REHABILITATION AND LONG-TERM CARE HOSPITALS PAYMENTS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

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REHABILITATION AND LONG-TERM CARE HOSPITALS PAYMENTS

THURSDAY, APRIL 10, 1997

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 1:35 p.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisories announcing the hearing follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
March 21, 1997
No. HL–9

CONTACT: (202) 225–3943

Thomas Announces Hearing on Rehabilitation and Long-Term Care Hospitals Payments

Congressman Bill Thomas (R–CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on rehabilitation and long-term care hospitals. The hearing will take place on Thursday, April 10, 1997, in room 1310 Longworth House Office Building, beginning at 1:00 p.m.

In view of the limited time available to hear witnesses, oral testimony will be heard from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Medicare payments to rehabilitation facilities and long-term care hospitals have increased rapidly in recent years. The Prospective Payment Assessment Commission recently examined Medicare spending for these providers. Between 1990 and 1994, rehabilitation facility payments increased from $1.9 billion to $3.9 billion—an average annual increase of 20 percent. Long-term care hospital payments increased from $200 million to $800 million—an average annual increase of 41 percent.

Rehabilitation facilities and long-term care hospitals are paid under a system established in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Under TEFRA, operating payments are based on an individual facility's costs or a facility-specific limit. The discharge-level limits are calculated for each individual hospital using cost report data from the second year that the facility is in operation, updated to the current year. Therefore, for some hospitals, their target payments are based on cost report data that is more than a decade old. Capital payments are based on costs.

TEFRA was intended to be an interim system until a prospective payments system (PPS) could be established. Fifteen years later, rehabilitation and long-term care hospitals remain under this "temporary" system. In the Omnibus Budget Reconciliation Act of 1990, the Secretary of Health and Human Services was instructed to reform the TEFRA system or replace it with a PPS. There has been little progress in this area.

The President's fiscal year 1998 budget proposal contains provisions to recalculate all TEFRA hospital targets using more recent cost report data. A target ceiling and floor would be imposed to reduce the variation across facilities. Capital payments would also be reduced to 85 percent of costs, for fiscal years 1998 through 2002. In addition, the administration would impose a moratorium on long-term care hospitals, effective upon enactment.

In announcing the hearing, Chairman Thomas stated: "Medicare payments for rehabilitation facilities and long-term care hospitals are spiraling upward. Notwithstanding the fact these facilities provide important services to seniors, Medicare needs to find ways to become a more prudent purchaser."

FOCUS OF THE HEARING:

This hearing will focus on the President's fiscal year 1998 budget policies related to rehabilitation facilities and long-term care hospitals in light of the recommendations of the Prospective Payment Assessment Commission, as well as the policies contained in the Medicare Preservation Act of 1995 and the Balanced Budget Act of 1995.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement and a 3.5-inch diskette in WordPerfect or ASCII format, with their address and date of hearing noted, by the close of business, Thursday, April 24, 1997, to A.L. Singleton, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least 1 hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments. At the same time written statements are submitted to the Committee, witnesses are now requested to submit their statements on a 3.5-inch diskette in WordPerfect or ASCII format.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at 'HTTP://WWW.HOUSE.GOV/WAYS__MEANS/'.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–225–1904 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including avail-

ability of Committee materials in alternative formats) may be directed to the Committee as noted above.

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*****NOTICE—CHANGE IN TIME AND ROOM*****

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
April 1, 1997
No. HL–9-Revised

CONTACT: (202) 225–3943

Time and Room Change for Subcommittee Hearing on Thursday, April 10, 1997, on Rehabilitation and Long-Term Care Hospitals Payments

Congressman Bill Thomas (R–CA), Chairman of the Subcommittee on Health, Committee on Ways and Means, today announced that the Subcommittee hearing on rehabilitation and long-term care hospitals payments previously scheduled for Thursday, April 10, 1997, at 1:00 p.m., in 1310 Longworth House Office Building, will begin instead at 1:30 p.m. in the main Committee hearing room, 1100 Longworth House Office Building.

All other details for the hearing remain the same. (See Subcommittee press release No. HL–9, dated March 21, 1997.)

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Chairman THOMAS. The Subcommittee will come to order. In a number of hearings, we have examined several aspects of Medicare part A spending. It is clear that in recent years the Health Care Financing Administration has focused its effort on inpatient hospital care. For prospective payment rewards, efficient hospitals maintain access to care for beneficiaries and contain spending. In the meantime, Medicare payments for other part A services, including skilled nursing facilities, home health care, and PPS-exempt hospitals have spiraled upward under antiquated payment systems.

Today we will examine two of the PPS-exempt providers: long-term care hospitals and rehabilitation facilities. While a relatively small number of Medicare Part A Trust Fund spending, these payments have mushroomed in recent years, and our attention is focused on them in terms of the percentage increase rather than total dollar amount.

In its March 1997 report to Congress, the Prospective Payment Assessment Commission reported that Medicare payments to reha-

bilitation facilities increased from $1.9 billion in 1990 to $3.9 billion in 1994, an average annual increase of nearly 20 percent, or double the overall Medicare average.

Even more alarming was the growth in payments to long-term care hospitals, which grew from $200 million to $800 million during the same period. If your math is any good, that is a rate of more than 40 percent.

Why are these payments growing at such rapid rates? Perhaps it is because of the incentives resulting from Medicare payment policy made under a "temporary" payment system that was established in the Tax Equity and Fiscal Responsibility Act of 1982.

Clearly, the system is inadequate, and apparently the administration now agrees. However, their approach to deal with the problem, at least for a long-term care hospital, is to call for a moratorium on new providers. It is hard to believe that after 15 years the administration, in weighing its options, has decided that the moratorium is the only option. I cannot believe that they could not implement a PPS system for long-term care hospitals or rehabilitation facilities. Obviously, all of us need to do better than this.

Today we will hear from several witnesses regarding Medicare payment policies for these providers. But before we hear from our panel of experts—and that is in no way to denigrate the first witness that we have, because he has a longtime concern in this area, and has talked to me about it—it is a pleasure to have as our first witness the gentleman from New Jersey, Mr. LoBiondo.

If you have any written statement, it will be made a part of the record, but you can address the Subcommittee in any way you see fit.

STATEMENT OF HON. FRANK A. LOBIONDO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. LOBIONDO. I will have a short presentation, Mr. Chairman, and then we will have experts testify a little bit later on. I want to thank you very much for the opportunity to make remarks today on the issue of reimbursement for rehabilitation hospitals under the Medicare Program.

I appreciate the chance to speak on this subject because I think that the current payment system is in serious need of reform. I would also like to take the occasion to talk about legislation that I introduced, H.R. 585, which would reform the current imbalanced system in favor of a more equitable approach.

As the Ways and Means Committee prepares to craft a Medicare reform package, I would like to bring to your attention an important fact: Adopting a prospective payment system for rehabilitation hospitals will help to slow the steady depletion of Medicare's finances. That was the conclusion of the Medicare Board of trustees in its 1996 annual report. The board found that the adoption of a prospective payment system for additional types of health care providers, such as rehabilitation hospitals, could postpone the depletion of the Hospital Insurance Trust Fund beyond the year 2001.

Why is this? Mainly because the existing payment system is fiscally unbalanced and from the beginning was never intended to be permanent. Developed under the Tax Equity and Fiscal Responsibility Act, TEFRA, of 1982, the current system encourages unre-

strained growth of providers, services, and spending. Rather than sensibly scaling payments to rehabilitation hospitals on the basis of patient services, payments from the Medicare Trust Fund simply increase as new hospitals and spending proliferate.

At the same time, however, TEFRA limits on payments per discharge create a serious imbalance between older and newer facilities. First, it provides inadequate payments to older hospitals—in most cases, far less than operating costs. Second, it pays much higher amounts, and even bonuses, to newer facilities.

And from a humanitarian standpoint, the current payment system is flawed because of a de facto bias against severely impaired patients. By giving the same financial value to all rehabilitation patients, TEFRA provides an incentive to treat short-stay and less complex cases over more seriously disabled patients who require a longer hospital stay.

As a result, this quick turnaround environment makes it very hard for facilities to take advantage of innovations in treatment programs. It is no exaggeration to say that many Medicare beneficiaries who need long-term rehabilitative care have been ill-served by the Medicare Program that has the obligation to treat them. TEFRA created these conditions and, if not reformed, they will continue.

I also believe it is no small matter when the agency set up to monitor the Medicare Program—the Prospective Payment Assessment Commission—advocates for this change in the TEFRA system.

Mr. Chairman, this is only a basic description of the problem. I do not want to go into too many details, because you have an excellent resource who is here today to testify on this issue. Richard Kathrins, the president of Betty Bachrach Rehabilitation Hospital in Pomona, New Jersey, which is in my congressional district, has been a valuable asset, both in identifying specific problems and in formulating an effective solution.

In the time remaining, Mr. Chairman, I would just like to talk briefly about H.R. 585, the legislation that I have introduced, that could go a long way toward ending the misuse of money occurring under the current rehabilitation hospital payment scheme. My bill makes the payment system for rehabilitation hospitals more cost effective. More importantly, it puts all hospitals—old and new—on a level playingfield.

Specifically, my bill directs the Secretary of Health and Human Services to implement a prospective payment system for the approximately 1,000 rehabilitation hospitals in the Nation by October 1, 1998. Under the PPS, providers are paid similar amounts for similar services. Payments made by Medicare would be determined by a patient's needs. That way, the system will reward innovation, and not penalize hospitals that treat the severely disabled. Finally, H.R. 585 would benefit the Medicare Trust Fund by eliminating incentives for duplicate services.

Mr. Chairman, I must also note that the RAND Corp., under contract from the Health Care Financing Administration, is now completing a comprehensive study on Medicare payments to rehabilitation hospitals. In addition to emphasizing the distortions of the current system, it is my understanding that RAND has designed a

model prospective payment system to replace TEFRA. When the report on this study is officially released, I would like to forward RAND's observations to your Subcommittee for your review and consideration. I would also like to offer any suggestions warranted by that report to amend H.R. 585.

Once again, Mr. Chairman, thank you for the opportunity to testify on this important piece of legislation and how it might fix some of the current problems facing rehabilitation hospitals. When it comes to restoring Medicare's financial health, I hope this is one issue that we can all agree on. Thank you very much, Mr. Chairman.

Chairman THOMAS. Thank you, Frank. Thank you for your legislation, and especially your understanding and willingness to be ready to amend it as new information emerges, in order to make it a vehicle that would be as responsive as possible to suggested changes in the area.

Mr. LOBIONDO. Yes. Thank you, Mr. Chairman. I look forward to working with you.

Chairman THOMAS. My pleasure. Any questions from any of the Members? No? Thank you very much, Frank.

Mr. LOBIONDO. Thank you.

Chairman THOMAS. Now I would call Barbara Wynn, who is the Acting Director of the Bureau of Policy Development at the Health Care Financing Administration; and Dr. Newhouse, Chairman of the Prospective Payment Assessment Commission; who will be accompanied, as usual, by Dr. Young, the Executive Director of ProPAC.

As usual, any testimony will be made a part of the record, and you can address us in any way you see fit. Why not start from right to left. Barbara, if you will begin? These microphones are very unidirectional, so you need to speak directly into the microphone.

Thank you very much.

STATEMENT OF BARBARA WYNN, ACTING DIRECTOR, BUREAU OF POLICY DEVELOPMENT, HEALTH CARE FINANCING ADMINISTRATION

Ms. WYNN. Good afternoon. My name is Barbara Wynn, and I am the Acting Director of the Bureau of Policy Development at the Health Care Financing Administration.

I am pleased to be here today to speak to you about Medicare proposals in the President's budget for hospitals that are excluded from the Prospective Payment System, or PPS. I would like to start by providing some background on the types of hospitals that are excluded from PPS and how they are paid. I will also discuss some of the shortcomings of the current payment system, and how the proposals in the President's budget would improve them. Finally, I will discuss HCFA long-term plans for reforming payments to rehabilitation and long-term care hospitals.

Since 1983, most hospitals have been paid under the inpatient prospective payment system. However, certain types of specialty hospitals and units are excluded from PPS because the PPS diagnosis-related groups do not accurately explain resource costs for these facilities.

Excluded facilities are paid in accordance with the Tax Equity and Fiscal Responsibility Act of 1982, or TEFRA. TEFRA facilities include rehabilitation, psychiatric, children's, cancer, and long-term care hospitals, rehabilitation and psychiatric hospital distinct part units, Christian Science sanatoria, and hospitals located outside the 50 States and Puerto Rico.

TEFRA facilities are paid on the basis of Medicare reasonable costs, up to a hospital's specific limit per discharge. Each hospital has a separate limit, or target rate, which was calculated using its cost per discharge in a base year. Hospitals whose costs are below their limit are entitled to bonus payments up to a maximum of 5 percent of the target amount. Hospitals whose costs exceed their target amounts are entitled to additional Medicare payments, to help cover their costs, up to 10 percent of the target amount. Hospitals that experience significant increase in resource-intensive patients may apply for additional Medicare exceptions payments.

There are 3,462 TEFRA facilities. Total Medicare expenditures for these facilities in fiscal year 1994 were $6.8 billion, which is 8.4 percent of Medicare expenditures for all inpatient hospital care. Medicare expenditures for postacute care provided in TEFRA facilities include $3.3 billion for rehabilitation hospitals and units and $473 million for long-term care hospitals.

By comparison, Medicare fiscal year 1994 expenditures for skilled nursing facility care were $6.9 billion, and for home-health agency services, $12.7 billion.

In recent years, the number of patients being transferred from PPS hospitals to TEFRA hospitals has increased rapidly. In addition, the number of discharges from TEFRA hospitals to other postacute care settings has increased, while the average length of stay in TEFRA facilities has declined. We believe these trends reflect a response by providers to incentives in the current payment systems.

In addition, the payment methodology creates an incentive for newly established hospitals to inflate base period costs in order to create a higher target rate or limit. Thus, the existing TEFRA payment methodology may give an unfair advantage to newer facilities with more recent base periods, in comparison to older TEFRA providers.

The President's fiscal year 1998 budget includes a variety of proposals that would help reduce the inequities and inappropriate incentives created by the current payment system, including:

Encouraging efficient provision of services by reducing the update factor for fiscal year 1998 through 2002 to market basket minus 1.5 percentage points, and reducing capital payments 15 percent;

Rebasing each TEFRA hospital's target rate by using more recent cost data, and limiting the target rates to not less than 70 percent, but not more than 150 percent, of a national mean rate for each type of hospital;

Reducing the incentive for new providers to maximize base-year costs, and by limiting the cost-based reimbursement for a new TEFRA provider to 150 percent of the national mean target amount for that type of provider;

Eliminating bonus payments in excess of hospitals' costs, and modifying the cost sharing formula for hospitals with costs in excess of that target amount;

Finally, maintaining a safety net for hospitals whose costs exceed 150 percent of their target amount, by providing after rebasing additional payments for significant changes in patient acuity.

The President's budget also includes a moratorium on the establishment of new long-term care hospitals. Under current law, the only characteristic these hospitals have in common is an average length of stay greater than 25 days. Patients in different long-term care hospitals receive services that are comparable to those provided by other types of providers, rehabilitation hospitals, psychiatric hospitals, and skilled nursing facilities that serve medically complex patients.

As we modify our payment systems for these provider types, we believe that newly certified facilities should be classified by the nature of the services they provide, rather than by their average length of stay. Otherwise, we will be establishing different methodologies for similar services and allowing facilities to choose the provider classification which will result in the most favorable payment. The moratorium would not affect any current providers.

Finally, the President's budget grants the Secretary authority to collect patient assessment data from all providers of postacute care. HCFA intends to use this data to continue developing an integrated payment system for postacute services. The integrated payment system for postacute services will address the rapid growth and postacute spending, and eliminate the incentive for providers to discharge patients from one setting to another based on payment considerations rather than an assessment of patient needs.

Currently, payments for the same clinical services vary depending upon treatment setting, and may create incentives that inappropriately affect treatment decisions. HCFA's long-term goal is to develop an integrated beneficiary-centered system of paying for postacute services that would avoid these inappropriate incentives.

The integrated system would encompass care provided in rehabilitation hospitals and units, long-term care hospitals, skilled nursing facilities, and agencies. Service delivery would be integrated through a core patient assessment tool, which would describe patient care needs and would be used to assess patients' functional status as they move across treatment settings. Payment would be integrated into a single system that would apply to the bundle of services the beneficiary needs. In addition, the integrated system would be site-neutral to avoid creating incentives to maximize reimbursement by treating patients in inappropriate settings.

HCFA has taken some of the initial steps toward our goal of developing an integrated payment system. For example, we are currently testing prospective payment systems for skilled nursing facilities and home-health services. Ultimately, these systems may form the basis of an integrated system. We are also looking at expanding the SNF Prospective Payment System to accommodate similar admissions in either rehabilitation or long-term care hospitals.

Although we have already put substantial thought and effort into the development of this system, its implementation would require

additional work. We still need to develop a core patient assessment instrument that can be used across various settings, and we need to develop a payment system that recognizes appropriate variations in cost. In addition, we need legislative authority to implement the system.

Our long-term goal of developing an integrated system represents a shift in thinking from previous years. For several years, we have been evaluating patient classification systems that could be used in a prospective payment system for rehabilitation hospitals and units. Most recently, we funded an evaluation by the RAND Corp. of a system known as Functional Related Groups, or FRGs, which is based on a coding system known as the functional independence measure, or FIM.

RAND has prepared a draft report that finds in general that this system provides a reasonable and feasible approach for classification of hospital inpatient rehabilitation services. However, considerable work would be needed before a prospective payment system can be implemented. For example, the technical advisory panel on the project questioned the reliability of the FIM and the breadth of the cognitive measures it includes.

In addition, RAND developed their model system based on data from a limited set of rehabilitation facilities that significantly underrepresents rehabilitation units. RAND also identified potential coding problems that could affect the validity of the payment system and undermine its effectiveness in controlling cost.

The limitations of the RAND FRG-based system probably could be resolved with careful analysis, additional data collection, refinement of the FIM descriptors, and training of coders. The question then is whether we should devote significant resources toward refining this system, rather than to the task of developing an integrated payment approach.

However, consistent with our current thinking about reforming payments to postacute care providers, we no longer believe that developing a separate prospective payment system for rehabilitation hospitals is the best approach. Patients needing rehabilitation services are treated in several different settings with similar outcomes. We do not believe it would be appropriate to establish individual payment systems for each type of setting. We are concerned that the different systems would create payment incentives that would influence clinical decisions about appropriate treatment settings for some patients.

For example, if we were to implement an episodic or per-discharge prospective payment system for rehabilitation hospitals such as the FRG system, rehabilitation facilities would have an incentive to discharge patients as quickly as possible and transfer them to other postacute settings, in order to maximize Medicare payments. We are also concerned that an episodic payment system, by creating incentives for early discharge, may not encourage optimum outcomes. The RAND study found a correlation between length of stay and improvement in functional status.

In order to avoid creating these incentives, we intend to develop an integrated postacute payment system that is based on the patients' service needs, rather than the type of provider furnishing the services. We are modifying the patient assessment instrument

used in the SNF demonstrations so that it can also be applied to the services furnished by rehabilitation facilities.

If we continue to develop a system that can be used across all postacute settings, we could be ready for implementation as early as 2002. We believe that the benefit of having a more comprehensive system where the incentives are in place to place the patient in the most appropriate setting, rather than where the payment is highest, is worth the additional wait. Without such a comprehensive system, the episodic prospective payment system for rehabilitation facilities will further encourage short lengths of stay and discharges to SNF facilities in order to maximize Medicare payment.

In summary, our immediate goal is to improve the tougher payment system through the reforms included in the President's budget. Our long-term goal is to create a beneficiary-centered payment system for postacute services that encourages appropriate care for patients regardless of setting in which they are treated, and that promotes quality, access, and continuity of care, while adequately controlling costs.

Thank you. I would be pleased to answer any questions you might have.

[The prepared statement follows:]

Statement of Barbara Wynn, Acting Director, Bureau of Policy Development, Health Care Financing Administration

Introduction

Good morning. My name is Barbara Wynn and I am the Acting Director of the Bureau of Policy Development at the Health Care Financing Administration, Department of Health and Human Services. I am pleased to be here today to speak to you about proposals included in the President's budget for hospitals and distinct-part hospital units that are excluded from the hospital inpatient prospective payment system (PPS). I would like to start by providing some background on the types of hospitals that are excluded from PPS, and how they are paid. I will also discuss some of the shortcomings of the current payment system for PPS excluded facilities, and how the Medicare proposals in the Administration's budget would improve this payment methodology and control spending growth. Finally, I will discuss HCFA's long-term plans for reforming payments to rehabilitation and long-term care hospitals by developing an integrated payment system for all post-acute care.

Background

Since October 1, 1983, most hospitals have been paid under the hospital inpatient prospective payment system (PPS). However, certain types of specialty hospitals and units are excluded from PPS because the PPS diagnosis related groups do not accurately account for the resource costs for the types of patients treated in those facilities. Facilities excluded from PPS include rehabilitation, psychiatric, children's, cancer, and long term care hospitals, rehabilitation and psychiatric hospital distinct part units, Christian Science sanatoriums, and hospitals located outside the 50 states and Puerto Rico. These providers continued to be paid according to Section 1886(b) of the Social Security Act, as amended by Section 101 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. They are frequently referred to as TEFRA facilities.

TEFRA facilities are paid on the basis of Medicare reasonable costs per case, limited by a hospital specific target amount per discharge. Each hospital has a separate payment limit or target amount which was calculated based on the hospital's cost per discharge in a base year. The base year target amount is adjusted annually by an update factor. Hospitals whose costs are below their target amount are entitled to bonus payments equal to half of the difference between costs and the target amount, up to a maximum of five percent of the target amount. Medicare also makes additional payments to hospitals whose costs exceed their target amounts. For these hospitals, Medicare pays bonus payments equal to half of the amount by which the hospitals costs exceed the target amount up to 10 percent of the target amount. Hospitals that experience significant increase in patient acuity may also apply for additional Medicare exceptions payments.

There are 3,462 TEFRA facilities, including 1,117 hospitals and 2,345 units. Currently, the TEFRA facilities certified for Medicare include:

- 1,063 rehabilitation facilities, of which 191 are hospitals and 872 are units;
- 2,112 psychiatric facilities, of which 639 are hospitals and 1,473 are units;
- 186 long term care hospitals;

- 70 children's hospitals;
- 9 cancer hospitals;
- 17 Christian Science sanatoriums: and
- 5 hospitals located in U.S. territories, including the Virgin Islands, American Samoa, Guam, and Saipan Mariana Island.

Total Medicare expenditures for TEFRA hospitals and units in FY 1994 were $6.8 billion, which is 8.4 percent of Medicare expenditures for all inpatient hospital care. Medicare expenditures for post acute care provided in TEFRA facilities include $3.3 billion for rehabilitation hospitals and units and $473 million for long term hospitals. By comparison, Medicare FY 1994 expenditures for skilled nursing home care were $6.97 billion and for home health agency services $12.7 billion.

Strengths and Weaknesses of the TEFRA Payment System

Since the inception of TEFRA, there have been changes in practice patterns that have weakened the effectiveness of TEFRA, and hindered its ability to control costs. First, since the implementation of PPS, more patients are being transferred to TEFRA hospitals and units. We believe this trend reflects a response by providers to the incentives in the current system. This increase in utilization of TEFRA facilities has fueled the rapid growth in TEFRA payments in recent years. In addition, the number of discharges from TEFRA facilities to other post-acute care settings has increased, while average length of stay in TEFRA facilities has declined. This also suggests an attempt by providers to maximize payments by discharging patients to other settings to avoid exceeding their TEFRA cost limits.

As the number of TEFRA discharges has increased, so has the number of new TEFRA facilities. The TEFRA per discharge target rate payment methodology creates an incentive for newly established TEFRA hospitals to inflate base period costs in order to create a higher target rate. Thus, base period costs for new TEFRA hospitals and units may not reflect the costs of efficient operations. In this way, the existing TEFRA payment methodology may give an unfair advantage to newer hospitals and units with more recent base periods, in comparison to older TEFRA providers.

The President's FY 1998 budget includes a variety of modifications that would help alleviate the inequities and inappropriate incentives created by the current TEFRA payment system, which I will discuss in more detail below.

Administration Legislative Proposals

We strongly believe that improvements must be made to the current TEFRA payment system. The President's FY 1998 budget includes several legislative proposals to strengthen the TEFRA payment system. These include:

- Encouraging efficient provision of services by

  - Reducing the update factor for FY 1998 through FY 2002 to the percentage increase in the excluded hospital market basket minus 1.5 percentage points, and

  - Reducing reasonable cost capital payments to PPS-exempt providers by 15 percent;

- Reducing the disparities between costs and payments for certain hospitals by rebasing every TEFRA hospital per case rate using costs from the facility's two most recent cost reporting periods, and then limiting the per case rates to not less than 70 percent but not more than 150 percent of a national mean rate for each type of hospital (e.g., separate means for psychiatric hospitals, rehabilitation hospitals, and the other types of facilities).

- Reducing the incentive for new providers to maximize base year costs, by limiting the cost based reimbursement for a new TEFRA provider to 150 percent of the national mean for that type of provider.

- Eliminating incentive payments for hospitals with costs below their target amount and modifying the cost sharing formula for hospitals with costs in excess of their target amount. Medicare will not make additional cost-sharing payments to providers whose costs are less than or equal to 110 percent of the target amount. Medicare will pay half of the excess costs, up to 20 percent of the target amount, for hospitals with costs between 110 and 150 percent of the target amount.

- Providing a safety net for hospitals whose costs exceed 150 percent of their target amount by providing, after rebasing, additional payments for significant changes in patient acuity.

In addition to these improvements to the current system, the President's budget would help control payments to TEFRA hospitals, curtailing the rapid increase in the establishment of new long term care hospitals by subjecting all new long-term care hospitals to Medicare's inpatient PPS. Under current law, the only characteristic long-term care hospitals have in common is an average length of stay greater than 25 days. Patients that are currently using long-term care hospitals are receiving services that are comparable to those provided by other types of providers: rehabilitation hospitals, psychiatric hospitals, and skilled nursing facilities that serve medically complex patients. As we modify our payment systems for these provider types, we believe that newly certified facilities should be classified by the nature of the services they provider rather than their average length of stay. Otherwise, we will be establishing different methodologies for similar services and allowing facilities to choose the provider classification which will result in the most favorable payment. The moratorium on exemption from the inpatient PPS would not affect any current providers.

Finally, the President's budget includes a provision granting the Secretary authority to

collect patient assessment data from all providers of post-acute care, including rehabilitation hospitals and units, and long term care hospitals. HCFA intends to use this data to continue developing an integrated payment system for post acute services.

Long Term Goal for Post Acute Services

Utilization of post-acute services has grown rapidly in recent years. As average length of stay in acute care hospitals has declined with the implementation of PPS, more and more patients are being discharged to post acute settings. In addition, we have found an increase in the number of transfers from one post acute setting to another. The current TEFRA payment system, which establishes payment limits on a per discharge basis and provides bonus payment to hospitals with costs below their target rate gives providers an incentive to move patients out of these hospitals quickly. A recent HCFA study found that the number of discharges from rehabilitation hospitals to SNFs increased by 48 percent from 1992 to 1994. In addition, average length of stay in rehabilitation hospitals has been declining in recent years, from 22.2 days in 1992 to 18.5 days in 1996.

To address the rapid growth in post acute spending and eliminate the financial incentive for providers to discharge patients from one post acute setting to another based on financial considerations rather than an assessment of patient needs, HCFA intends to develop a single, integrated payment system for all post-acute care services. Currently, the payment methodology for post-acute care depends on the treatment setting. In the existing fragmented system, payments for the same clinical services vary depending on the treatment setting. This variation in payments across settings may create incentives that inappropriately affect treatment decisions. HCFA's long term goal is to develop an integrated, beneficiary-centered system of paying for post-acute services that would avoid these inappropriate incentives.

To the extent our research confirms it is feasible and appropriate, the integrated post-acute care payment system would encompass care provided in rehabilitation hospitals and units, long-term care hospitals, skilled nursing facilities, and home health agencies. An integrated system must be able to promote quality of care, access to care, and continuity of care while controlling costs. Service delivery would be integrated through a core patient assessment tool, which would describe patient care needs and would be used to assess patients' functional status as they move across treatment settings. Payment would be integrated into a single payment system that would apply to the bundle of services the beneficiary needs. In addition, the integrated payment system should be site-neutral to avoid creating incentives to maximize reimbursement by treating patients in inappropriate settings. A site-neutral payment system may allow for variations in certain costs, such as room and board, among different types of providers. However, it would avoid influencing clinical decisions about the appropriate site of care by providing the same basic payment for the same treatment in different sites.

More work is necessary to develop and implement a reliable and equitable, integrated payment system for post-acute inpatient care. HCFA has taken some initial steps toward this

goal. For example, we are currently testing prospective payment systems for skilled nursing facilities and home health services. Ultimately, these systems may form the basis of the integrated system. HCFA is also exploring the possibility of expanding the SNF PPS to accommodate similar admissions in either rehabilitation or long term care hospitals.

HCFA would need legislative authority to implement an integrated payment system that would apply to post-acute services in SNFs, HHAs, long term care hospitals, rehabilitation hospitals and units, and other facilities. HCFA still needs to undertake development and assessment of a core patient assessment instrument with common elements that can be used across various treatment settings. An equitable payment system based on a single prospective rate or limit would have to allow for recognition of appropriate cost differences, due for example to geographical price differences, practice pattern variations, and other appropriate factors. Thus the cost data would be employed to determine a basic rate or payment limit structure, and to establish appropriate adjustments for cost variations within that structure and payment policies when multiple providers furnish services within the same episode of care. Decisions would also need to be made regarding recognition and payment for outlier cases. Thus, although HCFA has already put substantial thought and effort into the development of an integrated post-acute care payment system, implementation of such a system would require, at a minimum, several years of additional work.

PPS for Rehabilitation

HCFA's long term goal of developing an integrated payment system for post acute care represents a shift in thinking from previous years. For several years, HCFA has been researching possible patient classification systems for rehabilitation cases in order to implement a prospective payment system for rehabilitation hospitals and units. The most promising system we found was the Functional-Related Groups (FRGs) system developed by Margaret Stineman and colleagues at the University of Pennsylvania and SUNY-Buffalo. This system is based on a rehabilitation coding system known as the Functional Independence Measure (FIM), a scoring system developed and owned by Uniform Data System for Medical Rehabilitation (UDSMR) that measures the degree of functional independence in rehabilitation patients. Over a year ago, we contracted with the RAND Corporation to evaluate the FIM/FRG and the feasibility of a PPS-type system based on these measures. RAND has prepared a draft report that finds, in general, that this system provides a reasonable and feasible approach for classification of hospital inpatient rehabilitation services. However, considerable work would be needed before a PPS can be implemented.

For example, the Technical Advisory Panel on the project questioned the reliability of the FIM and the breadth of the cognitive measures it includes. Further analysis of the FIM would be needed before a system based on the FIM could be implemented. In addition, RAND developed their model system based on data from a limited sample of rehabilitation facilities, that significantly under-represents rehabilitation units. In fact, Medicare pays for nearly twice as many discharges from rehabilitation units as it does from freestanding rehabilitation hospitals. In order

to ensure that the system accurately predicts costs across all facilities, HCFA would need to collect data from all rehabilitation hospitals and units in order to determine appropriate payment weights. RAND also identified potential coding problems that could undermine the effectiveness of their PPS model at controlling costs. Uncorrected, these problems could lead to case-mix "creep" after implementation of an FRG-based PPS. RAND expanded the original FRGs to account for complications and comorbidities (CCs). Although rehabilitation facilities are supposed to code CCs on the Medicare bill, this information is not currently used for payment or any other purpose; therefore, it is likely to be subject to error. In fact, RAND found that the rehabilitation units recorded CCs in approximately 26% of cases, while freestanding facilities did in only 16% of cases. The high level of error in coding could lead to case-mix creep, which would threaten the validity of the payment system.

The limitations of the FRG-based system developed by RAND probably could be resolved with careful analysis, additional data collection, refinement of the FIM descriptors and training of coders. The question, then, is whether we should devote significant resources toward refining this system rather than to the task of developing an integrated payment approach. Our best estimate is that we could be ready to implement a FRG-based PPS in 2 ½ years after enactment of legislation. This time frame includes 6 months to develop the data elements and 2 years for data collection and development of the final system.

However, recent study findings have caused a shift in our thinking about methods for reforming payments to rehabilitation facilities, and we no longer believe that developing a separate PPS for rehabilitation hospitals is the best approach. Rehabilitation patients are treated in several different settings with similar outcomes. Therefore, we believe that an integrated post-acute payment system offers the best approach. If we were to establish individual payment systems for each type of setting, we are concerned that potentially different incentives inherent in each of the payment systems would influence clinical decisions about the appropriate treatment settings for some patients. For example, if we were to implement an episodic PPS for rehabilitation facilities (like the FIM/FRG system) and a per diem system for SNFs (as we proposed in the FY1998 President's budget), rehabilitation facilities would have an incentive to discharge patients as quickly as possible to a SNF. In that way, the rehabilitation hospital could collect the full Medicare payment, and the SNF could continue to bill Medicare on a per day basis. The incentive for maximizing Medicare payments in this way is even greater in cases where an acute care hospital owns both the rehabilitation unit and the SNF. Moreover, we are concerned that an episodic payment system for rehabilitation hospitals, by creating incentives for early discharge, may not encourage optimum outcomes. The RAND study, for example, found a correlation between length of stay and improvement in functional status.

In order to avoid creating these incentives, we would like to pay rehabilitation facilities as part of an integrated payment system for non-acute inpatient care, that is, a "service-specific" rather than a "provider-specific" system. HCFA has already taken initial steps toward development of the integrated payment system described above. For example, we have prospective payment demonstrations underway for both SNFs and HHAs, and are proposing

national implementation of PPS for SNFs (in FY1998) and HHAs (in FY2000) in the FY1998 President's budget. Currently, we are modifying the patient assessment instrument used in the SNF demonstration so it can also be applied to the services furnished by rehabilitation facilities. A single patient assessment instrument would give us a meaningful comparison of a patient's severity and functional limitations across settings. This will allow for better coordination of patient care as well as a consistent measure of case-mix.

If we continue to devote our effort to developing a system that can be used across all post-acute settings, we could be ready for implementation as early as 2002. We believe that the benefit of having a more comprehensive system where the incentives are to place the patient in the appropriate post-acute care setting rather than where the payment is more advantageous is worth the additional wait. Without such a comprehensive system, a per discharge FRG system for rehabilitation facilities will further encourage short lengths of stay and discharges to SNF facilities in order to maximize Medicare payment. In contrast, the integrated post acute payment system will reduce transfers of patients from one setting to another simply to maximize payments, and will ultimately, allow us to gain control of the rapid growth in post-acute care.

Conclusion

In summary, our immediate goal is to improve the TEFRA payment system through the reforms included in the President's budget. Our long-term goal is to create a beneficiary-centered system of post-acute services that promotes quality of care, access to care, and continuity of care while adequately controlling costs. Our preference is to seek legislation that allows us to establish an integrated post acute care payment system with a single core data assessment tool and patient classification system, and a coordinated set of payments that encourages appropriate care for patients regardless of the setting in which they are treated.

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Chairman THOMAS. And you are welcome. I know this is the first time you have appeared before the Subcommittee—and this is the Senate, not the House.

Ms. WYNN. Whoops.

Chairman THOMAS. This is the House, not the Senate. And you get one to a customer. So, I appreciate your testimony, Ms. Wynn. All of that was alluding to the fact that your staff should have briefed you that a 20-minute presentation was probably a little longer than we normally get when we have all of the written material and we have already read it.

Ms. WYNN. I appreciate your patience.

Chairman THOMAS. No, it is good stuff. I did read it.

Dr. Newhouse.

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

Mr. NEWHOUSE. Thank you very much, Mr. Chairman. It is a pleasure to be back with you and the other Members of the Subcommittee today. You have my written testimony, and I would just like to walk through four issues.

The first issue is our recommendation on the update factor; and two issues that Ms. Wynn mentioned, the new provider exemption and the so-called FIM–FRG system for rehabilitation hospitals; and finally, the long-term hospital-within-a-hospital issue.

On the update factor, our recommendation is the market basket minus eight-tenths of a percent. And that is pretty straightforward. The eight-tenths of a percent is our estimate of the error in the prior market basket. And we did not see any scientific and technological advance factor coming in; so hence, market basket minus the error from last year.

On the three policy issues, we agree with the administration on the incentive effects, or the poor incentive effects, of the new provider exemption. For new hospitals, the rate going forward is based on the second year of operation. You get your cost in the first 2 years of operation, so there is no incentive to hold down the cost. And in fact, there is an incentive to keep the costs high because your rates going forward are going to be based on that. So our recommendation is to simply do away with the new provider exemption. The Commission came out a bit differently than the administration there.

That leaves open the issue of how to handle the new providers. We would take some kind of average, or average within subgroup adjusted for local payment factors like wage indices.

The second issue is the functional independence measure, function related group system that Ms. Wynn mentioned, as well, the classification system for the rehabilitation hospitals and units. We came out a little differently than the administration here. We think this is just about ready for prime time, and we would urge going forward with it as soon as possible.

We are not opposed to—in fact, we favor—the integrated system, for the reasons that Ms. Wynn mentioned. But the real issue is what to do until we have the integrated system—that is, for the next 5 years, say—with the rehabilitation hospitals and the units. There are a thousand of these institutions. In 1994 they got $4 billion, as you noted in the opening statement, and the increase has been pretty rapid.

We think that the TEFRA system has gone on much longer than anyone anticipated in 1983, as you said in your opening statement. And this seems like a pretty good shot for getting a chunk of it out from under cost-based reimbursement and into prospective payment. And while there are some disadvantages to it that were mentioned, we think the advantages outweigh the disadvantages, and we would do it as an interim step until we have the integrated system.

Finally, the long-term hospital-within-a-hospital issue: As you know, we have separate payments for distinct part rehabilitation units and distinct part psychiatric units. We do not have separate payments for distinct part long-term units. And the reason is that the prospective payment system by its nature is supposed to average patients with different lengths of stay within the same DRG.

And we are concerned that if there were separate, in effect, units, which is how we see long-term hospitals within hospitals, that it would potentially violate the integrity of the overall prospective payment system for acute care hospitals. So we have urged that the issue of long-term hospitals within hospitals be intensively monitored, with a concern about whether it may be gamed against the Federal Government.

So thank you, Mr. Chairman. Those are the three issues I wanted to emphasize. And I will be happy to answer your questions.

[The prepared statement and attachments follow:]

Statement of Joseph P. Newhouse, Ph.D., Chairman, Prospective Payment Assessment Commission

Good afternoon, Mr. Chairman. I am Joseph Newhouse, Ph.D., Chairman of the Prospective Payment Assessment Commission (ProPAC). I am accompanied by Donald Young, M.D., the Commission's Executive Director. We are pleased to be here to discuss the Commission's recommendations to improve payment policies for rehabilitation facilities and long-term care hospitals. During my testimony, I will refer to several charts. These charts are appended to the end of my written testimony.

As you know, ProPAC has been concerned about the rapid growth in expenditures for post-acute care providers. Several weeks ago, we testified before this Subcommittee on the Commission's recommendations to reform payments for skilled nursing facilities and home health agencies. This afternoon, I would like to discuss our recommendations concerning two other post-acute care providers: rehabilitation facilities and long-term care hospitals. While qualification for Medicare payments to these facilities is not premised on a prior hospitalization, over two-thirds of their patients first receive care from an acute care hospital.

Rehabilitation hospitals and distinct-part units of general hospitals, as well as long-term care hospitals, are excluded from Medicare's Prospective Payment System (PPS). As I will discuss later in my testimony, long-term care units are not excluded from PPS. To qualify for exclusion, rehabilitation facilities must serve an inpatient population in which at least 75 percent of patients receive care for one of 10 specified conditions related to neurological and musculoskeletal problems and burns. These patients must require and receive at least three hours of physical or occupational therapy on a daily basis. Long-term care hospitals have an average inpatient length of stay that is longer than 25 days, and are not otherwise classified as rehabilitation or psychiatric hospitals.

Payments to rehabilitation facilities and long-term care hospitals have grown rapidly over the past several years. Between 1990 and 1994, payments to rehabilitation hospitals and units more than doubled, from $1.9 billion to $3.9 billion (see Chart 1). While Medicare payments to long-term care hospitals are comparatively small, they increased four-fold over the same period, from $200 million to $800 million, with annual increases of over 60 percent between 1992 and 1994 (see Chart 2).

This morning, I first will summarize the Commission's recommendations on Medicare payments to these providers. Afterwards, I will review our recommendation on new providers. Finally, I will briefly discuss the Commission's views on long-term care hospitals within hospitals. These recommendations are published in their entirety in our most recent *Report and Recommendations to the Congress*, which we released March 1.

TEFRA PAYMENT POLICY

Rehabilitation facilities and long-term care hospitals are paid in accordance with the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Payments for inpatient operating costs are based on each provider's Medicare-allowable inpatient costs compared to a facility-specific payment ceiling. The ceiling equals the number of Medicare discharges multiplied by a target amount. The target amount, in turn, equals the provider's allowable costs per discharge in a base year, trended to the current year by an update factor. The base year is 1982 for facilities that were in existence at that time, and the second full cost reporting period for hospitals that began operating after 1982. Providers that keep their costs below their ceiling receive their costs plus additional incentive payments. Facilities with costs above their ceiling receive the ceiling amount plus some additional payments to offset their losses up to a specified amount.

In specific situations, a provider with operating costs that are substantially higher than its payment ceiling may receive an additional amount, known as an exceptions payment. Because of data limitations, however, we do not know the

amount of payments received under the exceptions process. Medicare-allowable inpatient capital costs are paid in their entirety.

Prospective Payment Systems

When TEFRA was enacted, Mr. Chairman, it applied to all hospitals. The Congress intended it to be a temporary measure to slow hospital expenditure growth until a fully prospective payment system could be implemented. When PPS was implemented, however, specialty providers--which included rehabilitation facilities and long-term care hospitals, as well as psychiatric facilities, and childrens' and, subsequently, cancer hospitals--were excluded primarily because diagnosis-related groups (DRGs) used for acute care hospitals did not predict these facilities' resource costs accurately. The Congress expected that a separate prospective payment system would be implemented for these providers shortly after PPS. Such systems have yet to be implemented, however.

Mr. Chairman, the TEFRA payment system must be replaced as soon as possible. It has failed to curb rising expenditures. In addition, it has led to payment disparities across providers. This is because of the use of facility-specific historical costs to set target amounts. Providers that may have been more efficient in their base year, as reflected in relatively low costs per case, have a low target amount and, consequently, receive lower payments. These providers face more difficulty in keeping their costs below their ceiling, and they are less likely to receive incentive payments. Moreover, because the update mechanism does not account for changes in case mix or treatment patterns for individual facilities, these and all providers are more likely to incur losses if they treat a patient population that is more complex than the population they treated in their base year.

Providers that had relatively high costs per case in their base year have a greater opportunity to keep their costs below their payment ceiling. These providers receive their full costs plus incentive payments. This is especially true for new providers because they can be exempt from payment ceilings for up to their first three years of operation. To the extent they allow their initial costs to be unusually high, new providers can establish target amounts that are higher than their future costs and, therefore, receive higher payments than their similar but older counterparts.

A ProPAC analysis of 1993 data showed that long-term hospitals that were first subject to TEFRA in 1989 or earlier performed much worse financially than more recent hospitals (see Chart 3). As a group, these hospitals had an average payment-to-cost ratio of 0.85, compared to 1.06 for hospitals that came under TEFRA between 1990 and 1992, and 1.04 for hospitals first subject to TEFRA in 1993. While they are not the subject of this hearing, psychiatric hospitals and distinct-part units, also showed similar trends. Rehabilitation facilities, however, tended to perform well financially, on average, regardless of when they entered the system.

The Commission recommends that prospective payment systems for rehabilitation facilities and long-term care hospitals be implemented as soon as possible. Such systems would move away from cost-based payments and encourage providers to furnish care efficiently. In addition, as you know, we have recommended prospective payment systems for skilled nursing facilities and home health agencies. To the extent post-acute providers furnish similar services, prospective payment systems are necessary to offset the incentive to shift services among providers based upon their payment system.

A primary component of a prospective payment system is an adequate patient classification system, which is used to adjust payments to reflect patients' resource needs. As a result, facilities that treated more complex patients would not be underpaid, and facilities that treated less complex patients would not be overpaid. I would like to take a moment to discuss issues related to a case-mix system for rehabilitation facilities, and then for long-term care hospitals.

Rehabilitation Facilities--Research on a case-mix classification system for rehabilitation facilities is the most advanced among the PPS-excluded facilities. This system is known as the "functional independence measure-function related groups" (FIM-FRGs). It assigns patients to groups primarily on the basis of functional status, though diagnosis and age also are determinants. A recent evaluation of this system indicated that FIM-FRGs may be effective predictors of resource use among rehabilitation patients and that they could be an adequate basis for prospective payment.

Long-Term Care Hospitals--A case-mix measure for long-term care hospitals has yet to be developed. Assigning this research a lower priority than the other case-mix systems may be appropriate given Medicare's lower expenditures for these services. On the other hand, long-term hospitals as a group appear to be more heterogeneous than other providers. This may be due in part because the only qualification criteria is an average length of stay greater than 25 days. Consequently, a prospective payment system that distinguishes providers based on their case-mix may be more necessary for this group than others.

Modifying The TEFRA Payment Method

To the extent that the TEFRA system will remain in place until prospective payment systems for PPS-excluded providers are implemented, the Commission recommends that the Congress consider modifying it to ameliorate the payment disparities that exist between old and new providers. This could be done in one of several ways. For example, target amounts could be rebased to reflect more recent cost data. This would account for differential changes in patient complexity, treatment patterns, or input price differences. This method, however, also could penalize hospitals that had constrained their costs over time by rebasing to lower target amounts. To the extent that the target amounts were based on inflated initial costs, though, reducing these amounts would be appropriate. The Medicare regulations permit HCFA to establish new target amounts for providers that demonstrate specific circumstances, although we understand that this authority has been rarely invoked to date.

Other options that would help lessen the payment disparity include applying floor and ceiling limits to individual providers' target amounts. This would narrow the payment gap by bringing hospitals at either end of the range closer to the average. Because we do not have adequate patient classification systems, however, hospitals that have higher costs because they treat a sicker population could be disadvantaged.

Another option would be to have differential updates to recognize that all hospitals and units do not face identical cost increases. The updates to the TEFRA target amounts in fiscal years 1994 through 1997 were based, in part, on facilities' prior financial performance. Overall, the updates during this period ranged from the projected increase in the PPS-excluded facility market basket index to the market based increase minus 1.0 percentage point. Under current law, however, the PPS-excluded update for fiscal year 1998 and beyond is a single national percentage. Reinstituting a differential update process may be appropriate to recognize appropriate cost differences across providers.

TEFRA Payment Update

ProPAC is mandated by law to recommend an appropriate update for the TEFRA target amounts. Our update recommendation is based on a framework that incorporates the forecasted increase in HCFA's PPS-excluded market basket, an adjustment for differences between HCFA's and ProPAC's market basket, a correction for past forecasting errors, and cost increases resulting from scientific and technological advances.

HCFA's current projected market basket increase is 2.8 percent. Our framework reduces this amount by 0.1 percentage points because we believe HCFA's

market basket does not adequately reflect the labor characteristics of the hospital market, and by 0.7 percentage points to account for the fiscal year 1996 forecast error. No adjustment was made for science and technology because the Commission believes that new technologies will not substantially increase PPS-excluded facilities' costs. Based on this update framework, the Commission believes that the target amounts should be increased by an average of 2.0 percent in fiscal year 1998. This amount would allow facilities to continue to provide quality care to Medicare beneficiaries.

ELIMINATING THE NEW PROVIDER EXEMPTION

Mr. Chairman, the Commission believes that the initial exemption period for new rehabilitation facilities and long-term care hospitals should be eliminated. In fact, the Commission recommends eliminating the new provider exemption for all PPS-excluded providers.

As I have described, under the current payment systems new rehabilitation and long-term care hospitals are exempt from the TEFRA payment ceilings for up to three years; new rehabilitation units are exempt for one year. During this period, these providers receive full cost reimbursement for all the services they provide, subject only to meeting Medicare's definition of reasonableness. Because no limits are applied during the exemption period, providers have no incentive to avoid high costs during this period. Moreover, they have an incentive to incur higher costs because their future payment ceilings are based on their costs per discharge in their base year which, for hospitals, is their second full cost reporting year. Under this method, high base-year costs translate into higher target amounts, which result in more payments in subsequent years.

New provider exemptions have contributed to rising expenditures and have helped to fuel rapid growth in the number of these facilities. Between 1990 and 1996, the number of rehabilitation facilities increased 29 percent and the number of long-term care hospitals more than doubled (see Chart 4).

The Commission recommends that payments to new rehabilitation facilities and long-term care hospitals during their start-up periods should be limited, based on an average target amount for comparable groups of providers. In addition, we believe that new providers' base year target amounts should be likewise limited so that they do not have an incentive to inflate their base year costs per discharge to receive higher payments in subsequent years.

There are several options for determining appropriate limits, for both the start-up period and for establishing the base year target amounts. They could be calculated using data from all providers within a group, such as rehabilitation hospitals. Alternatively, the limits could be based on the cost experience of subsets of providers. The criteria for setting such groups could be predicated on provider characteristics such as age, geographic location, or size. A better option would be to identify groups based on the types of patients they treat but, as I have discussed, such comparisons would require additional information.

LONG-TERM CARE HOSPITALS WITHIN HOSPITALS

Finally, Mr. Chairman, I would like to take a moment to briefly discuss an issue specific to long-term care hospitals. This is the emergence of facilities known as "hospitals within hospitals." As you know, hospitals qualify for long-term care status, and are therefore excluded from the PPS system, if their average length of stay is longer than 25 days. Unlike rehabilitation facilities, the Medicare statute specifically does not recognize long-term care units.

PPS presumes that some of a hospital's patients will cost more to treat than its payment rate while other cost less, but that in the aggregate, payments and costs will be about equal. Long-term hospitals are exempted from PPS because they risk systematic underpayment under PPS because most, if not all, of their cases are long-

stay cases who cost considerably more than the average. This rationale does not apply to long-term care units, however, because the costs associated with their long-stay cases are intended to be offset by shorter stay cases in the rest of the hospital.

The "hospital within a hospital" model has emerged because long-term care hospitals are reimbursed separately under Medicare, but long-term care units are not. These entities are housed within another hospital or are on the same campus as another hospital. To ensure they are distinct and separate entities, HCFA requires that they have a governing body and management staff that are separate from the host hospital, and meet other requirements.

Some policymakers have expressed concern that these entities were designed as a way for acute care hospitals to ensure higher payments for long-stay cases, thus undermining the incentives of PPS. The Commission recommends that the growth in hospitals within hospitals be closely monitored to determine if recognizing these entities for payment purposes is appropriate policy.

CONCLUSION

The Commission believes that important reforms are needed in the payment methods for rehabilitation hospitals and units and long-term care hospitals. We have suggested some interim reforms until prospective payment systems can be implemented.

This concludes my formal statement, Mr. Chairman. I would be pleased to answer any questions you or other members of the Subcommittee may have.

Chart 1. Medicare Rehabilitation Facility Payments and Discharges, 1990-1994

Year	Payments* (In Billions)	Discharges (In Thousands)
1990	$1.9	172
1991	2.4	207
1992	3.1	234
1993	3.7	262
1994	3.9	288
Average Annual Increase	19.7%	13.8%

* Reflects program and beneficiary payments.

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

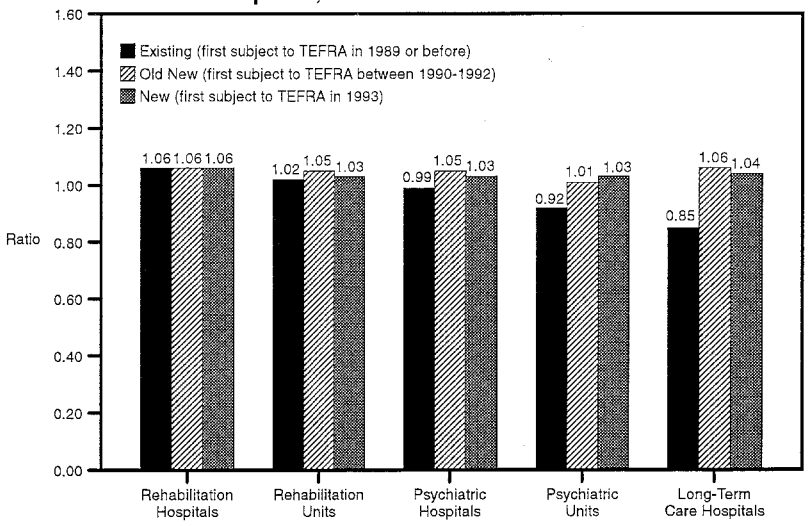
Chart 2. Medicare Long-Term Care Facility Payments and Discharges, 1990-1994

Year	Payments* (In Billions)	Discharges (In Thousands)
1990	$0.2	17
1991	0.2	19
1992	0.3	21
1993	0.5	27
1994	0.8	36
Average Annual Increase	41.4%	20.6%

* Reflects program and beneficiary payments.

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Chart 3. Medicare Payment to Cost Ratios for Rehabilitation and Psychiatric Facilities, and Long-Term Care Hospitals, 1993



SOURCE: Health Care Financing Administration.

Chart 4. Medicare-Certified Rehabilitation Hospitals and Units and Long-Term Care Hospitals, 1990-1996

Provider Type	1990	1991	1992	1993	1994	1995	1996	Percent Increase 1990-1996
Rehabilitation	813	852	923	980	1,019	1,029	1,048	28.9%
Hospitals	135	152	164	184	195	196	189	40.0
Units	678	700	759	796	824	833	859	26.7
Long-Term Care Hospitals	90	91	102	115	146	176	185	105.6

SOURCE: Health Care Financing Administration, Office of Survey and Certification.

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Chairman THOMAS. Thank you very much.

Ms. Wynn, I guess our concerns are fairly similar. As I outlined, you have got something that was created as a temporary patch in 1983. Your testimony is basically talking about a perfect system somewhere in the future, and I am looking at the time that has already expired.

And I notice in your testimony you say, "Hospitals that experience significant increase in patient acuity may also apply for additional Medicare exception payments." And it is my understanding that the period covering 1990–1992 produced 68 percent of the rehabilitation facilities receiving exceptions of payments totaling $4.8 million. And during the same period, 58 percent of long-term care hospitals received exceptions payments totaling 5.1.

I believe those are accurate figures, and both of them represent significantly over a majority of the facilities. Now, at what point do you decide that making exception payments for more than a majority of the facilities means you have got to move to something else?

Ms. WYNN. Right. Your point is well taken. And the reason, in essence, that we are proposing the rebasing is to remove the disparity between the costs and payments that currently exist for the TEFRA providers. And we really see that as an interim measure, so that the target amounts will reflect what their current cost and case mix is.

Chairman THOMAS. But if you are making that many exceptions to try to keep TEFRA afloat in an equitable way, and it is a temporary structure, why does the administration not buy Dr. Newhouse's recommendation of taking the other structure—which clearly has some flaws—which has got to be at least as good as a 60-plus percent exception procedure on a yearly basis?

Ms. WYNN. Well, the rebasing will eliminate the need for most exceptions.

Chairman THOMAS. And when are we going to do this?

Ms. WYNN. This would be in fiscal year 1998.

Chairman THOMAS. Right.

Ms. WYNN. So, it would be accomplished immediately.

Chairman THOMAS. And it will not have any additional need for adjustments clear through 2002 when your new program is online?

Ms. WYNN. We would still retain a safety net for any hospital whose costs ended up being 150 percent above its rebased target amount. And there may be a need for an adjustment at that point.

Chairman THOMAS. So, you are just going to take a deep breath and continue doing what you have been doing, is basically what you are saying?

Ms. WYNN. Well, we see it as an interim measure. And I think the problem that we have is that, both on policy grounds and on more practical grounds, we do not feel that moving to the FRG system would be appropriate. And in terms of policy, there were really three things that are guiding that.

One is the belief that with patients receiving similar services payments should be similar for those patients; and that there is a significant overlap in the services that are received by patients in skilled nursing facilities, rehabilitation facilities.

Chairman THOMAS. That's right. And this is to be utilized on an interim basis?

Ms. WYNN. Right. The rebased system.

Chairman THOMAS. I Understand. And we have had TEFRA for 15 years?

Ms. WYNN. Yes, we have.

Chairman THOMAS. And that has basically been an interim basis, a temporary structure?

Ms. WYNN. That was the original intent of it, that it would be an interim system.

Chairman THOMAS. What has HCFA been doing for 15 years, if what you have now offered is an interim adjustment for the interim proposal?

Ms. WYNN. We have been really hampered by the lack of an adequate case mix classification system. And it is not just a matter of having the resources to develop the classification system itself. It is a matter of whether there is data available on which that system could be developed.

Chairman THOMAS. And you are now confident that you have that data?

Ms. WYNN. Well, the system that the FRGs are based on, the FIM, is a proprietary system operated by UDS out of the University of Buffalo. We had to enter into a protracted negotiation process with them to get access to that data. The data base itself represents only 30 percent of the rehabilitation hospitals.

Chairman THOMAS. I understand.

Ms. WYNN. That means that 70 percent are not using that data base.

Chairman THOMAS. I understand, but what have you been doing for 15 years, is the point. In your testimony you talk about a core patient assessment instrument. Obviously, that is what you are talking about. You are going to need that. When is it going to be developed?

Ms. WYNN. We believe that we could develop a core patient assessment instrument that would work across all of the postacute settings within about 18 months.

Chairman THOMAS. I am trying to understand the event that occurred between 1982 and your testimony that now allows you to tell me that you can get a measurement instrument in 18 months that we have not been able to do for the past 15 years.

Ms. WYNN. Well, the reason why we can is that we have explicit statutory authority to collect the patient assessment data for skilled nursing facilities.

Chairman THOMAS. Oh, it has been Congress' fault? Is that it? Over the 15 years we were not able to communicate that you needed statutory approval to collect this data? When was that given to you?

Ms. WYNN. The skilled nursing facility, the MDS? I am not sure what year.

Chairman THOMAS. The statutory power to collect the data you were unable to collect before.

Ms. WYNN. We do not have statutory authority yet——

Chairman THOMAS. Oh.

Ms. WYNN [continuing]. To collect the data to develop a functional status measure for rehabilitation hospitals, to actually implement and collect that data. That is why we are using this proprietary system.

Chairman THOMAS. Are you asking for statutory power now to do it?

Ms. WYNN. Yes, we are.

Chairman THOMAS. What is the vehicle for that request?

Ms. WYNN. It is in the President's budget proposal.

Chairman THOMAS. And in the first term of the Clinton administration, was it in the budget?

Ms. WYNN. I am not certain, sir.

Chairman THOMAS. I am trying to figure out when in this 15-year period we discovered that we needed the statutory authority to collect the data to get off of a temporary system which has been patched up in a way that 68 percent of the units are affected by an exception rule.

My problem is, I am listening to Dr. Newhouse and the Commission that advises us, and they are telling us we have got a plan that is a whole lot better than what we have currently. And our decision will be: Do we go ahead with the plan that is better than what we have got; or do we accept your argument that if we buy a moratorium within 18 months you are going to generate a data base that has not been there because of statutory limitations for 15 years, and by the year 2002 you will be able to provide us with a complete structure for reorganizing?

Ms. WYNN. It is possible that we may actually be able to expand the SNF PPS system to include rehabilitation and long-term care hospitals prior to 2002. That may prove to be something that would be feasible. The entire integrated system that would also include home-health agencies, we do not believe would be possible before 2002.

Chairman THOMAS. Dr. Newhouse, what are the advantages if we take this other position, if we tell you that you have told us your system is imperfect, theirs is imperfect. What are the advantages? Is it that we are going to get a perfect system? And in terms of the time that we have already spent, is it worth the hope that

in fact it will occur over the next 18 months to 5 years, if it has not in the last 15?

I think it is a loaded question, but I tried not to make it that way.

Mr. NEWHOUSE. Right. I understand. HCFA has been laboring under resource constraints in developing these systems. But we are where we are, and we are confronted with what is the best way to go forward from here. I think the problem is well recognized, that the TEFRA system gives inappropriate incentives. There is no perfect answer here that is perfectly defensible. Our judgment on the Commission was that it was better to, as I said, move toward prospective payment for this part of the TEFRA set of hospitals and units.

Chairman THOMAS. Let me ask you a question that I know you have not anticipated. And you may not have the answer to it, and I obviously do not, and that is why I am asking it.

In terms of the exception process—and I understand, using a temporary device you have got to make adjustments. But I would think at some point, as the exceptions grew—unless from day one the exceptions were more than 50 percent on the payment adjustments—at some point you saw those exceptions growing. When they reached 68 percent in terms of utilizing the exception procedure to try to create some degree of fairness within the payment structure, somebody should have said, "Maybe we need to revisit this."

Has it been a rapid growth of exceptions, do we know? Are any of your resource people aware? Has this crept up in the last couple of years, or are we looking at a pretty steady increase? Or did they jump up in 1985–1987, and we have simply done this as an adjustment on the TEFRA mechanism for 15 or 12 or 10 years?

Mr. NEWHOUSE. I do not know.

Ms. WYNN. The general trend was for a number of years an increasing number of exceptions as hospitals were under their TEFRA limits longer. Now, however, a number of hospitals that had needed exceptions, no longer do, because they have made such significant reductions in their average length of stay. So that now I believe more than half of rehabilitation hospitals are earning bonus payments.

Chairman THOMAS. Well, that is another problem. You got into bonus payments versus exceptions, so you are going to win either way.

Dr. Young, I know that you want to answer this question. And it is more appropriate, I think, that you should answer it, because it comes out of the March 1997 report which, although Dr. Newhouse deals with a lot, you are kind of primarily responsible for.

I have noticed in the testimony from the Long Term Acute Care Hospital Association there are several statements from your March 1997 report, and I want to know if you want to clarify whether your Commission's findings indicate that there are two distinct groups of long-term care hospitals and that Medicare payments should reflect this division. Is that what your report said?

Dr. YOUNG. No, it is not. We do not believe that there is evidence that there are two distinct groups of hospitals. There is a contin-

uum when you array long-term care hospitals. At one end of that continuum are low-cost hospitals; at the other end of that continuum are high-cost hospitals.

Even for the high-cost hospitals, however, we cannot separate out how much of that cost is due to differences in their mix of patients, and how much of those higher costs are due to Medicare's very generous policies in regard to setting the base-year payment rate.

Chairman THOMAS. Thank you. Does the gentleman from Maryland wish to inquire?

Mr. CARDIN. Thank you, Mr. Chairman. Let me concur with your comment that it is difficult to understand why we have not made more progress to moving toward a PPS system for the TEFRA facilities. Dr. Newhouse, if I understand your testimony, you believe we can make more rapid progress than Ms. Wynn believes.

I would just encourage us to try to move this process more rapidly. I think 15 years is too long, and that we could start to make progress more quickly than HCFA has indicated today, and I look forward to trying to develop some recommendations to reflect that.

Part of my concern is that when you have two different systems, when you have a person who is admitted to a hospital under a DRG system, that there is a tendency to early discharge that person into a TEFRA hospital and double dip and get that paid on a cost basis. Whereas, if we had a prospective payment system we could deal with that issue in a more straightforward way.

I am curious as to whether the double dipping problem is a serious problem? Have either ProPAC or HCFA reviewed whether there are opportunities here for cost savings by avoiding that type of an abuse of the system.

Mr. NEWHOUSE. Well, we know that as the acute care length of stay has fallen in recent years, the postacute side, of which the rehabs are part, has exploded. And while there may be some other reasons for that, like chronic long-term use on home health, we think there is a link between the financial incentives under prospective payment and the piece that is kind of out from under prospective payment; namely, the excluded hospitals and units.

Mr. CARDIN. Is there an effective way to deal with that under the current system where you have one cost-based and the other under PPS?

Mr. NEWHOUSE. Well, you have put your finger on the problem. And we think, as we have testified before, there are some short-term fixes you can do on the SNF and home health side, although they will not solve this underlying macroincentive-type problem. But this is why we would at least try to make the playingfield more level between the acute hospital and the rehabilitation hospital and unit as soon as possible.

Now, that still leaves unbalanced now the acute care hospital and the rehabilitation side with the rest of the postacute side, as Ms. Wynn mentioned. And that is the down side of doing that. But we are going to have some imbalance here. The issue is kind of where to have the scales tip.

Ms. WYNN. If I may, I think that that is one of our areas of concern, that the prospective payment system that we are developing for SNFs is on a per diem basis, and the FRG system is on a per discharge basis. So the same kind of incentive that you currently

have from the acute care hospital to discharge patients rapidly to postacute services—We may well be creating the same kind of incentive to rapidly discharge patients from a rehabilitation hospital to a skilled nursing facility or for home health.

We are already seeing some indications of that. For instance, between 1992 and 1994 there was a 27-percent increase in the number of cases that had both rehabilitation care and home-health care, and there was a 48-percent increase in the number of cases that had both rehabilitation hospital care and SNF care. The number of cases that had only rehabilitation hospital care, however, remained absolutely flat.

Mr. CARDIN. And I appreciate the difficulty of dealing with this under the current system. It is just another reason to move along faster to a system that would be more accountable.

Ms. WYNN. Right. One other point on that, if I may. There is still considerable practical implementation work that would be needed for the FRG system. Seventy percent of the hospitals——

Mr. CARDIN. I hate to interrupt, but you are always going to have those problems. I understand that. Any time we implement a new system, there are going to be problems, and we are going to have to make adjustments after we have gotten into it because we do not get it perfectly right the first time.

Ms. WYNN. Right.

Mr. CARDIN. We understand that.

Ms. WYNN. Right.

Mr. CARDIN. But unless we start to move more aggressively, we will be talking about this 5 years from now, or 10 years from now.

Ms. WYNN. Right. This implementation is not actually in refining the payment system; it is coding and training the coders to use the coding system. In other words, it is a system that has not been used by 70 percent of the hospitals, and their coders would need to be trained, tested for reliability, and we would have to have some confidence in that.

Mr. CARDIN. Thank you, Mr. Chairman.

Chairman THOMAS. The gentleman is welcome.

Does the gentleman from Louisiana wish to inquire?

Mr. MCCRERY. Thank you, Mr. Chairman. It is frustrating, not only because it has been so long and we keep waiting for some formula to come out that will solve all these problems. But it is also frustrating because I know, after not very much experience with the Medicare system on this Subcommittee, that whatever we come up with will have problems; it will not be perfect; it will not work for very long; and we will have to come up with some new formula or some adjustments to it. I mean, it is like trying to squeeze the balloon and keep it from getting out of shape as you squeeze it.

Ms. WYNN. That is right.

Mr. MCCRERY. It is just impossible. So, I am just frustrated. I have made this speech before, and a lot of you already know what I am thinking. I am just frustrated with the whole system of trying to manage a marketplace, when we are actually creating the marketplace. And I am not smart enough to do that, and I do not think government—I do not think anybody on this Subcommittee and the whole Congress put together is smart enough to do that. And we just keep creating things for entrepreneurs to chase, and that does

not necessarily reflect what the market is, or should be. So, I am just frustrated with the whole thing.

I am willing to keep playing this game but, dad-gum, I am getting tired of it. And I long for the day when maybe we will say, "Enough is enough," and maybe we will go to some sort of defined contribution plan where there is really an opportunity for the market to take shape as consumers want it to take shape, and not as we policymakers direct it. Thank you.

Chairman THOMAS. If anyone feels moved, they can respond. My assumption is, that was a statement.

Mr. MCCRERY. It does not require a response.

Chairman THOMAS. It does not require one.

Does the gentlewoman from Connecticut wish to inquire?

Mrs. JOHNSON. Thank you, Mr. Chairman. And thank you for your testimony.

The Chairman has mentioned that more than 60 percent of the institutions, I gather, get exception payments. And what I want to ask—and you may not know this. But you know, in 1989, we very, very clearly gave the Secretary the power to make adjustments, to rebase, to adjust up or down. So, there should not really be this enormous disparity in the system, given the authority that the Secretary has to decrease target rates or assign new more representative base periods to hospitals whose payments are distorted.

But given that disparity, do you know any instances in which the Secretary has exercised this authority? And if not, why not?

Ms. WYNN. We did implement that authority through regulation, and we have done some rebasing. I do not have the numbers that I can provide.

Mrs. JOHNSON. So you have implemented that authority. I would be interested in knowing, did you implement it in 1989? I do not expect you can answer this right now, Ms. Wynn, but did you implement it in 1989? And how many instances of rebasing or in how many instances have you exercised that? Presumably, if you had not exercised that then the more than 60 percent figure would be higher.

Ms. WYNN. I will need to provide that for the record.

Mrs. JOHNSON. Yes, I would like to do that, because I know I have worked with a hospital that has tried for years to get rebased, is based on 1982, but has managed to keep up with technology. Not only does the current system provide incentives for new hospitals to come in at the highest possible cost, but we give them reimbursements; and then we look at these institutions that were based earlier and we expect them somehow to meet the current quality standard of care without any accommodation in their rate for the cost of the new technology and so on and so forth.

Ms. WYNN. Right. That is why the President's proposal is for an across-the-board rebasing, to address both of those issues.

Mrs. JOHNSON. Yes, the problem is, of course, that when you have institutions that were based in 1982, to suggest that in 1997 we now wait until 2002 to fix this is really not tolerable. Because the costs already are really so distorted and the problems are so severe we are in danger of losing our lowest cost high-quality facilities, because the newer facilities at high reimbursement rates are going to find it easier to survive in the competitive environment of

the future, buying new technology and stuff, than the lower based facilities.

So, I really do want to know in how many instances the administration has exercised the authority that it was given, and whether the changes have been down or up in terms of rates, and what effect this has had on the overall picture.

[The following was subsequently received:]

Q: If over 72% of hospitals get exceptions, why wasn't it done in 1989 when we gave the DHHS Secretary power to adjust and rebase hospitals? Did the Secretary exercise his authority? How many hospitals were rebased?

A: Our records do not indicate that 72 percent of TEFRA hospitals are receiving exceptions. Of the 3462 TEFRA hospitals and units, relatively few request exceptions. The actual number is difficult to determine since many requests are made by hospitals for multiple years. However, we can report that 516 exception requests were processed by HCFA's fiscal intermediaries in 1996. Those 516 exceptions include multiple year requests and each year is counted separately. While we cannot at this time determine the precise number of exceptions granted to TEFRA hospitals, we know that it cannot be even close to 72 percent. In fact, only 41 percent of those hospitals even exceeded their limits.

We have only rebased 4 hospitals (see attachment). These 4 hospitals received redesignations to new base periods because their original base periods had become egregiously unrepresentative of their current operating costs, and we did not believe that the more targeted exception payment process could address their situations. Two of the rebased hospitals were State-run psychiatric facilities, which had extreme problems resulting from treating patients who courts ordered admitted instead of being sent to jail. These special cases contributed to their extreme problems in controlling costs.

Although we have the statutory authority to rebase a hospital's TEFRA target, we are reluctant to rebase low target rate hospitals in an upward direction without also rebasing hospitals with high target rates downward. Since we realize that the only requests for rebasing would be from those that anticipated an increase, we have been very stringent with respect to rebasing target amounts, allowing rebasing in only a few extreme situations.

Standards for Rebasing: HCFA assigns a new base period to a TEFRA hospital or unit if it determines that the original base period is no longer representative of the reasonable and necessary operating costs of the provider's inpatient services.

The criteria to justify a new base period are:

- The costs are reasonable and justified, and they exceed the provider's ceiling;
- The provider has experienced a permanent, substantial, and significant change in the nature of medically necessary services provided since its base period;
- The cost reporting period begins on or after April 1, 1990; and
- The relief provided in the HCFA adjustment process is not adequate.

This does not mean that financial difficulties or the inability of a hospital (or unit) to keep within its target amount are automatic grounds for an assignment of a new base period. In most cases, if a hospital has exceeded its target amount in a cost reporting period, HCFA may authorize a payment adjustment if the hospital can adequately document its reasons as provided in instructions. Therefore, since the adjustment mechanism addresses most situations where there is a distortion between the base year and the current period, the circumstances under which HCFA assigns a new base period are limited.

I trust that these responses adequately address your questions. Please do not hesitate to call me if you have further questions or concerns.

PROVIDERS REBASED SINCE 1985

Provider Name	Provider Number	Type of Provider	Rebase Year
Touro Hospital New Orleans, LA	19-S046	Rehabilitation distinct part unit	1985
Lake Erie Institute of Rehabilitation Erie, PA	39-3046	Rehabilitation hospital	1985
Crafts-Farrow State Hospital Columbia, SC	42-4001	Psychiatric hospital	1988
Rusk State Hospital Rusk, TX	45-4009	Psychiatric hospital	1989

—

Mrs. JOHNSON. Dr. Newhouse, do you have any comment on this authority that they have had and their, I think, probably, failure to exercise it?

Mr. NEWHOUSE. I am not aware of the data on how frequently it has been exercised. You clearly have the data on the amount of exceptions.

Chairman THOMAS. Will the gentlewoman yield?

Mrs. JOHNSON. Yes.

Chairman THOMAS. I have got in front of me the Omnibus Budget Reconciliation Act of 1990 conference report. And it says:

> Development of national prospective payment rates for current non-PPS hospitals: The Secretary of Health and Human Services shall develop a proposal to modify the current system under which hospitals that are not Subsection D, non-PPS, of the Social Security Act receive payment,

and so forth.

> Reports: By not later than April 1, 1992, the Secretary shall submit the proposal developed under Paragraph One to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

And just to go on:

> By not later than June 1, 1992, the Prospective Payment Assessment Commission shall submit an analysis of, and comments on, the proposal developed under Paragraph One to the same Committees.

Dr. Newhouse, I want to know why you have not submitted the analysis, nor commented on the proposal that was required of the Secretary by April 1, 1992.

Mr. NEWHOUSE. Well, Dr. Young informs me that I was not on the Commission then; that we did submit a report, but not an analysis of the administration's report, the Secretary's report.

Chairman THOMAS. Well, why did you not submit an analysis? You are required under the Omnibus Budget Reconciliation Act.

Mr. NEWHOUSE. We did not receive such a report.

Chairman THOMAS. What happened, Ms. Wynn?

Ms. WYNN. We essentially have been unable to develop the system because we have not been able to establish appropriate case mix classification systems, and the research, for instance, that we have——

Chairman THOMAS. Did you submit a report that said you could not live up to what was asked of you under this?

Ms. WYNN. No, sir, we did not.

Chairman THOMAS. So you just ignored the "shall" for Congress requiring you to tell us what you were going to do?

Ms. WYNN. No, we did not——

Chairman THOMAS. Ignore it?

Ms. WYNN [continuing]. Ignore it at all. We undertook a number of efforts to explore the possibility. We entered into the negotiation, for instance, to use the FIM instrument, and have funded the RAND study as far as the rehabilitation services are concerned.

Chairman THOMAS. OK. I just want to underscore for the gentlewoman from Connecticut in her point that it was not just 1982. And Congress did not ignore it. We in fact directly requested something. And Dr. Newhouse has talked about something. And HCFA's basic position is, "It is not as good as we would like, so we are not going to use it, and will continue this discussion for a number of years. In 2002, we are going to have it done."

I just wanted to underscore that, because obviously previous Congresses were concerned about TEFRA and how long we were going to operate under it, as well. I thank the gentlewoman.

Mrs. JOHNSON. Yes. I certainly have been very concerned about our inability to rebase a hospital based in 1982, and our unwillingness to look at that, and our willingness to continue—if you look at the data provided in Dr. Newhouse's testimony, spending for rehab and long-term care hospitals has grown by leaps and bounds, 95 percent between 1990 and 1993 alone. And you would think there might have been more attention to low-cost hospitals, and that might have been taken into account when giving out new rates.

But I want to just ask one last question of both of you. First of all, there is a school of thought that says that in long-term care we should distinguish between acute care and chronic care, in the long-term care hospitals. Having toured a lot of these hospitals, it seems to me this is logical. Where do you come down in that debate? And second, where do you stand on the new now quite well-developed NALTH rebasing proposal?

Mr. NEWHOUSE. Our view is that, as Dr. Young said earlier, there are low-cost long-term hospitals and high-cost long-term hospitals, but we do not think we can satisfactorily distinguish between them, in terms of a payment system.

Mrs. JOHNSON. It does seem to me that, for instance, ventilator patients: a clear grouping. Why can we not deal with that? Other

long-term care—there are some categories of long-term care that reflect acuity and intensity that it seems to me we ought to be able to identify. I am afraid that by going down the sort of simple path of one reimbursement rate we are going to end up disadvantaging the more costly patient.

Mr. NEWHOUSE. Well, there is that danger, Mrs. Johnson. That is very right. My concern I think would be how you do this for part of the patient mix at the hospital, and how then one would have, in effect, a TEFRA-type system, if I understand where you are headed, for just part of the patients in the hospital. Now, I frankly have not thought that one through.

Mrs. JOHNSON. Well, I have not either, and I am certainly not an expert in this area. That is why I am asking this rather basic question. But it does seem to me that even in long-term care hospitals there is a difference between the chronic patient, who is really going to be there years, and the patients more and more that are rehab and they are sort of long term but they are short term. So, I think there are a lot of problems with the single reimbursement rate, and I would ask you to help me on that in the months ahead.

I also am very interested in this rebasing proposal that is revenue-neutral. And I wondered what you thought about the sort of national target rate limit mechanism that keeps that rebasing revenue-neutral.

Mr. NEWHOUSE. We would support the notion of rebasing. If you look at my chart 3, particularly for the long-term hospitals, you see the hospitals that have come in most recently have much higher payment-to-cost ratios than the old hospitals, the so-called original hospitals. Actually, in this chart it just distinguishes 1989 or before, so it is probably even more discrepant than this exhibit shows.

But the concern is, as I mentioned, because of the new provider exemption, the new providers come in—and you mentioned, too, in your questions. They have an incentive to come in at high cost to establish their ceiling. And this chart is an effort to say, yes, that in fact appears to have gone on.

Mrs. JOHNSON. Well, I think that the NALTH proposal basically pays for the rebasing by gradually limiting the overpayments. I mean, that is the way, as a sort of relative layman, I hear this. Would you disagree with that?

Mr. NEWHOUSE. Well, the rebasing would be an effort to then get back some of the——

Mrs. JOHNSON. Money from the national target group.

Mr. NEWHOUSE [continuing]. The people who have come in at a high cost and then drop their cost—and get incentive payments. So, we would support that idea.

Mrs. JOHNSON. Thank you. That is the way it appears to work.

Ms. WYNN. Mrs. Johnson, I understand that the proposal has what I would call selective rebasing; that it is only an opportunity for hospitals whose costs are above their target amount to be rebased. The Administration's proposal is for an across-the-board rebasing.

Mrs. JOHNSON. When? When would the across-the-board rebasing take place?

Ms. WYNN. The President's fiscal year 1998 proposal is to rebase all hospitals, both those that are above their target amount and those that are below.

Mrs. JOHNSON. And how do you pay for it?

Ms. WYNN. Part of it is by eliminating the disparity between costs and payments. The rebasing itself is a redistribution of payments among the TEFRA facilities themselves. So that those with costs above their target amount, the cost of rebasing them is paid for in part by rebasing those who now have costs below their target amount.

Mrs. JOHNSON. I think you mean vice versa, but anyway—the ones whose rebasing needs to be adjusted up get paid for by the ones who get rebased essentially down.

Ms. WYNN. That is correct.

Mrs. JOHNSON. I will be interested to look at that and see what its impact is. It is true that the proposal that I am referring to really rebases the most disadvantaged group.

Ms. WYNN. Right.

Mrs. JOHNSON. And that in itself is hard to pay for. I mean, the more you rebase, the more you have to reduce the reimbursements for the more generously reimbursed.

Ms. WYNN. Right.

Mrs. JOHNSON. So you have to eliminate their exceptions, or reduce their exceptions.

Ms. WYNN. The other way that we are paying for it is by eliminating the bonus payments altogether; whereas I understand the National Association of Long Term Care proposal is to just limit the amount of bonus payments that an individual hospital could receive; whereas the President's proposal would eliminate bonus payments altogether.

Mrs. JOHNSON. Considering the state of the art in terms of its imprecision, which we all acknowledge, I think perhaps the more flexible bonus payment system has a place. But I would be interested in pursuing this with you in greater detail.

Ms. WYNN. I would be pleased to.

Mrs. JOHNSON. Because I think this is one of the things we absolutely have to do this year.

Ms. WYNN. I would be pleased to talk to you about it.

Mrs. JOHNSON. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

Does the gentleman from California wish to inquire?

Mr. Becerra.

Mr. BECERRA. Thank you, Mr. Chairman.

Let me ask a first question. And that is, do we know if anyone has done any research or analysis of the long-term care or rehabilitation hospitals to see what their occupancy rate has been over the course of, say, their first 5 years of operation?

Ms. WYNN. That information is certainly available.

Mr. BECERRA. Has anyone analyzed it to find out what happens after that third year?

Ms. WYNN. I am not aware of any studies that have specifically focused on that question.

Mr. BECERRA. Might it be worth doing, to find out how occupancy rates change after the second or third or, probably, fourth year?

Ms. WYNN. We will be happy to look at that for you.

Mr. BECERRA. I would appreciate knowing. I am not sure how to approach this one. I have information here that says that the average TEFRA limit of for-profit hospitals is about 17,000; for nonprofits it is about 15,000; that the average cost per discharge for for-profits is about 15,000; as opposed to about 12½ thousand for nonprofits. Dr. Newhouse, what makes for-profits cost so much more?

Mr. NEWHOUSE. Are these long-term hospitals, the excluded hospitals?

Mr. BECERRA. I would imagine it is both long term and rehabilitation. This breaks it down by for-profit and nonprofit.

Mr. NEWHOUSE. OK. A couple of things. First, my guess is, although I have not seen the numbers, that the new entrants are disproportionately proprietary hospitals. And we know that the new entrants are coming in with higher costs than the prior hospitals.

Second, as we have all here lamented, we do not have an adequate measure of case mix. So any time one has got different hospitals, the hospitals that are the higher cost hospitals can always say, "Well, we have sicker patients," and there is really no data to shed light on the accuracy of that claim. So whether it is the case mix or whether it is the financial incentives is really impossible for me to say. Maybe Ms. Wynn has some data on that.

Mr. BECERRA. But it could be one of those two factors?

Mr. NEWHOUSE. Yes, and as I say, I think part of it is the new entrants and the incentives of the new entrants.

Mr. BECERRA. Dr. Newhouse or anyone else on the panel can try to see if you can answer this for me. The understanding I am beginning to develop here is that these startups get to include their basic costs. And HCFA does the job of auditing to make sure those costs are reasonable as they are going along. And a lot of these for-profits—or most of them, if not all of them—are corporations, correct?

Ms. WYNN. That is correct.

Mr. BECERRA. Executive compensation is included within a corporation's cost, is it not?

Ms. WYNN. Yes, it is.

Mr. BECERRA. We know that a number of executives make a handsome salary or compensation package. I think we would all agree on that. Ms. Wynn, what do we do to make sure that, as corporations are entitled to do, they include within their basic costs of running that hospital the cost of providing compensation to the chief executive officer or other high executives, that we are making sure that they charge only a reasonable amount for that particular cost?

Ms. WYNN. When the costs are audited—and because of resource constraints, only a small percentage of hospitals' costs are actually audited—we would expect the intermediary to essentially be alert to situations where compensation might be unreasonable and to make an evaluation as to whether those costs are prudent based on sort of what the going rate is for individuals with comparable responsibilities.

Mr. BECERRA. Three quick questions: One, are those costs isolated within whatever records you have, so that you can find them without too much of a problem?

Ms. WYNN. No, they are not readily identified.

Mr. BECERRA. How do you then determine whether or not a reasonable amount has been charged by that hospital for its basic hospital costs with regard to the employees, the compensation for the chief executive officer, for example?

Ms. WYNN. Right. At the hospital level information is obtained on what we would call owners' compensation. But when you are talking about large corporations you do not have that data available. So that the real evidence would be if the administrative costs of the facility appeared to be out of line.

Mr. BECERRA. Let me ask, do you check to find out how much they are charging you, or how much they are saying were costs incurred in operating that hospital, as it pertains to chief executive officers?

Ms. WYNN. They file a cost report.

Mr. BECERRA. Does that cost report break down that particular item of compensation for a chief executive officer?

Ms. WYNN. No, it does not. You can identify administrative salaries as a single line item that would cover everything from the clerk typist through to the chief administrative officer.

Mr. BECERRA. And if they have an administrative cost of $10 million, how do you know how much of that $10 million pertains to one person?

Ms. WYNN. If that $10 million was out of line with the size of the institution where you are talking about an audit situation—the intermediary could, if it appeared to be out of line——

Mr. BECERRA. How would the intermediary know?

Ms. WYNN. They have comparative data and experience with the costs being incurred by other hospitals, as well.

Mr. BECERRA. But you still have no sense of what those costs are itemized. You are just going based on comparisons.

Ms. WYNN. That is correct.

Mr. BECERRA. What if all of the other hospitals are including high executive salaries within their administrative costs, so that everyone seems to be about the same?

Ms. WYNN. It would be more difficult to detect unreasonable situations then.

Mr. BECERRA. So, then let me ask my baseline question that I asked earlier. Can HCFA determine what amount is being included within the administrative costs by these for-profits for executive salaries?

Ms. WYNN. We have the authority to determine that.

Mr. BECERRA. Can you.

Ms. WYNN. We do not have an ongoing mechanism that we have used at this point.

Mr. BECERRA. So, if I were to ask you today to provide me with the amount that corporations are including in their administrative costs that relates to executive salaries, could you provide me with that information?

Ms. WYNN. We could not readily provide you with that information. We would have to go out to each intermediary, that would

then have to go to each of the hospitals to obtain that data. So that is not information that we have available.

Mr. BECERRA. Does that not concern you? You have some executives, I understand, I have got some figures before me—I do not need to mention them—but some individuals are getting compensation packages that amount to $8 million in 1 year. And does it not concern you that you may not know how much of that $8 million is being included in the administrative costs for that for-profit corporation to run a hospital and ultimately get reimbursement from the Federal Government?

Ms. WYNN. It concerns me that we do not have the resources or the ability to essentially examine every cost for reasonableness. Yes, it does.

Mr. BECERRA. And there I can appreciate and empathize with you, if you need the resources to do it. Let us put aside for a second the empathy for the resources that you need. If you had the resources, do you think it would be worthwhile to do? You may say "No." I mean, it may not be worth your while. You may spend more money of the Federal Government, the tax dollars, just trying to figure out how much corporations are including in administrative costs for their executives and what it is worth.

Ms. WYNN. Right.

Mr. BECERRA. But I am just asking, is that of interest to you?

Ms. WYNN. Quite honestly, it depends in part on the situation. For instance, where you do have a prospective payment system, and that is one of the beauties of it——

Mr. BECERRA. We are not in a prospective payment system.

Ms. WYNN. But when you are on a cost-based system, what would concern us the most is whether costs in general for that facility—in other words, the bottom-line costs—appear to be out of line. And there are certainly some excluded hospitals that have far higher target amounts. And again, with the lack of the case-mix measurement system it is harder for us to get to whether those costs are reasonable or not. And that is an area of concern, certainly.

Mr. BECERRA. Mr. Chairman, you have been gracious with the time, and this will be the last question I ask.

What would you consider reasonable costs to associate to an executive's compensation that is included within the administrative costs of a corporation that is a for-profit hospital?

Ms. WYNN. I am not an expert in executive compensation, so I really cannot——

Mr. BECERRA. As a nonexpert. As a nonexpert.

Ms. WYNN. You are asking a civil servant. Anything over—I am not qualified to answer that.

Mr. BECERRA. At all? Not even as a reasonable layperson? [Laughter.]

Ms. WYNN. Not even, no, sir. But we would expect the intermediary to be able to answer that question and to investigate it where it appeared to be an unreasonable compensation package.

Mr. BECERRA. But you have no opinion as to what might be considered reasonable to include? What would be excessive?

Chairman THOMAS. Mr. Becerra.

Mr. BECERRA. Yes, Mr. Chairman.

Ms. WYNN. I am sorry.

Chairman THOMAS. Might I ask a question in a slightly different way?

Mr. BECERRA. Certainly.

Chairman THOMAS. Which results in the expiration of your time. [Laughter.]

Do you not have the ability to set reasonable reimbursement guidelines for physical therapists?

Ms. WYNN. Yes, we do.

Chairman THOMAS. And have you not recently done that?

Ms. WYNN. Yes.

Chairman THOMAS. Do you have the ability to set reasonable reimbursement guidelines for administrative costs?

Ms. WYNN. Yes, we do. In fact, we are currently doing that for home health agencies.

Chairman THOMAS. Now, let me pause there—and yield a portion of my time to the gentleman from California. [Laughter.]

Since you have the ability to set administrative costs on reasonable guidelines, he might very well ask the question——

Mr. BECERRA. Do you have reasonable guidelines for administrative costs? [Laughter.]

And if not, would you consider instituting some?

Ms. WYNN. First of all, at the present time we do not have those for hospital executive compensation. And it is certainly something that we can take a look at.

Mr. BECERRA. I do not want to end it on that note. You can take a look at a lot of things. I asked if it was something you would consider.

Ms. WYNN. Yes.

Mr. BECERRA. Is it worthwhile?

Ms. WYNN. I think the first thing we need to understand is the extent to which there are abuse or unreasonable compensation arrangements.

Chairman THOMAS. Reclaiming my time——

Mr. BECERRA. Thank you, Mr. Chairman.

Chairman THOMAS. It seems to me we would be chasing our tail trying to create a reasonable reimbursement guideline, when we could be spending our time imposing a prospective payment system——

Mr. MCCRERY. Amen.

Chairman THOMAS [continuing]. Which in fact would be self-corrective, because if that is where they want to spend their money, they may not be in business all that long.

Mr. BECERRA. And if I could add, Mr. Chairman, you are absolutely correct. But if I just heard correctly, we have waited 15 years. And unless we have any expectation it is going to end any sooner, at some point we had better know what is reasonable.

Chairman THOMAS. I appreciate the gentleman's generous use of "we waited 15 years." We waited 3, and I am tired of waiting.

Mr. BECERRA. Well, 11 of those 15 years were when you were in the executive branch.

Chairman THOMAS. No, I was not. They were. [Laughter.]

Mr. BECERRA. Yes. That is true. They were not us.

Chairman THOMAS. Does the gentleman from Nevada wish to inquire?

Mr. ENSIGN. Thank you, Mr. Chairman. By the way, it would be interesting to ask somebody who worked in McDonald's what a fair compensation for a Member of Congress would be. I do not think that you would get that $133,600 would be a reasonable figure. So that kind of line of questioning I think discounts the theory that somebody is worth what they make, which is determined by the marketplace. It is the only fair way for anybody's value to be determined.

Chairman THOMAS. Would the gentleman yield?

Mr. ENSIGN. Just a second. I want to ask a fundamental question in this whole system. And that is, what incentives in the whole area of long-term care do we have for providing better quality care at less cost, under the current system?

Ms. WYNN. Under the current system——

Mr. ENSIGN. Better quality at less cost.

Ms. WYNN. The incentives for efficiency are built in through the TEFRA methodology.

Mr. ENSIGN. But I prefaced that question "better quality, less cost."

Ms. WYNN. I understand that.

Mr. ENSIGN. Do you think that the systems under TEFRA are incentives for better quality at less cost?

Ms. WYNN. There is nothing within the TEFRA system that provides incentives to improve quality.

Mr. ENSIGN. Right, and I agree with that. And as a matter of fact, I think that some of the questions from the gentleman from California sound like fair questions, but the problem is——

Chairman THOMAS. Excuse me?

Mr. ENSIGN. Listen. I said they sound like fair questions.

Chairman THOMAS. No, no, no. "The gentleman from California."

Mr. ENSIGN. Excuse me. The gentleman on the end in the Minority party from California. [Laughter.]

The Chairman's questions are always fair questions, by definition. [Laughter.]

Anyway, while the line of questioning sounds fairly reasonable up front, following along with what Mr. McCrery talked about. I have only been up here for a couple of years, but it seems like a lot of the answers that we try to come up with are because the government set up a bad system in the first place. And some of the answers are bad answers, or they are not great answers, because the system was bad in the first place.

The system that we have now has no incentives for providing better quality at less cost. We do not have those built into the current system. And that was really the only point that I wanted to make. And I just wanted to make sure that you felt the same way.

So thank you, Mr. Chairman. That is really all I had.

Mr. BECERRA. Will the gentleman yield some of his time?

Mr. ENSIGN. Surely.

Mr. BECERRA. I agree with the gentleman. His point is well taken. You should be paid what you earned. It is a matter of whether the taxpayers should pay for that. If someone is being paid $8 million and the company that individual is making the money

from is including that within the cost which ultimately will be reimbursed to some degree by the taxpayer——

Mr. ENSIGN. Oh—reclaiming my time—I think a cost-based system is a terrible system. It has been proven time and time again, a cost-based system is a terrible system. And that is what I was saying; that your questions sound reasonable because it was a terrible system in the first place.

Mr. MCCRERY. A cost-based reimbursement system is a terrible system if somebody besides the consumer is paying the bill.

Mr. ENSIGN. Yes. There is no accountability. It takes accountability out of the system. And that was really the whole reason for the line of questioning. Thank you, Mr. Chairman.

Chairman THOMAS. I want to thank the panel. If Members have no additional questions, we will move on to the next panel, because I believe they are anxious to present testimony to the Subcommittee.

I want to thank you all.

Ms. WYNN. Thank you, sir.

Mr. NEWHOUSE. Thank you.

Chairman THOMAS. The next panel will be Patrick Foster, senior vice president of the Inpatient Division of HEALTHSOUTH, Birmingham, Alabama, on behalf of the Federation of American Health Systems; Kathleen C. Yosko, I believe it is, president and chief executive officer, Schwab Rehab Hospital and Care Network, Chicago, Illinois, on behalf of the American Rehabilitation Association; J. Rod Laughlin, president, Transitional Hospitals Corp., Las Vegas, Nevada, and president of the Long Term Acute Care Hospital Association of America; and James Standish, chief financial officer, Hospital for Special Care, New Britain, Connecticut, on behalf of the National Association of Long Term Hospitals.

I want to thank you all for coming. Any written statement that you may have will be made a part of the record. And you may address us in the time that you have in any way that you see fit to inform the panel. Let me just say that we will start from my left, your right, and move across the panel.

I do want to mention that these microphones are unidirectional, and you will want to speak directly into them. Thank you very much for coming. And Mr. Foster, the time is yours.

STATEMENT OF PATRICK A. FOSTER, SENIOR VICE PRESIDENT, INPATIENT OPERATIONS, HEALTHSOUTH CORP., BIRMINGHAM, ALABAMA; ON BEHALF OF THE FEDERATION OF AMERICAN HEALTH SYSTEMS

Mr. FOSTER. Thank you, sir. Mr. Chairman and Subcommittee Members, thank you for the opportunity to address this Subcommittee today. I am Pat Foster, senior vice president with the HEALTHSOUTH Corp., which is a member of the Federation of American Health Systems.

The federation represents a large portion of the PPS-exempt facilities in the Nation. It represents approximately 70 percent of the freestanding rehabilitation hospitals, 50 percent of the behavioral hospitals, and 35 percent of the long-term care facilities. As a result of that, we feel like we have the qualifications to address the

issues that are at hand related to the quality of patient care and the cost of patient care.

The President's budget for this year addresses a lot of things, and some of those things we think will add to the Medicare cost. We think they are a Band-Aid approach. And some we think will reduce the cost of providing care. The President's proposal includes both short- and long-term approaches and issues. Let me address short-term issues first.

Our chief concern is rebasing. We do not support rebasing. Rebasing is a redistribution of Medicare funds from the efficient provider to the inefficient provider. And we, again, think this is a Band-Aid effect. There is an exemption system which has been referred to today where facilities can rebase. We have in fact had one facility that was allowed rebasing. This has been in place since 1989, and the Secretary of HHS has the authority to do this. So what I am saying is it does work. We have had one facility that has been approved, and one in fact that was not.

Closely related to this proposal in the President's budget is the elimination of the incentive payment. We do not support the elimination of the incentive payment today. We again think that is an interim approach. The one thing that works in the existing system is it does reward the efficient providers. And if we take this out, we are rewarding the inefficient providers.

It is very similar to the DRG payment. The DRG payment, the PPS payment, and the PPS-exempt payment are different in one way. The PPS payment allows a provider to keep 100 percent of the difference in their cost and what their DRG amount is; whereas the incentive payment with PPS facilities generally is about 5 percent of the TEFRA limit. And the President's proposal suggests the elimination of this, and we do not support that.

The existing system works. It does reward the efficient provider. It does save health care dollars. I have some charts up that show under the present system what has occurred in my company, the HEALTHSOUTH Corp. And as you can see, the costs since 1994 have gone down. And there are a variety of TEFRA limits in these hospitals, a lot of these. In fact, one hospital is one of the oldest hospitals in the country. And as our costs have gone down, our clinical outcomes have gone up. So we have the incentive in place today.

Let me talk about capital reduction. We do not support the reduction in capital. The 15-percent reduction is drastic. We are very sensitive to the Medicare mix. In a PPS-exempt facility, 60 percent to 65 percent of our patients are Medicare. In a PPS facility, it is about 40 percent.

An example, Mr. Chairman, would be at our facility in Bakersfield, and how this would affect the facilities that are new in the South and the West. In Bakersfield, California, we have a rehabilitation hospital, and our capital cost per day is $189. The average amount in our company is $128. So this will definitely impact facilities, and I think you will find that is consistent with the facilities in the South and the West.

We know we must continue to reduce Medicare expenditures, and we are committed to do that. We support several things in the President's proposals in this year's budget. We support the infla-

tion update cuts. ProPAC recommended 2 percent; the President, 1.3. In lieu of rebasing, we would even recommend lower than the 1.3.

We do support and encourage elimination of the new provider exemption. That exemption allows facilities to be inefficient in the first 2 years of operation, and we thoroughly and strongly suggest that every facility should be cost efficient out of the gate.

For the long term, we absolutely support going to a PPS system. The thing that we do not support is, the system that has been under review right now does not represent the large portion of the freestanding rehabilitation hospitals in the United States of America. And as we are driving our costs down, the data that is being used was generated in 1994. So, we do definitely support PPS. Absolutely, we do. But we do not support it in the form that it is today.

In summary, we are willing to share our commitment, and willing to share the commitment to drive down Medicare costs. Please, whatever we do, let us make sure that it does not jeopardize patient care. And when we implement a PPS system, let us ensure that it takes care of implementing excellent clinical outcomes for the patient.

Thank you very much.

[The prepared statement follows:]

Statement of Patrick A. Foster, Senior Vice President, Inpatient Operations, HEALTHSOUTH Corp., Birmingham, Alabama; on Behalf of the Federation of American Health Systems

Good afternoon. I am Pat Foster, Senior Vice-President of Inpatient Operations for HEALTHSOUTH Corporation. I am pleased to be here today to testify on behalf of the Federation of American Health Systems ("The Federation") before the Committee on rehabilitation and long-term care hospital payment policy. The Federation is the representative of 1,700 investor-owned and managed health care organizations, which include almost 1,100 of the nation's acute-care hospitals, and over 600 specialty hospitals. In addition to representing acute-care PPS hospitals, the Federation also represents a broad cross-section of PPS-exempt providers. Particularly important for this hearing, the Federation's members include the single largest PPS-exempt providers in the rehabilitation, psychiatric and long-term care sectors, and the majority of all PPS-exempt freestanding specialty hospitals.

My company, **HEALTHSOUTH Corporation**, is the nation's largest rehabilitation provider with 60 freestanding rehabilitation hospitals, and over 700 outpatient clinics. Another Federation member, **Horizon/CMS**, has 33 freestanding hospitals and over 250 outpatient rehabilitation centers. Together, they represent the vast majority of the nation's freestanding inpatient rehabilitation hospitals.

Magellan Health Services is nation's largest behavioral health care provider with nearly 100 psychiatric hospitals and 150 outpatient clinics. Magellan also manages mental health benefits for over 12 million Americans through arrangements with large private and public employers, and state Medicaid programs. Together with numerous other member companies, the Federation represents over 50% of all psychiatric hospitals, and hundreds of additional units in acute-care facilities.

In the long term care sector, **Vencor** is the nation's largest provider of long-term care services with 38 long-term care hospitals, and 311 nursing centers. Horizon/CMS has 15 long-term care hospitals, and **American Transitional Hospitals** operates 11 long-term hospitals. In total, the Federation represents over 35% of all long-term care hospitals, including the majority of freestanding hospitals.

In addition to these providers, Federation acute-care hospital members provide a substantial amount of care in these areas as well.

Because the Federation represents such a broad cross-section of the PPS-exempt provider community, we are uniquely qualified to comment on proposed changes contained in the President's FY 98 Budget proposals and recommendations made by ProPAC affecting these facilities. We appreciate the opportunity to appear before the Committee to address these issues today.

The Federation has been and remains strongly supportive of the Committee's efforts to reform and modernize the Medicare program. We know this will take a great deal of work and that costs must be reduced while quality and outcomes continue to be improved. We are willing to shoulder a fair share of the Medicare cost containment burden and think we can meet this challenge if we have the opportunity to work closely with the Committee and Congress on new policy approaches.

However, there are two cautionary notes that must be taken into account as we design the plans to get there. First, PPS-exempt providers are very different from PPS hospitals in the types of services they provide, the types of patients they

treat and the way they are reimbursed. Second, the President's Budget imposes on the PPS-exempt sector a disproportionate amount of the budget cuts in the Medicare program. This may have unintended consequences that exacerbate existing problems rather than moving the program forward.

Compounding the effect of the reductions are several important distinctions between PPS-exempt and PPS hospitals the Committee should consider. Unlike PPS providers, PPS-exempt providers are paid only their actual allowable costs. PPS-exempt providers also treat a higher proportion of Medicare patients than most acute-care hospitals, further limiting the potential for cost-shifting. For example, Medicare constitutes 60% of HEALTHSOUTH's patient mix, and 75% of Vencor's patient mix. The average acute-care hospital has a 40-45% Medicare patient mix. Despite their higher percentage of Medicare patients, PPS-exempt providers do not receive Medicare disproportionate share payments (DSH). As a result of these differences, proposed reductions can have a more pronounced effect on cost-based exempt providers.

We recognize that there are short-term and long-term measures under consideration. In the long-term, all the Federation members agree that a well thought out, case mix adjusted prospective payment system may be the most effective way to control costs and maintain the proper incentives for efficiency and improved quality. In the short-term, while we begin moving in that direction, we have to find ways to control costs and generate savings in this area. We want to work with you to achieve both goals. In fact, it is imperative that we be allowed to provide this kind of input because there are short-term policies, some prominently featured in the President's Budget proposal, that will actually take us in the wrong direction--further away from our mutual long-term goal of a cost-effective, quality enhancing, prospective payment system.

THE SHORTER TERM-- ACHIEVING SAVINGS IN THE CURRENT SYSTEM

Rebasing

Chief among the "wrong-direction" approaches is the President's proposal to rebase TEFRA limits for all PPS-exempt providers whose base year comes before 1991. The effect of such a proposal will be to reward hospitals that have had increasing costs and to penalize hospitals that have controlled their costs. Current TEFRA limits have successfully encouraged facilities to deliver care in the most cost-effective manner. Many well managed facilities have been able to maintain their cost levels within the limits without adversely affecting the quality of patient care. For example, HEALTHSOUTH has demonstrated decreases in Medicare charges, cost per day and cost per discharge from 1994-1996, while improving outcomes performance for beneficiaries. Inefficient hospitals which have not taken steps to control their costs are penalized by the imposition of TEFRA limits, as envisioned by Congress when the TEFRA system was implemented. The President's proposal to now recalculate TEFRA limits would result in a redistribution of Medicare funds away from efficient hospitals which have worked hard over the years to control their costs to inefficient providers who have not brought their costs under control.

As ProPAC observes, rebasing would penalize hospitals that have constrained their costs (often our hospitals) by paying them less. At the same time, facilities that had not become more efficient would be rewarded by higher payments. I would assume Congress wants to encourage efficiency--as a PPS

system would--not penalize it. We hope the committee would not adopt a proposal with such perverse effects.

The President's proposal would also establish arbitrary floors and ceilings on TEFRA limits. The proposal would establish a floor of 70% of the national average and a ceiling of 150%. This approach disregards critically important factors such as patient type and acuity level treated in each type of PPS-exempt facility, and will only serve as a disincentive for PPS-exempt providers to treat sicker, more complex patients.

In addition, it must be pointed out that at the same time the Administration proposes such dramatic ill-conceived changes, it is ignoring tools already available to the Secretary to provide relief for efficient hospitals which have exceeded their limits due to legitimate factors. An exceptions process already exists by which older facilities with lower TEFRA limits can receive adjustments or a new base year--rebasing on a case-by-case basis.

Inflation Update Cuts

As an alternative to rebasing to produce Medicare savings, and in view of Congress' imperative to preserve the Medicare Part A trust fund, Federation members are prepared to work with the Committee to establish differential market basket updates based on historical costs. Even though ProPac recommended a 2% inflation update for PPS-exempt facilities, our members are prepared to accept a lower update to avoid ill-conceived, budget-driven rebasing proposals. For example, the Committee should examine reducing target amount updates for those facilities with costs consistently below their TEFRA limits, while increasing updates for hospitals that can document legitimate reasons for consistently exceeding their limits. We understand the need to make adjustments for some older facilities, but such relief should not result in undue penalties for providers that have responded to the existing incentives for efficiency.

Elimination of Efficiency Incentive Payments

A closely-related proposal included in the Administration's Budget requires the elimination of incentive payments for provider efficiency. Currently, PPS-exempt facilities may receive certain incentive payments to encourage them to, and reward them for, reducing their costs to the Medicare program. In such cases, Medicare splits the additional savings achieved when a PPS-exempt provider manages to come in below its projected cost or target amount with the provider, giving the provider the lesser of half the difference between the target amount and the provider's actual cost or five percent of the target amount. As Medicare shares in the savings when facilities come in below their targets, so Medicare also shares in the risk that a facility may not be able to meet its target and may have to exceed it. In such cases, facilities with operating costs above the target amount receive the target amount plus 50 percent of the difference between the target amount and the actual cost, up to 110 percent of the target amount. In this way, Medicare provides a strong disincentive to avoid going over the target amount, and an even stronger incentive to try to beat the target amount.

The President's proposal would eliminate the incentive payment for providers who keep costs below the TEFRA rate. In addition, for providers with higher costs, it would subsidize only those costs in excess of 110% of the TEFRA rate, up to 20% of the rate. That is, TEFRA hospitals would be expected to bear more of the risk and none of reward for efficiency.

Absent a fully developed prospective payment system, the existing incentive policy seems to be exactly the right type of incentive. Its elimination makes no sense and runs counter to the development of a PPS system. For example, PPS for acute-care hospitals has been quite successful in encouraging efficiency by rewarding hospitals that control costs below DRG payment levels with 100% of the of the savings.

Finally, it would be imprudent to make major changes to the TEFRA system just prior to establishment of PPS for excluded facilities. The Federation would recommend that Congress seek less dramatic changes to the current payment system and focus on the development of a sound prospective payment system for PPS-exempt facilities.

15% Capital Reduction

The Administration has proposed to reduce PPS-exempt capital reimbursement by 15%. This is a harsh, immediate cut that hits PPS-exempt facilities hard. If capital reimbursement is reduced, it should be to a level no less than that currently proposed for acute-care hospitals, and should be phased in, as it was for acute-care hospitals. Under the President's Budget proposal, acute-care hospitals would be reimbursed for 90% of capital costs compared to the proposed 85% for PPS-Exempt providers. Further, acute-care facilities have experienced the 10% reduction in the past and have had the opportunity, albeit with great difficulty, to adjust. PPS-exempt have always been reimbursed 100% of capital. Not only is the reduction larger and more immediate, but the impact of such a reduction is more pronounced for PPS-exempt facilities since they are reimbursed only at cost to begin with and traditionally have a higher percentage of Medicare patients.

In addition, reducing capital reimbursement would have some significant long-term negative effects. Many of our PPS-exempt hospitals make large capital investments to upgrade facilities, enabling them to reduce operating costs. Reducing capital reimbursement could discourage companies from making these investments or reinvesting in older facilities. Additionally, it probably has a disproportionate impact on facilities in the South and West, which often have newer facilities with higher capital and depreciation costs. In contrast, an overall update reduction impacts all providers the same by region.

Redefinition of Hospital Transfers

While there are differences of opinion among Federation members, a majority oppose the Administration's proposal to redesignate as a transfer, rather than a discharge, the movement of a patient from a PPS setting to a PPS-exempt setting. The acute-care providers are adamantly opposed to this approach since they believe it undercuts the effectiveness of the PPS system and the successes it has reaped in reducing length of stay and cost to the Medicare program. It will create perverse incentives to keep patients in inpatient settings, and penalize providers who have increased effectiveness.

Furthermore, ProPAC's data shows that hospitals do not appear to be discharging patients "early" to PPS-exempt facilities. According to ProPac, in most cases, beneficiaries who used a post-acute provider immediately after being discharged had longer hospitals stays than those who did not. For example, patients who were hospitalized for a stroke and subsequently transferred to a

post-acute provider, had an ALOS of 9.4 days in the acute-care facility. By contrast, acute-care ALOS for those who did not use post-acute care was 6.5 days. Acute-care facilities also point out that the bulk of the cost in a hospital stay is front-loaded and any payment made on a per diem basis would have to account for the increased intensity of resources consumed on the front end of a hospital stay.

Most of the PPS-exempt members also question this proposal, citing doubts about whether the proposal will save Medicare any money. They fear the acute-care hospitals will have an incentive to keep patients longer, deferring or jeopardizing use of other, possibly more appropriate or cost-effective rehabilitation or specialty care settings. While this proposal is "scored" as savings by OMB, ProPAC's views and reality would argue that it may, indeed, increase costs.

Repeal of New Provider Exemption

ProPAC has proposed an elimination of the automatic exemption from TEFRA limits for new providers. Currently, new providers have two years to establish their target amounts, during which they are paid on an actual cost basis. ProPAC notes the perverse incentive for a new provider to inflate its costs during the base setting period and instead would only allow these new providers to receive the national average target amount for each facility type during their base-setting period. Some of our members agree that the new provider exemption is primarily an incentive to attract new providers that may no longer be needed or affordable. Others note that there are areas where new providers may be needed and without the new provider exemption, it will be hard for these new providers to receive adequate reimbursement for their sicker patients. In their view, it creates a disincentive to treat these sicker patients.

THE LONGER TERM--
CREATING THE RIGHT SYSTEM

As discussed in my opening remarks, we believe that the best way to achieve efficiencies and create the right incentives in this part of the system long-term is through the development of well-thought out, case-mix adjusted prospective payment systems for post-acute PPS-exempt providers. Some sectors will be ready earlier than others, such as home health and skilled nursing facilities, while others will not be able to move in that direction until much more work is done to see if prospective payment is even possible, such as psychiatric services.

Prospective Payment System for Rehabilitation Hospitals

The Administration has been looking to phase-in prospective payment systems for specific types of PPS-exempt providers, notably rehabilitation hospitals. The Federation's members providing rehabilitation services--both in freestanding and in hospital units--are supportive of moving toward a prospective payment system as soon as practicable, but have strong reservations and currently oppose the patient classification system being developed by RAND Corporation under contract to the Health Care Financing Administration.

The Federation's rehabilitation hospital members are concerned that the RAND data being used to develop the patient classification system commonly referred to as functional related groups or FRG's do not reflect critically

important elements. Specifically, the data sample used by RAND included information surveyed from only two member hospitals (ignoring nearly 70% of all freestanding rehab hospitals). Further, the patient classification system does not account for co-morbidities or for the length of time a patient has been an inpatient of an acute-care hospital prior to admittance to a rehabilitation hospital or unit. These are critical factors in determining anticipated resource needs of rehab patients. Our members are also concerned about the RAND study's intention to include long term patients within the rehab patient classification system, since these are distinct patient types that are not comparable. We are interested in supporting PPS for rehab-- but most definitely not this PPS that excluded the bulk of the country's rehab providers.

PPS For Long-Term Care Hospitals

The National Association of Long Term Hospitals commissioned the Lewin Group to perform a feasibility study of a prospective payment system for long term hospitals in 1995. The results were promising and the study was offered to ProPAC and HCFA for their comments and input. The Lewin Group is proceeding with the study and is expected to have a patient classification system completed by approximately May of 1997, a payment system by the Fall of 1997 and a final report ready by the Summer of 1998.

The Secretary of HHS was charged by Congress to develop PPS for exempt hospitals, including long-term care hospitals, more than a decade ago. There is no evidence that HHS or HCFA has completed any substantial work on such a system.

Psychiatric Hospitals Must Continue To Be Considered Separately

There is virtual unanimity, including at HCFA, that psychiatric services, because by their nature they are hard to classify and predict, may have the farthest to go in order to develop a prospective payment system. While significant research has been done to evaluate prospective payment system options for many other types of providers, the limited research which has been done to date related to psychiatric facilities has not resulted in a viable methodology to classify patients in a manner which accurately predicts resource consumption. For example, the resources consumed by a patient admitted in the surgical department of a general hospital in need of a tonsillectomy are predictable with a narrow range of deviation from expected cost levels. The same is not true for a patient admitted to a psychiatric hospital with a diagnoses of psychosis, who may or may not need an MRI, and may or may not immediately respond to an array of various therapies. Until a methodology is developed which accurately predicts resource consumption, a meaningful prospective payment system for psychiatric systems cannot be developed. Accordingly, while FAHS members support the development of prospective systems, this may be an even longer term goal for psychiatric facilities.

SNF PPS

The Administration has included a proposal to establish a per diem prospective payment system beginning in FY 1998. While our members with SNFs generally agree that prospective payment is needed and they are ready to transition to such a system, they are sure to emphasize that there still are a substantial details to be addressed regarding its implementation. Any prospective payment system must incorporate accurate case-mix adjustments, along with

important elements. Specifically, the data sample used by RAND included information surveyed from only two member hospitals (ignoring nearly 70% of all freestanding rehab hospitals). Further, the patient classification system does not account for co-morbidities or for the length of time a patient has been an inpatient of an acute-care hospital prior to admittance to a rehabilitation hospital or unit. These are critical factors in determining anticipated resource needs of rehab patients. Our members are also concerned about the RAND study's intention to include long term patients within the rehab patient classification system, since these are distinct patient types that are not comparable. We are interested in supporting PPS for rehab-- but most definitely not this PPS that excluded the bulk of the country's rehab providers.

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geographic and other valid adjustments. For example, according to ProPAC, while hospital-based SNFs have higher cost-per-day, they have lower costs-per-stay. More analysis needs to be done, but this tends to indicate higher resource utilization per day by patients in hospital settings. How will these types of differences in acuity of patient and intensity of resource utilization be taken into account? Perhaps, a case-mix adjusted episodic system would be more appropriate. How will the need for high cost ancillary services such as rehabilitation therapies, which varies greatly among SNF patients, be fairly addressed? The HCFA must work closely with the health care community to develop appropriate reimbursement methodologies. This proposal should be carefully developed by HCFA through full notice and comment rulemaking to achieve maximum industry input.

HHA PPS

The Administration also proposes to implement a prospective payment system for home health payment beginning in 1999. While the Federation supports the establishment of PPS for home health, many of the same concerns about proceeding with caution apply. The home health industry has developed a PPS proposal that deserves serious consideration and should serve as the basis for the legislative provisions. Any regulatory components should be developed in close consultation with the industry and through full notice and comment procedures.

Unified Post-Acute Payment System

The Administration has included in their budget a proposal to allow the Health Care Financing Administration (HCFA) to develop a unified post-acute payment system. While we do generally support the concept of a case-mix adjusted prospective payment system for all post-acute services, we must emphasize that it is only conceptual support at this time. Although we believe this is an appropriate direction for further study, neither the Congress nor the industry, (nor apparently HCFA) has seen any of the crucial elements of such systems spelled out. How would payments be adjusted for case-mix? Would payment be on a per-day or per-episode basis? What exceptions and special payment rules would apply. How would it be phased in? How would the prospective systems vary across the different provider types: rehab, long-term hospital, skilled nursing and home health?

Given the need to resolve such large issues, we are extremely concerned that the HCFA is proposing that it be given the authority to implement prospective payment using interim final rulemaking authority. This would mean that HCFA could implement major program change, affecting a significant portion of the health care sector, without the opportunity for Congress, the industry or the beneficiaries to have any input. While we are supportive of HCFA and enjoyed a good working relationship with the Administrator and the staff, we would certainly hope that this Committee would not agree to such an unprecedented approach. Such a "blind" delegation of policymaking would set the stage for a potential policy debacle that will end up back in Congress' lap.

Conclusion

In conclusion, we are concerned about both the level of cuts and the direction of many of the policies included in the President's Budget. PPS-exempt facilities are becoming increasingly important players in delivering care to the

Medicare and non-Medicare populations alike. We know we are, and have to be, part of the solution. We want to work with the Committee to develop policies that not only will achieve an appropriate level of Medicare savings, but also will help promote the right incentives and provide the best care in the most appropriate setting for the patient. Thank you for this opportunity to share our views with you today.

—

Chairman THOMAS. Thank you, Mr. Foster.

Ms. Yosko.

STATEMENT OF KATHLEEN C. YOSKO, PRESIDENT AND CHIEF EXECUTIVE OFFICER, SCHWAB REHABILITATION HOSPITAL AND CARE NETWORK, CHICAGO, ILLINOIS; ON BEHALF OF THE AMERICAN REHABILITATION ASSOCIATION

Ms. YOSKO. Yes, good afternoon, Mr. Chairman and Members of the Subcommittee. Today, I am appearing on behalf of the American Rehabilitation Association, the principal membership organization of rehabilitation facilities, of which I am the chairman of the board of directors. I am also president and chief executive officer of Schwab Rehabilitation Hospital and Care Network in Chicago. Also present today, as Congressman LoBiondo mentioned, is Richard Kathrins, president of Betty Bachrach Rehabilitation Hospital in New Jersey.

The objective of medical rehabilitation is to eliminate or minimize disability. We seek to restore a person's ability to live, work, and enjoy life after an illness, trauma, stroke, or similar event has impaired one's physical or mental abilities. Christopher Reeves' spinal cord injury and President Clinton's recent knee injury are just two of the many examples of rehabilitation.

Many of the conditions requiring rehabilitation services are associated with advancing age, particularly strokes, orthopedic conditions, and arthritis. Medicare is the primary payer of over two-thirds of those who need rehabilitation.

Rehabilitation hospitals and units are excluded from the Medicare PPS. Rehabilitation facilities are paid on the basis of reasonable cost, subject to ceilings imposed under TEFRA. TEFRA limits were imposed in 1993 as a temporary method for controlling costs. HCFA was charged with developing a PPS suitable for rehabilitation, but this never occurred.

TEFRA distorts the delivery and cost of hospital rehabilitation services in a number of ways. I will highlight the two most critical problems. TEFRA limits do not adjust for changes in the case mix or increased acuity of patients. They treat all cases as having the same value. Hence, inherent in the system is a financial incentive to treat short-stay, less complex patients, not more severely disabled patients.

The current system is inequitable because it allows new rehabilitation providers to establish much higher TEFRA limits than older ones. These new facilities can establish TEFRA limits based on contemporary costs, and can be reimbursed significantly more than older hospitals. The incentives within any rehabilitation payment system should encourage the treatment of all patients according to

their individual rehabilitation needs. The current TEFRA system is an ineffective reimbursement structure to accomplish this goal.

Rehabilitation hospitals and units would be better served with a reimbursement system that is accurately calibrated to the intensity of the needs of the patients we serve. That in turn best serves the ultimate goal of rehabilitation: to enable persons with disabilities and chronic illness to live independently in the community.

While some rehabilitation providers prosper and others struggle under TEFRA, no one defends it, including HCFA. Replacing this system with a rehabilitation PPS has been recommended by ProPAC in 1996, and more strongly in 1997, as well as the trustees of the Health Insurance Trust Fund.

In 1990, Congress directed HCFA to submit recommendations for rehabilitation payment reform by April 1992, but again, nothing happened. Rehabilitation providers then funded research to develop a patient classification and payment system for rehabilitation called the functional related groups, FRGs. This system, now existing, covers almost all Medicare patients. It is designed to account for variations in the case mix of patients, unlike the TEFRA system.

In the fall of 1995, HCFA contracted with the RAND Corp. to evaluate the FRG system and, if found to be suitable, design a PPS for rehabilitation. This work is now complete. RAND has reported to HCFA that FRGs are suitable as the basis for an accurate rehabilitation payment system.

The Administration's Medicare proposals ultimately represent an endorsement of the current rehabilitation payment policy. We oppose the administration's TEFRA proposals because they do not cure the flaws of the present system. They do nothing to chart a course for the efficient use of rehabilitation resources under Medicare.

In conclusion, any rehabilitation payment reform should ultimately focus on the needs of patients. A rehabilitation PPS would, one, establish the proper incentives to treat all patients, regardless of case mix; and two, assure that newly developed rehabilitation facilities are founded on community need, rather than the current payment incentives.

There is a bill in Congress that establishes a rehabilitation PPS based on FRGs. This is H.R. 585. We look forward to the final RAND report, in order to identify necessary modifications to the bill. There may be other ways to structure rehabilitation PPS. The important point is that the current TEFRA system is inequitable and outdated, and should be replaced with a rehabilitation PPS that accounts for case mix.

Thank you, Mr. Chairman, for this opportunity, and I would be pleased to answer any questions.

[The prepared statement follows:]

STATEMENT OF KATHLEEN C. YOSKO
PRESIDENT/CEO
SCHWAB REHABILITATION HOSPITAL AND CARE NETWORK
ON BEHALF OF THE AMERICAN REHABILITATION ASSOCIATION
SUBMITTED TO SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

April 10, 1997

Mr. Chairman and Members of the Subcommittee:

My name is Kathleen Yosko. I am the President and CEO of Schwab Rehabilitation Hospital and Care Network in Chicago, Illinois. Schwab is a freestanding rehabilitation hospital with numerous outpatient sites throughout the city and suburban areas. We serve over 1200 people annually just at our hospital. I am also the chair of the Board of Directors of the American Rehabilitation Association on whose behalf I am appearing today. This statement addresses the need for reform of the present system under which the Medicare program pays for services rendered to its beneficiaries by rehabilitation hospitals and units.

With me today is Richard Kathrins, President and CEO, Betty Bacharach Rehabilitation Hospital in Pomona, New Jersey who has been a leading force in helping bring this issue to your attention today. Together we represent a large teaching system, and a freestanding hospital. Our institutions are currently under the limits imposed by the existing payment system. Yet, we firmly believe we must move rehabilitation hospitals and units to a rehabilitation prospective payment system (RPPS) for reasons discussed below.

The American Rehabilitation Association (formerly the National Association of Rehabilitation Facilities) is the largest not-for-profit organization serving vocational, residential and medical rehabilitation providers in the United States. Our membership includes about 300 medical rehabilitation hospitals and units.

The objective of medical rehabilitation is to eliminate or mitigate disability. We seek to restore a person's ability to live, work and enjoy life after an illness, trauma, stroke or similar event has impaired his or her physical or mental abilities. Most patients enter rehabilitation after an acute hospital stay. About 450,000 people per year receive such services as inpatients in rehabilitation hospitals or rehabilitation units of general hospitals. Many more receive such services as outpatients. There are now about 200 rehabilitation hospitals and 860 rehabilitation units in general hospitals recognized by the Medicare program.

Many of the conditions requiring rehabilitation services are associated with advancing age, particularly strokes, arthritis and orthopedic conditions. Accordingly, a relatively high percentage of the persons who need rehabilitation are covered by Medicare. In 1995 about 72% of discharges from rehabilitation hospitals and units and 67% of total days of care were covered by the Medicare program. These figures do not include Medicare beneficiaries who have chosen to enroll in managed care plans. Thus, Medicare has a profound impact on the delivery of rehabilitation services.

I. THE CURRENT PAYMENT SYSTEM SHOULD BE REFORMED

Rehabilitation hospitals and units are excluded from the Medicare PPS and are paid for services to Medicare patients on the basis of reasonable cost, subject to per-discharge ceilings imposed under TEFRA. TEFRA limits were imposed in 1983 as a temporary measure. They distort the delivery and cost of hospital rehabilitation services in a number of ways:

- TEFRA limits do not adjust for change in case mix and/or increased acuity of patients. This means that completely legitimate increases in intensity of services or length of stay will push a provider's costs over its limit.

- TEFRA limits place pressure on rehabilitation hospitals and units to cut average length

of stay as a means of reducing per-discharge cost. By treating all rehabilitation discharges as having the same value, the system provides a strong incentive to treat short stay, less complex cases and avoid more severely disabled patients.

- New hospitals and units can establish limits based on contemporary wage levels and other costs, thereby achieving much higher limits than older hospitals. Hence, hospitals in the same service area may have widely differing TEFRA limits and reimbursement for similar services. This has led to enormous growth in rehabilitation providers. Medicare is paying the bill.

- This system inhibits the development of new programs for severely disabled patients by existing providers, because any change in services that increases average length of stay or intensity of services will likely result in costs over a TEFRA limit. Meanwhile the Medicare program encourages the development of new rehabilitation hospitals and units. This adds unnecessary cost while eroding the service capacity of established institutions.

- The administrative process for adjustment of TEFRA limits does not provide a remedy because it does not produce timely decisions and does not recognize many legitimate costs.

- Because HCFA routinely allows new providers much higher limits than older ones, the construction of new hospitals and creation of new units is encouraged. There are about four times as many rehabilitation hospitals and three times as many units now than when TEFRA limits were introduced. Large incentive payments are being paid to new hospitals while many older facilities lose money on Medicare patients because of much lower TEFRA limits.

II. THE MEANS EXIST TO REPLACE TEFRA WITH A PROSPECTIVE PAYMENT SYSTEM FOR REHABILITATION PROVIDERS

While some providers are helped and others hurt by this system, no one (including HCFA) defends it. Its replacement with a rehabilitation prospective payment system (RPPS) has been recommended by ProPAC repeatedly and the Trustees of the Health Insurance Trust Fund.

In 1990 the Congress directed HCFA to submit recommendations for reform by April 1992. Nothing has been forthcoming. To try to fill this void rehabilitation providers funded research to design a patient classification system to serve as the basis for a PPS for rehabilitation. This work was done at the University of Pennsylvania and was highly productive. There now exists a system of patient classification groups that include almost all Medicare patients. These classifications, known as functional related groups (FRGs), predict the duration and intensity of rehabilitation services based on a patient's age, diagnosis and functional abilities on admission.

In the fall of 1995 HCFA awarded a contract to the RAND Corporation to evaluate this system and, if it was found to be suitable, to design a prospective payment system for inpatient rehabilitation. This work is substantially complete. RAND has reported to HCFA that FRGs are a sound means of predicting resource use and has developed a complete set of recommendations with respect to case weights, outliers, treatment of transfer cases and other components of a rehabilitation PPS. It follows the structure of the acute PPS, substituting FRGs for the DRGs. Since it had a much larger database than did the original researchers in 1990, it refined and expanded the system to 82 FRGs. The final RAND report which is due at the end of this month will include the results of simulations of the system, and recommendations to assure that quality is maintained and any perverse incentives are eliminated or mitigated.

All that is needed is legislation to implement it. We are not talking about an academic exercise, but rather a technically sound system designed for HCFA that can be

introduced with modest lead time.

Adoption of a payment system whereby hospitals are paid based on the types of patients they treat is needed. It would eliminate the incentive in the present system to develop new hospitals and units (adding ever more cost) and compensate all providers based on services provided rather than the completely arbitrary and inequitable TEFRA system. Most importantly, a PPS for rehabilitation would eliminate the most perverse aspect of the present system--the explicit message to hospitals to avoid severely disabled patients. The Congress never envisioned such an effect when TEFRA was adopted as a temporary measure.

A PPS for rehabilitation, even if budget-neutral upon adoption, would result in considerable savings to the Medicare program by eliminating the strong bias in favor of new providers. In the short term some providers of services would receive less in Medicare payments as the inequities of the present system are rectified. But, payments based on patient need can only serve the legitimate interests of both hospitals and patients - and the government - over the longer term.

Legislation has been introduced in the House to authorize PPS for rehabilitation facilities, based on the payment system developed by RAND. The text is suitable and is commended to the Committee. It is H.R. 585 the Rehabilitation Hospitals and Units Medicare Payment Equity Act of 1997.

III. THE PRESIDENT'S MEDICARE PROPOSALS WOULD NOT FIX THE FLAWS OF THE TEFRA SYSTEM

Unfortunately, the President's proposals for Medicare reform do not include a PPS for rehabilitation, although prospective payment systems are proposed SNFs and HHAs. The Administration would continue the thoroughly discredited TEFRA system, albeit with adjustments. This is essentially an endorsement of present payment policy, for which no affirmative defense is (or can be) offered. TEFRA has failed to control costs and has distorted patient care in the process. In its 1996 Annual Report ProPAC reported sharply higher payments for rehabilitation and long term hospitals. This was found to have occurred largely because of the TEFRA system which, ProPAC noted, "encourages the development of new facilities and rewards those that have high costs." In its 1997 March 1 Report ProPAC was stronger on this point. It recommends a case-mix adjusted prospective payment system for rehabilitation hospitals and distinct-part units should be implemented as soon as possible. It stated "Because the work to develop a prospective payment system based on FIM-FRGs should be completed soon and the system has strong support from the rehabilitation industry, implementation in the near term is feasible."

The President's proposals would continue the incentive under TEFRA for providers to avoid severely disabled patients. This flaw will continue until a prospective payment system which adjusts payments for case mix is adopted.

The Administration's proposals for tinkering with TEFRA are discussed below. They are mixed in their impact. Their worst feature is the illusion that they cure the flaws of present law, without doing so. They would not provide an adjustment for payment reflecting case mix. Only a PPS will do that, but enactment of them would likely be taken as having "fixed" TEFRA and thereby eliminate the need for a PPS, a very unfortunate outcome. An analysis of the components of the President's proposals based on documents received to date and discussions follows, without having the final documents or language,:

- **Rebasing of TEFRA Limits.** The Administration would rebase TEFRA facilities using an average of FYs 1992 and 1993. While rebasing has the superficial appeal of making all equal by adopting recent cost as the basis for future limits, in fact rebasing would perpetuate the inequities of the past. It would lock into new TEFRA limits the discriminatory effects of old ones while doing nothing about the obvious need for a payment system that reflects case mix. Were these interim measures tied to a date for

implementation of a PPS they would be more suitable. However, enactment of these proposals would likely be used to rationalize further delay on a PPS and thereby do more harm than good. The Budget proposes to keep TEFRA through at least 2002.

• **Elimination of Incentive Payments.** If TEFRA limits are rebased there should be an incentive to reduce cost per discharge under new limits. Rebasing would eliminate incentive payments relative to old limits. There is no reason to eliminate them with respect to new ones.

• **Floors and Ceilings on Limits.** No TEFRA limit would be less than 70% of the national average (for the appropriate type of provider) and adjusted for regional wage variations. This is a good idea, if done as an interim measure. A ceiling of 150% would be applied as well. As temporary expedients these actions might mitigate the effects of the TEFRA system, but without a case mix adjustment factor, they have no fundamental logic.

• **Updates.** An update of TEFRA limits at market basket minus 1.5% has the effect of continuing to encourage providers to admit and treat low cost patients and avoid more disabled and complex cases. Without adjustment of payments for case mix, lowering limits inevitably has this effect. This proposal again makes the case for a PPS so that payments are scaled to patient need and the efforts of smaller updates apply evenly to all facilities and patients.

• **Reduce Capital Payments.** The Budget proposes to reduce capital payments by 15%. Without a PPS, in which capital cost would be subsumed, this proposal is quite arbitrary. Most new facilities, the creation of which was induced or aided by the TEFRA system, have much higher capital cost than older ones. They would still receive much higher payments.

• **OBRA 93 Variable Updates.** The provision of variable updates, depending on whether a hospital or unit's costs are over or under its limit, is a sound idea. Under OBRA '93 facilities with limits 110% or more over their limits received the full market basket for TEFRA facilities as the update. Facilities under their limits receive the market basket minus 1%. This authority was enacted for FYs 1993 -1997. It would be eliminated under the Administration's proposals. If rebasing produces less variance from limits it may have limited effect immediately after rebasing, but over time TEFRA limits will inevitably become obsolete. This authority should be retained to protect facilities over their limits.

• **Adjustments**. The President would largely eliminate administrative adjustment of TEFRA limits. This makes no sense, particularly when coupled with the use of TEFRA well into the future. Since there is no case mix adjuster in the system it is essential that recourse to administrative adjustments continue.

• **OBRA 90 Cost Sharing.** This provision would largely be eliminated by having it apply only to cost more than 10% above a limit. Since most cost over limits is in this band the effect of this change would be to largely eliminate the source of relief. The present system should be retained.

• **Redefinition of "Transfer".** The Budget contains a proposal for reducing certain PPS payments for acute hospital services when a patient is moved to a rehabilitation provider. This is accomplished by defining such a move as a transfer rather than a discharge and admission. This change would provide an incentive to retain patients in acute beds longer, rather than initiating rehabilitation in a timely manner or sending them home when it may be inappropriate. It also would destroy the concept of averaging, an essential ingredient of the DRG system, by reducing payments on stays below the average, but not increasing them for stays over the average. ProPAC has recommended

against any such policy. It should be rejected.

• **Authority for a Comprehensive Post-Acute Prospective Payment System.** The Administration proposes that HCFA be given statutory authority to implement a comprehensive PPS for all post-acute services (rehabilitation, SNF, HHA, long term care hospitals). Apparently, the adoption of any such system would not, under any circumstance, be during the five-year period for which projections are made in this Budget proposal. This means that the adverse effect of the TEFRA system will continue past FY 2002. Unless the Congress enacts a PPS for rehab, a "temporary" measure to control costs pending a PPS will last at least 20 years!

Does the notion of a comprehensive payment system for post-acute services make sense? Perhaps in the long run. Does it make sense to continue a flawed system in the meantime, when a better alternative is available? Absolutely not.

Prospective payment schemes are proposed for SNFS and HHAs, when the methodologies for these types of providers are less developed and discrete than that fashioned by RAND for rehabilitation patients. If PPSs for these providers do not prejudice the movement to an ultimately unified payment system for post acute service, neither does one for rehabilitation. The stated goals of such a system are to recognize the relative costs of treating different kinds of patients and to avoid incentives to treat patients in one venue or another, depending on payment. These goals can be achieved for rehabilitation by implementation of the RAND payment system for rehab. If, and as, HCFA perfects an alternate or complementary system, a RPPS can be modified accordingly or integrated into it. It is hard to imagine a comprehensive case-mix adjusted system that is incompatible with the weightings produced by the FRG system. Thus, early implementation of a PPS for rehab based on the RAND report will further, not retard, the longer term goal.

IV. BUNDLING REHABILITATION INTO THE DRG PAYMENTS IS A POOR IDEA

Before concluding, I would like to address one other point. From time to time, it has been suggested, most recently by a CBO report "Medicare Spending on Post-Acute Care Services: A Preliminary Analysis" that rehabilitation services should be "bundled" into DRG payments. ProPAC has recommended that a demonstration of this idea be started. This is not a good idea, or at least the mechanics are sufficiently difficult as to defeat the principle.

In addressing this manner I assume that "bundling" means increasing a DRG payment and making the DRG provider responsible for rehabilitation and other post-acute services. Presently the DRG payment covers only the acute stay, and the provider of rehabilitation is paid separately.

The main reason to oppose bundling is its potentially adverse effects on patient care.

Acute care medicine is addressed to the immediate medical condition of patients. It focuses on the pathology and chemistry of a given diagnosis. Rehabilitation is concerned with the patient's ability to function--to perform the daily activities of living, working and otherwise enjoying life. For example, in the acute phase, a physician attending a stroke patient is concerned with reducing cranial swelling and the potential for another stroke through drug therapy. Rehabilitation of the patient would center on restoring or improving his or her ability to walk, talk, use his or her arms and legs and adapt to any residual limitations of these functions. This is done through the interdisciplinary provision of physical, occupational, speech and other therapies, as well as psychological counseling to deal with the depression that often accompanies newly experienced physical disability. Rehabilitation also involves working with families and others who are affected by the patient's condition and whose response is likely to affect the patient's progress.

Good medical practice calls for the coordination of these different types of services, but in concept and philosophy they are quite different.

The fundamental problem with bundling rehab into DRGs is that it creates a conflict of interest for acute providers, who will have a strong financial incentive to deny or abridge rehabilitation services. About 860 hospitals have rehabilitation units, but most do not. There are over 5,000 hospitals in the country. The incentive to give short shrift to rehabilitation is particularly telling in the case of a hospital that must refer the patient to another provider for services. Thus, bundling would likely reduce the availability of rehabilitation services and/or encourage the creation of more rehabilitation units, duplicating capacity that now exists.

Further, to my knowledge there is no basis for computing the amounts by which DRGs should be increased for rehab (and/or other post acute services). Such costs vary widely depending on the patient's diagnosis, age, degree of impairment, family circumstances, medical condition and other factors. As noted, a patient classification system for rehabilitation patients has been developed and we hope it will serve as the basis for a PPS. It does not, however, tie to DRGs. Rather, its primary element is the functional status of a patient upon admission to rehabilitation. Thus, any bundling of rehabilitation into DRGs would be extremely arbitrary and therefore harmful to patients.

Finally, there is no current system to monitor whether care is appropriately provided under such a system; in other words, to measure outcomes. Rehabilitation providers are unique in the health care system in that they focus on outcomes--the improved functional capabilities of their patients. A decline in utilization of their services, which would inevitably accompany bundling, would result in a loss of such focus and higher levels of residual impairment and dependency. It would also likely result in higher acute medical costs as patients do not regain function and independence.

For these reasons we believe that bundling rehabilitation into DRGs is a very poor idea.

V. CONCLUSION

The actions taken by this Committee and this Congress with respect to the Medicare program will have profound effects on persons who have or acquire disabling conditions. The actions we recommend will preserve and enhance the availability of rehabilitation services to Medicare beneficiaries while eliminating wasteful and inequitable practices under current law and provide for longer term budgetary savings.

Again, Mr. Chairman, thank you for this opportunity. I will be pleased to answer any questions.

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Chairman THOMAS. Thank you, Ms. Yosko.
Mr. Laughlin.

STATEMENT OF J. ROD LAUGHLIN, PRESIDENT, TRANSITIONAL HOSPITALS CORP., LAS VEGAS, NEVADA; AND PRESIDENT, LONG TERM ACUTE CARE HOSPITAL ASSOCIATION OF AMERICA

Mr. LAUGHLIN. Thank you, Mr. Chairman. Mr. Chairman and Members of the House Ways and Means Subcommittee on Health, my name is Rod Laughlin. I am president of Transitional Hospitals Corporation in Las Vegas. I am also president of the Long Term Acute Care Hospital Association of America. I appreciate the opportunity to speak to you to address the President's proposed Balanced Budget Act of 1997 as it addresses payment for long-term care hospitals.

Our association supports a PPS-type system for long-term care, and we look forward to providing any data that HCFA may need to assist in development of that sort of system. In the interim, we

are willing to absorb our fair share of reductions in Medicare payments.

ProPAC noted in 1994 that PPS-exempt providers accounted for about 7.2 percent of total part A payments. The long-term care hospitals represent only 10 percent of that amount, or about seven-tenths of 1 percent of total part A payments. So we really are a small piece of the Medicare problem.

Based on the CBO's March 1997 analysis of the President's budget, the PPS-exempt hospitals should not be asked to bear more than about $3.7 billion in cuts on a fair-share basis.

Medicare reductions are more hurtful to long-term hospitals and other PPS-exempt hospitals, as you have heard, because we tend to have a higher percentage of Medicare patients—typically, about 65 percent in the exempt hospitals, compared to 35 to 40 percent in regular community hospitals. PPS-exempt hospitals have a greater dependency on Medicare revenues, and they are less able to shift unreimbursed Medicare costs to other payers.

I would like to discuss our position on several issues that have been proposed as ways to reduce costs and save money for Medicare. First of all, with regard to the moratorium on new long-term hospital exclusions, our association is totally opposed to that moratorium. I think the moratorium probably came about as a result of some of the percentages of growth that have been tossed out, numbers at 30 percent annual growth and even higher.

I would like to say, though, that those percentages are misleading because they are starting from a very small base. Even today I think there are only 186 or so long-term hospitals in the whole country. The largest growth in this long-term hospital sector is in the hospital-within-hospital area.

HCFA has in place ample regulations to control the growth of hospitals in hospitals. These regulations are not being consistently enforced region by region. There is not consistent interpretation of the rules by all of the various intermediaries. And the first step that should be taken is to ensure that those rules are consistently applied. That will cut down on a number of the hospital-in-hospital facilities that exist currently that violate the rules.

Finally, the moratorium is a bad idea because it eliminates important treatment services that achieve very good patient outcomes—sometimes medical miracles—that are not generally available in short-term facilities, and certainly not available in some of the sub-acute facilities and nursing homes that are not able to treat the high-end acute patient that our association represents.

With regard to the cap on the TEFRA target, rebasing, other changes to TEFRA, we are opposed to those changes, not because TEFRA is not a flawed system and does not need some changes, but we are opposed to a single approach to TEFRA. The reason for that is that there are a number of different types of hospitals within the category called long-term hospitals.

It is not our purpose to misrepresent ProPAC's position on this issue. In our presentation to you we quoted some statements from their report to Congress of March 1997. I would just say that the main reason ProPAC and no one else can distinguish the costs related to the two types of hospitals is that we do not have a patient

classification system. One of those needs to be developed by HCFA in the earliest possible time.

Putting a 150-percent cap on the TEFRA cost structure will put our association's hospitals out of business, because they are treating, by design, very, very sick patients. We treat the sickest of the sick. We do not have any chronic patients. We tend to discharge those patients. And so we have some higher cost, very sick patients.

We are in favor of maintaining the incentives on TEFRA at the present time. I think if there are going to be changes to TEFRA, again, they need to address the fact that there are at least two classifications of hospitals within the long-term category.

Two ideas we can live with are the reduction in the market basket updates of 1½ percent annually, which the CBO says saves about $3 billion over 5 years; and the reduction of the capital payments to 85 percent of allowable cost. That will save another $600 million over 5 years. These two items alone would save $3.6 billion from the long-term care category, which is just about our fair share.

In conclusion, let me say that we want to say "No" to the moratorium. We think any change to TEFRA needs to recognize the two classes of long-term hospitals. We think HCFA should be enforcing the current rules on hospital within hospital, which are being widely violated. We think cuts to all hospitals should be proportional to their impact in the Medicare Program. And we certainly support the development of a PPS system.

Thank you.

[The prepared statement follows:]

LONG TERM ACUTE CARE
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STATEMENT OF THE
LONG TERM ACUTE CARE HOSPITAL ASSOCIATION OF AMERICA
BEFORE THE
HOUSE WAYS AND MEANS HEALTH SUBCOMMITTEE
ON
PRESIDENT CLINTON'S BALANCED BUDGET ACT OF 1997
April 10, 1997

Mr. Chairman and members of the House Ways and Means Subcommittee on Health, my name is J. Rod Laughlin. I am the President of Transitional Hospitals Corporation as well as the President of the Long Term Acute Care Hospital Association of America. Thank you for the opportunity to present our views on the President's proposed Balanced Budget Act of 1997. My remarks will focus on those provisions of the President's Medicare budget which target PPS-exempt hospitals and, in particular, provisions which impact PPS-exempt long term acute care (LTAC) hospitals. In discussing the Medicare proposal it is important to note that payments to all long term care hospitals constitute seven tenths of one percent (0.7%) of hospital Part A payments. It is within this proportional context that I will direct my remarks about the President's Medicare cost cutting proposals.

Before getting into the President's budget plan, it is important that I describe the differences between acute and chronic long term care hospitals. This is essential since Medicare does not currently distinguish between these two types of facilities. In fact, there are two types of long term care hospitals. One provides services for medically-complex patients who are critically ill - these are known as long term acute care hospitals. The other class of long term care hospitals is typically organized and staffed mainly to stabilize patients with much lower acuity levels - these are referred to as long term chronic care hospitals. The one common denominator between these two types of long term care hospitals is that, on average, their patient stays are 25 or more days. Typically, LTAC hospitals' patients have multiple body system complications and failures which require daily physician visits and significant ancillary and nursing services. Many of these LTAC hospital patients have respiratory problems and are ventilator-dependent. The goal for treatment is maximum medical recovery and a return to home and family.

The difference between acute and chronic long term care hospitals was recently highlighted in the March 1997 Prospective Payment Assessment Commission's Report And Recommendations To The Congress which states:

> "Long-term care hospitals are hard to define as a group . . . . because they provide a diverse mix of comprehensive rehabilitation, chronic respiratory care, and pain and wound management services. Despite this heterogeneity, long-term care hospitals generally fall into two major categories. Some facilities tend to treat more chronic types of patients who require less intensive services. A large proportion of newer long-term care

> hospitals, many of which specialize in respiratory services and weaning ventilator-dependent cases, appear to treat a sicker patient population." [Emphasis added.]

The LTAC Hospital Association has recommended to HCFA and ProPAC that, to be designated as an LTAC hospital, such a hospital must, at minimum, have an intensive care unit, be capable of treating ventilator-dependent cases, and have at least 30 percent of its patients with respiratory problems.

Such peer groupings of long term hospitals will result in a more equitable application of any payment reductions which are based on average cost per discharge. Proposals to cap target payment amounts or base year cost calculations by using an overall group average will, by definition, discriminate against those providers that treat sicker Medicare beneficiaries who require more intensive resources. In this regard, the ProPAC Report also states:

> "Much of the difference in financial performance among long-term care hospitals may be explained by their heterogeneous nature. . . . Because of this and the pressure of the payment limits over time, older hospitals have lower costs per case than newer ones. A more meaningful distinction among long-term care hospitals would be patient mix differences, which cannot yet be measured."
>
> "For these reasons, HCFA should step up its efforts to develop an adequate patient classification system for long-term care hospitals. Such a system not only would form the basis for a prospective payment system for these providers, but also would be an essential tool for analyzing differences in patient resource use and costs among long-term care hospitals."

The ProPAC Report specifically recommends:

> "A case-mix adjusted prospective payment system for long-term care hospitals should be developed and implemented as soon as possible."

The LTAC Hospital Association strongly supports this recommendation and we are willing to assist HCFA in gathering the data necessary for developing, administrating, and evaluating such a system. In the meantime, any payment limits on long term care hospitals must account for the two separate categories which ProPAC has recognized.

I would now like to share with you our reaction to the provisions of the President's budget plan that impact long term acute care hospitals.

SEC. 11207. MORATORIUM ON NEW LONG TERM CARE HOSPITAL EXCLUSIONS.

This proposal would, upon enactment, deny all new long term care hospitals the current exemption from the Medicare prospective payment system (PPS) for short-term acute-care hospitals. Since PPS is incapable of fairly paying such hospitals (due to their much longer than average lengths of stay), the proposed elimination of a PPS exemption would effectively prevent such facilities from participating in Medicare and would deny beneficiaries the value of such services. Never, in the history of the Medicare program, has Congress acted to deny beneficiaries access to

a covered service by precluding new providers from operating under an appropriate payment system.

The adverse and unfair impact of such a change was recognized by the Ways and Means Committee in 1993 and again in 1995 when it rejected earlier efforts by the current administration to impose such a moratorium.

CAP ON TARGET AMOUNTS FOR NEW LONG TERM CARE HOSPITALS

During the 1995 congressional budget debate, the Senate Finance Committee adopted a provision which would have established a cap on the payment limit or "target amount" for new long term care hospitals. The proposal would have limited the target for new hospitals to 130 percent of the average cost per case of all long term care hospitals. However, because of the major cost differences between chronic and acute long term care hospitals, such a cap would only impact new LTAC hospitals and prevent their future establishment. Consequently, to the extent this committee is considering such an approach, we strongly urge the committee to mandate that the Secretary of HHS establish two classes of long term care hospitals for purposes of establishing any payment limits - one for chronic and one for LTAC hospitals.

We cannot overstate the importance of the need to acknowledge and recognize the differences between acute and chronic long term care hospitals during the period until an appropriate PPS-type system is implemented. Such recognition is essential for the continued viability of long term acute care providers in any payment scheme which limits reimbursement based on an average cost per case.

SEC. 11208. PAYMENTS TO HOSPITALS EXCLUDED FROM PPS.

Reductions in Medicare payments present a special problem for PPS-exempt hospitals including LTAC hospitals. This problem stems from the fact that they treat a higher percentage of Medicare beneficiaries than PPS hospitals, i.e., on average, Medicare beneficiaries represent about 65 percent of PPS-exempt facilities' patient base and only about 35 percent of patients in general acute care hospitals subject to PPS. Thus, PPS-exempt facilities have a greater dependency on Medicare revenues than PPS hospitals and are less able to shift unreimbursed Medicare costs to other payers. As a result, the negative cost impact of the same percentage reduction on PPS-exempt hospitals is about twice that of PPS hospitals. Congress must carefully balance the need for budget savings with the financial vitality of PPS-exempt providers.

(a) REDUCTIONS IN UPDATES.

This proposal would reduce the update market basket factor by 1.5 percentage points annually for the five year period 1998 through 2002 for all PPS-exempt hospitals and units, including long term care hospitals. This discount is a third larger than the President proposed for PPS hospitals. Nevertheless, we believe that all hospitals have a shared responsibility to contribute to a balanced budget and a solvent Medicare Part A Trust Fund and are prepared to support this proposal.

(b) REBASING FOR PPS-EXEMPT HOSPITALS

This proposal would recalculate PPS-exempt hospitals' and units' target amounts while imposing an arbitrary range on these amounts. Such rebasing would reward inefficient hospitals and arbitrarily penalize those hospitals providing cost-effective services. We strongly oppose this proposal.

(d) ELIMINATION OF INCENTIVE PAYMENTS

Medicare provides economic incentives to PPS-exempt providers to control their reimbursable costs. In cases where the reimbursable costs are below the provider's target amount, Medicare not only reimburses the full allowable cost of providing services to Medicare beneficiaries but also pays the provider the lesser of (i) half of the difference between the ceiling and the provider's actual cost or (ii) 5 percent of the target amount. In order to receive the full incentive reward, a provider would have to have average costs that were less than 90 percent of its target amount. Between 90 percent and 100 percent of the target amount, the facility and Medicare share equally in the financial benefit. The administration proposes to eliminate this incentive policy. We believe, however, that the incentives reward efficiency and should be retained. We would be willing to consider adjustments in the sharing formula, if the aggregate impact of all payment reductions in reasonable.

SEC. 11209. REDUCTIONS IN CAPITAL PAYMENTS FOR PPS-EXEMPT HOSPITALS.

This proposal would reduce payments for capital costs to 85 percent of the allowable cost for PPS-exempt hospitals and units. This provision is more restrictive than that proposed for PPS hospitals. Such restrictions should be the same for all hospitals. PPS-exempt hospitals should not be required to carry more of the proportional budget balancing burden than PPS hospitals.

SEC. 11206. TREATMENT OF TRANSFER CASES.

This provision of the President's plan would redefine PPS hospital patient transfers to include PPS-exempt hospitals and skilled nursing facilities. Currently, PPS hospitals discharge such patients prior to admission to PPS-exempt hospitals and skilled nursing facilities. We believe that this revision would create inappropriate incentives for PPS hospitals to retain patients that could be treated more appropriately in post-acute settings.

In its March 1, 1996 Report to Congress, the Prospective Payment Assessment Commission (ProPAC), while recommending that " . . . Medicare payments should be modified to account for the shift in services from acute to post-acute settings . . .", went on to say that " . . . [b]roadening the definition of transfer cases, however, is not an appropriate solution." Essentially, ProPAC is concerned that such an approach will discourage the use of post-acute care providers and result in longer inpatient stays.

We believe that LTAC hospitals with specialized clinical teams of professionals can care for many patients in a more appropriate patient care setting and achieve better outcomes.

SEC. 11291. FEES FOR INITIAL SURVEY AND CERTIFICATIONS.

This proposal would impose a fee on new Medicare providers for their initial surveys and certifications. Noting the funding levels for this activity in the DHHS budget, we believe that this is a reasonable Medicare program change.

SEC. 11297. DEVELOPMENT AND IMPLEMENTATION OF AN INTEGRATED PAYMENT SYSTEM FOR POST ACUTE SERVICES.

This proposal would allow the Secretary to establish a single payment system for all post acute providers, including long term care hospitals. Such a system, while attractive on the surface, has major implications for the American health care delivery system that have not been addressed by the research community. While the proposal does not authorize the Secretary to implement such a system before 2002, no funds are authorized to conduct the necessary research. We are especially sensitive to the need for such research noting the long delay in development of a patient classification system for long term care hospitals. We would welcome the opportunity to participate in any further study of these issues.

CONCLUSION

In closing, the following summarizes our concerns about the President's proposed FY 1998 budget:

1. **Any change in the payment methodology for PPS-exempt long term care hospitals must include recognition of the distinct differences between acute and chronic long term care hospitals.**

2. **Medicare's PPS-exempt payment policies must remain fair and equitable for long term acute care hospitals.**

3. **Medicare's payment policies, if revised, must not include market entry restrictions for new long term acute care hospitals.**

4. **The aggregate impact of any Medicare payment reductions must be proportional to the PPS-exempt long term acute care hospitals' share of program payments.**

Finally, the Long Term Care Hospital Association of America believes that all parties have an obligation to contribute their fair share toward the goal of eliminating the federal deficit and securing a balanced budget. At the same time, we believe that no one group should be targeted for a disproportionate share of the budget savings. Based on its March 1997 "Report and Recommendation to the Congress," ProPAC noted in 1994 that PPS-exempt long term care hospitals accounted for 0.7 percent of total Part A program and beneficiary payments. And, by extension, ProPAC's analysis revealed that in the same year, PPS-exempt providers accounted for 7.2 percent of such payments. We believe that PPS-exempt providers should be limited to 7.2 percent of total Part A payments and long term care hospitals should not be expected to bear Part A provider savings greater than 0.7 percent. Thus, based on the Congressional Budget Office's (CBO's) March 1997 analysis of the President's budget, PPS-exempt providers should not be asked to bear more than $3.7 billion in cuts. According to the CBO analysis, the President has targeted PPS-exempt providers with about $4.1 billion in payment reduction - $400 million over our fair share.

Thank you, Mr. Chairman, for his opportunity to address this subcommittee. I would be pleased to answer any questions.

Chairman THOMAS. Thank you, Mr. Laughlin.
Mr. Standish.

STATEMENT OF JAMES F. STANDISH, VICE PRESIDENT AND CHIEF FINANCIAL OFFICER, HOSPITAL FOR SPECIAL CARE, NEW BRITAIN, CONNECTICUT; ON BEHALF OF THE NATIONAL ASSOCIATION OF LONG TERM HOSPITALS

Mr. STANDISH. Mr. Chairman and Members of the Subcommittee, thank you for inviting me to speak before you today on behalf of the National Association of Long Term Hospitals. My name is

James F. Standish. NALTH has approximately 45 member institutions located across the United States, 90 percent of which are not-for-profit organizations which exist for the benefit of the communities in which they operate.

While my remarks today are made on behalf of the National Association of Long Term Hospitals, many of the issues related directly to Hospital for Special Care, which participates in the Medicare Program as a long-term hospital and is located in New Britain, Connecticut. Hospital for Special Care is a founding member of NALTH, and I am the Hospital for Special Care's vice president and chief financial officer.

The notice of today's hearing correctly indicates that the current TEFRA system of payments treats older long-term hospitals differently than new long-term hospitals. In 1996 ProPAC reported to Congress that older, as opposed to new, long-term hospitals had the lowest margins of any type of hospital which participates in the Medicare Program. In fact, Hospital for Special Care loses an average of $5,000 per Medicare discharge.

In light of the unfair inequities which exist among TEFRA-rated hospitals it is important for Congress to assess a number of important issues related to the potential restructuring of any payment program governing long-term hospitals. A summary of recommendations by NALTH, to which I will testify today, are as follows:

Number one, the current TEFRA system, as others have said, should be discarded as soon as possible in favor of a long-term hospital prospective payment system. In fact, our association is spending upward of a half-million dollars to begin developing such a system, and expects to complete a long-term hospital patient classification system, together with a payment system, by the summer of 1998. NALTH will continue to meet with the congressional staff and HCFA as it develops the long-term hospital PPS.

We believe that a PPS is the only true solution to replacing the flawed TEFRA system which, as others have mentioned, was a temporary system we still live with 15 years hence. It is essential that a valid case-mix-adjusted patient classification system be at the root of a prospective payment system.

As was stated in the recent ProPAC report to Congress in March, payment amounts should vary depending on the intensity and nature of services beneficiaries require, rather than basing payment on the setting or type of long-term care facility providing the service. NALTH agrees with ProPAC's logic, and urges speed in the development of a patient classification system. This system should be pursued instead of establishing an arbitrary breakdown of long-term hospitals based on the type of facility. Again, the focus should be on the type of service provided.

Number two, while completing development of a PPS system, Congress should not require rebasing of TEFRA rates based on average cost, as has been proposed by the President. Again, the use of this average cost as a payment limit would produce an invalid patient classification system and reward hospitals which change the type of patients they serve to minimize resource use after the establishment of the new base year. It is well documented that long-term hospitals serve a heterogeneous mix of patients. The use

of an average would erroneously assume that long-term hospitals serve patients who require similar medical resources.

Number three, until a long-term care PPS is implemented, cost savings we believe may be achieved by imposing a national limit on the difference between allowable costs and TEFRA ceiling amounts. This is further outlined in Attachment C to my testimony on file.

The national ceiling would have two functions. First, it would place a limit on incentive payments for new hospitals; and second, it would reduce the rate of increase and target ceilings for existing long-term hospitals with incentive payments.

Number four, long-term hospitals with distorted base years, like Hospital for Special Care which has been significantly under-reimbursed, should be allowed to update their base year if they serve a significant disproportionate share population of 25 percent or more. This is more fully outlined in Attachment B to my testimony on file.

Number five, Congress should continue the minimum payment protections it has established for PPS-exempt hospitals whose allowable costs exceed their TEFRA limit. This issue primarily affects long-term hospitals with older target rates.

NALTH believes strongly that Congress should grandfather long-term hospitals which are colocated with other hospitals as of September 30, 1995, from special conditions of Medicare participation which the Secretary has applied to these hospitals.

In summary, I urge the Subcommittee to recognize that it is anticipated that NALTH's proposal for selective rebasing is made at least budget neutral by our cost-savings proposal. In addition, it is our intent for the development of the PPS system for long-term hospitals to also be budget neutral. Only a PPS for long-term hospitals which appropriately classifies patients by level of care will correct the unfair inequities which exist today under the flawed TEFRA system.

If interim measures are taken to modify the existing TEFRA system before a PPS is in place, I urge that you take the unfair inequities of the current system into consideration, and do not cause more harm to certain long-term hospitals. NALTH is prepared to work on a united front to resolve these issues.

I wish to thank you and the Subcommittee staff again for inviting me here today and for your courtesy and attention to these important issues, and I am pleased now to answer any questions you may have.

[The prepared statement and attachments follow:]

Statement of James F. Standish, Vice President and Chief Financial Officer, Hospital for Special Care, New Britain, Connecticut, on Behalf of the National Association of Long Term Hospitals

Mr. Chairman and members of the Subcommittee, thank you for inviting me to speak before you today on behalf of the National Association of Long Term Hospitals ("NALTH"). My name is James F. Standish. NALTH has approximately forty-five member institutions located across the United States. While my remarks today are made on behalf of the National Association of Long Term Hospitals, many of the issues relate directly to the Hospital for Special Care which participates in the Medicare program as a long term care hospital and is located in New Britain, Connecticut. The Hospital for Special Care is a member of the National Association of Long Term Hospitals and I am the Hospital for Special Care's Vice President and Chief Financial Officer.

Background

The notice of this hearing points to an extraordinary 41% annual growth rate in Medicare Program expenditures made to long term hospitals from 1990 to 1994. The notice of hearing also, correctly, indicates that the current TEFRA system of payment treats older long term hospitals differently than new long term hospitals. In 1996 PROPAC reported to Congress that "older" as opposed to "new" long term hospitals had the lowest margins of any type of hospital which participates in the Medicare program. NALTH believes it is important for Congress to assess a number of important issues related to the potential restructuring of the Medicare payment policy governing long term hospitals. A summary of recommendations by NALTH to which I will testify today, are as follows:

1. The current TEFRA system should be discarded as soon as possible in favor of a long term hospital PPS. Our Association is developing such a system and expects to complete a long term hospital patient classification and payment system by the summer of 1998. NALTH will continue to meet with Congressional staff and HCFA as it develops the long term hospital PPS. We recommend that this year Congress enact legislation which would authorize the Secretary, after consulting with Congress, to adopt a long term hospital PPS in the year 2000. The Secretary should be required to report to Congress on her progress in establishing a long term hospital payment system on or before the commencement of 1999.

2. In the interim, Congress should not require a rebasing of TEFRA rates based on average costs, as has been proposed by the President. The use of average costs as a payment limit would produce an invalid patient classification system and reward hospitals which change the type of patients they serve to minimize resource use after the establishment of the new base year period. It is well documented that long term hospitals serve a heterogeneous mix of patients. The use of an average would erroneously assume that long term hospitals serve patients who require similar medical resources. For the same reasons, as well as the technical considerations contained in Attachment "A" to my testimony, the 130% limitation on target rates of new hospitals contained in Section 8402(b) of last the year's Balanced Budget Act should not be adopted.

3. Until a long term care hospital PPS is implemented, cost savings may be achieved by imposing a national limit on

the difference between allowable costs and TEFRA ceiling amounts. The national ceiling would have two functions -- first, to place a limit on incentive payments for new hospitals and, second, to reduce the rate of increase in target ceilings for existing long term hospitals with incentive payments.

4. Long term hospitals with distorted base years, like the Hospital for Special Care, which have been significantly under reimbursed should be allowed to update their base year if they serve a significant disproportionate share population of 25% or more.

5. Congress should continue the minimal payment protections it has established for PPS exempt hospitals whose allowable costs exceed their TEFRA limit. This issue primarily affects long term hospitals with older target rates. At the present time, the Medicare program shares the loss incurred by these hospitals up to 10% of an individual long term hospital's target amount. Currently, long term hospitals with old base years are also allowed a full market update. This provision of the Act expires in 1997 and should be continued. The President's proposal would eliminate both of these necessary safeguards.

6. If Congress chooses to restructure the TEFRA system prior to adoption of a long term hospital PPS, NALTH proposes the following rules be established for long term hospitals in the future.

- Limit the number of Medicare discharges that would qualify for incentive payments to a base year ratio of hospital discharges to total hospital licensed bed capacity. This provision would eliminate the incentive of the current TEFRA system which allows "new" long term hospitals to maximize TEFRA target payment by increasing Medicare discharges after the establishment of a base year.

- Limit allowance of base year administrative costs to a grouping of long term hospitals by bed size, related party status, area wages and other appropriate hospital characteristics.

- As part of payment restructuring allow long term hospitals which have experienced two consecutive years of losses to be paid allowable costs for a two year period and to establish a new TEFRA base year subject to the above "new" hospital rules.

7. NALTH believes strongly that Congress should grandfather long term hospitals which are co-located with other hospitals as of September 30. 1995, from special conditions of Medicare participation which the Secretary has applied to these hospitals.

In considering issues related to long term hospitals I believe it is important for Committee members to understand the nature and scope of services these hospitals provide. In

November of 1995 Lewin-VHI issued a report which had been commissioned by the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services on various classes of non-PPS Medicare providers, including long term care hospitals. This report found that long term hospitals provided "unique services for special populations ... requiring long patient stays and complex care". In the past, when PROPAC reviewed the services provided by long term hospitals, it determined there was great variation in terms of case mix and intensity between long term care hospitals. Long term hospitals, in fact, provide services to patients who have suffered multiple body system failures requiring hospital technology and services. For example, the Hospital for Special Care specializes in ventilator weaning for pediatric and adult populations in an intensive care setting. The Hospital for Special Care also has specialized spinal and head injury; pulmonary, and neurological behavioral care programs. I understand that the largest AIDs unit in the United States is located in a long term care hospital. While long term hospitals are notable for the diversity of their programs, their patients share common elements. Long term hospitals treat patients who are at a hospital level of care due to catastrophic illness or an injury requiring specialized programs of care and who would deteriorate rapidly if placed in a lower level setting. A significant segment of long term hospitals serve patients who, during their hospital stay, convert to either MediGap insurance or, in many instances, to Medicaid eligibility. For this reason, some long term hospitals experience relatively high percentages of Medicare patient admissions and Medicaid patent days.

Medicare Payment Issues

Long term hospitals present unique payment issues which do not affect other classes of PPS-exempt hospitals. As PROPAC has noted on virtually an annual basis, long term hospitals serve a diverse patient population. Because long term hospitals provide patients with markedly diverse programs of care, the resources used to render patient care differ significantly between hospitals. Long term hospitals differ from rehabilitation hospitals and units which must serve patients who fall within ten standardized rehabilitation diagnoses. The President's proposal does not reflect the differences in resources used by long term hospitals and will not work well for long term hospitals for various reasons.

- First, the President's proposal would rebase all long term hospitals with a national ceiling and floor of 150% and 70% of national average cost. The use of a measure of central tendency such as an average is inappropriate for long term hospitals because, unlike other classes of PPS exempt hospitals, long term hospitals do not serve a homogeneous case mix. The payment limitations proposed by the President would provide an economic incentive to dismantle treatment programs for patients with complex medical care needs. These patients would become likely candidates for repeat PPS hospital and SNF admissions.

- Second, the President's proposal would eliminate incentive payments which are now available for PPS exempt hospitals which have reduced the growth of operating costs per discharge below levels authorized by Congressionally approved update factors. Incentive payments constitute a surrogate payment for the disproportionate share population which is uniquely cared for by long term hospitals. Since a disproportionate share methodology does not exist for PPS exempt hospitals, elimination of incentive payments would de facto penalize long term hospitals for continuing to serve catastrophically ill patients who may also be dually eligible for Medicare and Medicaid benefits.

- Third, the President's proposal would eliminate adjustments to TEFRA rates unless hospital costs exceed TEFRA limits by 150%. This provision would magnify one of the acknowledged flaws of the TEFRA system by insuring that the new base year becomes quickly distorted due to changes in patient severity, hospital technology and other factors.

The Committee is urged to consider a different approach to long term hospital payment policy. NALTH proposes that existing long term hospitals, on a selective one-time basis, be allowed a new base year. Hospitals such as the Hospital for Special Care, which has experienced two or more years of Medicare allowable costs exceeding its TEFRA payment limit, and which serves over a 25% disproportionate share population would be rebased under this proposal. So too would a long term hospital which is located in a state that provides no Medicaid coverage to Medicare beneficiaries who have exhausted their Medicare day limit and meet the other tests of this proposal. A complete description of this new base year proposal is included as Attachment "B" to my testimony.

We believe approximately 10 - 15 long term hospitals will qualify for rebasing under this proposal. This measure will partially address the inequity of the current TEFRA payment system for hospitals with distorted base years. Hospitals with distorted base years serve catastrophically ill Medicare beneficiaries and have no real opportunity to cross subsidize Medicare losses. It is important to note that PROPAC has found that the average Medicare payment to cost ratio is lower for "older" long term hospitals, like the Hospital for Special Care, than for all other classes of hospitals including PPS hospitals. Many of the "older" hospitals like the Hospital for Special Care, treat patients who require the same intensive hospital care as "new" hospitals, but do so for a lower average cost. Last year, PROPAC reported that for these hospitals Medicare payments covered only 85% of operating costs. The Hospital for Special Care loses $4,699 per Medicare beneficiary discharge in unreimbursed costs because its target amount of $10,994 is well below its Medicare allowable cost of $15,693 per Medicare patient discharge. The rebasing proposal would allow the hospital to role forward its base year from 1983 to year 1993 in order to recognize the current scope of services and related costs provided by the hospital. It is our hope and expectation that the Medicare cost

saving proposal which we have presented to the Committee will more than offset the cost of rebasing these hospitals.

Establishment of a Long Term Hospital Prospective Payment System

PROPAC has on an annual basis recommended the development of a prospective payment system for long term care hospitals. The National Association of Long Term Hospitals agrees with this recommendation and believes there is good reason to establish a long term hospital PPS. There is, perhaps, universal agreement among policy makers that the current TEFRA payment system has become inequitable and inefficient. To restore equity to long term hospital payment policy the National Association of Long Term Hospitals has engaged the Lewin Group to establish a PPS for long term care hospitals. The first phase of this project involved a feasibility study including an in depth review of whether the current short term, acute hospital PPS system could be used for long term care hospitals. The feasibility study determined that it could not because of large differences between acute and long term hospitals in length of stay. This research has been provided to the staff of this Committee as well as to PROPAC and HCFA. The Lewin Group did, however, find that there were promising correlations between DRGs, case mix and resource use by long term hospital patients. Current research being conducted by Lewin includes a reconfiguration of DRGs to reflect the variation in case mix across long term hospitals as well as a reweighting of DRGs to reflect differences in length of stay and resources used. NALTH anticipates presenting additional work on long term hospital PPS to the Staff of this Committee, HCFA and PROPAC in either June or July of this year. At that time we hope to have completed substantial work on the development of a patient classification system for long term hospitals. The current work plan for the study calls for the completion of a long term hospital PPS by June of 1998. The new long term hospital PPS will include a patient classification system and a payment system complete with outlier and disproportionate share payment methodologies. It is the National Association of Long Term Hospital's intention to establish a workable PPS system which is budget neutral.

Alternative Cost Savings Proposal

Attachment "C" to my testimony contains cost savings measures which the National Association of Long Term Hospitals believes Congress should consider in lieu of the President's cost savings initiatives. In making this proposal, the objectives of the Association are: (1) to provide financing for the selective rebasing of long term hospitals which meet a disproportionate share test; (2) to preserve the current payment system for long term hospitals which are currently certified until a long term hospital PPS is implemented; and (3) to create financial incentives to slow the growth of long term hospitals. Cost savings would be achieved by establishing a national ceiling on the difference between Medicare allowable costs and target rate ceilings. This difference between TEFRA ceiling amounts and allowable costs is currently used to calculate incentive payments for so-called "winner" hospitals under the TEFRA payment system. It is important to understand that TEFRA ceiling amounts for so-called "winner" hospitals are not actually expended by the Medicare program on patient care, but are included within

projected spending by the Congressional Budget Office. The cost savings proposal would reduce the difference between allowable costs and TEFRA limits to establish a national ceiling on both TEFRA ceilings and incentive payments for long term hospitals established in the future. The national ceiling would be established in a one time calculation at the 75th percentile of the difference between allowable costs and TEFRA ceilings for long term hospitals with incentive payments. As additional cost savings, long term hospitals with incentive payments would, in a graduated fashion, experience a reduction in update factors.

Grandfather Long Term Hospitals Co-Located with Other Hospitals as of September 30, 1995 and Make Certain Other Corrective Changes

HCFA has adopted regulations directed at long term hospitals which are co-located with other hospitals. The regulations set forth requirements to assure a long term hospital is independent from its "host" hospital in terms of the delivery of patient care services. The National Association of Long Term Hospitals does not object to the policy objective of these regulations. One aspect of the regulations, however, has proved to be inequitable. The regulations require that the two hospitals have independent governing bodies. HCFA's current interpretation of this regulation has had the following inequitable consequences. A long term hospital which is part of a state hospital system and located on the same campus as a state university teaching hospital is in technical violation of the regulation because local law requires that its governing body be a public hospital authority. Long term hospitals owned by various religious organizations and not-for-profit hospital parent organizations must be able to appoint and remove subsidiary hospital Board members and otherwise act as a parent organization in order to discharge their fiduciary duties. HCFA staff has recently rendered opinions, orally, that parent organizations may not exercise authority to appoint and remove Board members of subsidiary long term hospitals which are co-located with other hospitals on the same campus. A number of long term hospitals owned by states and not-for-profit organizations did not have notice of this regulation when they established their long term care hospitals. Accordingly, we believe it is appropriate to provide for a grandfathering of these hospitals from the regulation. We further believe it is important for the Boards of Directors of new long term hospitals to be able to adequately discharge their fiduciary duties through the appointment and removal of Board members of their corporate subsidiaries. The Congressional Budget office has estimated the grandfathering provision would increase Medicare outlays by $3 million in FY 1997 and by less than $.5 million in 1998.

Opposition to Section 11279 - Development of an Integrated Payment System for Post Acute Services

The National Association of Long Term Hospitals believes that good reasons exist to oppose this provision of the President's proposal. This proposal would essentially "carve out" the entire post acute spectrum of care for a single prospective payment. This type of payment system would create economic incentives which do not appear to be in the best interest of program beneficiaries. A large "post acute" payment would create a

powerful incentive to discharge patients even earlier from the fixed price PPS hospital setting. The establishment of such a payment system would require a patient classification system which would measure resource use from the home health care setting to the hospital level, including long term and rehabilitation hospitals. It may well be impossible to establish such a patient classification system. It should be remembered that HCFA has been attempting to establish a case mix based classification system for home health agencies for approximately 12 years. It would seem extraordinary that HCFA would be able to establish a valid payment system for a much wider spectrum of services in a few years. In connection with this issue, the National Association of Long Term Hospitals invites the Committee's attention to the perverse consequence that such an integrated payment system could have on beneficiary benefits. An integrated payment system premised on being "site neutral" is anything but "site neutral" from the beneficiary's perspective. Benefit days are determined based upon the site that a patient is treated. That is, there is a different benefit package available to patients treated in hospitals as opposed to skilled nursing facilities. Additionally, different co-insurance and deductible amounts apply depending on the classification of the site, hospital, SNF, or home health agency, where a Medicare beneficiary receives services. The incentive under an integrated "site neutral" payment system would be for patients to be shifted to the lowest level of care in order to trigger co-insurance payment amounts and to exhaust covered days as quickly as possible. This is a particularly serious problem for the extreme outlier population which is treated by long term care hospitals. We understand that this very problem has presented itself in the Medicare Managed Care Program. The current analogy for an integrated "site neutral" payment system is indeed the current Medicare managed care payment system. Research on this issue has noted the potential shifting of patients to an inappropriately low level of care, for example, to a SNF, to cause the exhaustion of Medicare benefits and the subsequent shifting of patient financial risk to other payors such as the Medicaid Program. See Attachment "D" hereto. Finally, Section 11279 calls upon Congress to abdicate its traditional oversight authority to review and approve payment systems. Accordingly, it should be rejected on policy grounds.

Opposition to Establishment of Two Classes of Long Term Care Hospitals

The National Association of Long Term Hospitals opposes the establishment of two classes of long term hospitals, one for so-called "chronic" and one for so-called "acute" long term care hospitals. What is needed is an appropriate patient classification system to measure and fairly pay for intensity of patient care and resource use. In order for any patient to be admitted to a long term care hospital, the patient must meet hospital level utilization review criteria. The Health Care Financing Administration has approved explicit long term hospital admission and continued stay screening criteria for Provider Review Organizations operating in two states. The establishment of two classes of long term hospitals for payment purposes would simply result in a new class of high cost TEFRA hospitals. We assume Congress would not endorse a policy which would encourage the creation of a large number of hospitals which only perform

heart transplants, because such hospitals would have extremely high costs. Heart transplants are usually performed in hospitals which also provide less intensive and, therefore, less costly, hospital services. Most NALTH members provide both high intensity services such as ventilator care and lower intensity services such as wound care which reduces overall hospital costs.

I wish to thank you again and the Committee's staff for inviting me here today and for your courtesy and attention to these important issues. I would be pleased to answer any questions you may have.

nalth\js.tst\jan

ATTACHMENT A

Technical Issues Relating to Section 8402(b) of the Balanced Budget Act of 1995.

- Subparagraph (ii) of Section 8402(b) is ambiguous whether the proposed 130% TEFRA payment limit applies to LTHs which were in the process of establishing a target amount and, therefore, were on a cost basis on October 1, 1995. If Congress is to pursue a 130% or similar target rate limit, NALTH believes this language should be clarified to exclude hospitals which were assigned a provider number of a non-subsection (d) (i.e. non-PPS) hospital until some date subsequent to enactment of this provision. In the absence of this clarification, the TEFRA limit might be applied retroactively to hospitals which incurred cost and established programs without notice of the 130% payment limitation. NALTH has proposed clarifying language concerning this issue which is included in Attachment 3.

- There is no provision to update the 130% payment limit from a 1991 target rate payment amount of approximately $16,160 per patient discharge. At the same time, under subparagraph (b)(i), a moving TEFRA rate floor would be established at 50% of the national mean target amounts for each fiscal year. If the 130% TEFRA ceiling is fixed at 1991 levels, the 50% TEFRA floor, which is to be recalculated annually, may at least theoretically exceed the national payment ceiling for new hospitals.

- Section 8402(b) would insert a new subsection (F) into Section 1886(b)(3) which would apply the 130% TEFRA rate payment limitation and 50% TEFRA payment rate floor to a "rehabilitation" hospital currently (or unit thereof)." Rehabilitation hospitals may not operate separate rehabilitation units, (see 42 C.F.R. §412.25(a)(l)(ii)), because a PPS excluded hospital may only be assigned one target amount per discharge. NALTH believes this language could be clarified to apply to rehabilitation hospitals and rehabilitation hospital units as defined by the Secretary. See 42 C.F.R. §412.23(b).

ATTACHMENT B

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March, 1997

NALTH SELECTIVE OPTIONAL REBASING PROPOSAL

NALTH proposes to allow long term hospitals which meet a disproportionate share test and which have experienced two years of Medicare losses to elect to change their base year period to the hospital's fiscal year 1993. Under the proposal, a long term hospital must satisfy two requirements to qualify for rebasing. First, the hospital would be required to have Medicare losses (i.e. its Medicare costs exceed its TEFRA limit) for both fiscal years 1992 and 1993. Second, a hospital must demonstrate that 25% or more of its inpatient population was Medicaid and Medicare SSI eligible during the hospital's 1992 and 1993 fiscal years. This disproportionate share test would be calculated in the same manner as is currently the case for hospitals subject to the prospective payment system with the exception that a 25% disproportionate share standard would be used. A long term hospital located in a state which provides no inpatient benefits under the Medicaid program to a Medicare beneficiary who has exhausted the day limit imposed on Medicare benefits would be excused from meeting the disproportionate share test. NALTH understands that Texas may be the only state that excludes this class of individuals from Medicare coverage.

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ATTACHMENT C

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NALTH COST SAVING PROPOSAL

March 18, 1997

I. Establishment of National Target Rate Ceiling.

- Savings are achieved:
  - By imposing a national limit on the amount LTH TEFRA ceiling amounts may exceed allowable cost.

Using the national TEFRA ceiling to limit the rate of growth of target amounts for existing LTHs and to limit target amounts for "new" LTHs.

- By establishing a national LTH target rate limit which would be calculated once, using the most recent cost reporting data for LTHs with incentive payments. Cost reports for LTHs whose costs exceed target ceiling amounts would not be used in the calculation of the national target limit.

- The national target rate ceiling would be calculated as follows and as set forth in the Attachment hereto:
  - For each LTH with an incentive payment, net program payments, composed of allowable program costs and incentive payments, would be subtracted from target rate ceiling amounts. This calculation will produce "authorized but not spent amounts" for each LTH. A sample calculation of authorized but not spent amounts is contained in column (e) of the Attachment hereto.

- The national LTH target rate limit would be set at the 75th percentile of "authorized but not spent amounts." Based on 1993 Medicare cost reports, NALTH has estimated the national limit on TEFRA ceilings under this method to be $8008.50.

II. Application of the LTH National Target Rate Limit.

- LTH TEFRA ceiling amounts would be reduced where authorized spending for an individual LTH exceeded the national limit as illustrated in column (h) of the Attachment hereto.

- It is proposed that LTHs certified for program participation at the time of enactment of the cost savings provision (i.e. current LTHs) would have their incentive payments calculated as if no national target rate limit was imposed.

- For "new" LTHs, the LTH national ceiling on target rate amounts would act as a ceiling on both allowable cost and incentive payments.

- The LTH national target rate ceiling would be subject to any PPS update authorized by Congress.

- For all LTHs whose target limits exceeded the national LTH TEFRA limit, TEFRA ceiling amounts would be reduced to the national limit as illustrated in column (h) of the Attachment hereto. In the example contained in the Attachment, authorized spending for the two hypothetical hospitals would be reduced 15% from $70,000 to $59,500 (column (g)÷(a)).

- Where a LTH target ceiling is reduced by the national limit, update amounts for future years would be applied to a lower target rate ceiling thereby reducing the growth of target amounts. For example, assuming a 2% update factor, the rate of growth in the target ceiling of Hospital "B", illustrated in the Attachment, would be reduced from $800 (2% of $40,000) to $600 (2% of $30,000), a 25% decrease.

III. Additional Savings Through Reduction in Up-Date Factor.

After imposition of the national limit on target amounts additional cost savings would be achieved by reducing the up-date factor in a graduated manner so that LTHs with the highest incentive payments would receive the greatest reduction as follows:

Percentile of Incentive Payments	Reductions in Up-date Factor
76% - 100%	75%
50% - 75%	50%
25% - 49%	25%
0% - 24%	0%

Note on CBO Scoring.

Currently, the CBO scores a reduction in the up-date factor as a major cost savings measure. A reduction in the update factor for TEFRA hospitals with incentive payments has only a marginal effect on TEFRA ceiling amounts and Medicare expenditures. An actual reduction of TEFRA amounts for LTHs should result in more significant cost savings because it directly reduces authorized spending.

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Cost Savings Proposal
National Association of Long Term Hospitals

	(a) Authorized Spending (TEFRA) Ceilings)	(b) Actual Cost	(c) Incentive Payment	(d) Net Program Payments (b) + (c)	(e) Authorized But Not Spent (a) - (d)	(f) National Limit[1]	(g) Reduction in Auth-orized Spending (e) - (f)	(h) Adjusted TEFRA Ceilings (a) - (g)
Hospital A	$30,000	$20,000	$1,500	$21,500	$8,500	$8,000	$ 500	$29,500
Hospital B	$40,000	$20,000	$2,000	$22,000	$18,000	$8,000	$10,000	$30,000
	$70,000	$40,000	$3,500	$43,500	$26,500		$10,500	$59,500

(----------Current Law----------)

nalth154.smg

[1] Based on NALTH's review of FY 1993 cost reports a national LTH target rate limit set at the 75th percentile of "authorized but not spent amounts" is estimated to be $8,008.50.

ATTACHMENT D

SUBACUTE CARE: POLICY SYNTHESIS AND MARKET AREA ANALYSIS

Submitted to:
Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation

Submitted by:
Lewin-VHI, Inc.

November 1, 1995

Lewin-VHI
A Value Health Company

[illegible]

VALUE HEALTH

care (expected to increase) and the form of care provided. But those we interviewed we: troubled by what they currently saw of managed care.

For patients whose care is paid for on a per diem basis, managed care health plan have a strong incentive to discharge that patient as soon as possible to a lower level of car and, eventually, home. A number of acute care and subacute care providers expresse: concern that these incentives are leading some managed care organizations to skimp on can and to discharge patients to the next level lower before the patient is ready. As discussed i Chapter Five, some institutional subacute providers believed they were being pressured t discharge some patients home before the patients were ready. Providers of home healt services expressed their concern that some of the patients they now see at home require a level of care better provided in an institutional setting. In brief, in most of our interviews we were told that managed care organizations are generally focusing on little else but costs.

We also found that there is considerable confusion about the Medicare managed care benefit when beneficiaries are treated in subacute care settings, including concern regarding the following issues:

- Concerns that some Medicare managed care plans are attracting new enrollees with the promise of "unlimited" hospital coverage, but in practice are moving these beneficiaries from acute care hospitals to subacute SNFs early in a spell of illness and then cutting off coverage after a limited stay;[2]
- Concerns that Medicare beneficiaries are not made aware of their right to question a non-coverage decision by managed care plans;
- Concerns that Medicare managed care patients may be being placed in non-certified beds at subacute care facilities; and

[2] Some long-term hospitals have been particularly concerned with this issue. While we were not able to verify the extent to which the situation actually occurs, we did hear about it from a number of concerned providers. The issue is described as follows in a issue paper prepared by a long-term hospital.

"As one of their enrollment inducements to Medicare beneficiaries, Medicare managed care entities frequently market unlimited day coverage for inpatient hospital care. Beneficiaries who join these Medicare "at risk" HMOs understand they no longer need to purchase the 365 day hospital benefit which is mandated for Medigap policies. It is, however, the experience of most PPS-exempt hospitals, including long-term hospitals, that Medicare managed care contractors divert virtually all post-acute PPS-exempt hospital patients to subacute facilities. By doing so, Medicare managed care contractors require Medicare beneficiaries to prematurely exhaust their limited 100 day nursing facility benefit, not their unlimited hospital benefit.

This referral pattern is unique to Medicare managed care contracting and is not based on price considerations or patient outcomes. Thus, the current Medicare managed care program provides an economic incentive to place chronically ill and disabled Medicare beneficiaries that qualify for hospital level services in "subacute" SNFs. This will cause beneficiaries to prematurely exhaust their Medicare SNF day benefits and spend down to Medicaid status."

Chairman THOMAS. I want to thank all of the panel. And as you noticed from the first panel, our ability to understand why we are doing what we are doing and the changes that have been made here are a little more difficult than in some other areas, because this is a kind of a patchwork operation; notwithstanding the fact that it is growing because services are being provided, apparently in ways that people want them in facilities that they want.

Trying to understand the charts, especially the one on the right: Mr. Foster, when you say "aggregate Medicare cost per discharge," can I change "cost" to "payment"? Is that what that is?

Mr. FOSTER. No, sir, that is cost.

Chairman THOMAS. If that is the aggregate Medicare cost per discharge, you get paid differently than that?

Mr. FOSTER. It depends on the TEFRA limit for the individual facility.

Chairman THOMAS. What does that show me, then? You see, to me a Medicare cost is what it costs Medicare in payment per discharge. But that is not what that chart is?

Mr. FOSTER. Yes, sir, that is what that is. What that chart shows with the existing system that is in place, the cost—we have acquired a lot of hospitals over the last 2 years, and there is a big variance in the TEFRA limit. And what that chart shows from 1994, the cost per Medicare discharge was 14,204. In 1996, that cost has gone down per discharge to 11,622.

Chairman THOMAS. But it says up top, "same store comparisons." So are we comparing different hospitals that came on at different times?

Mr. FOSTER. No, sir. No, that is same store.

Chairman THOMAS. It says "same store comparisons."

Mr. FOSTER. Right. I am sorry, yes, sir.

Chairman THOMAS. So one store in 1994 is the purple line, and in essence the same store is the 1996 green line?

Mr. FOSTER. Yes, sir, correct. You are correct.

Chairman THOMAS. So in 1994, getting back to Mr. Becerra's concern about administrative costs——

Mr. FOSTER. Yes, sir.

Chairman THOMAS [continuing]. Since that is not a broken-out item, if we can, to try to explain it, let us assume that the hospital opened in 1994. Can we do that?

Mr. FOSTER. Yes, sir.

Chairman THOMAS. Will that work?

Mr. FOSTER. OK.

Chairman THOMAS. Let us say it opened in 1994. And you have fixed where you have administrative costs. And you have maybe 100 patients. Now, is it possible that between 1994 and 1996 the administrative costs would remain the same, but you could perhaps double your patient load to have 200 patients for the same administrative costs, which would certainly show a cost-per-discharge reduction, and that would be an efficiency kind of thing?

Mr. FOSTER. Yes, sir, per day. If you have more patient days divided into your total cost, if your census increased from 50 to 100, your cost per day would go down, and it would affect that. You are absolutely correct.

Chairman THOMAS. So you could open up with a top-heavy administrative arrangement in the hospital, not increase it over that period, but add what would be the normal amount of patients, and get this same chart?

Mr. FOSTER. Theoretically, you could.

Chairman THOMAS. Rather than build the administration as your patient load increases?

Mr. FOSTER. Yes, sir.

Chairman THOMAS. And would there be any incentive for having a top-heavy administration when you opened the hospital, versus building the administration as the patient load grew, under current reimbursement structure?

Mr. FOSTER. Theoretically, yes, sir.

Chairman THOMAS. In the real world, is there?

Mr. FOSTER. No, sir.

Chairman THOMAS. No.

Mr. FOSTER. No, sir.

Chairman THOMAS. You would not be reimbursed more if you had a larger administrative structure going in?

Mr. FOSTER. You would, yes, sir. But I am saying that is not the case with this data. Same stores in 1994 included a lot of hospitals that came on with our company.

Chairman THOMAS. I understand. But if you look at the 11,600——

Mr. FOSTER. Yes, sir.

Chairman THOMAS. Now, again, this is not what Medicare pays; this is the Medicare cost.

Mr. FOSTER. Right.

Chairman THOMAS. In discussing with the first panel and Ms. Wynn, where she talked about the percentage of incentive reimbursements, does any of this 11,600 reflect the reimbursement cost?

Mr. FOSTER. Yes, sir.

Chairman THOMAS. That is all of the money that comes from HCFA?

Mr. FOSTER. That is Medicare cost per discharge.

Chairman THOMAS. I understand that. But since we did not say it was Medicare payment——

Mr. FOSTER. Right.

Chairman THOMAS [continuing]. How does the 14,200 as a Medicare payment reflect any of the incentive payments that she discussed between 1994 and 1996? This is not discussed on this chart.

Mr. FOSTER. OK. The chart shows that the Medicare funds that are reimbursed to HEALTHSOUTH, or this particular facility, the funds that are reimbursed are going down, the expenditures that are required are going down.

Chairman THOMAS. Per discharge?

Mr. FOSTER. Yes, sir, cost per discharge.

Chairman THOMAS. Where would a chart show the total amount? Or are you telling me that the 11,600 is the total amount of payment? I know it says "cost." You do not have a payment chart. What I am looking for is, what would have happened between 1994, if this is the first year the hospital opened, and 1996, in terms of what it would cost us, if you will, the taxpayers, in terms of Medicare payment per discharge?

Mr. FOSTER. OK.

Chairman THOMAS. Where do the incentives show up? Or have none of your hospitals participated in that incentive program that she discussed?

Mr. FOSTER. Yes, sir. If you look at the 1994 data, say you have a TEFRA limit of, say, $16,000. Then you are allowed to participate with the current system up to 50 percent in the difference in the

cost per discharge and the TEFRA limit, not to exceed 5 percent of the limit. So in this particular case, as the cost goes down, it reduces Medicare expenditures.

Chairman THOMAS. But the amount per patient goes up? When you say "cost" there, is that cost plus the——

Mr. FOSTER. Yes, sir, per day. If you have more patient days divided into your total cost, if your census increased from 50 to 100, your cost per day would go down, and it would affect that. You are absolutely correct.

Chairman THOMAS. So you could open up with a top-heavy administrative arrangement in the hospital, not increase it over that period, but add what would be the normal amount of patients, and get this same chart?

Mr. FOSTER. Theoretically, you could.

Chairman THOMAS. Rather than build the administration as your patient load increases?

Mr. FOSTER. Yes, sir.

Chairman THOMAS. And would there be any incentive for having a top-heavy administration when you opened the hospital, versus building the administration as the patient load grew, under current reimbursement structure?

Mr. FOSTER. Theoretically, yes, sir.

Chairman THOMAS. In the real world, is there?

Mr. FOSTER. No, sir.

Chairman THOMAS. No.

Mr. FOSTER. No, sir.

Chairman THOMAS. You would not be reimbursed more if you had a larger administrative structure going in?

Mr. FOSTER. You would, yes, sir. But I am saying that is not the case with this data. Same stores in 1994 included a lot of hospitals that came on with our company.

Chairman THOMAS. I understand. But if you look at the 11,600——

Mr. FOSTER. Yes, sir.

Chairman THOMAS. Now, again, this is not what Medicare pays; this is the Medicare cost.

Mr. FOSTER. Right.

Chairman THOMAS. In discussing with the first panel and Ms. Wynn, where she talked about the percentage of incentive reimbursements, does any of this 11,600 reflect the reimbursement cost?

Mr. FOSTER. Yes, sir.

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funds that are reimbursed are going down, the expenditures that are required are going down.

Chairman THOMAS. Per discharge?

Mr. FOSTER. Yes, sir, cost per discharge.

Chairman THOMAS. Where would a chart show the total amount? Or are you telling me that the 11,600 is the total amount of payment? I know it says "cost." You do not have a payment chart. What I am looking for is, what would have happened between 1994, if this is the first year the hospital opened, and 1996, in terms of what it would cost us, if you will, the taxpayers, in terms of Medicare payment per discharge?

Mr. FOSTER. OK.

Chairman THOMAS. Where do the incentives show up? Or have none of your hospitals participated in that incentive program that she discussed?

Mr. FOSTER. Yes, sir. If you look at the 1994 data, say you have a TEFRA limit of, say, $16,000. Then you are allowed to participate with the current system up to 50 percent in the difference in the cost per discharge and the TEFRA limit, not to exceed 5 percent of the limit. So in this particular case, as the cost goes down, it reduces Medicare expenditures.

Chairman THOMAS. But the amount per patient goes up? When you say "cost" there, is that cost plus the——

Mr. FOSTER. The TEFRA limit, you would get 5 percent. Say your TEFRA limit——

Chairman THOMAS. You see, my problem is, it does not say "payments." It says "cost."

Mr. FOSTER. Yes, sir.

Chairman THOMAS. Now, we talked about the incentives. Is that cost plus the incentives, or just cost?

Mr. FOSTER. Oh, I see what you are saying. That is cost per discharge, yes, sir.

Chairman THOMAS. Where are the incentives?

Mr. FOSTER. The incentives are not shown. But the incentive would be constant, depending on your TEFRA limit. The thing that changes is you share in 50 percent in the difference of the cost.

Chairman THOMAS. But you have to have a base year.

Mr. FOSTER. Right.

Chairman THOMAS. And if we use 1994 as the base year, and you have got the 14,200——

Mr. FOSTER. Yes, sir.

Chairman THOMAS [continuing]. And you are now showing us that the cost per discharge has been reduced, but they give you an incentive payment based upon an interaction of that, and where is it on the chart? Is it in the 11,600, or would we add more money to the 11,600 in 1996 to show the incentive payments?

Mr. FOSTER. It is in the 11,600.

Chairman THOMAS. Total?

Mr. FOSTER. No, the incentive payment is not. The purpose of this chart——

Chairman THOMAS. No, I understand the purpose of the chart.

Mr. FOSTER. OK.

Chairman THOMAS. I am trying to get an answer out of you, because you do not have a chart that shows what I want to see.

Mr. FOSTER. OK. Yes, sir.

Chairman THOMAS. Which is what your Medicare payment was in 1994, and what your Medicare payment was in 1996.

Mr. FOSTER. OK.

Chairman THOMAS. You have shown me a cost per discharge.

Mr. FOSTER. Yes, sir. OK.

Chairman THOMAS. I can produce that chart by frontloading my administrative costs in 1994, and then holding them constant while I increase patients, which gives me a lower cost per discharge——

Mr. FOSTER. Absolutely.

Chairman THOMAS [continuing]. And wind up making more money.

Mr. FOSTER. Absolutely.

Chairman THOMAS. And that chart shows me—in other words, it does not tell me anything. You would have to tell me in your 1994 hospital what your percentage of administrative costs were, versus 1996. And I have got to believe that you are not getting that amount of money per patient in 1996, 11,600, versus 14,200. So I guess a simpler question is, what does this chart show me, and why did you put it up?

Mr. FOSTER. OK. What I am trying to show you, sir, is the hospitals that are in this 14,204 were hospitals that are same stores, but they are hospitals that we acquired, that came into the company where the base year had already been established. And these costs have been reduced not by increasing census, but by decreasing a lot of the administrative costs that were in the facilities that came on with HEALTHSOUTH. And that is why we support the elimination of the new——

Chairman THOMAS. Yes, but that chart does not show me that.

Mr. FOSTER. OK.

Chairman THOMAS. Because there is no patient load number.

Mr. FOSTER. Yes, sir.

Chairman THOMAS. Have you increased patients?

Mr. FOSTER. No, sir, patient load would be about the same. Patient days would be about the same.

Chairman THOMAS. Well, I guess what we need is, obviously, more data to be able to understand the argument that you are making.

Mr. FOSTER. Yes, sir.

Chairman THOMAS. Because I can wind up creating a chart like that either through the ratio of administration to personnel and the incentive payment with a number of adjustments. I am trying to figure out what I am getting except three lines going down.

Mr. FOSTER. Yes, sir.

Chairman THOMAS. Which I understand was the intent. But it does not tell me anything. I just wanted you to know.

Mr. FOSTER. Yes, sir.

Chairman THOMAS. I also have in my charts—and you did not put it up—you have a big one called "Charges."

Mr. FOSTER. Yes, sir.

Chairman THOMAS. I do not know what that means.

Mr. FOSTER. That is charges per discharge per patient. That is gross charges. What that shows, as costs go down, charges have gone down, and clinical outcomes have improved. And under the

current system, you have the incentive to reduce your cost and to reduce the outlay of funds from Medicare because of the 50–50 share, not to exceed 5 percent of the limit.

Chairman THOMAS. I understand the argument.

Mr. FOSTER. And very frankly, sir, that is one reason that we support elimination of the new provider exemption.

Chairman THOMAS. I guess one of my difficulties is that, if you are going to go ahead and provide us with charts, you really ought to provide us with charts that I think make your point fairly easily.

Mr. FOSTER. Yes, sir.

Chairman THOMAS. Rather than having three lines that look good that go down.

Mr. FOSTER. Yes, sir.

Chairman THOMAS. Because I do not understand why you put Medicare cost per discharge, instead of Medicare payment per discharge, because frankly our concern has been the payment.

Mr. FOSTER. Yes, sir. But the savings come in the cost, and not necessarily the payment. In other words, if it costs $14,000 per discharge—my example for the DRG. If this was a PPS facility and, say, my DRG payment was $20,000 and my cost was $14,000, a DRG or a PPS facility would share 100 percent in that. If it is a PPS-exempt facility, then it is no more than 5 percent of the limit. It is 50 percent of the difference in the cost per discharge, not to exceed 5 percent of the limit. So these savings are passed on to Medicare——

Chairman THOMAS. That is an argument that could be made for that.

Mr. FOSTER. Yes, sir.

Chairman THOMAS. But I just want to say that, based upon the payment structure that was explained to us and the incentive payments that are included, a front-heavy administrative structure with lower patients, if when keeping that front-heavy administrative structure and bringing more patients in, can produce the same chart. Do you agree?

Mr. FOSTER. Yes. I agree.

Chairman THOMAS. So what I am telling you is that chart does not tell me anything. Because I can create the same-looking chart by gaming the system by introducing a hospital in the last 5 years that has, as the ProPAC showed us, the higher base, and then play the game. So I am just trying to say, if you are going to present us with a chart that you want to use to convince us of a certain thing, you ought to not be able to have it interpreted four different ways.

Mr. FOSTER. Yes, sir.

Chairman THOMAS. Especially two ways, one of which is negative and one of which is positive.

Mr. FOSTER. Yes, sir.

Chairman THOMAS. Ms. Yosko.

Ms. YOSKO. Yes.

Chairman THOMAS. You are in favor of that RAND rehabilitation study?

Ms. YOSKO. Yes.

Chairman THOMAS. My understanding is that one of the comments that Ms. Wynn and others made was that 70 percent of the

freestanding rehabilitation hospitals were not included in that study. Is that true?

Ms. YOSKO. I am not exactly sure of the mix that was included in the RAND study. But we have been involved with a lot of the reviewing of the data that is coming out of RAND. We are waiting for the report that is due out this month. And we believe that it is a sound system and that there may be some technicalities, but the technicalities could be worked out.

Chairman THOMAS. So you do not think a study that leaves out 70 percent of the freestanding rehabilitation hospitals is in any way flawed?

Ms. YOSKO. We believe that today the FRG system is probably the best mechanism we have. It is a system that really does adjust for case mix. And the current system, the TEFRA system——

Chairman THOMAS. Well, no, I understand. Let me ask you another question, then. Why would you leave out 70 percent of the freestanding rehabilitation hospitals in a study? I mean, was that on purpose?

Ms. YOSKO. I cannot address that. Our organization, the American Rehabilitation Association, was not involved with the selection process of that, so I cannot address that, sir.

Chairman THOMAS. Well, you understand our concern, if you are going to ask us to support legislation based upon a RAND rehabilitation study which in fact leaves out 70 percent of the freestanding rehabilitation hospitals, that creates an automatic question on the validity of the data that we receive. My guess would be that you probably would want to try to provide the best data available. And I guess I will have to talk to RAND as to why they would ignore that segment of the industry, or do you know something about that segment of the industry that would produce a study significantly different and so that is why it was left out?

Ms. YOSKO. I cannot address that.

Chairman THOMAS. I cannot, either. I would just suggest that if you are going to ask us to support legislation backed by the RAND rehabilitation study, somebody had better figure out what we do when 70 percent of the freestanding rehabilitation hospitals are not included in this study. That is going to be tough.

Mr. Laughlin, long-term acute care hospitals, how many do you have?

Mr. LAUGHLIN. Our company?

Chairman THOMAS. Yes.

Mr. LAUGHLIN. Our company has 20.

Chairman THOMAS. Twenty? How many of them were opened in the last 5 years?

Mr. LAUGHLIN. All of them.

Chairman THOMAS. What prompted you to open them in the last 5 years, rather than in the previous 5-year window?

Mr. LAUGHLIN. Well, I just decided to start the company in 1992.

Chairman THOMAS. Any reason why in 1992?

Mr. LAUGHLIN. I recognized that this was a treatment area that had a great need across the country.

Chairman THOMAS. It had nothing to do with the payment cost ratio between hospitals that are new startups versus old hospitals?

Mr. LAUGHLIN. No, sir. I did not even know about that disparity.

Chairman THOMAS. Right. OK.

Mr. Standish.

Mr. STANDISH. Yes.

Chairman THOMAS. In your testimony, you say in your second point, "Incentive payments constitute a surrogate payment for the disproportionate share population which is uniquely cared for by long-term hospitals."

I thought incentive payments, as discussed, were to reward hospitals for keeping their costs below their ceiling.

Mr. STANDISH. They are. I think that the point made is that, because of the severe nature of the disease and illness of our patients, they tend to be those that at some point in their term of illness will cross over to the Medicaid Program.

Chairman THOMAS. But you do not think the incentive payments were set up to be a surrogate payment for the disproportionate share population, do you?

Mr. STANDISH. No.

Chairman THOMAS. Or that is just the way you guys view them now?

Mr. STANDISH. Right.

Chairman THOMAS. OK. Does it make sense? I mean, if you are going to provide a payment for a disproportionate share of the population, what about those hospitals that do not have that profile and are getting incentive payments?

Mr. STANDISH. If a hospital has a TEFRA limit that is reasonable and they are able to keep their costs below it, as I believe the incentive payment concept was originally conceived, then that payment process would make some sense.

Chairman THOMAS. Is it easier for a hospital that has been created in the last 5 years to do that, versus one that was created 10 years ago?

Mr. STANDISH. I would imagine so. Our hospital is 53 years old, and I am most familiar with it. But certainly, the data that has been presented would indicate that.

Chairman THOMAS. And given the rapid increase in the payments and the number of hospitals, is there something that has occurred in the last few years in terms of the unique approach of this kind of a hospital, versus the payment structure, that might account for the number of hospitals that have been opened, since you are a longtime one?

Mr. STANDISH. I am led to believe that many of the more recently opened long-term hospitals care for a population that does not include some chronic lower intense patients than others do.

Chairman THOMAS. Why?

Mr. STANDISH. I do not know the answer. Again, we are not one, so I do not know the answer to that. Our hospital cares for a large population of both, but primarily the sicker, just as the newer hospitals care for.

Chairman THOMAS. Does any panel member want to react to any question that I have asked?

Yes, Mr. Laughlin.

Mr. LAUGHLIN. Mr. Chairman, I appreciate the opportunity to answer that question. Our company was founded with that very mission in mind. We specifically did not want to be in the sub-

acute care business; we wanted to take the sickest patients we could find. A large majority of our patients come out of other hospitals' ICUs. And we are focusing on that patient that has been stabilized but needs an intensive intervention over a longer term period of time.

The kind of patient we are taking we refer to as the sickest of the sick. They are patients that are often on life support. They are people who have been unable to be weaned off ventilators or waked up from comas or dealt with in the normal short-term hospital according to their protocol. And we take that patient and get some outstanding results.

We are not keeping those patients into what I would call a chronic stage. Our average length of stay averages 45 days, so we are doing an intensive intervention in that patient and getting them to the point where either they are well and can go home, or we have taken them as far as we can. And at that point we make a discharge decision to another facility or to home with home health care support.

These are train wrecks, they are very costly patients because of the things that they need to have done to them. And that is why I am so concerned about any change in TEFRA that is not tied to an acuity measure.

Chairman THOMAS. Do you believe that there was a kind of a market created for this type of service because of the diagnostic related group structure imposed on hospitals; that this may have been done more frequently in hospitals prior to the DRGs being put in place?

Mr. LAUGHLIN. I do not think the DRG system has anything to do with it, really. The kind of patient I am talking about is a pretty rare patient. When we go into a community, there is no one hospital that has enough of these——

Chairman THOMAS. OK, then let me ask you some questions, because I am curious about how you got started. In 1992, you were looking at a niche that was there that had not been met, and you were going to meet it. And you were looking at providing a service for the sickest of the sick, in terms of the acute care structure. What came about for you to be able to focus in that market?

Mr. LAUGHLIN. In my own case, why did I start the company?

Chairman THOMAS. Yes. Yes, I am just curious.

Mr. LAUGHLIN. I started talking with a group of pulmonologists about what makes the difference in being able to wean a patient, and I learned that the longer a patient has been in somebody's ICU the harder they are to wean. And I also learned that the techniques they can follow in an intensive intervention, with 3 to 4 hours of respiratory therapy per day and bringing in a multidisciplinary team where everybody is focused on weaning that patient, can get outstanding results.

And in some of my hospitals we are weaning 80 percent of the people we get who have come to us as weaning problems. And it is all because of the technique we are applying to it.

Chairman THOMAS. And if we move toward a prospective payment system, what is it that you are most concerned about?

Mr. LAUGHLIN. I just have a concern that we need to get there. I am looking forward to providing the data from our hospitals and

working with HCFA to try to come up with a system that will work.

Chairman THOMAS. And once we get a system in place, what is it that you would be most concerned about not working?

Mr. LAUGHLIN. I think, as long as that system's design is reasonable and there is a testing period and a phase-in period for it, I do not see why we cannot adopt a system like that for long-term care.

Chairman THOMAS. So you are just willing to live with whatever system has been tested, because you would be at a level playingfield with other people who are doing the same thing?

Mr. LAUGHLIN. Exactly. I am sure we would lose money on some patients; hopefully, we make some, and we average out OK in the end.

Chairman THOMAS. Well, that is the way the system is supposed to work.

Any last comment on the prospective payment system from any of your particular perspectives, as to what you would be most concerned about? The same thing, as long as it is fairly reasonable and it is applied to everybody?

Mr. FOSTER. Yes, sir. One comment: The RAND study did not take into consideration comorbidities—or at least, it is my understanding that it did not—or acuity level of the patient. I think some consideration needs to be given to that, and onset days, the number of days a patient is in a PPS facility. Just minor.

Chairman THOMAS. Yes, I was not even going to get to the methodology of the RAND study.

Mr. FOSTER. OK. Yes, sir.

Chairman THOMAS. I just could not figure out why they had left out 70 percent of the hospitals.

Mr. FOSTER. Yes, sir.

Chairman THOMAS. That was what threw me.

Ms. YOSKO. May I add something?

Chairman THOMAS. If in fact that statistic is correct, and I will be talking to RAND to find out.

Go ahead, Ms. Yosko.

Ms. YOSKO. I have gotten some further information. Again, I am not a technical expert on RAND.

Chairman THOMAS. I understand.

Ms. YOSKO. But apparently, RAND used only large data bases for rehabilitation, which was the UDS. And they had really no interest to exclude any organizations. So about 40 percent of the Medicare patients who were receiving service were included in this study in 1994. And the outcome was that RAND found that patients in UDS reflected case mix for all rehabilitation patients.

Chairman THOMAS. So the 40 percent sample they were comfortable with gave them a pretty good reflection of 100 percent of the universe?

Ms. YOSKO. That is my understanding, yes, sir.

Chairman THOMAS. OK.

Mr. STANDISH. I just wanted to add, if I could, to make sure that it is understood that the National Association of Long Term Hospitals is undertaking an effort to develop a PPS system using Medpar data with the folks from Lewin. I think the question on the

biggest concerns that we have just is that we have been able to prove that the existing PPS system for acute care hospitals does not work for long-term hospital patients because of the long term of stay and the multiple comorbidities that exist with our patient population.

Chairman THOMAS. I just want to provide fair warning to everybody that, as was observed in the last Congress, there is a bipartisan interest—and Mr. Cardin I thought presented it quite well, without any prompting whatsoever—about the need to get on with this, both in terms of skilled nursing facilities and home health care, which were the areas that we focused on, frankly, in the last Congress. There is a bipartisan desire to have a system.

Those folks who do not think it is coming do not understand. And those folks who work with solid data to help us create a system, rather than us relying on HCFA or getting in a closed room and making a decision, have a better chance of getting a prospective payment system that does what we want it to do but, probably more important from your point of view, does not do the things you are afraid it is going to do if we do not work with you.

So we would love to look at any examples that you do come up with; notwithstanding whatever someone might say about the base study. We are going to find one, and we are going to implement it faster than HCFA indicates they are going to try to. I can assure you of that.

Does the gentleman from California wish to inquire?

Mr. BECERRA. Thank you, Mr. Chairman.

Let me go back to the discussion about charts and what they imply, and ask Mr. Foster if you could tell me—I hope you have the information—what your occupancy rate has been over the last several years?

Mr. FOSTER. It has been right around 80 percent.

Mr. BECERRA. Eighty percent?

Mr. FOSTER. Yes, sir, about 80 percent.

Mr. BECERRA. And are we talking about licensed beds, or available beds?

Mr. FOSTER. Licensed beds.

Mr. BECERRA. OK. I am looking at your FEC filing. It showed 70 percent for the year ending 1995, but it says—let me see, let me read the line. "During the year ended December 31, 1995, the company's inpatient facilities achieved an overall utilization, based on patient days and available beds, of 70.5 percent."

Do you mean there in this filing by "available beds," licensed beds, according to your answer that you just gave?

Mr. FOSTER. I would say licensed beds, yes, sir.

Mr. BECERRA. And you are indicating you have an occupancy rate of about—not utilization rate, occupancy rate—you did not mean 80 percent occupancy rate, did you?

Mr. FOSTER. I am not sure I understand your question.

Mr. BECERRA. OK. By 80 percent, you meant to imply that is the number of beds at some point filled?

Mr. FOSTER. Yes, sir.

Mr. BECERRA. OK. And that 80 percent corresponds to your last year of documentation? Are we talking 1996?

Mr. FOSTER. Yes, sir.

Mr. BECERRA. Do you happen to know what the occupancy rate or utilization rate—whichever we wish to use—of licensed beds was in 1995?

Mr. FOSTER. No, sir, I do not.

Mr. BECERRA. Do you have that?

Mr. FOSTER. The reason I do not is a lot of these facilities had come over in 1994 and had been in existence for years and years. An example is Mechanicsburg, Pennsylvania, when we acquired the NME Division rehabilitation facilities. That is one of the older rehabilitation facilities in the country, and it came over. So the historical data——

Mr. BECERRA. Do you have an easy way to track for the various facilities what the occupancy rate has been over the last, say, 5 years?

Mr. FOSTER. Yes, sir.

Mr. BECERRA. If we were to ask for that, would you be able to provide it?

Mr. FOSTER. Absolutely.

Mr. BECERRA. Thank you. Let me ask, and actually, Mr. Foster, you mentioned in your testimony a bit, that HEALTHSOUTH does not receive any disproportionate share payments. If I could ask each of the panelists to tell me, what percentage of your patient base is Medicaid, SSI, and uncompensated care, if you happen to know? And if you do not know, you can just tell me you do not know.

Mr. FOSTER. I do not know.

Mr. BECERRA. OK.

Mr. FOSTER. Are you talking about PPS-exempt Medicare?

Mr. BECERRA. Thank you for clarifying. PPS-exempt Medicare.

Mr. FOSTER. Medicare?

Mr. BECERRA. Yes. Well, let us put it this way. I am talking about PPS-exempt facilities.

Mr. FOSTER. Yes, sir.

Mr. BECERRA. And you mentioned that you do not receive any Medicare disproportionate share.

Mr. FOSTER. Yes, sir. What I intended to say was that there was a disproportionate share of Medicare patients in a PPS-exempt facility, if you looked at the national average, related to the reduction in the capital cost. So there is more of a Medicare mix in a PPS-exempt facility; at least, that is what our data shows.

Mr. BECERRA. And you are probably right. But I will tell you that I know a lot of PPS facilities that are salivating to get Medicare patients these days. So my question to you is, with regard to PPS-exempt facilities, do you know—and this is a question for all of the panelists—what percentage of your patient base is Medicaid, SSI, and uncompensated care?

Ms. YOSKO. I can speak for my own organization, Schwab Rehabilitation Hospital in Chicago. We have 55 percent Medicaid inpatient.

Mr. BECERRA. Five-five?

Ms. YOSKO. Fifty-five percent inpatient; and another 40—between 43 and 45 percent Medicare; and a couple of percentage points, about 2 percent, managed care patients; and the rest is uncompensated care.

Chairman THOMAS. How much would that be?

Ms. YOSKO. I am sorry?

Chairman THOMAS. How much would that be, the rest, when you say "the rest"?

Ms. YOSKO. Oh, well, the other 2 percent or so, 2 or 3 percent, to make up 100 percent.

Chairman THOMAS. So it is about 2 percent?

Ms. YOSKO. Ninety-five percent of our patients are either Medicare or Medicaid—about 55 percent are Medicaid; another 40 are Medicare—and about 2 percent is managed care.

Mr. BECERRA. So about 5 percent are uncompensated?

Ms. YOSKO. Uncompensated, yes.

Mr. BECERRA. OK. The rest of the panelists? And Mr. Foster, I will get back to you on that.

Mr. LAUGHLIN. In our case, we have about 2 percent uncompensated; around 8 percent Medicaid, 7 to 8 percent; Medicare is about 75 percent; and managed care, insurance, what have you, is about 15 percent.

Mr. STANDISH. In Hospital for Special Care, combined Medicaid-Medicare is 86 percent.

Mr. BECERRA. Can you break down Medicare and then Medicaid?

Mr. STANDISH. Medicare would be the smaller percentage. Because of our TEFRA rate we tend to take fewer cases than we otherwise might, so that the bulk of the 86 would be Medicaid, the disproportionate share of population that you are talking about.

Mr. BECERRA. But give me a sense, and roughly. We will not hold you to these figures.

Mr. STANDISH. Seventy.

Mr. BECERRA. Seventy percent of the 80 percent?

Mr. STANDISH. Seventy percent of the total.

Mr. BECERRA. Of the total, is Medicaid?

Mr. STANDISH. Right. Another 16 percent would be Medicare.

Mr. BECERRA. OK.

Mr. STANDISH. With probably 5 percent uncompensated; and the difference, managed care and traditional insurance plans.

Mr. BECERRA. About 9 percent?

Mr. STANDISH. Yes.

Mr. BECERRA. OK. Mr. Foster?

Mr. FOSTER. Sir, our Medicaid and uncompensated care would be about 8 percent, but I would like to clarify that.

Mr. BECERRA. OK, but if you could break it down as well, Medicaid versus uncompensated?

Mr. FOSTER. Medicaid would be about 5 percent, and uncompensated the other 3.

Mr. BECERRA. OK, and managed care, or fee-for-service?

Mr. FOSTER. About 60 percent Medicare, and the other would be non-cost-based HMO. There is very little fee-for-service.

Mr. BECERRA. Right. So 32 percent would be the remainder for managed care?

Mr. FOSTER. Yes, sir.

Mr. BECERRA. OK. Did you want to explain something?

Mr. FOSTER. Yes, sir. I just wanted to make sure that I did not mislead you on when I talked about disproportionate Medicare. PPS-exempt facilities are not entitled to any disproportionate care

payment. I just wanted to make sure that I clarified that. I think you understand that, but just to make sure.

Mr. BECERRA. Actually, go ahead and explain it.

Chairman THOMAS. Will the gentleman yield briefly?

Mr. BECERRA. Surely.

Chairman THOMAS. The problem was, you used "disproportionate share" in a way that we do not use "disproportionate share," that was all.

Mr. FOSTER. Yes, sir.

Chairman THOMAS. It is just that you used that to describe an unfair allocation; when "disproportionate share" to us means a very specific thing.

Mr. FOSTER. Yes,

Chairman THOMAS. That is what happened.

Mr. FOSTER. Sorry.

Chairman THOMAS. But I have a question, actually, on the basis of your responses to Mr. Becerra. Because the other three of you talked about managed care in a 2 to 3 to 4 percent range, and I heard, Mr. Foster, you talking about one-third as managed care?

Mr. FOSTER. Yes, sir, is non-cost-based, non-Medicare and Medicaid patients. We have a high——

Chairman THOMAS. OK. Well, I am trying to understand because, obviously, one of the growing areas is the managed care area. And is this a growing market? Your Medicare-Medicaid I understand, but I am frankly a little surprised.

Do any of you have contracts with managed care organizations, and that is how you get your 2 percent?

Ms. YOSKO. Yes.

Mr. STANDISH. Right.

Chairman THOMAS. Do any of you have a growth factor on where this is going over the next 5 years?

Mr. FOSTER. Yes, sir.

Mr. STANDISH. Oh, yes.

Mr. FOSTER. It is definitely going to increase.

Chairman THOMAS. Well, if they double, it is up to 4 percent. So I mean, I am asking for—if it triples, it is up to 6. See, I can do that.

Mr. STANDISH. You get to the issue of the definition of "managed care." In Connecticut, our Medicaid payment is a per diem, so that we are at risk after a per diem payment.

Chairman THOMAS. Yes.

Mr. STANDISH. So if that is defined as managed care in your mind, then we are up to 70 percent of our business that is managed care.

Chairman THOMAS. OK. But the point I want to make is—and I will yield back to Mr. Becerra, because he has got a line of questioning and I do not want to interrupt it—but as long as you are looking at that you folks are operating from a basis of Medicaid-Medicare, and we have to go into it with a different approach. But if you are actually out there on the open market in terms of managed care risk contracts, and people are contracting with you more frequently, that gives us a kind of an independent check on what others think you are doing that, one, is effective and, probably as importantly, two, is cost effective.

And so I guess I would just say, from a knee-jerk reaction, the higher the contracted managed care portion of what you are doing, the more comfort it allows me, in terms of the Medicaid and Medicare government-supported portion of your program.

I thank the gentleman for yielding.

Ms. YOSKO. May I say something to that? Our organization, Schwab, again, is representative of other specialty hospitals within the inner city. We are related to two trauma networks, so we receive really high-intensity patients in need of rehabilitation.

We have about 32 managed care contracts, and the business is very low, and even though we have very competitive rates. But what we see happening in the rehabilitation facility that I am at is there is a lot of shifting going on, and patients who could benefit from rehabilitation services go to nursing homes within the private sector of the managed care contracting. So the Medicaid is high because that is usually what we see from the trauma centers.

Chairman THOMAS. And there would be a growing awareness of the cost-effective use of a facility——

Ms. YOSKO. Yes.

Chairman THOMAS [continuing]. Versus continued longer term payment of the skilled nursing facility but not getting them up and out, as Mr. Laughlin described.

Thank you for yielding.

Mr. BECERRA. Thank you, Mr. Chairman.

Actually, could I ask that you submit for the record those numbers you just gave us? Because I tried to write them down; I hope I got them accurately. But if you could just give us those numbers for the record, I would very much appreciate that.

Ms. YOSKO. Yes.

Mr. BECERRA. I do not want to have wrong numbers down for what you have just said.

Mr. FOSTER. Absolutely.

Mr. BECERRA. Let me ask a question, and actually direct it at Mr. Laughlin. I believe in your testimony you mentioned that you would be against rebasing of the targets. Can you just really briefly—because I do not want to take up a lot of time; I know there are other questions that will be asked—say why you are opposed to the rebasing?

Mr. LAUGHLIN. Well, what I said was, I was opposed to rebasing and other changes to TEFRA without there being a recognition that there are different classes of hospitals within the long-term hospital category. Because these hospitals have different missions and different emphases, and that necessitates different staffing patterns and different cost structures.

Mr. BECERRA. I agree. Now, if you could rebase taking into account the different characteristics of the facilities, so that those that have high acute patient loads are gauged according to that family of providers, would that then cause you to change your opinion of rebasing?

Mr. LAUGHLIN. It would.

Mr. BECERRA. You mentioned also that all of your facilities have come online over the last 5 years. I suspect that means that most of your facilities are fairly new?

Mr. LAUGHLIN. Yes, sir.

Mr. BECERRA. Would it be fair to say that the newer the facility, the lower your overhead costs would be, as opposed to, say, an older facility with older equipment?

Mr. LAUGHLIN. I do not think the age would necessarily have anything to do, or much to do, with the overhead costs. The approach that we have taken in our company and many other companies in our association—and other associations have done the same thing—we try to find unused hospital facilities that can be rehabbed at a low cost. So we are trying to keep the capital cost per bed as low as possible.

Even though these are new hospitals, it is not that we have got necessarily new, expensive hospital facilities. The cost in these new hospitals is primarily related to staffing. The kind of patient that I am treating requires a very high level intervention with a lot of ACLS-certified RNs, strong respiratory therapy. This is the cost factor in what we do. And we are treating a lot of patients with very difficult VRE-type infections that require third-level antibiotics that cost $200 or $300 a day per dosage. So that is where the cost comes in. We are really tying it back to what the patient's acuity demands.

Mr. BECERRA. And I think it is a good point. And we should take with caution just assuming that any provider that has come online over the last few years is going to have a better infrastructure automatically because of that. So I take that as a good note to keep in mind.

Mr. LAUGHLIN. Hospitals, though, even within our own association and even hospitals within my company, vary in terms of the patient load they treat, what their focus is. If a hospital has a higher emphasis on wound care, I mean, if a physician comes along and says, "I like your facility in Tampa; I am going to bring all my wound-care business to you and create a wound-care clinic here," it is going to knock your cost structure down, because that is a cheaper illness to treat than, say, a hospital that has 75 percent respiratory. And so that happens within our company, within our association, and within the industry as a whole.

Mr. BECERRA. Thank you, Mr. Chairman.

Chairman THOMAS. Does the gentlewoman from Connecticut wish to inquire?

Mrs. JOHNSON. Thank you very much. And it is a pleasure to welcome Mr. Standish here, and to acknowledge the really marvelous work of the Hospital for Special Care in New Britain, which is a very old facility.

Mr. STANDISH. It is.

Mrs. JOHNSON. With a long and honorable history, and was into this business long before there were many in the Nation.

Mr. STANDISH. Right.

Mrs. JOHNSON. And is very highly regarded in terms of quality of care. You know, I think to sort of cut to the core of this—because it is late—I think we are all in agreement that we need a case classification system, but we do not know how to do it right now. So the real issue is, what do we do between now and for the next couple of years, or whatever time it takes—2 or 3 years—to get the data for a classification system.

And I think we really have three alternatives. We have the President's proposal. And Mr. Standish, you make some very interesting comments in your testimony about the President's proposal. And I would like to have you talk about the President's proposal and its impact on hospitals, versus NALTH's proposal. And if you are familiar with it, which you may not be, and may need to get back to us—and then anyone else in the panel who wants to comment, can—the proposal that was in the Balanced Budget Act of 1995, which was the effort of this Subcommittee to address this interim problem that you face.

So, I think we need to just kind of buckle down on what are our choices here, because they will have very disparate impacts on the system. At least, certainly, the President's proposal using an average cost would have an immediate impact. So Mr. Standish, if you would enlarge on either two or three of these alternatives, I would appreciate it.

Mr. STANDISH. Sure. I think that an area of agreement between the two associations before you here actually is the President's proposal does not work, for the reason that any system that attempts to make an adjustment to TEFRA rates based on an average simply is not proper, because the populations served in each of our hospitals, as Rod just explained, is so diverse. In fact, the only true answer, short of a change, would be the identification by patient of the intensity and the acuity level of that patient.

And so therefore, what NALTH has come up with is an alternative rebasing proposal that examines those hospitals that have had more than 2 years of Medicare losses and serve that disproportionate share population, as you are aware that the Hospital for Special Care does, and there are many others.

And it sets in place a rebasing mechanism for those hospitals for the short period—and we truly believe that a patient classification system will be available next summer. That is about 15 months from now. To the extent that the CBO determines that that costs anything to implement, NALTH has also developed a cost-savings proposal that is outlined in Attachment C.

And there is a numerical chart submitted with my testimony that walks us through the case of a hospital whose authorized spending TEFRA ceiling is, say, a $40,000 amount. And it is "Hospital B" on that exhibit.

Our understanding is that the Congress currently uses the target limit, the upper ceiling, as the authorized spending amount. In fact, in many instances, that amount is not actually spent on patient care. And so our proposal would be to simply determine across the hospital population the difference between the upper authorized amount, but not spent, take a portion of that, allow it to be spent, but reserve a piece for savings that would be totaled, we believe, more than enough to pay for the selective rebasing.

Mrs. JOHNSON. In other words, you would reduce the authorized amount to cover the rebasing costs?

Mr. STANDISH. Right.

Mrs. JOHNSON. And you think 10 to 15 percent would be affected by the rebasing proposal?

Mr. STANDISH. Right.

Mrs. JOHNSON. That is really important, because ProPAC has repeatedly testified that the old hospitals in this category had the lowest margins, and have been for years really disadvantaged by the system. So this would provide an immediate redistribution, in a sense, without harming the other hospitals in the system.

Mr. STANDISH. I think that is right. I think that if both parts of what I just explained are taken together, they both help the older, disadvantaged hospitals, while not hurting the rest of the population. And again, this is an interim solution, pending the PPS implementation which we are working on.

Mrs. JOHNSON. Would anyone else care to comment on that proposal versus the administration's proposal?

Mr. FOSTER. I would like to make a few comments. I think anything that we do needs to be done quickly, going to PPS. I think the ultimate PPS system should be even capitation. I do not understand why the system that is in place that allows the Secretary since 1989—does not provide relief where necessary on a case-by-case basis. And I would suggest that we look at that.

Mrs. JOHNSON. Well, certainly some of us have been looking at it for a number of years.

Mr. FOSTER. Yes, ma'am.

Mrs. JOHNSON. And have been working very closely with the administration.

Mr. FOSTER. Yes.

Mrs. JOHNSON. Frankly, nothing happens. And so I think Congress really does have to act to fill the void at this time, to enable us to go into a new payment system. But when you say capitation, is that different than a classification system?

Mr. FOSTER. The payment would be different. You are paid *x* number of dollars per covered life.

Mrs. JOHNSON. Regardless of nature of illness?

Mr. FOSTER. Yes, ma'am.

Mrs. JOHNSON. That is what ProPAC was talking about. And I have a lot of concerns about that, particularly in this type of treatment. I think Mr. Laughlin was talking earlier about the incentive then to focus——

Mr. FOSTER. I agree.

Mrs. JOHNSON [continuing]. On areas of lower cost patients. I know certainly for the Hospital for Special Care, they were one of the earliest institutions in America that took ventilator-dependent patients. And for years they lost money on those patients, because the system could not acknowledge the problems. And yet, they have been a leader now in weaning, as well.

So I think classification has the advantage of aligning cost and care in a macro setting. So you do not get into rewarding high-cost institutions, but you also do not get into the problems that the original DRG system got into with no recognition of outliers.

Any other comment?

Ms. YOSKO. Yes. I would just like to say that, again, we do oppose the administration's proposal, one, because it does not adjust for case mix and, two, because, as many have mentioned, it continues these existing inequities between the old and the new providers.

We are not necessarily in opposition to a postacute payment system. But in terms of waiting another 5 or even 10 years—or who knows? We have been working within the Rehabilitation Association with the FRG system for sometime and believe the technicalities could be worked out and could be a preferential treatment, at least for the rehabilitation segment of the industry. FRGs could be even rolled in, or be compatible with some larger system, if that system gets developed.

Mrs. JOHNSON. You mean for the rehabilitation hospitals?

Ms. YOSKO. Yes, the rehabilitation hospitals.

Mrs. JOHNSON. All right. Thank you.

Mr. LAUGHLIN. If I could comment, Mrs. Johnson. I would urge the Subcommittee to deal with the pieces of the President's proposal that we have information on. I think overall the proposal is horrible, but the two elements that we do know about and that we can deal with today are the reduction in the market basket updates, and also the reduction in capital payments.

Those things can generate most of the savings that are necessary from the PPS-exempt hospitals and the long-term hospitals; if necessary, to reduce slightly, maybe by 1 percent, the incentive payment formula. That would be a possibility. But I think the changes to TEFRA are premature because, number one, we do not have the patient classification system, we do not have a good acuity index. And any change on an average basis is going to penalize the really sick, higher cost patient that is now getting some outstanding care in our hospitals.

Mrs. JOHNSON. Thank you very much, Mr. Laughlin. And I thank the panel for your testimony today.

Ms. YOSKO. Thank you.

Mr. STANDISH. Thank you.

Chairman THOMAS. Are there any final statements by any of the panel?

I want to thank you very much for your testimony. And obviously, as we move forward we may need to revisit this area. But thank you for your willingness. As you may know, we have not focused in separate ways on these areas, but we are now going to try to do that, because I think you have been lumped in for too long in a general way. And at least it is showing some maturity or sophistication on our part to give you an opportunity to inform us of what you are doing particularly, and not in a general setting.

The Subcommittee hearing is adjourned.

[Whereupon, at 4:08 p.m., the hearing was adjourned.]

[A submission for the record follows:]

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Statement of
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Executive Director
The National Association of Psychiatric Health Systems
For the House Ways and Mean Health Subcommittee
Hearing on
Rehabilitation and Long-term Care Hospitals' Payments

April 10, 1997

MR. CHAIRMAN, I am pleased to write you today on behalf of the National Association of Psychiatric Health Systems for the House Ways and Means Health Subcommittee hearing on rehabilitation and long-term care hospitals' payments. NAPHS represents over 400 behavioral healthcare systems that are committed to the delivery of responsive, accountable, and clinically effective treatment and prevention programs for people with mental and substance abuse disorders. Most of our members are free-standing psychiatric hospitals and psychiatric units within general hospitals. NAPHS members generally do not provide post-acute care; they serve as primary treatment settings for persons with psychiatric and addictive disorders.

I very much appreciate this opportunity to share our views on Medicare payments to psychiatric hospitals and units which, along with rehabilitation and long-term care hospitals, are exempt from Medicare's Prospective Payment System (PPS). Specifically, I would like to address provisions in the President's fiscal year 1998 budget proposal regarding Medicare payments to psychiatric hospitals and units.

Background
PPS applies to all hospitals participating in the Medicare program; however, certain exemptions are specified by law. At present, five classes of specialty hospitals (psychiatric, children's, rehabilitation, cancer, and long-term) and two types of distinct-part units in general hospitals (psychiatric and rehabilitation) are excluded from PPS. These hospitals fall under the TEFRA system (as mandated by the Tax Equity and Fiscal Responsibility Act of 1882), which reimburses under a system of limits based on reasonable and allowable costs. Psychiatric hospitals and units have remained excluded from PPS because psychiatric diagnoses do not adequately predict the cost of treatment, as research has consistently shown. The TEFRA system has been an effective method of controlling costs and Medicare expenditures without compromising quality of care.

Problems with the President's FY1998 Budget Proposal
While NAPHS fully supports congressional and administration efforts to reduce the federal deficit and ensure the viability of the Medicare program, we are concerned about several provisions in President Clinton's budget plan relating to Medicare payments to psychiatric hospitals and units. One is a proposal that calls for rebasing TEFRA payments to psychiatric hospitals and units (which means using a more recent base year to calculate payments to these facilities). Another provision would set ceilings and floors for these hospitals' and units' target rates. A third proposal would eliminate incentive payments for psychiatric hospitals and units.

NAPHS opposes the President's proposal to rebase TEFRA payments to psychiatric hospitals and units, because it would result in a redistribution of patient care funds from efficient providers to inefficient providers. Those hospitals that have successfully reduced patient costs and achieved an incentive bonus under TEFRA would lose under rebasing, while hospitals that have not succeeded in lowering costs would be rewarded. These are the wrong incentives. Also, TEFRA rebasing would increase regulation and micromanagement at a time when the Medicare program is moving toward more flexibility in the purchasing and provision of healthcare services for beneficiaries.

NAPHS opposes the President's proposal to set ceilings and floors for TEFRA payments to psychiatric hospitals and units, because such action is anti-competitive and ignores real differences in providers. Imposing a uniform, national ceiling, for instance, would unfairly treat all hospitals the same when their costs and patient populations are different. Capping payments would penalize those facilities that exceed the cap because of justifiable circumstances such as a more complex case mix, higher teaching costs, or higher costs associated with a particular geographic area, among other factors. A ceiling that does not adequately cover a hospital's costs may force some hospitals to reduce the types and level of services they offer, thereby limiting patient access to necessary and appropriate care.

NAPHS opposes eliminating incentive payments under the TEFRA payment system, because doing so would take away the only incentive TEFRA providers have to reduce their expenditures. (Under the current system, payments for inpatient operating costs are based on each provider's allowable costs per discharge or a target amount. A facility with operating costs below its limit—its target amount times the number of Medicare discharges—receives its costs plus an *incentive payment* equaling 50% of the difference between its costs and its limit or 5% of the limit, whichever is less.)

NAPHS supports maintaining the current TEFRA payment system for psychiatric facilities and units for the following reasons:

- The TEFRA system has effectively controlled costs. From 1992 to 1993, average psychiatric hospital operating costs per case declined by 4.7%, and average operating costs for psychiatric units in general hospitals declined by just under 1.0%. These costs are projected to remain stable or decline in the foreseeable future.

- The incentives in the TEFRA payment system to keep costs below the limit are much stronger today because of the increase in patient days delivered to Medicare patients. In many psychiatric hospitals, Medicare has become a much more significant payer than

in the past; consequently, there is strong pressure for TEFRA facilities not to exceed the limit.

- As Congress intended, the current system rewards cost-efficient behavior and penalizes inefficient hospitals.

- TEFRA is relatively simple to administer, and it does not require the accumulation and maintenance of complex data bases.

- Prior to OBRA '90, the design of TEFRA was challenged because it disadvantaged some providers due to disparities in TEFRA limits. However, the TEFRA reforms included in OBRA '90 substantially solved several basic problems. These reforms included allowing TEFRA facilities and units to receive 50% of their losses up to a maximum of 120% of their limits. In addition, there was some attempt to streamline the exception and adjustment process, although problems still exist, and rebasing was allowed on a case-by-case basis.

- In addition to the OBRA '90 changes, OBRA '93 legislation established a differential update for TEFRA facilities that were over their limits with facilities over their limits by more than 10% receiving the full Medicare update.

NAPHS believes that any reductions proposed for PPS-exempt facilities and units should be *proportional* to the reductions proposed for PPS facilities, which the President's plan fails to do.

NAPHS would be pleased to work with you, Mr. Chairman, and the other members of the Health Subcommittee to develop more equitable and appropriate solutions to reducing Medicare costs.

Thank you for this opportunity to present our views on the President's proposed FY1998 budget as it relates to Medicare payments to psychiatric hospitals and units.