assume other responsibilities that are currently fulfilled by outside suppliers These responsibilities and services would add significant costs to a nursing facility Importantly, current law allows a nursing facility to act as a Part B supplier, presumably those facilities who choose to do so now would continue this practice in the future if it is their best option.

- Consolidated Billing Is, At Best, Budget Neutral: The proposed legislative prohibition against the use of outside suppliers is considered revenue neutral, as it is characterized by the Congressional Budget Office as a billing requirement. In reality, fully consolidated billing would likely increase costs to the health care system, since the supplier community provides valuable billing expertise, inventory control, staff education and clinical services which the facilities will need to replace

- Consolidated Billing Is Not Necessary For Prospective Payment: It is argued that consolidated billing is necessary to collect the data needed to construct a prospective payment system for nursing facilities. However, there is no prospective payment proposal for the Part B benefit, which will continue to exist unless Congress specifically eliminates it.

Medicare Fraud and Abuse Prevention: Supplier Standards

As a professional trade association, HIDA wholeheartedly supports the rigorous enforcement of laws that ensure that Medicare pays reasonable reimbursement amounts for medically necessary items and services on behalf of Medicare beneficiaries. HIDA has long advocated the responsible administration of the Medicare program, and has repeatedly identified specific abusive or illegal practices occurring in the marketplace to assist the government's anti-fraud efforts. HIDA has also assisted in the development of additional targeted policies designed to aid the government in the administration of the Medicare program. For instance, HIDA urges the Health Care Financing Administration (HCFA) and Congress to require that all Part B suppliers comply with standards that will assure Medicare beneficiaries receive a consistent quality of DMEPOS services.

The following recommended supplier standards result from a fundamental belief that the current Medicare Supplier Standards (42 CFR 424.57 et seq) are simply insufficient Importantly, it is not just the de minimus nature of the standards that is deficient, but also the process Medicare uses to determine whether a provider actually meets those standards The following recommended standards therefore would inject some substantive meaning into the notion of being a Medicare provider of DMEPOS services.

These new standards are intended to build upon those currently administered through the Medicare National Supplier Clearinghouse (NSC) These standards would therefore apply to all firms that have or apply for a Medicare Part B supplier number in order to provide DMEPOS services and bill Medicare on behalf of beneficiaries. They reflect the consensus of a wide array industry leaders, national associations, state associations, HIDA Members, and other constituent interests

If the NSC adopts the recommended standards and changes the process by which it determines whether a provider actually meets the standards, Medicare will realize an immediate benefit by ensuring that beneficiaries receive DMEPOS items and services only from legitimate firms If an effective screening

process is used, unscrupulous firms will never have an opportunity to engage in abusive behavior because they will never be able to bill the Medicare program on behalf of beneficiaries. Consequently, the standards will significantly contribute to reducing fraud and abuse in the Medicare program. For these reasons alone, Congress should require HCFA to adopt these supplier standards.

ORGANIZATION OF STANDARDS:

1. Basic Business Standards—would apply to all firms applying for a Medicare Part B Supplier/Provider number and any firm that currently has a Part B supplier number issued by the National Supplier Clearinghouse.

2. Standards for Providers of Respiratory Products—would apply to all firms providing respiratory products and services to Medicare beneficiaries, and billing Part B for those products.

3. Standards for Providers of Home Infusion Therapy—would apply to all providers of home infusion therapy, and billing Medicare Part B for these products.

4. Supplier Enrollment/Application Procedures and Verification—describes a new process by which suppliers would receive a Medicare Part B supplier/provider number. The process includes verification of information submitted to Medicare, and an on-site visit to the firm.

NOTE ON TERMS:

Please note that the following terms are used interchangeably:

- ⇨ patient, consumer, client
- ⇨ supplier, provider

BASIC BUSINESS STANDARDS FOR PART B SUPPLIERS

The basic business standards should apply to all providers/suppliers that apply for a Medicare supplier number, and that are in the business of providing medically necessary DMEPOS services to Medicare beneficiaries either in their home or in a nursing facility.

STANDARD BB-1:

AS PART OF THE APPLICATION PROCESS, THE PROVIDER/SUPPLIER MUST PROVIDE BASIC INFORMATION, INCLUDING:

1. Name
   A. Registration/business license
   B. D/B/A ("doing business as")
2. Tax identification number
3. Address verification
4. Proof of insurance
   A. General product liability insurance
   B. Professional liability insurance (if company has health care professionals as employee(s))

STANDARD BB-2:

Provider/supplier must comply with all federal, state and local regulatory requirements (e g , licensure), and show proof of compliance when applicable.

Standard BB-3:

Provider/supplier must provide evidence of financial soundness May be demonstrated in many different ways, for example by:

A. Bank references
B. Insurance—property, liability
C. Trade credit references
D. Etc. (Dun & Bradstreet or other credit reports)

STANDARD BB-4:

Provider/supplier must have policies and procedures to cover basic scope of services for appropriate product lines.

STANDARD BB-5:

Provider/supplier must maintain all professional and business licenses and certifications, and show proof when applicable.

STANDARD BB-6:
Provider/supplier must have 24-hour a day, 7 day a week service availability for appropriate products and response to emergency situations.

STANDARD BB-7:
Provider/supplier routinely monitors the quality and appropriateness of services, equipment and supplies provided.

STANDARD BB-8:
Provider/supplier has a corporate compliance program.

Standard BB-9
Provider/suppliers (owners and officers) shall not have been convicted of violations of Medicare and/or Medicaid rules and regulations.

Standard BB-10:
Provider/supplier attests that it is knowledgeable of the Medicare laws, regulations and policies pertaining to the billing of the applicable services, equipment and supplies provided.

Standard BB-11:
Provider/supplier has the capability (either directly or through contractual arrangements with other entities) to service customer locations, as evidenced by product inventory, distribution systems, and emergency backup systems.

Standard BB-12:
Provider/supplier provides its customers with educational resources relative to the products and services provided such as assistance with understanding Medicare regulations, provision of Medicare's toll free beneficiary help line, equipment inservices (if applicable), and product information.

Standard BB-13:
Provider/supplier has policies and procedure to document and resolve customer complaints and inquiries.

Standard BB-14:
Provider/supplier maintains regular business hours.

Standard BB-15:
Provider/supplier maintains a physical business location with its business name evidently displayed.

Standard BB-16:
Provider/supplier has procedures to document maintenance and repair programs for equipment as applicable.

Standard BB-17
The patient/caregiver must be informed of the provider's compliance with all applicable HME Federal and State laws, regulations and Standards.

Standard BB-18
The provider/supplier must assure that all the necessary and appropriate patient/caregiver education has been provided or arranged for with respect to the services, equipment, and supplies provided.

Standard BB-19
The provider/supplier must provide patient/caregiver training in the safe and proper use of equipment, with a follow-up demonstration.

Standard BB-20
The provider/supplier must inform, in general terms, the patient/caregiver of his/her financial responsibilities.

Standard BB-21
The provider/supplier will assure that environmental considerations are addressed such that the continuing needs of the patient/caregiver are met in the safest possible manner.

Standard BB-22
The provider/supplier only uses equipment and supplies that conform to generally accepted industry manufacturing standards.

Standard BB-23
The provider must have a valid, current and accurate prescription for all equipment and supplies provided.

Standard BB-24
The provider/supplier must notify the prescribing physician of apparent patient non-compliance.

SUPPLIER STANDARDS FOR PROVIDERS OF RESPIRATORY PRODUCTS

These provider standards would apply to providers of respiratory products (in addition to the Basis Business Standards described above).

Standard Resp-1:
All patient/caregiver information must be kept in confidence (except when required to be released, for example, by JCAHO; and provider will first obtain client's permission).

Standard Resp-2:
Providers may only provide respiratory therapy equipment for which it is an authorized dealer.

Standard Resp-3:
The provider must perform and document scheduled in-home routine preventative maintenance of provider-owned (i.e., rental, loaner) equipment.

Standard Resp-4:
Either directly or through contracting with another entity, the provider must perform and document manufacturers' scheduled maintenance of provider-owned (i.e., rental, loaner) equipment.

Standard Resp-5:
Provider cleans, stores, and transports respiratory therapy equipment in accordance with the manufacturer's recommendations and all applicable Federal and local laws ad regulations.

Standard Resp-6:
The provider must have a valid, current and accurate prescription for all respiratory therapy equipment dispensed.

Standard Resp-7:
The provider must secure physician approval, either through a change in the prescription or through physician-approved protocols, before respiratory therapy equipment modality substitutions are made.

Standard Resp-8:
The provider only utilizes the services of personnel who are appropriately trained, qualified, and competent for their scope of services.

Standard Resp-9:
The provider utilizes services of health care professionals that adhere to all Federal and State laws, rules, and regulations.

Standard Resp-10:
Providers providing life supporting or life sustaining respiratory therapy equipment assume the responsibility to directly provide or arrange for the services of a respiratory therapist or equivalent.

SUPPLIER STANDARDS FOR PROVIDERS OF HOME INFUSION THERAPY

These provider standards would apply to providers of home infusion products (in addition to the Basis Business Standards described above).

PERFORMANCE STANDARDS

Standard IV-1

Provider has competent staff:

A. Provider has trained, competent technical staff
B. Provider has access to qualified health professionals

Standard IV-2

Provider performs client assessments, which includes:

A. Appropriateness of therapy
B. Safety of home environment
C. Development of plan of care to establish product and service needs

Standard IV-3

Provider coordinates client care with other providers and practitioners

A. Communication and interaction with other providers and practitioners
   a. Patient assessment/service plan
   b. Changes in patient's needs
   c. Changes in patient's care regimen

Standard IV-4

Provider has a valid, current and accurate prescription for all products dispensed.

Standard IV-5

Provider schedules activities, including

A. Who does what and when

Standard IV-6

Provider performs patient/caregiver training which includes:

A. Indication for therapy
B. Administration of medications or formula
C. Operation and maintenance of pump
D. Inventory storage and management
E. Self-monitoring
F. Emergency response

Standard IV-7

Provider delivers, sets up and pickup equipment and supplies.

Standard IV-8

Provider performs ongoing monitoring and follow-up, including:

A. Assess response
B. Assess functioning of therapy delivery system
C. Assess product utilization, patient compliance
D. Assess continuing need for therapy (with others)
E. Equipment tracking, cleaning, maintenance and repair

Standard IV-9

Provider provides access to emergency response services

A. Services are available 24 hours a day, 365 days a year
B. Provider responds within reasonable time
C. Provider provides intervention as indicated.
   a. Technical
   b. Clinical—provide instruction, visit or contact other provider

INFORMATION MANAGEMENT

Standard IV-10
Provider manages the following information related to the client:

A. Maintain clinical records
B. Patient satisfaction/grievances
C. Complications
D. Unscheduled deliveries and visits
E. Utilization data by service, by patient
F. Goals of therapy, patient needs

APPLICATION PROCESS -- FOR A MEDICARE PART B SUPPLIER NUMBER

The verification that a provider/supplier meets the Medicare supplier standards is vitally important to the provider/supplier industry, beneficiaries and the Medicare Program to ensure that only viable providers/suppliers provide medically necessary DMEPOS items and services to Medicare beneficiaries.

HIDA recommends that non-governmental independent organizations verify that providers/suppliers comply with the Medicare supplier standards, both initially and on an ongoing basis. This recommendation is similar to the structure used world wide by the International Standards Organization (ISO). This process would be simple, minimize bureaucracy and paperwork, and most importantly, ensure the suppliers comply with the standards.

1. National Supplier Clearinghouse (NSC) would certify organizations that wish to verify suppliers meet the Medicare supplier standards.

2. These organizations would verify compliance based solely on the Medicare supplier standards. Verification would include:
   A complete review of the application,
   Written follow-up on questionable areas
   On-site visit to verify/check remaining questionable areas

3. There would be a time limit to complete the review process (no more than 90 days)

4. The provider/supplier pays the fee to the verification organization (a portion of which may go to the NSC to cover administrative costs).

5. There would be a three year cycle for renewal of Medicare supplier number to ensure ongoing compliance with the Medicare supplier standards. The fee would cover the three year cycle.

Note: HIDA supports a reasonable application fee to cover costs of verification. The recommendation is made with the understanding that these verification procedures will actually weed out the "bad actors;" non-legitimate companies would not be able to get a Medicare supplier number because of the rigorous screening of all applicants.

CONCLUSION

HIDA appreciates the opportunity to submit this statement to the Committee. We urge Congress and HCFA to strengthen the Medicare program by implementing rigorous supplier standards, requiring nursing facility consolidated billing during the 100-day Part A benefit, and opposing competitive bidding acquisition schemes. These recommendations will aid in the ongoing effort to combat Medicare fraud and abuse while promoting the provision of consistent, high quality services to Medicare beneficiaries.

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