ADMINISTRATION'S PLAN TO DELAY IMPLEMENTATION OF THE BALANCED BUDGET ACT OF 1997

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

SECOND SESSION

JULY 16, 1998

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ADMINISTRATION'S PLAN TO DELAY IMPLEMENTATION OF THE BALANCED BUDGET ACT OF 1997

THURSDAY, JULY 16, 1998

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

The Subcommittee met, pursuant to notice, at 11:12 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
June 26, 1998
No. HL-22

CONTACT: (202) 225-3943

Thomas Announces Hearing on the Administration's Plan to Delay Implementation of the Balanced Budget Act of 1997

Congressman Bill Thomas (R-CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, announced today that the Subcommittee will hold a hearing to examine recent policy decisions by the U.S. Department of Health and Human Services (HHS) to delay implementation of the Balanced Budget Act of 1997. **The hearing will take place on Thursday, July 16, 1998, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 11:00 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Invited witnesses will include the Administrator of the Health Care Financing Administration (HCFA), Nancy-Ann Min DeParle. 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:

The Balanced Budget Act of 1997 created the Medicare+Choice program to bring seniors more health plan choices, implement new preventive benefits, modernize Medicare's payment systems, and create new tools to fight health care waste, fraud, and abuse. These changes represent the most comprehensive reforms to the Medicare program since its inception in 1965. On June 18, 1998, HCFA released a 833 page regulation, dubbed the "Mega-Reg," which details the Medicare+Choice program.

In an internal memo dated June 11, 1998, to the Deputy Secretary of HHS, the Administrator of HCFA requested a delay in implementation of two important Balanced Budget Act provisions--the per episode home health prospective payment system and the outpatient prospective payment system--and to delay fiscal year 2000 updates for the hospital prospective payment system and for the physician fee schedule.

This revelation follows an announcement last week that the Administration was curtailing plans to distribute Medicare+Choice information booklets to 38 million beneficiaries. Instead, HCFA will distribute detailed information only to 5.5 million beneficiaries in "specific markets" -- Ohio, Florida, Arizona, Oregon, and Washington. As part of the Balanced Budget Act, the Secretary was instructed to inform all beneficiaries about their new private plan options which included Medical savings accounts, provider-sponsored organizations, private fee-for-service plans, and coordinated care plans. The Secretary was required to use a number of different means to educate America's seniors including booklets, a toll-free number, an internet website, and other forms of community outreach.

In announcing the hearing, Chairman Thomas stated: "I am very disappointed to hear of the Administration's failure to implement Balanced Budget Act changes and its plan to delay payment updates for the doctors and hospitals who care for our seniors. I am particulary troubled by the fact that the two prospective payment systems that the Administration wants to delay were originally proposed by the Administration as part of the President's fiscal year 1998 budget proposal. It's not fair to the seniors in this country to promise them more health care choices and then deny them the means to make those choices."

(MORE)

FOCUS OF HEARING:

Nearly a year after Congressional passage, HCFA has missed a number of deadlines in implementing the Balanced Budget Act of 1997. The hearing will focus on two key aspects of HCFA's implementation of Congressional intent:

First, the hearing will examine HCFA's delay in development of new payment systems for Medicare fee-for-service providers. Second, the hearing will examine the delay in informing seniors about their new Medicare+Choice options.

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 six (6) single-spaced copies of their statement along with an IBM compatible 3.5-inch diskette in WordPerfect 5.1 format, with their name, address and hearing date noted on a label, by the close of business, Thursday, July 30, 1998, 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 one 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 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

*****

Chairman THOMAS. On August 5, 1997, President Clinton signed in to law a bipartisan congressional plan that saved Medicare from imminent bankruptcy. As the anniversary of the bill signing approaches, the Department of Health and Human Services seems unable to implement key portions of our Medicare plan, even though the administration assisted in writing it.

Health and Human Services has recently announced the following actions: They have decided to curtail a nationwide educational campaign required by law to educate seniors on how the new Medicare options will operate. They admit that one priority on which everyone agrees—fixing the high level of co-insurance that seniors now pay for hospital outpatient services—will not be implemented for some time.

They've acknowledged that changes—again required by law—in the way hospital outpatient departments and home health agencies are paid will not be implemented on time, even though the Department requested these changes and has been working on these new payment systems for years.

Because of implementation delays, the home health prospective payment system will not be implemented on October 1, 1999. Therefore, this will likely force Congress to take some corrective action to address problems in the interim payment system for home health care, and as a matter of fact, we have a Member of the House and a Member of the Senate to address that as our first panel today.

Health and Human Services says that the Year 2000 computer problems will delay implementation of the new laws of other Medicare provisions, despite the fact that Congress was assured years ago that HHS, especially HCFA, was developing a new computer system, known as the Medicare Transaction System, to handle the problem. Millions of dollars were spent and the project did not produce, I believe, a single line of computer code.

In short, key portions of our bipartisan Medicare agreement are being unilaterally unraveled. As a result of these decisions by the administration, we decided to convene this hearing to examine the implementation, or the failure thereof, of last summer's agreement. The purpose of this hearing should be to start the process of making sure Medicare delivers for the people it serves, and does not operate as a tool to deliver someone's political agenda or aspirations.

The Department's decision to suspend the educational campaign for seniors, and to a troubling extent the failure to consult in a timely manner with Congress on implementation problems, presents, I believe, a very serious challenge to the credibility of the administration. I find it interesting that at the same time the administration is pushing a patient bill of rights, and the first item is a patient's right to information, we're basically saying that we're going to be limiting seniors' access to similar information about the new Medicare+Choice program.

Nevertheless, the White House has announced a number of other new health initiatives. So far, the administration clearly has time and resources for its own priorities, while it neglects initiatives already enacted into law, especially a program like the Medicare+Choice program, which encourages private health plans

to develop broader benefit packages for seniors, rather than relying on the old centralized price controls of the current system.

Despite spending more than $210 billion last year for 34 million seniors, about $6,000 a beneficiary, Medicare still does not cover long-term care or most prescription drugs in its basic package. Obviously, the Medicare Commission is meeting and attempting to address this, among other problems with the Medicare program.

During the course of this hearing, I'm interested in learning the administration's answers to a series of questions, among them, for example: If the administration intends not to honor the current law's effective dates as to outpatient departments, nursing home consolidated billing, and other key provisions, what is the legal authority that the Department would rely on for such action? And if the Department intends to offer legislation requesting congressional acquiescence on these implementation delays, when do you expect to send such legislation to the committees of jurisdiction? In either case, what is the impact of these implementation delays on senior spending, the Medicare trust funds, the overall Federal budget? We would especially like to receive the analysis of the Health Care Financing Administration's chief actuary on the impact of these.

It just seems to me that when you look at everyone involved, I want to make sure that HCFA's priority is to be beneficiary service in all regards, particularly as it pertains to their ability to improve beneficiary's benefits and lower their costs.

In dealing with doctors and hospitals I think it's fair to say that doctors and hospitals have seen almost nothing but perpetual changes, usually in one direction in terms of reimbursement, but continued changes. They face enough challenges without HCFA holding payments hostage and questioning payment updates. Taxpayers deserve a program that runs efficiently, that does not use resources, or lack thereof, as arguments for failing to adhere to its core mission in a truly administrative and management capacity.

And just let me say that I believe there are thousands of capable and well-meaning civil servants inside HCFA and in the Department of Health and Human Services who, to a certain extent, are not being allowed to do their jobs perhaps the way they think they should be done by virtue of the way this administration has played politics with Medicare.

I find it troubling that the new law of the land may be over-ridden, not by a court, but by administrative fiat. The Balanced Budget Act is not a political document; it's the Nation's law. We all have a responsibility to implement it, and I look forward to the information that's going to be provided to us.

At this time I'd recognize my colleague from California, the gentleman, Mr. Stark.

Mr. STARK. Well, thank you Mr. Chairman. I'd like to offer the first non-political move and say that I understand that Dr. Ganske resigned from the Medicare Commission this morning. I'm making myself available to replace him on the Republican side. I'll take the pledge for no new taxes, and we can start right out and have some real fun. [Laughter.]

But, thank you for holding this hearing. I join in your concern about the delays in the implementation of the Balanced Budget

Act, even though I didn't vote for it. Frankly, it's incomprehensible to me to sort out this 2000 problem and why it's gotten so far out of hand. I've introduced the Medicare contractor reform legislation to give HCFA more power to get results from their contractors. We should pass that legislation so HCFA's abilities and responsibilities are more clearly defined in the future. It is clear to me that HCFA will need legislation to delay payments to providers. The administration should submit that legislation as soon as possible. I'm certainly not a computer programmer, and I won't try and second-guess this year 2000 mess.

I would like to concentrate on the beneficiary education issue and the "mega-reg" implementing the Medicare+Choice program. I'd say congratulations to the administration for not mailing the new Medicare handbook to all the seniors before the toll-free phone system is available to answer questions. I understand that's partly stalled by Land's End and other mail order catalogs who'll be doing all their Christmas business at the time the book hits.

This fall, seniors are going to be swamped with ads and salespeople pushing managed care plans. We know from our experience with Medigap policies that some of those sales pitches will be dishonest and/or disingenuous. It's essential that seniors be protected from high pressure sales pitches, the kind that caused some seniors to buy a dozen or more Medigap policies in the past.

I've introduced a bill that prohibits cold-calling by Medicare Choice plans, and it mirrors a provision in the Medicaid law. Until we have a prohibition on cold-calling, I urge HCFA to prohibit plans from assisting in the completion of the election forms. Their tentative decision to permit form completion is sure to lead to horror stories and the abuse of vulnerable patients.

In general, I'd congratulate HCFA on the "mega-reg" and the many strong consumer protection quality and anti-fraud provisions you're applying to the Medicare+Choice plans. There are many areas in which I urge stronger action, but in general it's a good beginning.

Specifically, I'm pleased with the shortening of the time in which appeals can be answered. The requirement that a health baseline be established within 90 days for managed care enrollees is a major step forward. You can't be a health maintenance organization if you don't know where your patients are or the basic health facts about them. Requiring them to establish a health baseline within 90 days seems to me to be a minimum step that HMDS ought to take to qualify for their monthly payments.

I'm pleased that HCFA has its quality improvement system for managed care, and I urge you to keep pressing its speedy development. On page 144 of the regulation you say it's uncertain whether any minimum performance levels will be established for the 1999 contract year. I think it needs to be given more attention. I urge you to establish at least several. For example, flu or pneumonia vaccination levels ought to be easy to establish and enforce. Zero tolerance for the accreditation organization's failures to identify non-compliance of health plans that expose beneficiaries to serious risks.

Finally, your stance on anti-fraud (pages 272 and 81) and the requirement that plans establish a compliance program. In the past,

plans have been paid for enrollees who they conveniently forgot to tell HCFA had left the plan. Innumerable plans have told HCFA they are providing the right level of benefits under the ACR requirements, then when a computer came to town, suddenly they were able to offer lots of new benefits at zero premiums. On its face, many plans have been filing false claims about their appropriate levels of service.

I urge that in addition to making these payment certifications subject to the False Claims Act, that in the future any claim about quality of care that is false be clearly subject to whistle-blower complaints.

Again, I look forward to the testimony of our colleagues from the House and Senate this morning, and I'll look forward to hearing the administration's testimony later. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you very much. As usual, any member who wishes to express themselves in an opening statement can do so in a written statement.

And at this time I would ask our colleagues, the United States Senator from Maine, the Honorable Susan Collins, and our colleague from New Jersey, Michael Pappas—and I know there is a degree of time pressure on the Senator. Your written statement will be made a part of the record, and you can address us in any way you see fit. I know the primary focus will be on a concern that all of us have, which is part of the changes in the Balanced Budget Act, which is now law, and that is dealing with home health care payments.

STATEMENT OF THE HONORABLE SUSAN M. COLLINS, A UNITED STATES SENATOR FROM THE STATE OF MAINE

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

Mr. Chairman, Congressman Stark, Members of the Committee, I thank you very much for allowing me to be here to present testimony to you this morning, and I want to commend you, Mr. Chairman, for holding this hearing to examine recent policy decisions by the Department of Health and Human Services to delay implementation of critically important provisions of the Balanced Budget Act.

As the Chairman has suggested, in the interest of time, I will ask that my statement be included in full, and I will concentrate primarily on my concern about the home health care interim payment system.

I am particularly alarmed, Mr. Chairman, that the administration has fallen behind in its implementation of the prospective payment system for home care. HCFA administrator Nancy-Ann Min DeParle did call me earlier this week, as she had promised at a hearing before the Senate Aging Committee earlier this year, to let me know that the Y2K problems with the Agency's computers have diverted resources and forced a delay in implementation. I do understand these problems. I very much appreciate her courtesy in calling me, but her call did not ease my underlying concern.

America's home health agencies provide invaluable services that have enabled a growing number of our most frail and vulnerable older Americans to avoid hospital and nursing home care and stay and get care right where they want to be—in their own homes.

However, critics of the system have long pointed out that Medicare's historic cost-based payment for home health care has inherent incentives for home care agencies to provide more and more services, which has in turn driven up costs. Therefore, there was widespread support for the Balanced Budget Act provision calling for the implementation of a prospective payment system for home care by October 1, 1999. Until then, home health agencies would be paid according to the new interim payment system.

Unfortunately, delaying the implementation of the prospective payment system, as HCFA has proposed, will only perpetuate the serious problems that we are currently experiencing with the interim payment system that is currently terribly flawed. I'm very concerned that the interim payment system inadvertently penalizes cost-effective and efficient home care agencies by basing 75 percent of their per patient payment limits on their Fiscal 1994 average cost per patient.

This system, Mr. Chairman, members of the committee, effectively rewards those agencies that have provided the most visits at the highest cost and spent the most Medicare dollars in 1994. The result is that it penalizes the low-cost, more efficient providers. I simply do not believe that is what Congress or the administration intended.

Home health agencies in the Northeast are among those that have been hardest hit by the formula change. As the Wall Street Journal observed earlier this year, "If New England had just been a little greedier, its home health agencies would now be a lot better off. Ironically, the region is getting clobbered by a system because of its tradition of non-profit community service and efficiency."

Moreover, there is simply no logic to the variance in payment levels. The average per patient cap in Tennessee is expected to be almost $2,000 higher than Connecticut's. The average cap for Louisiana is expected to be about $2,600 more than the cap for the State of Maine, my home State, without any evidence that the patients in these States are sicker or that the nurses and other home health care personnel in this region cost more.

The system also gives a competitive advantage to high-cost agencies over their lower-cost neighbors, even within the same State or region. This is true even when you can find no difference in the population of patients that they are serving. And finally, the system may force low-cost agencies to simply stop accepting patients with more serious health care needs.

Over the recess, Mr. Chairman, I visited two agencies in my State of Maine, one in Lewiston, Maine and one in my hometown of Caribou. One of these agencies told me of their fear that they would simply have to close their doors if the system is not reformed. That troubles me greatly because they're providing dearly needed, much needed services to very frail elderly people in rural parts of my State.

To rectify this problem, I've introduced Senate bill 1993, the Medicare Home Health Equity Act, which currently has 22 Senate co-sponsors from both sides of the aisle. This legislation, which is very similar to the House bill introduced by my colleague, Congressman Michael Pappas, who is here with me today, will level the playing field and make certain that home health agencies that

have been prudent and careful in their use of Medicare resources are not unfairly penalized.

The legislation will also ensure that home health agencies within the same region are reimbursed similarly for treating similar patients. I think that's a goal that we can all embrace. Instead of allowing the experience of high-cost agencies to serve as the basis for the new cost limits, my legislation would set a new per beneficiary limit based on a blend of national and regional average cost per patient.

Moreover, by eliminating the agency's specific data from the formula, the Medicare Home Health Equity Act will move us more quickly to the national and regional rates, which will be the cornerstone of the future prospective payment system, and it will do so in a way that I believe is budget neutral. I realize that in light of recent developments we will have to look at that issue and look at the specific formula changes.

But, Mr. Chairman, members of the committee, the need to fix the current interim payment system becomes all the more compelling if HCFA is unable to meet its October 1, 1999 deadline for implementing the prospective payment system. Moreover, the problem is exacerbated by the fact that the Medicare home health expenditures are to be reduced by an additional 15 percent on October 1, regardless of whether HCFA has developed a prospective payment system.

Cost-efficient agencies in Maine and elsewhere are already beginning to lay off staff, reduce hours, and some may actually be forced to close their doors because the reimbursement levels under this interim system fall so short of their actual operating costs.

Of course, Mr. Chairman, the real losers in this situation are our senior citizens. Cuts of this magnitude simply cannot be sustained without ultimately affecting patient care, and I know that is an outcome that no one on this committee wishes to see occur.

Again, Mr. Chairman, thank you very much for your leadership in this area and for the opportunity to testify. I look forward to working with you and my colleague, Congressman Pappas, to get a solution to this very real problem. Thank you very much.

[The prepared statement follows:]

TESTIMONY OF
U.S. SENATOR SUSAN M. COLLINS
TO THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
JULY 16, 1998

MR. CHAIRMAN, I commend you for holding this hearing to examine recent policy decisions by the Department of Health and Human Services to delay implementation of critically important provisions of the Balanced Budget Act of 1997 and appreciate your giving me the opportunity to testify.

The Balanced Budget Act contained sweeping reforms designed to preserve and protect Medicare, which provides critical health care coverage for 38 million aged and disabled Americans. It created the Medicare+Choice program to give older persons a greater range of health plan options. It took significant steps to slow the growth of Medicare spending and reduce health care fraud. At the same time, it protected beneficiaries' access to quality care and also introduced several new preventive benefits. Finally, this landmark legislation laid the foundation for essential longer term reforms that will be necessary to preserve Medicare for not just current, but future beneficiaries.

Therefore, I was very concerned and disappointed to hear of the Administration's failure to implement all of the Medicare+Choice provisions designed to educate seniors so that they can make informed decisions about their health plans. It simply does not make sense to provide a dazzling array of new options for beneficiaries, without giving them the information they need to navigate the system and make the right health plan choice for their health care needs.

Moreover, I understand that the Health Care Finance Administration (HCFA) has requested a delay in the implementation of two other important Balanced Budget Act provisions -- the prospective payment systems for hospital outpatient services and home health care -- even though these changes have been in the works for years and were included in the Administration's own FY 1998 budget proposal.

All this is particularly troubling at a time when the Administration and Congressional Democrats are proposing to vastly expand HCFA's regulatory role over private health insurance. How can we be seriously considering such an expansion of HCFA's regulatory role when it so clearly is having a difficult time fulfilling its current and primary responsibilities for Medicare?

I am particularly alarmed that the Administration has fallen behind in its implementation of the prospective payment system for home care. HCFA Administrator Nancy-Ann Min De Parle did call me on Tuesday — as she had promised at an Aging Committee hearing earlier this

year — to let me know that Y2K problems with their computers have diverted resources and forced the delay. I do understand their problems and very much appreciate the courtesy, but her call did not assuage my underlying concern.

America's home health agencies provide invaluable services that have enabled a growing number of our most frail and vulnerable Medicare beneficiaries to avoid hospitals and nursing homes and stay just where they want to be -- in their own homes. However, critics have long pointed out that Medicare's historic cost-based payment for home health care has inherent incentives for home care agencies to provide more services, which has driven up costs.

Therefore, there was widespread support for the Balanced Budget Act provision calling for the implementation of a prospective payment system for home care by October 1, 1999. Until then, home health agencies will be paid according to a new "interim payment system."

Unfortunately, delaying the implementation of the prospective payment system as HCFA has proposed will only perpetuate the serious problems we are currently experiencing with an "interim payment system" (IPS) that is critically flawed.

Under IPS -- which will remain in effect until HCFA implements a prospective payment system -- home health agencies will be paid the lesser of: their actual costs; a per-visit cost limit; or a new blended agency-specific per beneficiary annual limit based 75 percent on an agency's own costs per beneficiary and 25 percent on the average cost per beneficiary for agencies in the same region. These costs are to be calculated from cost reports for reporting periods ending in 1994.

I am concerned that this new system inadvertently penalizes cost-efficient home health agencies by basing 75 percent of their per patient payment limits on their FY 1994 average cost per patient. This system effectively rewards agencies that provided the most visits and spent the most Medicare dollars in 1994, while it penalizes low-cost, more efficient providers.

Home health agencies in the Northeast are among those that have been particularly hard-hit by the formula change. As the Wall Street Journal observed earlier this year, "If New England had been just a little greedier, its home health industry would be a lot better off now ....Ironically, [the region] is getting clobbered by the system because of its tradition of non-profit community service and efficiency."

Moreover, there is no logic to the variance in payment levels. The average per patient cap in Tennessee is expected to be almost $2,000 higher than Connecticut's, and the average cap for Louisiana is expected to be about $2,600 more than Maine's, without any evidence that patients in the Southern states are sicker or that nurses and other home health personnel in this region cost more.

This system also gives a competitive advantage to high-cost agencies over their lower cost neighbors, since agencies in a particular region may have dramatically different reimbursement levels regardless of any differences among their patient population. And finally, this system may force low-cost agencies to stop accepting patients with more serious health care needs.

I simply do not think that this is what Congress intended. To rectify this problem I have introduced S. 1993, the Medicare Home Health Equity Act, which currently has 22 Senate cosponsors. This legislation, which is similar to a House bill introduced by Congressman Michael Pappas, will level the playing field and make certain that home health agencies that have been prudent in their use of Medicare resources are not unfairly penalized. The legislation will also ensure that home health agencies in the same region are reimbursed similarly for treating similar patients.

Instead of allowing the experience of high-cost agencies to serve as the basis for the new cost limits, S. 1993 sets a new per beneficiary limit based on a blend of national and regional average costs per patient. This new formula will be based 75 percent on the national average cost per patient and 25 percent on the regional average cost per patient. Moreover, by eliminating the agency-specific data from the formula, the Medicare Home Health Equity Act, will move us more quickly to the national and regional rates which will be the cornerstones of the future prospective payment system, and it will do so in a way that is budget neutral. In fact, I understand that the House bill has received a preliminary score from the Congressional Budget Office that shows savings of $1.2 billion over five years.

Mr. Chairman, the need to fix the current interim payment system becomes all the more compelling if HCFA is unable to meet the October 1, 1999, deadline for implementing a prospective payment system. Moreover, the problem is exacerbated by the fact that Medicare home health expenditures are to be reduced by an additional 15 percent on October 1, regardless of whether HCFA has developed a prospective payment system.

Cost-efficient agencies in Maine and elsewhere are already beginning to lay off staff and some may actually be forced to close their doors because the reimbursement levels under this system fall so far short of their actual operating costs. Of course, the real losers in this situation are our seniors, since cuts of this magnitude simply cannot be sustained without ultimately affecting patient care.

MR. CHAIRMAN, thank you for giving me this opportunity to testify, and once again, I commend you for holding this important hearing.

Chairman THOMAS. Thank you very much, Senator Collins. And now it's my pleasure to recognize the gentleman from New Jersey, someone who has been a leader in attempting to offer solutions that would mitigate the problems associated with the interim payment system.

Michael, your written testimony will be made a part of the record, and if you could summarize it for us briefly, we would appreciate it.

STATEMENT OF THE HONORABLE MICHAEL PAPPAS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PAPPAS. Thank you, Mr. Chairman, Congressman Stark, and Members of the Subcommittee.

I first became acquainted with home health care agencies years ago when I was a county elected official in my home county in New Jersey. I was in charge of Human and Social Services, and I was impressed and continue to be impressed with the dedication of these agencies, many of which are non-profit, and the kind of work that they do in providing very important services to those that are in need of specialized care.

The cost benefit is pretty evident in that it can delay people from having to be institutionalized or hospitalized, and I think that's why so many people, like yourselves and us, want to try to see a solution to what Senator Collins has really framed very well. I can only emphasize and reiterate everything that she has said, but as I was one of the Members that voted for the Balanced Budget agreement, I certainly never intended to see this to be the case, and I'm glad to be, hopefully, part of the solution.

Over the winter recess, a home health care agency approached me and first made me aware of this dilemma, which is when we got to work on it and became aware of Senator Collins' efforts and the concerns by you, Mr. Chairman, and members of this committee and subcommittee, and I am very pleased with this hearing today and appreciate the opportunity to speak.

The situation, certainly in my State, is not unique. We could speak of Maine and probably most, if not all, of our States. Efficient agencies would be hurt by what has been presented as the solution in the form of an IPS, and I don't think that any of us want to see efficient agencies hurt, and therefore those that are being served possibly being denied or seeing their level of service decreased to the point of them maybe having to be institutionalized, which, again, in the other pocket, more funds would have to be spent to care for them.

In late March I introduced H.R. 3567, along with three original co-sponsors, one of them being Congressman Coyne, who is a member of this committee. And I'm very pleased that as of today we have 94 co-sponsors, both Members of the majority and the minority, as well as the independent people from all ideologic spectrums, all regions of the Nation, and that is really a culmination of so many other Members' efforts to see this very important problem addressed.

Almost 180 Members of the House have co-sponsored either my bill or other bills that have been introduced. Well over 200 Mem-

bers of Congress, in the form of co-sponsorships, sponsorships or signing "Dear Colleague" letters, have expressed their concern about the Balanced Budget agreement's effect upon this and IPS. But we were trying to put together a bill, we had a couple of concerns. We wanted it to be budget neutral, not to jeopardize the numbers in the Balanced Budget agreement, but we also wanted to reward efficiency and not penalize efficiency in every State in these efforts that need to be recognized.

We've heard about CBO and their ability or inability to score. There have been numbers thrown around as to what mine would do. Price Waterhouse, who had made an analysis, felt mine was budget neutral. We think from very preliminary drafts CBO thinks that it might even be better than that—$1.2 billion—but that's preliminary, and with what concerns that have been raised here today, we don't know what number will stick.

But I'm here today to certainly advocate for my efforts and that of Senator Collins. We think that there's a benefit to having two bills that are in both Houses that could move forward, hopefully quickly, with the level of support that they've received, but the most important thing for me is to just address the issue. And I certainly want to work with this committee and the members of it to move that ball down the field, so to speak, and to resolve this.

And Mr. Chairman, I thank you very much.

[The prepared statement follows:]

Statement of
Hon. Michael Pappas
Before the
Committee of Ways and Means
Subcommittee on Health

July 16, 1998

Thank you for the opportunity to offer remarks before this Committee today regarding the situation facing home health care. I also want to thank the committee for calling this important hearing and your continued leadership on this issue. Specifically, I come before this Committee today to add my voice to those concerned about the interim payment system. I know you have many witnesses today and I will try to be as brief as possible so that you may continue with your hearing.

Last year, most of us voted for the Balanced Budget Agreement as a historic step to produce the first balanced budget in a generation. We did so to restore sanity to federal expenditures across the board and we undertook many efforts to reign in the rate of growth of federal expenditures. Moreover, this committee and particularly this subcommittee has been very vigilant in seeking to ensure that home health care expenses are managed reasonably and that Medicare dollars are spent wisely.

As part of the Balanced Budget Agreement, Congress directed HCFA to develop an interim payment system as it moves to a prospective payment system. I am fully in support of a prospective payment system as I believe this will create the most efficient system for home health care. However, the transition to this system has been fraught with peril as numerous home health care agencies are being squeezed out of business.

In my home state of New Jersey, many home health care agencies have served the elderly and medical profession for many years. The Visiting Nurse Association among others have been community stalwarts for decades. They provide caring, professional and efficient medical

care to people in their homes. Without their less expensive and more user friendly services, Medicaid costs could be much higher.

However, the implementation of IPS has been devastating to the VNA in my state as it has been across the county. Let me read a newspaper headline that highlights the situation in one VNA. It is entitled "Layoffs for nurses Group". I have been told that others probably close their doors by October if nothing is done to correct this.

The situation in New Jersey is not unique. Every home health agency in every state that was an efficient agency has been hurt by the new IPS bill. Why, because HCFA's promulgation of the IPS is another example of Washington knows best. It is a "One Size Fits All" approach to fixing home health agencies. If you were a lean operation before - "Congratulations"- HCFA wants to cut your heart out. If you were a fat, bloated agency, HCFA would only put you on a diet. The final result will be a situation where the agencies that keep costs low are driven out of the business while those that do not will remain. Obviously, we did not intend this when we passed the BBA. This Congress must change the formula because it is not having the outcome we intended.

As such, I introduced H.R. 3567 with Congressman Bill Coyne of this committee and New Jersey colleagues Chris Smith and Jim Saxton. This bill is almost identical to the Senate bill 1993 introduced by Senator Collins and I am glad she is here today.

Since its introduction in late March, this bill has garnered 94 co-sponsors. This legislation has tremendous bi-partisan support. There are 53 Democrats 40 Republicans and one independent supporting it. There are conservatives, moderates and liberals. You have people from the Northeast, you have people from the South, West and Midwest. I think it is a very good bill and should be considered as the vehicle for this committee to move IPS reform this year before devastating cuts go into effect. This bill, which tracks the companion presented by Senator Collins in the Senate, offers a good chance at getting both bodies to move a bill that is similar in both houses.

It is important to note that by one count 231 Members of Congress have expressed concerned about the BBA and 178 have signed onto the various bills floating around Congress trying to reform the IPS. This is an issue we all face back in our districts.

The bill proposed by myself and Congressmen Coyne, Smith and Saxton is focused on two important goals. 1) It should not reopen the balanced budget agreement so it must be budget neutral. 2) it must reward efficiency in every state.

The IPS relies on agency specific data and gives the agencies that had the highest costs in FY 1994 the highest cost limits in FYs 1998-1999. As a result, agencies in a region may have dramatically different reimbursement levels regardless of any differences among the patient populations. Our bills level the playing field by basing the agency specific aggregate per beneficiary cost limit on a blend of 75% national and 25% regional average cost per patient data rather than on individual agency data. This ratio is the best to determine efficiencies in individual home health agencies.

Our legislation also changes the BBA requirement of changing the per visit cost limit from 105% of the median to 112% of the mean which provides enough of a margin to reduce costs while maintaining quality care for home health agencies in every region of the country.

The Congressional Budget Office has produced a draft report on the costs of this bill. In its memo CBO estimates that there can be $1.2 billion of savings if H.R. 3567 is implemented. Understanding the need for this committee to make sure that all regions are comfortable with IPS improvements, I believe the CBO scoring gives this committee much needed justification to restore the equity to home health agencies.

The list of home health agencies suffering from the IPS is tremendous. I believe this Congress must act and I hope this hearing will spur this committee and this Congress to quick action to help home health agencies which do so much to help people all across our country.

Chairman THOMAS. Thank you, Mike. The concern that I have, to try to underscore the magnitude of the problem, is that notwithstanding your good effort and the fact that the Congressional Budget Office scored your proposal as saving $1.2 billion—I appreciate your commitment to budget neutrality; you did a great job of going in the other direction. The information that I've received as of today, based upon clearly the reason for this hearing, is that CBO now says that the policy, notwithstanding that it would work, can't be implemented.

And so the concern that we have is, if we're going to try to solve the interim payment system which both of you and any Member who has co-sponsored either piece of legislation could clearly outline, and I think all of us are aware of, we don't know what it is that we can do that will address this problem because of the inability of HCFA to implement programs such as those outlined in your bill, which would have otherwise solved the problem. So, we're going to have to require probably a greater degree of participation voluntarily by HCFA in initiating potential solutions, because it wouldn't serve anyone's benefit for us to dream up plans, assuming HCFA's going to be under its ordinary operating capacity, when they're clearly going to indicate to us today that they're not able to do it. So it only heightens our concern about finding a solution. I believe we have to find one before we adjourn.

Senator Collins, I appreciate your testimony in which you indicated that Ms. DeParle called you to let you know that the Y2K problems, quote, "with their computers have diverted resources and forced a delay." One of the things we don't do well in the House—I hope you do it better in the Senate—is for one committee to pay attention to what the other committees are doing.

Our colleague from California, chairman of the Oversight—Subcommittee on Human Resources, Government Reform and Oversight Committee, Congressman Horn, has been holding a series of hearings on the issue of Y2K. We're clearly here today dealing with HCFA, but the argument, as you indicated, is the Y2K problem. Congressman Horn has been focusing for more than a year on the entire Federal Government, including the Congress.

And I just think it might be enlightening to you because you may not be aware of it, that on May 16, 1997, in front of that subcommittee was Bruce Vladek, who is the former Administrator of HCFA. And in discussing whether HCFA was ready to deal with the Y2K problems—now this is May 1997 when we were in the middle of negotiating the contents of the Balanced Budget Act, with the administration actively participating and, as I said, initiating proposals to be part of that plan—Administrator Vladek, in response to the GAO statement, said, quote—the GAO statement was that HCFA is not closely monitoring these critical activities of the Year 2000 compliance. He said, quote, "This particular assertion I frankly find kind of puzzling. Once we have MTS"—and, of course, that's the program that has now been totally scrapped with a cost of millions and millions of dollars—"we will have one set of software under the Government's ownership and the Government's control." We now know that was pie-in-the-sky and it isn't going to work.

So he went on then to say, "Let me say this to you, because I think this is the appropriate way to answer, we have required of all the Medicare contractors that they have completed their Year 2000 corrections by December 31, 1998. We will have the first part of 1999 to do extensive testing on the extent to which they have in fact accomplished these changes."

He went on to say, "We're talking about the actual re-writing of something like 20 million lines of software code. We will get this done. We will find things wrong during the testing process, but we will find that out in late 1998 or early 1999, not on December 31."

In response to a set of written questions—which I'm quite sure members, because they're not going to be able to stay the whole time, will submit to HCFA, as is normally done—in a response dated August 22, 1997, Mr. Vladek said—again repeating, "There are 20 million lines of code which were identified by HCFA as requiring modification for the Medicare standard systems. Where are you in the process of dealing with those 20 million lines of code?" Mr. Vladek said, "Approximately 8 million lines of code have already been re-written, and the additional 12 million lines are expected to be completed by December 1998."

This being late July, they're pretty much done. The cost of rewriting a single line of code has been estimated to be $1.10, and the funds for this project have been allocated in the Fiscal Year 1996 to 1998 budgets. So as we were anticipating the needs and concerns of this Department, along with other departments and agencies, the Administrator of the Agency indicated there was no problem—the funds were available and they were well along in addressing their concerns.

Now, that will be part of the discussion that we will have with the Administrator, Ms. DeParle, to get a clearer understanding. If this in fact is not true, what is true? Where are they? What resources do they have? And what is going to be the result in the failure to implement the law as it's currently written?

Your concerns are a major portion of it, but, frankly, it just goes across the board. So I really appreciate your initial willingness to try to offer a solution which would have worked had we been able to say HCFA could implement it. The Congressional Budget Office now says, notwithstanding that, they cannot score it because HCFA says they can't make it work. This will be a problem which we will resolve together and, hopefully, with the cooperation of the administration and HCFA to tell us what they can do to answer the interim payment problem.

Do any of my colleagues want to—the gentleman from Maryland, Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman. I'll be very brief.

First, let me thank both of our colleagues for being here. I'm one of the 200 that have joined in either legislation or letters urging this committee and Congress to pass corrective legislation for home health services. I think we need to do that, and I share many of the concerns that our chairman has raised, but I think it is important to point out that the IPS that we provided last year in the Balanced Budget Act is not working.

And regardless of whether there is a PPS system in place on the due date or not, the IPS that's in place now will cause and is caus-

ing a devastating impact in the State of Maryland and around the Nation, so we need to take corrective action on the IPS. We can change the mix. We can try to do it in a way that's budget neutral, and that's what we're hopefully going to be able to come out with.

But, Mr. Chairman, I must tell you, there are many agencies that are going to have a very devastating impact unless we can find a more creative way to deal with some of the more difficult circumstances in our community because our colleagues are exactly right. Those programs that were the most efficient, those programs that went out and dealt with difficult patients, difficult assignments, and did it in a most cost-effective way are the programs that are most at jeopardy, and that makes no sense whatsoever.

We, in passing the IPS, I don't think anticipated the problems that were going to be caused, and, I agree, we didn't intend to do what was done, but the law requires that type of action. And, yes, it would be a lot easier if we knew that the prospective payment system will be implemented on time, but as was pointed out by Senator Collins, the law also provides for another 15 percent cut next year, and we're heading in a very disastrous area.

And I would hope that we'll be looking at creative ways to correct the situation and not just placing all of the responsibility on HCFA in implementing a new system under the PPS to solve this problem, because I do think we have to deal with these problems now and come up with a solution now that will keep these services available to our seniors. They're very, very important programs. They're keeping our seniors healthy in our community, rather than being in more expensive institutional settings. That's saving money, makes sense, and we should work together with HCFA to come up with a correction to what we did last year, and I thank the chairman.

Chairman THOMAS. I thank the gentleman for his comments, and I couldn't agree with him more. The problem gets even more difficult as you analyze it carefully, because the 15 percent reduction is scheduled under law to go into effect whether or not the prospective payment structure is in place, which it will not be. The interim payment system has to be addressed, and it has to be changed before this Congress adjourns.

The difficulty is the usual process won't work, because we have a perfectly decent solution, and there are others that will be offered, but if the answer from CBO is that they now cannot tell us what will happen because HCFA says they aren't going to be able to implement any changes within a period of time, it makes it absolutely imperative that the administration not say they won't initiate a change, but that we sit down today—no later than tomorrow—and begin working out what is do-able and which addresses those fundamental problems.

No one intended the current situation. It is intolerable and it needs to be changed, but the circumstances under which those changes need to be worked out is extremely difficult given the testimony and the posture that we'll soon hear from the Administrator. We're not trying to drag this out in terms of the difficulties, but we do need to underscore, we do need to keep the public and the providers and the beneficiaries informed of what it is we are able

to do and not able to do, and that is the fundamental intent of this hearing.

And I know the Senator from Maine has a voting problem, which has just been created partially on our side, and the gentleman from California wants to be recognized.

Senator COLLINS. Mr. Chairman, could I ask to be excused? I do have a vote on right now, and I'd be happy to answer any questions in writing or call any member, but I do apologize. I'm going to miss the vote.

Chairman THOMAS. Thank you very much.

Senator COLLINS. My apologies.

Chairman THOMAS. Go tend to one of your primary functions. Thank you very much.

Mr. STARK. Mr. Chairman, I just wanted to mention for the record, and for Senator Collins and Congressman Pappas, that several of us signed a letter to the Administrator of HCFA asking that in the cases where some of the home health agencies are being back-charged for overpayments in Fiscal Year 1998, that HCFA allow those payments to be made over a period of time, periodically, or to put them on an installment plan or at least their credit card, which may help ease that burden in some cases. I would urge Congressman Pappas and other members of our committee to urge the Administrator to see if she could be lenient in collecting the money that is due for overpayments. I think it will be of some small assistance.

Chairman THOMAS. And that is precisely the reason for the hearing. We will continue to find additional concerns that we have to face.

If my colleagues have no additional questions, I want to thank the gentleman from New Jersey back to the drawing board. We look forward to the new plans.

Obviously, the Administrator is next on our witness list, and my belief is that it's probably going to be easiest for us, rather than to start you and then interrupt you, Nancy, just to say that the subcommittee will be in recess.

Do you want to try to vote on a rolling basis?

Can you do it in 10 minutes? Okay; the subcommittee will now hear from the Administrator of the Health Care Financing Administration. Your written testimony will, of course, be made a part of the record, and we would appreciate hearing from you within the timeframe allowed for purposes of getting your testimony in and then going to vote. Thank you for being with us. It's good to see you again.

STATEMENT OF THE HONORABLE NANCY-ANN MIN DEPARLE, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Ms. DEPARLE. Thank you. Mr. Chairman, Congressman Stark and members of the committee, thank you for inviting me here today to discuss our implementation of the Balanced Budget Act. Your leadership was critical in passing this landmark legislation, which makes significant changes to Medicare and is an essential step forward.

But with big changes come big challenges that we're working hard to meet. We are making solid, steady progress in implementing the more than 300 individual Balanced Budget Act provisions affecting our programs, and we have a strategy to meet the challenge of informing beneficiaries about the many changes they need to understand.

We are also making substantial progress in addressing the enormous and difficult Year 2000 problem. We must ensure that Medicare will be there to provide coverage for beneficiaries and payments to providers on January 1, 2000, just as it has for the last 33 years. That is and must be my number one priority. It involves renovating all computer and information systems and a deadline that nothing and no one can change.

Each computer system used by Medicare, its contractors, State Medicaid programs, and 1.6 million providers must be thoroughly reviewed, renovated, and tested to correct the glitches that could cause problems on January 1, 2000. Our contractors must renovate some 50 million lines of code. This is a major challenge, and it's one that I'm confident that we can meet, but to do so Year 2000 work must take precedence over other projects that require systems changes, including, as we've discussed this morning, some Balanced Budget Act provisions.

This includes projects that are complex, such as the home health and hospital outpatient department prospective payment systems that we were scheduled to implement in 1999. But it also includes some less complex changes such as routine provider payment updates that would occur in a critical window between October 1, 1999 and April 1, 2000. The updates, which would otherwise be a routine matter, could create an unstable environment when Year 2000 activity and risk will be greatest.

I want to emphasize, though, that we want to work with the Congress and providers to evaluate what our options are and ensure that any delays and provider updates do not create a hardship, and we will work with this committee to evaluate the legislative changes that may be needed.

I also want to emphasize, Mr. Chairman, that the vast majority of Balanced Budget Act provisions are not affected by the Year 2000, including the Medicare+Choice program. We've already implemented almost 200 of the roughly 300 provisions in the law affecting Medicare. We are pushing forward with regulations to implement the Balanced Budget Act. In fact, in a few days I hope we'll be sending to the Federal Register the regulations concerning the outpatient department PPS, even though it is affected on the implementation side by the Y2K.

If Year 2000 computer system renovations are completed ahead of schedule, I will make every effort to make sure that the delayed provisions are back on schedule, but at this time it appears that we must postpone them to focus resources and free systems for essential Year 2000 work.

Implementation of the Medicare+Choice program is not being delayed. However, as you have mentioned this morning, we have changed our initial plans for the Medicare+Choice information campaign to take the time to more fully focus test our approach in the field and make adjustments if necessary. We believe this will in-

crease the likelihood that the changes and that the new choices in Medicare will be understood and well-received by beneficiaries.

We have an eight-point Medicare education plan that includes beneficiary mailings, toll-free telephone services, Internet information, a national train-the-trainer program that just began this week to train people in the field, a national publicity campaign, State and community outreach, enhanced counseling from State health insurance advisory programs, and beneficiary feedback and assessment.

Instead of mailing new Medicare handbooks to all 39 million Medicare beneficiaries this fall, which was my original plan, we will first test the whole system in five States encompassing some 5 million beneficiaries. Outside these five States, we will send beneficiaries a bulletin with basic Medicare+Choice data and other Medicare information. We'll provide them with a toll-free number to call to receive health plan comparison information and additional information about medical savings accounts. We will carefully evaluate our efforts in the five test States so that we can improve them for the full-scale nationwide campaign that the Balanced Budget Act requires next year.

Mr. Chairman, this is the largest, most complex, and ambitious education effort in the history of Medicare. We want to work with the Congress, with providers, with beneficiaries and their families, and with seniors groups around the country to make the national Medicare education program the best it can be. We appreciate the help that you and your staffs have provided us so far and look forward to working with you further to make sure that our campaign is consistent with what you intended, as well as that it meets our beneficiaries' needs.

I look forward to continuing to work with this committee as we continue efforts to implement the Balanced Budget Act and to address the Year 2000 challenge, and I'll be happy to answer any questions you may have.

[The prepared statement and attachments follow:]

STATEMENT OF

NANCY-ANN MIN DEPARLE

ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

ON

"BALANCED BUDGET ACT IMPLEMENTATION"

BEFORE THE

HOUSE WAYS & MEANS HEALTH SUBCOMMITTEE

JULY 16, 1998

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration

Testimony of Nancy-Ann Min DeParle,
Administrator, Health Care Financing Administration
before the
House Ways & Means Health Subcommittee
Balanced Budget Act Implementation
July 16, 1998

Chairman Thomas, Congressman Stark, distinguished Subcommittee members, thank you for inviting me here today to discuss challenges in implementing the Balanced Budget Act. Your leadership was critical in passing this landmark legislation. It makes sweeping changes to Medicare, and is an essential step forward. It expands health plan options for beneficiaries through the Medicare+Choice program, and extends the life of the Medicare Trust Fund for 10 years.

But with big changes come big challenges. We are making solid, steady progress in implementing the more than 300 individual Balanced Budget Act provisions affecting our programs. We now have completed 189 of these provisions. Since I became administrator last November, we have published 64 regulations, including major Balanced Budget Act provisions such as the Medicare+Choice regulation. We have approved Children's Health Insurance Plans to cover a projected two million additional children for nearly half the states. We have issued 65 program guidance letters to state Medicaid and child health officials, 49 of which are related to the Balanced Budget Act. We have been working closely with state insurance regulators in monitoring enforcement of important Health Insurance Portability and Accountability Act provisions. We delivered 10 official Reports to Congress. We have made major strides in improving program integrity. And we made important strides in aggressively addressing the Year 2000 issue for Medicare and Medicaid information systems.

Balanced Budget Act implementation is an enormous effort which requires balancing of many competing priorities. One of the greatest challenges is informing beneficiaries about the many changes in the Medicare program. We are strongly committed to providing beneficiaries all the information they need to make the best possible decisions about health care.

The Balanced Budget Act directs us to embark on a broad effort, which we have named the National Medicare Education Campaign. This five-year strategy is designed to ensure that beneficiaries receive accurate and unbiased information about their benefits, rights, and options. This is the largest, most complex, and ambitious educational effort in the history of Medicare. We want to work with beneficiaries and their families, Congress, aging advocacy organizations, providers, and other experts to ensure that our education program is the best that it can be.

On top of our Balanced Budget Act efforts is the enormous and difficult task of ensuring that Medicare will be there to provide coverage for beneficiaries and payments for providers on January 1, 2000, just as it has for the past 33 years. This must be our top priority. It involves renovating all computer and information systems, and a deadline that nothing and no one, not even Congress, can change. We must and we will take remedial action to ensure that beneficiaries continue to receive care, that enrollment systems function, that providers are able to confirm beneficiary eligibility, and that payments to providers are not delayed.

We are making substantial progress in addressing the Year 2000 problem. Since I became HCFA Administrator in November we have:

- conducted at least one site visit to every claims processing contractor, and at least two site visits to every systems maintainer for independent verification and validation;
- provided clear instructions to contractors on everything they must do to be Year 2000 compliant, and made sure they assessed their status based on those instructions;
- negotiated a contract that makes clear the responsibility Medicare claims processing contractors have in ensuring that their systems are Year 2000 compliant;
- developed more realistic cost estimates for Year 2000 work after contractors reassessed their workload based on the instructions we provided;
- completed renovation of five of our six standard systems;
- completed renovation of 24 of our 37 most critical internal systems;
- initiated testing of renovated systems;
- conducted outreach to states, providers, and other health care entities; and

- gathered data from states on Medicaid system Year 2000 status;

The Year 2000 especially affects Medicare because of our extensive reliance on multiple computer systems. More than 183 systems are used in administering the Medicare and Medicaid programs, and 98 of these are considered "mission critical" for establishing beneficiary eligibility and making payments to providers, plans, and states. Medicare is the most automated health care payer in the country. We process nearly one billion claims each year, or about 17 million transactions each week. Fully 98 percent of inpatient hospital and other Medicare Part A claims are processed electronically, as are 85 percent of physician and other Medicare Part B claims.

The renovation process is complicated because each piece in the systems used by Medicare, its 60-plus claims processing contractors, interfaces with state Medicaid programs, and some 1.6 million providers must be thoroughly reviewed and renovated by those responsible for each particular system. They must be tested, both alone and for the complicated interfaces among them. To fix only the Medicare systems, we must renovate 49 million lines of code. We must renovate all Medicare-specific software, and work with new versions of vendor-supplied software, including operating systems that drive the hardware we use. Some hardware must be upgraded, and our telecommunications equipment and software must be compliant. We must assure that all data exchanges with thousands of partners are compliant. Testing of Year 2000 changes presents a far greater burden than testing of routine system changes because we must test multiple times on a range of different dates. For example, we must test February 29, 2000 and March 1, 2000 because 2000 is a leap year. Normally we would never consider so much change and testing at one time, but we have no choice.

Because of this imperative, Year 2000 work must take precedence over other projects that require systems changes, including unfortunately some Balanced Budget Act provisions. Many other private and public organizations, including most major insurance companies, have reached the same conclusion and are halting other projects involving information technology changes to clear the decks for the Year 2000.

Our independent Year 2000 verification and validation contractor, Intermetrics, advises that we must clear the decks of projects that could interfere with Year 2000 work. Intermetrics specifically advised us to "seek necessary relief from Congressional mandates, system transitions and version releases to allow near-term, focused attention to achieving Y2K compliant systems." This includes projects that are complex, or which would occur during a critical window between October 1999 and March 2000. Otherwise, they warned, "many of your most critical system renovations have risk of significant schedule slippage."

If Year 2000 system renovations are completed ahead of schedule, we will make every effort to put these provisions back on the original schedule. But at this time it appears that postponing some projects is necessary to focus resources and freeze systems so essential Year 2000 work can be done, and thereby avoid complicating factors in the critical months right before and after the new year.

BALANCED BUDGET ACT IMPLEMENTATION PROGRESS

I want to emphasize that the vast majority of Balanced Budget Act provisions are already implemented or will be unaffected by the Year 2000 issue. Many others can be completed before systems must be frozen for the critical Year 2000 transition period. These include:

- the Medicare+Choice program, including beneficiary and plan enrollment, new payment systems, new grievances and appeals procedures, new quality assurance mechanisms, collection of hospital encounter data for risk adjustment, review of adjusted community rate data submission that determines plan payment rates, and a test of competitive pricing;
- coverage for new diabetes and osteoporosis prevention benefits;
- a new prospective payment system that will help control skilled nursing facility costs;
- limits on hospital pay for diagnoses associated with frequent transfer to post-acute care;
- new fee schedules for outpatient therapies and durable medical equipment; and
- a competitive bidding demonstration for durable medical equipment.

Necessary Postponements

Projects affected by the Year 2000 include both Balanced Budget Act provisions and other agency priorities. For example, in April, we made the difficult decision to postpone final transitions to uniform systems for Part A and Part B contractors. Over the past two years we have whittled the number of different computer systems used by our contractors down to six from nine. Uniform systems will go a long way in helping us to streamline agency operations and provide better access to program data. But the delay is essential if our contractors are to renovate and test systems before our December 31, 1998 deadline. Postponing this activity allowed us to redirect both valuable programmer time and $20 million in FY 1998 appropriated funds to Year 2000 work.

At present, Balanced Budget Act provisions whose implementation we believe must be postponed include:

- prospective payment systems for outpatient hospital care and home health services;
- consolidated billing for physician and other Medicare Part B services in nursing homes;
- a new fee schedule for ambulance services.

These activities are being postponed because they involve complex systems changes and interactions with other systems at the very time such activity would interfere with critical Year 2000 work. Our claims processing contractors concur with the decision to postpone these activities; a July 7, 1998 letter expressing their support is attached to my testimony. Our actuaries project that the cost, if any, of these delays will be minimal.

We may also need to delay some activities that are not complicated but which involve changes that could create an unstable environment during a critical window of Year 2000 activity, such as provider payment updates. We will work with Congress and providers to evaluate our options and ensure that any necessary delays in provider updates do not create a hardship. And we will work with this Committee to evaluate whether legislative changes will be needed.

MEDICARE+CHOICE BENEFICIARY EDUCATION

The implementation of the Medicare+Choice program is not being delayed by Year 2000 activities. However, we have changed our initial plans for the Medicare+Choice information campaign in order to improve our approach.

Instead of going nationwide this fall with new Medicare handbooks to all 39 million beneficiaries, we are taking a phased approach to teaching beneficiaries about this complex program. We have an eight-point plan that includes:

- beneficiary mailings;
- toll-free telephone services;
- internet activities;
- a national train-the-trainer program;
- a national publicity campaign;
- state and community-based publicity and outreach campaigns;
- enhanced beneficiary counseling from State Health Insurance Advisory Programs; and
- targeted and comprehensive assessment of our education efforts.

We will first test the whole system -- including the handbooks, the toll free call center, the Internet site, and other local beneficiary information activities -- in five states encompassing some 5 million beneficiaries. We will also send the other 33 million beneficiaries a bulletin outlining the basic Medicare+Choice options and other useful Medicare information.

As we begin our education effort this year, we will be making a special effort to learn from beneficiaries. Through their comments, questions and focus groups, they will help us tailor our information so it is most useful to them. The HCFA actuary projects that one in four Medicare beneficiaries will opt out of original Medicare and be enrolled in one of the Medicare+Choice plans by the Year 2000. It is essential that we educate beneficiaries about all these options so that they understand what they need to know to make informed decisions.

The statute and regulations governing Medicare+Choice are extensive and include important beneficiary rights, protections, and plan requirements. Policies concerning when beneficiaries can join or leave plans change over time. Some types of plans are open only to certain groups of beneficiaries. And there are substantial differences among the various types of plans and among plans of each type in their own rules about choice of providers, access to specialists, cost sharing, and other issues.

BENEFICIARY EDUCATION STRATEGY

Helping 39 million beneficiaries understand the largest changes in Medicare history is an unprecedented task. The National Medicare Education Program may well be the largest education effort ever undertaken by a government agency. We must build beneficiaries' knowledge, step by step, starting with a foundation of basic facts on what Medicare covers and beneficiary rights and responsibilities.

Initially, our goals are modest. We have to make beneficiaries aware that they have a range of options, including original fee-for-service Medicare, HMOs, and new managed care options. And, of course, we need to make clear that if they are happy with their current coverage they do not have to make any change. Learning how to help beneficiaries understand the many details they need to know to make truly informed decisions is a more difficult task that will take more time. We need to be able to make information clear to both well-educated audiences and those with limited reading ability or other impairments.

That is why we are adopting a phased education strategy to use scarce resources wisely, learn as we go, and incorporate what we learn into continuously improving education services. We must start with basic information, and build on it so beneficiaries understand the options, details, and consequences and can evaluate plan-specific data to make truly informed choices before 2002, when beneficiaries will be able to change plans just once in the first six months of the year.

Our phased approach is consistent with advice from the Institute of Medicine, which hosted a meeting of experts in January to evaluate this task and develop recommendations. The IOM strongly recommended that we stagger mailings to allow for market testing and emphasize that beneficiaries do not have to make any change. I have attached the IOM recommendations to my testimony. IOM emphasizes that "Efforts to build trust and a level of comfort with [Medicare+Choice] are particularly important given the ongoing negative public perception and attitude about managed care in general." The American Association of Retired Persons also endorses our phased education strategy. A July 2, 1998 letter to me from AARP Executive Director Horace Deets calls the decision "the right course of action under the circumstances." I have attached this letter to my testimony as well.

Our own work with some 30 beneficiary focus group sessions, conducted by an outside contractor, Barents Group/Westat/Project HOPE/Sutton Social Marketing, also counsels against a nationwide mailing of all Medicare+Choice information to all beneficiaries before we have taken the time to test the entire education system, including the handbook, call center, and internet site.

For all these reasons, this fall we will mail Medicare beneficiaries who are not in the five pilot states basic Medicare+Choice information in a short, plain English bulletin. It will outline the basic Medicare+Choice options, and stress that beneficiaries do not have to make any change. It will discuss assistance for low-income beneficiaries, newly available preventive benefits, beneficiary rights, and other changes in Medicare. And it will tell beneficiaries how to obtain more information via phone, Internet, and other community resources about specific health plans available where the beneficiary resides.

We will pilot test comprehensive Medicare+Choice handbooks in five states -- Arizona, Florida, Ohio, Oregon and Washington -- with high, medium, and low levels of Medicare+Choice options and a total of 5.5 million beneficiaries. The handbooks will include more detailed information on Medicare+Choice options. They also will be tailored to each market, with side-by-side comparisons of costs and benefits for plans in that area.

We will pilot test our toll-free call center in the same five states. Call center personnel will answer questions about Medicare+Choice options. Special accommodations will be available for Spanish speaking and hearing impaired callers. We need to test the call center on this scale at first, both because of limited resources and to make sure we can handle all calls in a timely and user-friendly manner. We plan to phase in call center access to another 25 percent of beneficiaries every three months, with full nationwide service by August 1999.

We are making full use of the Internet to communicate with beneficiaries and those acting on their behalf. A consumer-friendly Internet site, Medicare.gov, is already in place with side-by-side comparisons of plan benefits and out-of-pocket costs.

We have almost 100 public and private partners assisting us in our Medicare+Choice education campaign, including the Administration on Aging and area Agency on Aging offices. Starting this week we began providing comprehensive training across the country to about 700 individuals with these organizations. These 700 individuals will in turn serve as trainers in their own organizations and communities

We will carefully evaluate how beneficiaries in the five test states use these materials and services, and identify areas that need to be refined or revamped. This is a critical opportunity to learn. We have time to refine materials and services before the nationwide mailing of education and plan comparison materials that the statute requires before the first coordinated annual enrollment period in November 1999.

We will continually work to improve education materials and services. We want to approach this task in partnership with Congress, providers, beneficiaries and their families, and beneficiary groups around the country. We have worked extensively with Congress and interested beneficiary groups to review our efforts, and believe that we can improve them further by continuing this process.

EDUCATION CAMPAIGN COSTS

Our phased education campaign allows us to make wise use of scarce resources. As you know, $200 million was authorized for the first year of this education campaign, but only $95 million was appropriated by Congress. We are supplementing those funds with $19.2 million in funds from HCFA's program management and peer review organization budgets.

For FY 1998, the first year of the education campaign, we expect to spend:

- $30.2 million on printing and mailing materials to beneficiaries and outreach partners; $20.5 million from user fees assessed on participating health plans, and $9.7 from other program funds. Of the $30.2 million, $9.3 million will go to producing and mailing the comprehensive booklet with localized plan comparison charts in the five test states, $13 million will go to mailing the Medicare bulletin to beneficiaries in other states, $4 million will go to providing an initial enrollment package to new beneficiaries, and $3.9 million will go to materials for training outreach partners who will also help beneficiaries understand their options.
- $50.2 million on the toll-free call center, $46.2 million from user fees and $4 million from other program funds. The call center itself will cost $38.2 million, and mailing printed comparison information on Medicare+Choice options available in local markets to beneficiaries who request them as the call center is phased into other states will cost $12 million.
- $22.3 million on program development, $16.8 million from user fees and $5.5 from other program funds. Evaluation of the education program will cost $2 million, fielding the Consumer Assessment of Health Plans survey will total $6.8 million, grants to state health insurance advisory programs will total $5 million, training outreach partners will cost $2.75 million. The rest will cover such activities as project integration and management and business requirements analysis.
- $9.9 million on community-based outreach activities, including health fairs, all from user fees; and
- $1.5 million on the Internet site, all from user fees.

For the second year, FY 1999, we believe an effective education campaign will cost $173 million. We propose to finance it by a combination of the full $150 million in user fees authorized in the Balanced Budget Act, plus $23 million from other agency accounts. We project spending:

- $50 million for printing and mailing the handbook and other materials;
- $68 million for the toll-free Call Center;
- $39 million for program evaluation, development and technology investments;
- $2 million for the Internet site,
- $14 million for health fairs and other community-based outreach.

The costs of beneficiary education are ongoing. The BBA authorizes $100 million in user fees for consumer education and information activities in fiscal years 2000 and beyond. From our experience so far, it is clear that this funding will be necessary if we are to educate and inform Medicare beneficiaries about the dramatic changes to the Medicare program.

CONCLUSION

We are making steady progress on Balanced Budget Act implementation. We are eager to help beneficiaries understand Medicare+Choice, and to implement the remaining Balanced Budget Act provisions in a careful and responsible manner. Clearly, we have no choice but to make Year 2000 management necessities our top priority. We look forward to working with this Committee as we continue efforts to implement the Balanced Budget Act and address the Year 2000 challenge, and I am happy to answer any questions you may have.

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July 7, 1998

Nancy-Ann Min De Parle
Administrator
Health Care Financing Administration
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Ms. De Parle:

We are writing in our capacities as the contractor members of the Joint HCFA/Contractor Y2K Steering Committee to comment upon the "HCFA Year 2000 Fact Sheet" which describes the priorities HCFA has established to balance the resource requirements demanded by:

- Y2K modifications to the numerous inter related systems;
- Testing the systems against one another to assure Y2K readiness; and
- Managing the numerous program, HIPAA change requirements and initiatives which will be implemented while these Y2K modifications and testing are occurring.

As you know, we have been working with senior HCFA management to help develop the HCFA/Contractor collaboration which will assure that fee for service Medicare claims will be processed timely and accurately on January 1, 2000.

A substantial portion of our advisory work with HCFA has been devoted to examining the critical processes in assuring Y2K readiness. We concluded, and recommended to HCFA, that as many non Y2K system changes as possible should be removed from contractor workloads so that technical resources could be devoted to assuring Y2K readiness. Non Y2K systems development work should be added back only after HCFA is satisfied that the contractors' and HCFA's systems are certified Y2K ready. We also recommended that no material system changes be introduced between October 1, 1999 and February 1, 2000.

The priorities described in the HCFA Year 2000 Fact Sheet are consistent with advice from our technical experts that resources must be focused on the Y2K effort. We believe that prioritization established by HCFA is an aggressive but feasible workload that is consistent with the availability of systems technicians and Medicare "subject matter

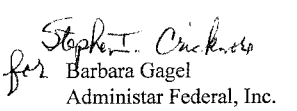
experts." However, there is little doubt that even these priorities will require HCFA and its Medicare contractors to manage resources to very high levels of productivity. Also, additional funding for contractors will be necessary to assure that sufficient resources can be acquired, and we appreciate the progress HCFA has made in acquiring that funding.

We appreciate the difficult decisions involved in HCFA's prioritization effort, and look forward to a collaborative and intensive working relationship to assure that claims are paid accurately and timely in the Year 2000.

Sincerely,

Bruce A. Davidson
Blue Cross & Blue Shield of Florida

Harvey Friedman
Blue Cross & Blue Shield Association



for Barbara Gagel
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2101 CONSTITUTION AVENUE WASHINGTON, D. C. 20418

Letter Report to the Administrator of the Health Care Financing Administration on Developing an Information Infrastructure for the Medicare+Choice Program

Committee on Choice and Managed Care
Office of Health Policy Programs and Fellowships
Institute of Medicine
June 22, 1998

Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration
200 Independence Avenue, SW
Room 314G
Washington, DC 20201

Dear Ms. Min DeParle:

In March 1998, the Institute of Medicine (IOM) Committee on Choice and Managed Care (see the attached list of members), held a one-and-one-half-day workshop on "Developing an Information Infrastructure for Medicare Beneficiaries." This workshop followed in the footsteps of the Committee's 1996 report, *Improving the Medicare Market: Adding Choice and Protections.* One of the 1996 report's seven major recommendations was the following:

> **The Committee recommends that special and major efforts be directed to building the needed consumer-oriented information infrastructure for Medicare beneficiaries. This resource should be developed at the national, state, and local levels, with an emphasis on coordination and partnerships. Information and customer service techniques and protocols developed in the private sector should be used to guide this effort, and the best technologies currently available or projected to be available in the near term should be used. (p. 89)**

The March workshop focused on the information and dissemination requirements established in the Balanced Budget Act of 1997 (BBA), as they pertain to instituting an open-season enrollment process by the year 2002 for Medicare beneficiaries and implementing the Medicare+Choice (Part C) program. As part of the BBA mandate, HCFA is required to mail an announcement of the new Medicare+Choice options to all 39 million Medicare recipients by November 1998. Approximately 50 people from the public and private sectors were invited to the workshop. They were selected for their special expertise on information needs and information technologies as they relate to exercising health plan choice in a competitive, managed care environment, especially among senior citizens.

We want to share some of the committee's findings and recommendations based on the presentations and discussions at the workshop, and on the committee's 1996 report. The committee supports the major provisions of the BBA pertaining to increasing Medicare beneficiaries' health plan choices and providing beneficiaries with better information about the options available to them. However, the committee would like to underscore the following findings and concerns:

- The introduction of Medicare+Choice brings with it new rules and procedures that will be totally unfamiliar to most beneficiaries. In addition, the scope and speed of the proposed changes are likely to cause confusion and anxiety among many elderly beneficiaries.

Medicare beneficiaries have had much less exposure to managed care than have people who are insured through their employers. While managed care enrollment for the over-65 population is increasing rapidly, according to May 1998 HCFA data only about 16 percent of people eligible for Medicare are enrolled in a managed care plan, compared to over 70 percent in the under-65 insured population. In addition, unlike most employed people—particularly those working in larger firms—whose employers help screen and evaluate their health plan options, most Medicare beneficiaries must rely on their own knowledge and judgment to select a plan wisely. In its 1996 report, the committee noted that the elderly need more time and require more outside help to make health care decisions. In addition, findings of a study presented at the workshop indicate that the information processing tasks that would be required of Medicare beneficiaries under the BBA are highly cognitive and would be difficult for *any* population to address successfully (Hibbard et al., 1997).

- The new system scheduled to be introduced by November 1998 will give many elderly people a broader array of health plan options from which to choose. However, although HCFA will present comparative information about the plans in a standardized format, most of the marketing materials available

from individual plans themselves will not be standardized or presented in a way that would be conducive to helping elderly people make informed decisions they could feel comfortable with.

The 1996 IOM study and experts at the workshop addressed the value of standardized packaging, pricing, and marketing of benefit options to allow beneficiaries to more easily compare the benefits offered by different plans. Representatives from the plans, however, told the committee that the current trend in private-sector marketing is to move toward "mass customization," whereby materials are tailored to an individual's demographic characteristics, socioeconomic status, neighborhood, ethnic group, language, and religious belief. To help decrease confusion and to make it easier for beneficiaries to make informed choices, the committee refers to the findings of its 1996 report to underscore the advisability of the government developing a common terminology that would be used by all plans to describe their benefits, as well as common formats for presenting the information; both efforts should draw on the best practices used by employers and by private and public organizations.

- Many beneficiaries do not understand how basic Medicare and Medigap coverage works. Far fewer elderly persons have even a rudimentary understanding of how managed care works or of how to choose among managed care plans, traditional Medicare, and Medigap.

Research over the past 12 years has documented how poorly Medicare beneficiaries understand the differences between traditional and managed care Medicare (Cunningham and Williams, 1997; Davidson, 1988; Hibbard et al., 1997; McCall et al., 1986; and Sofaer, 1993). Beneficiaries now face the daunting challenge of having to choose between two systems they do not understand, and, for many elderly persons, having to compare and to select from among many more plan options than employed populations face. In an examination of current survey research, the committee heard evidence at the workshop that 30 percent of beneficiaries in high-penetration managed care markets "know nothing" about managed care organizations, even though half of this group is currently enrolled in a managed care plan (Hibbard and Jewett, 1998).

- Despite HCFA's best efforts, a fall health plan marketing campaign is likely to produce, at the very least, a high level of confusion and anxiety among Medicare recipients—perhaps a backlash—and a host of questions about the impending changes.

Several presenters at the workshop commented that the increased range of health plan choices available to Medicare recipients under Medicare+Choice will likely spawn a great deal of anxiety and confusion among those unaccustomed to having to make such choices. The 1996 IOM report and testimony given at the March workshop spoke to the benefits of allowing

sufficient time for beneficiaries to learn about and understand the new system. The potentially daunting scope and speed of the transition to what, for most beneficiaries, remain uncharted waters underscores the need for building trust and familiarity in this arena. Trust and confidence can be greatly enhanced through the development and dissemination of reliable, objective, and understandable information. Efforts to build trust and a level of comfort with Medicare Part C are particularly important given the ongoing negative public perception and attitude about managed care in general.

- Compounding the likelihood of raised anxiety and confusion among the elderly will be a concurrent flood of mailings marketing existing plans as well as a number of new Medicare products. Despite current rules designed to monitor and control marketing materials sent to Medicare beneficiaries, such mailings can too easily include misleading or incomplete information. Most materials sent to the elderly lack a clear, understandable explanation of what it means to be part of a managed care plan and what coverage or cost trade-offs need to be considered by beneficiaries in order to make a good health plan choice. Such information must be part of the marketing materials to minimize dissatisfaction among beneficiaries that could subsequently lead to excessive, costly rates of plan disenrollment.

Many health plans understand the importance of spending time with Medicare beneficiaries up front to provide them with reliable information about the plan and how it differs from traditional Medicare. The committee, however, heard ample evidence that plans tend to interpret and relay information differently from each other. Experts who work with beneficiaries provided extensive evidence at the workshop that all too frequently, the information that plans provide is incomplete and confusing. A recent report published by the Kaiser Family Foundation also points to evidence that HMOs, particularly those using aggressive sales tactics, rarely include explanations of how they differ from traditional Medicare or detailed explanations of their benefits and coverage limits (Frederick Schneiders Research, 1998).

- Whereas HCFA is making Herculean efforts to prepare for Medicare+Choice, the information infrastructure and resources available for this daunting task appear inadequate, particularly in terms of the capacity to answer both the volume and content of the inquiries that will surely result from HCFA's mailing and from the marketing materials sent out by the health plans themselves. A major upsurge in the number of constituent calls to members of Congress should be anticipated as one consequence of the sweeping nature of implementing Medicare+Choice as it is now scheduled.

At its March workshop, the committee invited a representative of General Electric to discuss that company's Answer Center as a model for handling large volumes of toll-free telephone calls. The GE representative noted

that out of a 6-million person customer base, the Answer Center receives 8 million calls annually. He also informed the committee that GE places a high value on recruiting and training its Answer Center employees and prefers to employ college graduates rather than less well-educated clerks. The committee also received testimony from the California Public Employees' Retirement System (CalPERS), which reported that during its annual 1-month open-enrollment period, about 15 percent of their over 1 million members call its customer service center (Stanley, 1997). The timing of HCFA's fall mass mailing, as outlined in the BBA, will roughly coincide with the congressional elections. Presenters and congressional health staff members at the workshop both indicated that any likely surge in telephone calls would thus take place during a time when many members of Congress are in their home districts campaigning for reelection.

- If the current timetable and choice process hold, many elderly people are likely to make ill-considered choices that will ultimately undermine Congress' efforts to restructure Medicare.

Congress is moving the major federal entitlement programs that deal with health (Medicare and Medicaid) into managed care with the purported goal of saving money. This committee has previously found that "[b]eneficiaries who make misinformed choices can be hurt financially or clinically, or both" (Institute of Medicine, 1996, p. 85). Speakers at the workshop cautioned that any political rhetoric emanating from the beneficiaries' confusion may complicate Congress' long-term efforts in the managed care arena.

- Medicare+Choice is quite different from the Federal Employee Health Benefits Program, a program that many people are holding up as a model. The Medicare market consists of 39 million people, more than 3 times the size of FEHBP's membership. Further, FEHBP has involved the option to chose among plans for 35 years. Federal workers are very familiar with the options open to them, and many of them have a detailed understanding of how the various plans work. The opposite is true for Medicare beneficiaries. Furthermore, most federal workers have ready access to professional counselors in their benefits offices or to peers who can readily assist them with their questions

There are other clear distinctions between FEHBP and the Medicare program as well. Federal retirees have about 25–30 years' experience with an open-season enrollment environment. Even though the retirees may not have changed their health plan often over the past 25 or 30 years, they have had the opportunity to do so, and they have had direct interactions with health plans during this period. In addition, because they have been in this system for a number of years, the retirees already possess a great deal of knowledge about deductibles, copays, and so on. This level of familiarity and experience among beneficiaries indicate that HCFA's task will be much more complex than

FEHBP's. Jim Morrison, past director of FEHBP, indicated at the March workshop that federal employees in FEHBP trust that the Office of Personnel Management has adequately screened the health plans, thus limiting the likelihood of their making a poor health plan choice. Medicare+Choice introduces several new types of plans, such as preferred provider organizations (PPO's) and provider sponsored organizations (PSO's), that do not have a performance history that HCFA or beneficiaries can evaluate.

In light of the preceding findings and concerns, and keeping in mind this committee's prior work in the areas of beneficiary information and the development of a sound information infrastructure, the committee makes the following recommendations:

- **HCFA should stagger its mailings over a period of several months, both to reduce and spread out the certain upsurge in the volume of inquiries and to allow some level of market-testing of the material.**

- **HCFA should urgently request more time from Congress for additional educational efforts among beneficiaries and infrastructure development at the front end of the process.**

- **HCFA should delay the initial mailing until market-testing demonstrates that the differences among the various health plan choices and benefit packages will be presented in a standardized, easily understandable way.**

- **HCFA should focus on conveying a few key messages and the answers to a few select questions on topics about which the elderly most need assurance. For example: (1) Will I be able to continue seeing my current physician? (2) Will I be able to see a specialist if I think I need one? (3) Will the plan save me money, and if so, how? (4) How will my pharmacy costs be covered? (5) Can I leave the plan if I am unhappy? And (6) If I have a complaint, how will it be addressed?**

- **All the major groups that the elderly reach out to for help (e.g., HCFA, Congress, and local Health Insurance Counseling and Assistance Programs [HICAPs] among others) need to be enlisted in the effort and well prepared to respond to both the volume and content of the inquiries that will certainly result.**

- **Given that the vast majority of people eligible for Medicare have not had to change plans, and bearing in mind the anger and opposition that resulted from an earlier attempt to substantially change the program (i.e., the 1988 Medicare Catastrophic Coverage Act), beneficiaries should be reassured that: (1) They are not in any danger of losing traditional Medicare coverage if they prefer to keep it, and (2) they can delay making any choice at all indefinitely, in which case they would continue to be covered by traditional Medicare.**

We appreciate your consideration of our views. We will make this letter public on June 22, 1998. If you have any questions about the issues raised in this letter, please contact Marion Ein Lewin, Study Director at (202) 334-1506.

Sincerely,
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Stanley B. Jones, *Cochair*
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Shoshanna Sofaer, Dr.P.H.

cc: The Honorable Bill Archer
The Honorable Richard K. Armey
The Honorable Jeff Bingaman
The Honorable Tom Bliley
The Honorable Barbara Boxer
The Honorable John B. Breaux
The Honorable Tom Campbell
The Honorable John H. Chafee
The Honorable Dan Coats
The Honorable Susan Collins
The Honorable Kent Conrad
The Honorable Alfonse M. D'Amato
The Honorable John D. Dingell
The Honorable Thomas Daschle
The Honorable Christopher J. Dodd
The Honorable Richard Durbin
The Honorable Mike Enzi
The Honorable William H. Frist
The Honorable Greg Ganske
The Honorable Richard Gephardt

The Honorable Newt Gingrich
The Honorable Bob Graham
The Honorable Phil Gramm
The Honorable Charles Grassley
The Honorable Judd Gregg
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The Honorable J. Robert Kerrey
The Honorable Jon Kyl
The Honorable Joseph Lieberman
The Honorable Trent Lott
The Honorable Connie Mack
The Honorable John McCain
The Honorable Jim McDermott
The Honorable Daniel Patrick Moynihan
The Honorable Don Nickles
The Honorable Nancy Pelosi
The Honorable John Edward Porter
The Honorable Jack Reed
The Honorable John D. Rockefeller, IV
The Honorable William V. Roth, Jr.
The Honorable Olympia J. Snowe
The Honorable Arlen Specter
The Honorable Fortney Pete Stark
The Honorable William M. Thomas
The Honorable Henry A. Waxman
The Honorable Paul D. Wellstone
The Honorable Ron Wyden

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CHOICE AND MANAGED CARE:
Furthering the Knowledge Base to Ensure Public Accountability and Information for Informed Purchasing By and on Behalf of Medicare Beneficiaries

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July 2, 1998

Nancy-Ann Min DeParle, Administrator
Health Care Financing Administration
U. S. Department of Health and Human Services
200 Independence Avenue, N.W.
Room 314-G
Washington, DC 20201

Dear Ms. Min DeParle:

Last year, as part of the landmark Balanced Budget Act (BBA), the Congress and the President ushered in a major set of changes in the health care choices Medicare offers beneficiaries. In supporting expansion of Medicare choices, AARP emphasized the importance of solid, consumer-friendly information. HCFA recently announced that it would postpone national distribution of the revised Medicare handbook which was to have included information on the traditional Medicare program, the Medicare+Choice program and specific comparative information about Medicare+Choice plans.

We understand that your decision to postpone distribution and the related decision to phase in the 1-800 telephone lines over the next year is for the purpose of further testing and refining the contents of the handbook and the operation of the telephone assistance line. For the reasons outlined in this letter, we believe HCFA's decision is the right course of action under the cirumstances.

In Medicare+Choice, Congress established a worthy but ambitious goal: to allow Medicare beneficiaries to choose from among the broad range of health care options that are generally available in the commercial marketplace, and to provide beneficiaries with information that will enable them to make informed decisions. The goal is all the more ambitious because Medicare was given limited resources (roughly $2.50 per beneficiary) and a very short time to launch an educational initiative far more challenging than any similar effort in the private sector.

Educating beneficiaries so that they understand the complex range of choices facing them is an enormous task. Recent research in five cities conducted for AARP by Dr. Judith Hibbard of the University of Oregon found that many beneficiaries are not yet prepared to make knowledgeable choices even between the traditional Medicare fee-for-service program and the *current* HMO option. Preparing beneficiaries for the still more

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complicated task of choosing among a greater number of options poses a challenge that must be taken very seriously by HCFA, the Congress, and groups like AARP.

It is vitally important that the information provided to beneficiaries help them understand the differences among the options, assess the implications of the different options for their individual needs and circumstances, and understand the basic principles for navigating within the different types of plans. To accomplish this, HCFA should consult with those in the private sector who specialize in translating complicated information into plain English, and presenting it in a format that enables comparison. Publications should be extensively field tested before they are widely disseminated.

In the meantime, it is imperative that this additional time be put to good use by testing and improving the materials that will be sent to beneficiaries. It is also imperative that some information be available in the interim for those who will face new choices before the complete information system is operational. HCFA's decision to send general information to all beneficiaries this fall that will alert them to the changes in the Medicare program is a prudent course of action. Such material must target the types of information beneficiaries are likely to need before the more extensive handbook is sent to them next year.

AARP supported the BBA and Medicare+Choice in order to give beneficiaries the full benefit of innovations in health care delivery. Medicare+Choice can realize its potential only if beneficiaries acquire the knowledge that will enable them to exercise their leverage as informed consumers in the marketplace. HCFA needs to move expeditiously, but wisely, to prepare beneficiaries to make informed choices. Congress, too, must do its part, by providing sufficient resources to enable HCFA to carry out this challenging task.

AARP looks forward to working with HCFA and the Congress in helping beneficiaries to become active participants in the Medicare+Choice program. If you have any questions, please contact Tricia Smith or Cheryl Matheis of our Federal Affairs staff at (202) 434-3770.

Sincerely,

Horace B. Deets

Chairman THOMAS. I thank you very much, Ms. DeParle. We will be interested in pursuing some questions when we come back from recess. We do have a 5-minute vote following this one. I hope members can be back here by 12:15 p.m., 12:20 p.m. at the latest.

The subcommittee stands in recess.

[Recess.]

Chairman THOMAS. Thank you very much.

Ms. DeParle, I would like to ask you a series of relatively general questions, and I know my colleagues may have some specific questions about specific programs. And we're all anxious to try to understand as much as we can about the full impact of the consequences of what no one doubts is real, but, frankly, still a little perplexed about how we wound up in this context, especially based upon the information of a year ago that it was already paid for, that it was a problem that was well in hand, and that GAO should not be upset or was misleading in indicating we didn't have a handle on it. Apparently—no matter how much it pains me—GAO may have been more accurate than the HCFA Administrator.

But the things that we need to know, going back to my opening statement about the concerns of beneficiaries, given the promise of this program, which was a bipartisan initial effort to restructure Medicare. And now the latest information—that even on a interim payment system for home health care, the Congressional Budget Office can't score it because it contains programmatic changes that HCFA probably can't implement, given the policy that we now are beginning to fully appreciate that you are desirous of putting in place. My assumption is that it will require legislation.

But what I really want is to see if you can to this subcommittee commit that no claim will be delayed due to the problems that you've identified in the Year 2000 reprogramming. Can you now make that statement, that no claim will be delayed, or are you not able to make that statement?

Ms. DEPARLE. Mr. Chairman, I will commit to you that I'm doing everything possible to ensure that no claim will be delayed.

Chairman THOMAS. But you can't make the commitment that no claim will not be delayed. That's fine; I understand that. We just need to know the context in which you are working.

I know you do not want to be before us with the testimony that you gave us; you would much rather be in a different circumstance. And I just think it's going to be necessary, if you would, to provide us with the other functions that HCFA considered postponing or other alternative actions that you may have contemplated taking, because my assumption is this wasn't the first thing that you arrived at, and I do need to be able to at least provide my colleagues with some assurance that that was the case, if indeed that was the case.

[The following was subsequently received:]

HCFA's Office of the Actuary projects that the anticipated delays in implementing certain BBA provisions due to Y2K activities will increase Medicare expenditures by approximately $150 million (or 0.01%) over five years. As you know, after a reconciliation bill is enacted, the actual effect of the provisions may differ from the savings estimated when the law was passed. There may be changes in the implementation of other BBA provisions that could have a financial impact on the program. These impacts are not reflected in the estimate of Y2K-related delays.

Chairman THOMAS. I would very much like to have—and this subcommittee would—your guarantee that the beneficiaries will not be harmed by the failure to manage the computer system.

The one thing that I guess I'm most concerned about—and if you would just spend 30 seconds or so, and if you need to elaborate in writing, I would—because the current national law includes a limitation on beneficiary co-insurance liability for outpatient services. For so long there was a charade going on about how much was to be paid, and, frankly, beneficiaries were paying a far greater share, and it was all ultimately acknowledged and we put in place a changed process.

If, in fact, we freeze it now, since it's now known that in fact that process was not a fair and equitable one, are we saying that we're going to sustain that for a while longer? Because that clearly means that it's now clearly understood that beneficiaries are paying a greater share than probably they should. My guess is that's going to stay in place.

Ms. DEPARLE. Yes, sir. As you said, I'm not happy to be here today talking about this, and of all the things to have to delay, that change which we worked so hard together with you to put into place. It is very disappointing to me that we're going to have to delay it. But, yes, sir; I think that is right.

Chairman THOMAS. And of course my concern is that you have completed the mega-regs—so-called mega-regs—on the Medicare+Choice, which means the timeline goes forward for plans to be able, under those regs, to offer it. Are those deadlines planning to be met?

Ms. DEPARLE. Yes, sir.

Chairman THOMAS. Which obviously creates the concern—and the gentleman from California placed it in his perspective of concern—that plans will be out in the marketplace actively marketing product at a time that HCFA has indicated that the aggressive, full-court press educational program will not be going forward, that it will be narrowed to five States initially—and I think folks should focus not on the number of five, but on the percent of Medicare beneficiaries covered by those five States—in an attempt to try to move it in equal segments of the Medicare population.

But how are we expecting beneficiaries not within those States that are going to be aggressively educated to be able to make decisions? What is it that you're planning on doing for those folks?

Ms. DEPARLE. Well, as I said, we have an eight-point Medicare education program that's displayed over there on the poster. In the five States where we're going to be doing the full system all at once, there are 5 million beneficiaries, and we chose those States based on high, low, and medium penetration of HMO's, and then we'll keep moving around the country. But for everyone this fall, all beneficiaries will get a bulletin that we're currently in the process of focus group testing—and then we want to consult with your committee staff about it. It will notify them about the new changes. It will offer them a toll-free number that they can call that will just give them——

Chairman THOMAS. Let me ask you a question about that notification, because I know the President just this week instructed HCFA to mail to 100 percent of the Medicare beneficiaries, I be-

lieve—and correct me if any of my statement is wrong—a notice about the ability to subsidize a portion of the premium if you are a qualified Medicare beneficiary, which affects maybe 10 percent of the Medicare population. Is that going to be a separate mailing?

Ms. DEPARLE. No, sir. I think what he was talking about is that he has asked us to do a better job of notifying beneficiaries about their potential eligibility for this. Our plans are to do that in two ways. One is we will include a sentence in the bulletin that I was talking about that will go out to all beneficiaries, and the other is, through the Social Security system, which is, after all, how most beneficiaries sign up for this. We plan to put a notice on the premium payment statements that go out every year.

Chairman THOMAS. Okay.

Ms. DEPARLE. So it won't be a separate mailing.

Chairman THOMAS. All right. Now one of the things that I know—our colleague from Connecticut provided me with what was an example of how the Connecticut notification process worked with seniors. When we were out in Minneapolis-St. Paul for the Medicare Commission, we received a booklet—and there was some advertising to defray costs—but the point of any of this material—and I've got it, and I think you're probably familiar with it, but we'd like to show it to you. Here it is. This is the booklet, and it does provide, you know, as you go through it, a pretty adequate comparison on a chart.

[The booklet is being retained in the Committee files.]

And I know the Senators were concerned about a chart in the legislation which lets you make comparisons——

Ms. DEPARLE. Yes.

Chairman THOMAS [continuing]. And the gentlewoman's New England, very frugal approach to giving options, but, nevertheless, providing, you know, a full choice. And this is going on without any national, or at least minimal national role. Is that correct?

Ms. DEPARLE. Well, not quite, sir. We are providing through the Medicare.gov Internet site that plan comparison information. And in addition, the bulletin that I mentioned that we are sending out to all beneficiaries will have a number that they can call to get a printout of the plan comparison for their area if they want to order it through the mail. So we will be able to provide it to them that way.

I was with Congresswoman Johnson last week in Connecticut and I also saw the materials, and they were provided by one of the State health insurance advisory programs, also called ICA's—the one for Connecticut. They are one of the pieces of our information campaign. We will be helping them to make that information available as well.

Chairman THOMAS. On the Quimby notification, is this something that you had planned? Was it not something you had planned? Is there a cost involved to it beyond what you had planned?

Ms. DEPARLE. No. It is something we had planned. The draft of the Medicare handbook that I believe you saw had a section in it about it, and we had planned to notify beneficiaries about it through that process.

Chairman THOMAS. So the President's announcement was basically staged for the purpose of making it appear as though this was something he was concerned about and highlighting it as a separate item, but in fact it's something you were planning on doing all along. You know what I'm trying to say. I can try to soften it. But you see it's very difficult when you're telling us you're not going forward with programs, and we see a Rose Garden shot of the President announcing yet another new initiative by the administration which appears to require resources, either redirected or dedicated that hadn't been planned, to achieve a particular goal, when we look at programs that are statutory not going forward.

And a number of my colleagues have almost required me to ask you—it's going to be necessary for us to know in what context the cost of these numbers of initiatives—and I know the President has indicated an initiative with HIPPA to go forward in analyzing the oversight responsibilities to ensure that plans are satisfying their requirements under the law. Was this something that was planned as well, and he just announced it in a way that it looked like it was something special? Or was it in fact a new assignment? Do you know what I'm talking about?

Ms. DEPARLE. Yes; and you and I have discussed this and I understand your concern. What I want to emphasize to you is that my commitment and my priority is to implement the Balanced Budget Act, and I agree with you, Mr. Chairman, that that is not a political law. It is, in fact, a major step forward for the Medicare program and in fact for other programs that we administer, and I can assure you that my full attention is being devoted to that.

Chairman THOMAS. Well, the appearance is is that it's not, and that's the problem that we've got to deal with. And rather than try to ask you a series of Y2K questions—I guess I've given in to that phraseology—you heard the testimony of the previous Administrator. It frankly either was not grounded in fact, or something serious has happened between May 1997 and today about the resources available to HCFA to carry out the job and, in fact, the job itself and the timetable associated with carrying out that job.

Do you want to make any statement at all in regard to Mr. Vladek's testimony—that it was 20 million lines of code, 8 million had been done by the time the August 1997 letter was written, with 12 million remaining, December 1998 was going to finish it, and the funding was available from 1996 to 1998, so that no one should be concerned about the Y2K question?

Ms. DEPARLE. Yes, I would like to comment on that. I've read the testimony myself, and if you read the testimony closely, right after the part that you quoted there is a discussion of GAO's recommendations to us which included hiring an independent verification and validation contractor to go out to our contractors and to look, frankly, inside HCFA to make sure that we were doing the kind of planning and that it was really all there to move forward on the Year 2000. We did that last fall, and that contractor went out and visited all of our sites around the country that process Medicare claims and discovered that the assessments that had originally been done were not in the right ball park, that really we're talking about renovating more like 50 million lines of code.

I can tell you that on the internal code that we have to renovate, we're well along the way towards testing. We still have a lot of work to do, and this is a problem that I think was found to be a lot more difficult than had been thought. The GAO has been very helpful in that regard. They made, at that hearing that you're talking about, some recommendations. One of the first things I did last fall was sit down with Joel Willemssen and Gene DeDaro of GAO, who gave me a number of suggestions, many of which I've moved forward to implement. And I apologize for the fact that this problem has turned out to be a lot bigger than I think anyone thought.

Chairman THOMAS. No; I know how difficult it is for you. Maybe resent is too strong a word, but I know the concern that you have, and the fact that you have to appear before us to discuss this, but it's a fact of life. And my concern is, to what extent is this a failure to solve a management problem in the overall context? My question is, how are you doing on keeping your focus on core responsibilities?

I think you've answered the non-legislative initiative focus, that it isn't that much. But I wish the press would put it in the context in which it is delivered, then—that is, they're going to do it anyway, but I thought the Rose Garden would be a better place to announce it and maybe we can get a bigger spin out of it.

I am concerned about resources being focused for that purpose, and it goes back to some of the concerns that we had—all of us did—as we discussed putting this package together, where HCFA changes from a billpayer—now we're worried about paying the bills because you're so computerized—to a kind of a consumer-oriented education program. How is the skill mix among HCFA employees, in part a concern about not being able to meet the deadlines? Is that part of the concern?

And then, lastly, because I just want you to go ahead and talk about it awhile, is the vulnerability of HCFA. We had the MTS problem; for the record, I'd like you to tell me how much money was spent on that. Did we gain anything at all of positive leverage going into Y2K, or did you just have to drop that? And to the extent you were trying to put your eggs in that basket, did that perhaps give you a problem coming out the other side?

And then deal, finally, with the $23 billion that has been found to be waste, fraud, and abuse. I think it's better to say inappropriate payment or inability to determine appropriate payment. If you're fixing the Y2K problem, are we going to be able to address the problem associated with the GAO study on our inability to account for that? Is that a bonus that we'll get, perhaps, out of waiting beyond the current statutory time for putting programs in effect? And I'll just give you a minute or two to react to that.

Ms. DEPARLE. Well, I think there's no question that the Year 2000 problem has caused a focus and a coordination at the Health Care Financing Administration that perhaps wasn't there before. It has forced us to sit down and—for instance, you asked me about decisions made on the various systems that had to be delayed. When the independent verification and validation contractor first said to me—and the language they used was, "You must stop parallel development," which in their parlance means stop telling the

contractors to do all these changes at the same time you're telling them to renovate the code.

And what we had to do was sit down as a group—the policy people, the information systems people, the whole group of us—and decide what it was possible to get done. You had to balance the risk that you wouldn't be paying claims at all against our strong desire to get all of the changes in the Balanced Budget Act implemented, and I think it has forced a management focus that probably wasn't there in the past. So, yes, sir; I would like to think that is an advantage of this.

Chairman THOMAS. Let me interrupt you briefly on that point and just to explain that I know—and GAO was going to do this—we're going to go through the number of items that are currently on-line from—that's a quantitative analysis. At some point you had to look at the magnitude of programs, and I am a bit concerned that it was probably—obviously, from Congress' point of view—way too unilateral in terms of the decisions.

I would have appreciated, and I think my colleagues would have appreciated, given the manner in which this legislation was put together and passed, an earlier awareness, a prioritization, perhaps, shared with some of us, and an earlier notification so we could have begun some of the changes that are necessary. And that does concern me, about an unwillingness to share earlier if you did know about it and a prioritization of programs so that, given the very brief time left in the legislative process, we're not going to have to—which we are now—ram through something on the interim payment system for home health care and whatever else we find out we need to do. That does concern me.

Ms. DEPARLE. Yes, sir, and it concerns me, too, and I regret that. When I first heard about this, I did mention to you that I thought there was going to be a problem coming. I regret that you had to get the details from a leaked memorandum. My plan had been to come up and discuss it with you and your members of this committee, as well as other Members of the Congress, and I didn't get to do that at the time I would have wanted to, so I'm sorry for that.

Chairman THOMAS. Thank you. And I am concerned that the last item was the $23 billion of inappropriate payment. Are we going to get a bonus? Do you think that what you're doing on the Y2K is going to be of some measurable assistance in pinning down what it is and how it works that allows the GAO or the OIG to say there's $23 billion of inappropriate payments?

Ms. DEPARLE. Well, let me say this. The efforts that we're making and that this year got us a qualified statement from the Inspector General on our financial statements will not stop, and I don't expect them to be interfered with at all by the Year 2000 efforts. We are putting a major focus on getting our house in order from an accounting perspective and bringing the claims error rate down, and that is one of my top priorities.

Chairman THOMAS. The gentleman from California—thank you very much.

Mr. STARK. Thank you, Mr. Chairman. Could you just quantify for me this Year 2000 thing? On a percentage basis, how much of the Year 2000, quote, "problem" is a problem of changing Government-operated computer systems, and how much of it is a problem

of the contractors—the beltway bandits who are doing new implementation work and working for the intermediaries who don't have enough personnel to do their own work? I'm not sure I can identify what the problem is.

Do we have Federal computers that need a lot of reprogramming, or is it the fact that the intermediaries, the people you contract with, can't hire enough people because the people are all busy doing Year 2000 work elsewhere?

Ms. DEPARLE. Well, both our internal systems and our external systems need work. We've identified around 25 mission-critical systems that are internal to HCFA.

Mr. STARK. Just tell me, is it 25 percent internal and 75 percent external, or 50/50? Give me an idea.

Ms. DEPARLE. It's about 25/75 and——

Mr. STARK. So the major part of the problem is with outside contractors just having enough personnel to do the job. You can't hire any outside computer experts? You can't find them?

Ms. DEPARLE. Yes, and they're working hard to try to find the people, and I want to thank the Congress for providing us with the resources to do that.

Mr. STARK. Okay. Now, speaking of providing you with the resources to do that, there's some testimony that's been submitted for the record only. I can't ask them the question, so I'll ask you. This American Association of Health Plans, they're bleeding in their testimony to the fact that they've paid their $85 million, or whatever it is, to HCFA for this implementation of the education component of the new Medicare+Choice program. They say that last year HMO's and their enrollees represented 14 percent of the program, and they shouldered 100 percent of the cost of the Medicare+Choice information program at about $95 million, right?

Ms. DEPARLE. Yes, sir.

Mr. STARK. Now my calculations would say that they also avoided 14 percent of the graduate medical education burden, and they also avoided about 14 percent of the disproportionate share burden. Each of those would be about $1 billion. So, basically, for $2 billion that they didn't contribute—that all the other providers have to pay—they are complaining about $100 million. Is that a reasonable balance to their argument? Shouldn't they have paid into graduate medical education and the disproportionate share costs as well?

Ms. DEPARLE. Well, as you know, one of the policies in the Balanced Budget Act was to divert the graduate medical education payments so they go directly to the teaching hospitals, and we're in the process of implementing that.

Mr. STARK. But, I'm saying that their vocal complaints about coming up with $100 million when they've saved billions not paying their fair share into the system, not to mention uncompensated care and other costs that they avoided needs to be considered in that light. I just wanted to make sure that we get their testimony on the record and that we straightened out the accuracy of their perceived problem.

I'm always interested in Golden Rule and all these other great American patriots. I understand you had a meeting yesterday. Did you invite all the insurance companies in the world to come and evidence their interest in Medicare savings accounts?

Ms. DEPARLE. We invited everyone that we had heard from, and we asked Members to let us know, too, of companies——

Mr. STARK. How many showed up?

Ms. DEPARLE [continuing]. That might be interested in offering a demonstration.

Mr. STARK. How many showed up?

Ms. DEPARLE. I believe that representatives of about 11 different possible plans came to our meeting.

Mr. STARK. And did any of them say they were going to offer MSA's, outside of Golden Rule, who ought to be disqualified on ethical grounds?

Ms. DEPARLE. I don't think anyone has made a firm commitment yet. They asked a lot of questions about the payment schedule and all of that, so——

Mr. STARK. You want to bet me on how many are going to offer them? Do you want to make a guess?

Ms. DEPARLE. I'm not a betting person.

Mr. STARK. OK. [Laughter.]

Are you going to have some regulations on the pharmaceutical managed care benefits in terms of requiring them to disclose to beneficiaries where they limit pharmaceutical options or where there are incentives for the physician or the plan to substitute one drug for another? This is a very popular benefit that is being sold as an inducement. I think that without further regulation the beneficiaries could be disadvantaged. Are you considering regulations that would require a more honest, or more detailed, description of the types of problems beneficiaries could run into? Have you any?

Ms. DEPARLE. Well, it's not in the Medicare+Choice regulation, but I believe the kind of thing you're talking about should be reflected in the adjusted community rate. Now if you're asking to make that available to seniors, I don't think——

Mr. STARK. I want Senator Dole to know that Viagra isn't going to be covered or is going to be covered in his plan. So, before he signs up he knows what they're going to pay for or not going to pay for, or that they're going to substitute aspirin as a generic alternative. I think those kinds of disclosures would be important and ought to be required. You can't put them in your managed care regulations?

Ms. DEPARLE. Well, the regulation is already out, but we will be happy to work with you, Mr. Stark.

Mr. STARK. Okay. Excuse me, but the chairman probably isn't going to indulge me much longer here.

Chairman THOMAS. No, no. Go ahead.

Mr. STARK. Go ahead? All right.

The Balanced Budget Amendment got us enough money to extend the trust fund another 10 years. We extended the Medicare trust fund, and Chairman Thomas is trying to make it solvent for all time and hopefully you're going to recruit me to help him. But, we did hear that if we saved the budget surplus, the $650 billion estimate, it would take the Medicare trust fund out to 2020.

Now we've got a higher budget estimate, maybe another $1 trillion in surplus, that would probably take Medicare past the date of the bipartisan Commission's target of 2030. If we saved all of the CBO surplus for Medicare, how long would we extend the trust

fund? Would you guess? Do you know, or would you find out and submit to us how long the Part A trust fund would be protected? In other words, we don't have to make any changes in Medicare. We could just keep going and paying the good providers and providing the benefits, if we save the surplus and didn't spend it in other ways.

Ms. DEPARLE. I'd be happy to ask our actuaries and provide you with an answer.

[The following was subsequently received:]

The HCFA actuary estimates that applying the Federal budget surplus, as estimated by CBO, to the Medicare Trust Fund through 2008 would extend its solvency through 2033.

Mr. STARK. Thank you, Mr. Chairman.

Chairman THOMAS. Well, that is our concern, paying the good providers and my concern is that the window that's discussed might even be a quarter or extend to four months in the year 2000 of not paying providers, since we're so computer oriented. My assumption is you do not want to shift to a pay per payment structure, and that's just one additional question. The gentlewoman from Connecticut I know wishes to inquire.

One of the more high profile computer types in the administration is the Vice President, who has an ongoing initiative called the Re-inventing Government initiative. My understanding is that HCFA submitted a response or a report to the Reinventing Government operation of the Vice President. Is that correct?

Ms. DEPARLE. Well, I don't know about a report. I recently met with the person who's in charge of that over there to talk about that. What they wanted to know was about our Government Performance and Results Act objective and how we were doing on meeting them; things like reducing diabetes, things like that.

Chairman THOMAS. Would that bring up the year 2000 question?

Ms. DEPARLE. We did have a discussion of it, yes.

Chairman THOMAS. Do you have it in writing?

Ms. DEPARLE. I can get you the paper that I used to talk from.

Chairman THOMAS. How long was it?

Ms. DEPARLE. I didn't talk to him about—I didn't have a written thing about the year 2000.

Chairman THOMAS. No, but how long was the paper in discussing HCFA reinventing Government?

Ms. DEPARLE. It was mainly charts with the GPRA objectives and where we were with meeting them. It was a few pages.

Chairman THOMAS. A few pages. So, it wasn't a major presentation. I mean, it wouldn't do much good for the subcommittee to look at it to see what's going on in terms of innovation and redirection.

Ms. DEPARLE. I think this might be a different kind of report than what you're thinking of, because they have designated HCFA as one of the reinvention laboratories, but what we were supposed to do was to identify objectives—outcomes, objectives for our programs; things like increasing the number of children who are enrolled in Medicaid and the Children's Health Program, and what I did was just walk through where we were with each one of those. I'd be happy to provide it to you.

Chairman THOMAS. That's another administration high profile initiative. They're reinventing Government, and, obviously, HCFA would be, in my opinion, in the center of a number of key individual programs where reinvention of Government would be critical, but if the report was just a couple of pages, that probably doesn't focus on what we want to focus on.

The gentlewoman from Connecticut.

Mrs. JOHNSON of Connecticut. Thank you, Mr. Chairman, and welcome, Administrator DeParle. First of all, I just want to open by saying, I appreciate your accomplishments in getting the agency focused on the year 2000 problem. It is very impressive to me how focus matters, and your work to actually look and see whether the plan that had been made was being implemented has brought focus and, therefore, an effective action to the service of the agency and to the service of all of us, and I appreciate that. I think the example that both you and Commissioner Rosotti have set, really being able as administrators to focus on key issues, is very refreshing and certainly all the people of America are going to benefit from your excellent leadership on this issue.

I have been particularly concerned, as you well know, since I believe focus matters, in focusing on the problems that the home health industry faces as we make significant changes in how we pay for home health services in order to address some of the fraud and abuse problems that we know exist in that sector. Our rationale was very good. Our execution is poor for a lot of reasons, not the least of which is the availability of appropriate and accurate information. Be that as it may, regardless of the causes, the decision to delay the PPS system is going to have catastrophic effects in my region, because the interim payment system is going to be so catastrophic. I appreciate the time you have given to this. I appreciate your understanding of how New England is going to be disadvantaged. I know the testimony of my colleague from the Senate, Senator Collins, and Mr. Pappas did not break any new ground for you. I appreciate your coming up and hearing it directly from my agency people, because, indeed, they were eloquent, but I need to ask a few questions to see if we can get some of the issues straightened out and moved forward.

First of all, have you notified the fiscal intermediaries about the change in date for implementation of the surety bonds?

Ms. DEPARLE. Yes, I believe we have.

Mrs. JOHNSON of Connecticut. Well, they seem to feel that they haven't received the level of official notice they need. There was a two-week period in which the notice was to come. The period ended last Friday, and at least the intermediaries in my State have not received notification. Consequently, they are not able to relieve the small agencies of this obligation.

Ms. DEPARLE. Let me look into that immediately. As you know, there are six of those intermediaries, and I think I could pick up the phone and call them myself if I need to. They should know by now that they don't have to be requiring that, and, in fact, as you know, in our meeting, all of your agencies had already gotten surety bonds.

Mrs. JOHNSON of Connecticut. Right. So, but if you could make sure that that notification is there, so that they don't keep running into this, sort of, odd barrier.

And then the second thing that I would like you to consider is announcing or in formal writing indicating that you do not intend to use the resources of those surety bonds to cover any liability and that you would urge the companies that offered them to simply extend their useful life, because they aren't going to be called on until the effective date of the regulation. This is very important, because I know you don't have the legal authority for us to be able to allow consideration of the costs of these bonds, but, perhaps, if it was very clear that you weren't going to use—to reach into those bonds for liability purposes, we could get the private sector to think through extension and help us accommodate the cost more effectively or more fairly, I should say. This would provide a certain modicum of relief to agencies that have, in fact, played by the rules, and one of the problems, always, in deferring implementation dates is that there's a lot of ramifications, and the people who are hurt the most are the people who have tried to comply, and since the New England agencies are going to be so heavily damaged by our proposal anyway, they have also put the money into the surety bond, and I think we have an obligation to try to do that, and I know you share that. So, I just put those two suggestions on the table.

Then, I want to raise the issue about the dramatic changes in home health spending that have occurred since we passed this bill, and I would like to ask for your help in looking at how we can use those dramatic changes and expenditures to rewrite the 15 percent cut that goes into effect automatically as we move along, so it won't go into effect if we make the savings.

And, secondly, how we can use that dramatic cut in spending and really beyond, I think, our wildest imaginations to find a solution to the interim payment system since now it's going to be in place for such a long time. For example, maybe we could simply change the 1994 date. That would help a lot, if we had a more recent cost date. We're into 1998; we're going to be in 1999; we're going to be in the year 2000. So, since the system is saving more than anticipated, I think we have to look at mechanisms as simple as that change in date, because I would hope that your freeze on computer changes due to the year 2000 would not extend to that level of simple action. My understanding is that there is a difference between your ability to accommodate that kind of change and your ability to accommodate more complicated changes.

Ms. DEPARLE. Yes, and I want to work with the chairman and with the committee on alternative proposals, and we've been working on some ourselves. I do want to mention, though, that the base year is a critical thing from a system standpoint. The base year is one of the things that is very difficult to change, but some of the other ideas that you and I have discussed are things that could operationally be done, and I want to work with you on that.

Mrs. JOHNSON of Connecticut. Well, the reason the base year has come to my mind is because it's at least simple, and computer-wise, this is easy to implement.

Ms. DEPARLE. I agree, Congresswoman—it seems like it should be, but my understanding is that changing the base year is not simple from the standpoint of doing this formula.

Mrs. JOHNSON of Connecticut. Okay, then the other thing I did want to just get to briefly is this issue of the information. If there's one thing that I've been saying at every senior citizens' center I have been in since we've passed this bill was that the Government would provide you with the kind of information like we have always provided you on Medicare insurance plans, and we would guarantee that it would be simple, intelligible, and accurate, and you would be able to make a decision that was in your interest.

Now, I appreciate the decision that you've made, but I think there is so much more we could do. For instance, if you're going to send them some kind of two-page letter, why don't you from every area include the information that the area agencies have already developed. I mean, you print it on both sides, and it's five pages. If you're going to put the money into postage, why don't we in every State at least send them that much; that this is interim because it took a while for the regulations to be written; it took a while for the plans to get in, and by next year the plans will be more solid and then we will send you a formal handbook—which I think makes absolutely good sense anyway. But we have good information in Connecticut. I can't believe every State doesn't have good information. They're just not getting it. So, in addition to this information, the same organization, the Area on Aging, using Federal money from your office, also have an excellent handbook about how do you decide whether managed care is for you or not? What are the questions you should ask? How do you go about thinking about that? And, frankly, I think a mailing in a brown envelope that provided these things would be well worth the cost and much more important than funding some of the publicity efforts that you're planning to make. I mean, I know those are important, but, after all, we aren't reaching the whole population; we're reaching the seniors.

The other thing I would suggest is that you include it in a social security mailing. Why can't it go with whatever Social Security sends out regularly? So, let's look as a Government across lines and get at least the information we have out, because I can tell you that seniors desperately need it. Has there been any cross-agency information——

Ms. DEPARLE. There definitely has. We are working closely with Social Security, and we are working with the Area Agencies on Aging such as the one that we met up in Connecticut, and every beneficiary who wants comparison information will be able to get it. The difference is that the full handbook with all of that information tailored to each area wouldn't be going this fall. For next year, the first open enrollment period it will be there.

Mrs. JOHNSON of Connecticut. But I would ask you specifically to change your plans about this letter that's going to go out to the States where you're not going to send the booklet, and, instead, mail the material we have with an explanation that this is just a rough cut or whatever you want to say. Honestly, I don't think a letter of the generic type that you're describing is useful when we

already have such good information that you could reproduce and send. So, I would urge you to reconsider that plan.

I also am concerned about your plans to train trainers. I have talked a lot recently with who's available to help seniors understand this, and I think we're really nuts to follow the kind of process that we have in the past as useful as that may be as an auxiliary, but we really need now to provide an educational—to pay people who are in the business of health benefits to be able to explain this and present this impartially, and I think, really, we ought to be looking to the independent agents and bringing them in, and our money would be far better spent that way than the millions that we're going to put out there for other groups who are not professional at this business and may not be objective; that worries me a lot. I see a lot of biased stuff out there. So, I would ask that you look at the independent agents and look at some way of using them. They do this professionally. Furthermore, a lot of this for seniors also has implications for their estate planning or they're thinking about their future, and you could also, then, get information out there about long-term care options which even for a healthy 65 or 70-year old is still a viable option. So, I'm very concerned about it. As long as we're going to delay, let's try to do a better job than we might have been able to do if we hadn't had to delay.

So, there are a couple of other issues that I'd like to raise, but those are the top of my list. Thanks.

Ms. DEPARLE. Thank you.

Chairman THOMAS. And let me before I recognize the gentleman from Nevada indicate that the concerns that we have in terms of the way in which this program is being presented—and I know that we have discussed this—but, for example, someone who is a spokesperson for the Department, Mr. Michael Hash, in front of the Senate Special Committee on Aging on May 6th—and I didn't want to take it out of context, but I wanted to look at the full context of the statement that was made, and you were kind enough to provide the transcript with me—and it concerns me that attitude and approach of conveying these options has been almost consistently in a hedged or negative environment. At least the materials that we've looked at has been a neutral environment where you simply run a chart and maybe that's one of reasons the Senate put such emphasis on having a chart because it's harder to spin a chart. For example, he says to the Senate subcommittee—"They—meaning the seniors—need to know that their ability to obtain private supplemental Medicare insurance, if they return to the fee-for-service program after just enrolling from a managed care plan may not be on the same basis as their original opportunity to get those private supplemental plans without the existing conditions and without other limitations.

Whether it's in the context of the full blown Medicare Plus Program in which there's a full opportunity to go back to their original program or whether it's even in the interim in which they have a period of trying a Medicare Plus Choice in which they're guaranteed to go back to their previous with no preexisting condition. This is from someone who is supposed to be on the team explaining the program. Now, either he doesn't understand what was put into law

or there's an attempt to create an informational pitch that now you've got this, but, remember, you may be out there in the cold. There may be preexisting conditions which won't allow you to go back to the previous plan when you and I know we worked to make sure that there was an initial opportunity with no fear or danger of a lost position at all in trying this program. These are the kinds of things that create the impression that we're not all working together.

Ms. DEPARLE. Well, I understand your concerns there, and, as you say, we actually made improvements in that particular situation in the Balanced Budget Act.

Chairman THOMAS. But nowhere did I find a qualifier in his explanation of the program. In fact, repeatedly over pages—and I'm going to put it in the record—there was a negative connotation that there is a downside to anyone making a choice. There's nothing wrong with presenting clear options in a way that you can look at them. I was looking for somebody saying, "But you know you could get a paid prescription this way. Or you know that you could get some additional services traditional Medicare doesn't offer." I mean, I saw no ability to put any positive spin on this but rather a continual repeat of the downside of the option of Medicare+Choice, and, as you know, in the booklet that was going out, virtually every page was a reminder that you can stay in the current program and then a repeat of the dangers that may be present in trying to make an option, and I understand the concerns that somebody might have, but the concerns that the gentlewoman from Connecticut and a number of us have is that this material be presented in at least a neutral fashion, and I think so far there's quite a bit of evidence on the record both printed and stated that indicates that not everybody believes, maybe, that that's the way it ought to be, and maybe it's not intentional; maybe it's just living in the old environment and not learning the new, but isn't that part of the management problem of the reculturalization of HCFA?

Ms. DEPARLE. Yes.

Chairman THOMAS. And if you can't do it, we'll find somebody to do it.

Ms. DEPARLE. Well, Mr. Chairman, I think that this is the biggest, most ambitious educational campaign that we've ever attempted, and I think that we're going to have to work together to make it the best it can be. I believe we can do that, and I agree with you that our role is to be neutral.

Chairman THOMAS. My problem is that testimony as recently as May 6th in no way, I believe, in an objective analysis could be believed to be neutral. The gentleman from Nevada.

Mr. ENSIGN. Thank you, Mr. Chairman. I have a couple of different questions related to BBA and its implementation. The first one has to do with the medical nutrition therapy study that's being done by the National Academy of Sciences. In the Balanced Budget Act, we had directed that that would be a stand-alone study; that the National Academy of Sciences would determine what the benefits of nutrition therapy are and whether it's going to cost or save money. From what I'm hearing, the National Academy of Sciences wants to include the monies from the BBA in one of the studies that they're already conducting. I just wanted to ask you what the

status is on that and whether or not medical nutrition therapy is going to be a stand-alone study.

Ms. DEPARLE. My recollection, Congressman, is that the National Academy was conducting the study, and I thought it was a stand-alone study. I think that we were going to provide them some resources to do it. Our office of research has been working with them on——

Mr. ENSIGN. Can you make sure that it's going to be a stand-alone study, because that's one of the concerns that we have been getting feedback about; that it's not going to be a stand-alone study. So, since you're on the record today, can I get your assurance that it will be a stand-alone study?

Ms. DEPARLE. If I understand you correct, sir, yes, I think you can, and I will look into it and get back to you.

Mr. ENSIGN. Okay, I'd appreciate that.

[The following was subsequently received:]

The BBA did not require a separate study on nutrition therapy alone; rather, it required a study on several prevention-related topics including nutrition therapy. Specifically, Section 4108 of the BBA directed the Secretary to request the National Academy of Sciences (in conjunction with the U.S. Preventive Services Task Force, as appropriate) to analyze the expansion or modification of preventive or other benefits provided to Medicare beneficiaries. The study will consider both the short and long term benefits of such expansion or modification, and the costs to the Medicare program. The Secretary is to report to Congress on the study's findings within two years of the BBA's enactment. The BBA requires that the study consider Medicare coverage of at least the following benefits: (1) nutrition therapy, including enteral and parenteral nutrition and provision of services by registered dieticians; (2) skin cancer screening; (3) dental care; (4) routine patient care costs for beneficiaries enrolled in approved clinical trials; and (5) elimination of the time limit on coverage of immunosuppressive drugs for transplant patients. The study is being conducted by the Institute of Medicine (IOM), the health branch of the National Academy of Sciences. HCFA's contract with IOM for the study is currently under development.

Mr. ENSIGN. The second question has to do with the $1,500 cap on outpatient rehabilitation services. From what I understand, implementation of the cap could be a problem with all of the Y2K computer problems, the Y2K problems and all that. Some of the providers are concerned, or at least have expressed concern to me, that if there are Y2K problems, they are going to be penalized because of the $1,500 therapy cap—in other words, it will be difficult track. What provisions are being made for the $1,500 cap?

Ms. DEPARLE. It's my understanding, Congressman, that the $1,500 cap was just a function of the Balanced Budget Act, and I don't believe that there should be any problems related to the year 2000 on that, but I just left, before I came up here, a meeting with 100 different provider groups to talk through some of the year 2000 issues, and if this is one of them, we'd certainly be happy to work with them on it.

Mr. ENSIGN. Well, if you have one provider who doesn't have their computer problems worked out and you have another that does, so there's no sharing of the information through HCFA, are they in violation? Would they get into fraud problems? Some of the providers are afraid that there would be a fraud problem at this point. So, is the $1,500 cap going to be in place year 2000?

Ms. DEPARLE. Yes, it's my understanding that it will be.

[The following was subsequently received:]

No. The $1,500 cap on outpatient physical therapy will be delayed by Year 2000 problems. This provision was a part of the proposed physician fee schedule regulation that we recently published, but there are systems barriers to implementing the cap.

Mr. ENSIGN. Okay. Also, I want to make a comment about what you had addressed earlier and that was talked about earlier related to the President's proposals. You don't think that those proposals are taking away a lot of resources; that it's a fairly minimal amount. Just from my own experience being in management—and I was not the top but I was in upper-level management—I can tell you as a person in that position similar to the position you have been in, that when the CEO, in this case, the President, says something, that everybody jumps. In other words, if he puts down an initiative and there are a lot of resources, there is nothing else in people's minds except making sure that his wishes are carried out. That's normal in any company and in this case because he's kind of the big cheese of all of the administrative functions, if the President says something, everybody jumps. So, I would not minimize the amount of work that's probably being done to make sure that his initiatives are carried out. I know you're in a difficult position, really, to comment on this, but it is something that I think the President—as a warning to the President, that he should be careful of, just like any CEO or just like a Member of Congress. I have to be careful of what I say to my staff as a casual comment, because they'll put a lot of resources into something I didn't intend for them to put resources into, and the President needs to be very careful on what he says in the same regard.

Ms. DEPARLE. Well, with all respect to the President, I think if you ask my staff what they're more conscious of on a day-to-day basis it is my Balanced Budget Act implementation chart and where are we on this reg or that reg? I think they're very—I'm not sure they're jumping around—but I think they're very conscious of that being the priority, and the Medicare Education Program being the priority, and combating fraud, waste, and abuse being a priority and dealing with this year 2000 problem.

Mr. ENSIGN. Speaking of the fraud, waste, and abuse; if we had hypothetically—if we had a private company that was a provider and they failed to reimburse—let's say, one of the insurance providers, one of the managed care companies—and they had failed to reimburse three or four months—similar to what HCFA may do if they have problems with their updates. Would it be considered fraud for that provider? In other words, the Department of Justice has been fairly heavy-handed in its calling honest mistakes fraud. I mean, we've been hearing a lot about that in the news and getting a lot of feedback from, I think, a lot of Members of Congress' offices about the heavy-handedness right now of the Department of Justice between what it calls fraud and what are really honest mistakes. I guess, if they had a Y2K problem and it was three or four months, could that be interpreted as fraud?

Ms. DEPARLE. No, I don't think it could, but I think it is something that we all have to be concerned about. I know of at least one instance where a managed care plan had a situation like that, and we were looking into it, because you start to get concerned about whether beneficiaries are going to get services. That's why

I want to work with the Congress to make sure that we deal with this problem while we still have a year and a half to work on it instead of waiting until the last minute.

Mr. ENSIGN. And could you address the whole fraud and abuse issue? Mainly the fraud. From HCFA's perspective, do you think that the Department of Justice has been fairly going after fraud? Do you think that it's including honest mistakes in fraud or do you think that it has been an even-handed affair?

Ms. DEPARLE. Well, it's really hard for me to comment on what they've been doing. I can tell you that I think law enforcement has been an important participant in our efforts to make sure that Medicare gets what it pays for, and I can cite a number of examples where that has been very important, not only in stopping some pretty bad situations from occurring but also in deterring that conduct in the future.

I want to give you my perspective, though. From where I sit, administering this program, which includes your taxpayer dollars, I want to make sure that it's well managed and that we get what we pay for. If we overpay a provider, we should get the money back; I think everyone understands that. But I don't want to punish people who make honest billing mistakes, and I've met with medical societies around the country to try to make sure they understand that. The example I use is one that I got from reading one of the medical journals about a Beverly Hills doctor who charged Medicare for 1,600 people who were either in prison or deceased. That's just not right. That's the kind of thing that we have to stop, and the Justice Department has been an effective partner in working with us to do it, but if someone makes an honest billing mistake, no, sir, I don't think that's the kind of thing that we should be spending resources and energy on going after.

Mr. ENSIGN. Thank you, Mr. Chairman, for allowing me to question. I would just like to reiterate, I hope that that is more consistently done, because, yes, everybody wants to eliminate fraud from the system; they want to be good stewards of the taxpayer dollar, but at the same time, we don't want to turn just honest bookkeeping errors into fines and criminal offenses. Thank you, Mr. Chairman.

[Questions from Congressman Ensign submitted to Ms. DeParle and her responses follow:]

Questions for Nancy Ann Min De Parle

1. There is some concern by providers that HCFA cannot track the $1,500 annual payment limits due to Y2K problems. Based on Y2K concerns expressed recently, is HCFA equipped to track the implementation of the annual $1,500 payment limit imposed on outpatient rehabilitation services? And if not, what safeguards can be put in place to assist providers in complying with the payment limits.

2. The fact that the RUG demonstration for the SNF PPS allowed for a pass-through of non-therapy ancillaries, why wouldn't HCFA allow the same policy when it is clear that the RUG - III system does not adequately account for these services?

3. As part of the SNF PPS, how will HCFA address certain outlier patients where skilled nursing facilities will incur costs far in excess of what RUG - III system will reimburse?

4. Congress' intent with a transition to a new skilled nursing facility PPS was meant to ease facilities into the new system with minimal disruption to the Medicare population. Congress used the only data available, which was the 1995 cost reports. It's become clear that some skilled nursing facilities will actually be disadvantaged by the transition because they have increased the volume and acuity of their residents. What steps can HCFA take to ensure that facilities are not disadvantaged by the transition and patient access to SNF services will not be disrupted?

The Honorable John Ensign
Committee on Ways and Means
U.S. House of Representatives
Washington, D. C. 20515

Dear Congressman Ensign:

As requested, listed below are HCFA's answers for the record to questions from the July 16, 1998 hearing on BBA Implementation.

1) Outpatient Rehabilitation Therapy Cap.

We recognize that we must help beneficiaries and providers track spending under the cap. However, implementing the cap requires extensive computer system programming that may conflict with our Year 2000 work priority. We are continuing to evaluate whether partial implementation is possible. We recognize that providers cannot be expected to know the services a beneficiary received at another facility and would not hold them accountable for this information.

2) RUGS and Non-therapy Ancillary Services.

The Balanced Budget Act is very clear in requiring all skilled nursing facility (SNF) services to be included in SNF prospective payment system (PPS) rates. We do not have the legislative authority to allow a pass-through for non-therapy ancillary services. A change in legislation to create a pass-through for these services would likely significantly erode the $9.2 billion in savings projected over five years from SNF PPS. A budget-neutral pass through also would be virtually impossible without price and volume controls. And, since the HHS Inspector General has identified these services as being highly susceptible to fraud and abuse, it also could severely hamper program integrity efforts.

We allowed a pass-through in the demonstration in order to encourage SNFs to participate. The fact that these services were not bundled into the RUGS demonstration rate does not mean that these costs are not accounted for in the RUGS-III rates. RUGS-III categories are based on 1995 data that include these and other allowable costs. Many of these services also are captured in the case mix methodology, and thus lead to higher payment. Research is underway which may result in refinements to payment categories for these services.

3) Access to SNF Services.

SNF PPS is designed to ensure adequate payment levels by recognizing differences in resource use among patients with different clinical and functional characteristics. The Balanced Budget Act did not authorize an outlier policy for SNF PPS. There is, however, a three-year transition period where the rates will include a certain percentage of each SNF's historical allowable costs so that SNFs will have time to assess their efficiency and adjust to PPS.

4) Transition to SNF PPS.

There is a three year transition period where rates will include a declining percentage of each SNFs' 1995 allowable costs -- 75 percent the first year, 50 percent the second year, and 25 percent the third year. In the fourth year all SNFs will receive the full PPS rate. This provides time to adjust to the new system. Any impact from a change in case mix will automatically dissipate.

I hope you find this information helpful. Please contact me if you have questions.

Sincerely,

Nancy-Ann Min DeParle
Administrator

Chairman THOMAS. I think that's absolutely true, but when we're discussing a potential three-month window and the response was no, it probably wouldn't be fraud if you don't make your billing or payments, the time value of money in the context of sometimes the size of the dollar amounts that move back and forth. I think you're going to have to watch fairly carefully, because if this becomes an excuse for delaying, there are dollars in resources and the taxpayers deserve fair return on their dollar in a timely fashion, and that does concern me to a degree.

The gentleman from California wanted to be recognized.

Mr. STARK. Nancy, later we'll hear from a Visiting Nurses' Association with a suggestion of going to a 75 percent national rate, 25 percent regional rate. It's my understanding that that might solve some problems but also impact adversely those associations who are currently providing what are almost outlier benefits to very sick people. When you tinker with these mixes, whether it's national or association or regional, you get some unintended consequences. I'm sure the chairman is hearing as many complaints as I am. Do you have, or do you intend to have, some kind of a change that we'll be hearing about before Congress adjourns in October? I know we're going to hear from people later today, but I just wanted to ask you what suggestions you might offer to us or what help we could give you? What do you suggest?

Ms. DEPARLE. We have been working on some ideas. We've been providing technical assistance to members of the committee and have been working on some ideas ourselves. As I think the chairman noted earlier, we're constrained, because of this year 2000 problem, operationally in what we can do. The base year is an issue. It's very difficult to change that operationally. Changing around the percentages as you just suggested, that can be done, but, as you also pointed out, it can create other problems.

This is very complicated. Last week when I was with Mrs. Johnson up in Connecticut, I met a man who has run a home health agency dealing specifically with a mentally ill population, and its costs have been very high, higher than—the others in the room were $2,000, $3,000; this guy was at $8,000. So, if we move away from what the Balanced Budget Act did which was to put a great weight on agency-specific costs, a number of the people in that room in Connecticut, their reimbursements would have been better. This particular guy, who they all said was providing a very needed service, would do worse, and that's the problem with these formulas, but we want to work with the Congress, and I expect we'll be having discussions soon.

Mr. STARK. Is there something as simple as making some kind of an adjustment and then having some kind of an outlier provision? Or, does that jam up your computers? I don't want to prejudice any groups.

Ms. DEPARLE. From a policy perspective, outliers make a lot of sense, and we've been struggling with how we could do it operationally based on the data that we have, and we want to work with the committee on that.

Mr. STARK. Okay. Thank you very much. Thank you, Mr. Chairman.

Chairman THOMAS. No, thank you. I just want to underscore before I call the gentleman from Nebraska, the frustration that we now face when we don't know what you can do, and it was indicated here a simple base year adjustment which might be of some assistance is going to be very difficult to do. One of the options that had been examined in discussions with the industry was to deal—and the Senate had looked at it—was to deal with a copay arrangement. Frankly, we're going to leave no option unexamined, but we need your initiation and a quick reaction to ideas that we come up with so that we can come up with a solution that you can make work in the time frame that we have left. I'm very concerned of our ability to respond legislatively, and I think all of us feel we have to respond prior to adjournment.

Ms. DEPARLE. Yes, sir.

Chairman THOMAS. We can't play the usual games that we play given the conditions under which you've indicated you're going to be able to participate in the decision process.

The gentleman from Nebraska.

Mr. CHRISTENSEN. Thank you, Mr. Chairman. Nancy, I do want to tell you, it's been more pleasurable having you before us than your predecessor, and a lot of the things that have——

Ms. DEPARLE. I think I should say the same, I guess, I don't know.

Mr. CHRISTENSEN. A lot of the things that have been said are not your doing, but now you are stuck in this position, and I've just got some preliminary questions. And the first is, is there any truth that your department is still working off of 85 IBM mainframe computers or is that not true?

Ms. DEPARLE. I suspect it is still true.

Mr. CHRISTENSEN. Okay. So, you are working—HCFA is working off of 1985 IBM mainframe computers?

Ms. DEPARLE. I should check, Congressman, and get back to you for the record about the exact model, but I suspect we have some old equipment.

[The following was subsequently received:]

The 1985 IBM processors have been replaced with a 1996 IBM 9021–942 and a 1997 IBM 9672–R64.

Mr. CHRISTENSEN. My office is working off of 1996 Apples, and we're slow and way behind. So, I guess, one thing I'd like to see is—has the department put any kind of bid out for where you're going to be systems-wide in the next 10 years? Obviously, we have major problems over the next 12 months, but have you done anything as far as looking forward as far as your 2010 and where we need to be systems-wide; where we need to be with our programs, our software, our hardware? Is there any kind of bid process out there at this point?

Ms. DEPARLE. There is not a bid process. As the chairman mentioned, in the late eighties, HCFA began working on something that was called the Medicare Transaction System which was going to be a total revamping of its computer systems. Last year, we stopped that effort. We did get as far as getting the requirements out of it, but it didn't move nearly as fast as people thought, and it didn't appear to be designed to get where we need to go.

Mr. CHRISTENSEN. I think we've come to understand that that was $50 million or so, roughly——

Ms. DEPARLE. It's around $50 million.

Mr. CHRISTENSEN [continuing]. That has been, basically, down the drain.

Ms. DEPARLE. Well, we did get requirements out of it, but we did not get a new computer system to process our claims.

Where we are now is last year we brought in a new chief information officer who has been working on a vision for a new infrastructure. It is not a big bang approach like the Medicare Transaction System. It will not be one big computer system. It makes incremental changes over time, and what I'd like to do is offer you and other members of the committee a briefing on it, but, as you say, my chief information officer and his staff are spending 150 percent of their time on this immediate problem. There are no bids out on the post-year 2000 infrastructure, and, frankly, before we even got to that stage I would want the Members of Congress as well as others in the administration who need to see this to see it, understand it, and give me your suggestions and advice on it.

Mr. CHRISTENSEN. Could we go back to the chief information officer? When you came on board, you've inherited a real mess, but, also, in any private enterprise when a new manager or president or CEO comes on board, he cleans house. Have you cleaned house? Have you let anybody go that was responsible for the systems; that was responsible for making this serious adding problem in terms of 20 million lines of code compared to 50 million lines of code? Have you let anybody go in those areas of responsibility?

Ms. DEPARLE. No, I haven't, but I did, as you mentioned, I brought in a new chief information officer from New Mexico, from Los Alamos.

Mr. CHRISTENSEN. Should you let someone go? Should heads roll? I mean, this is pretty grave here. We're talking about taxpayer dollars here. I mean, I know that you are—you talk about bureaucracies of all bureaucracies, HCFA is it. I think in light of the fact that you are the head of the agency, that you should do all you can within your power to make some changes. You may be there for a year, two years, six months, but for the next person that comes in there, you would be doing the American taxpayer a big favor, but you would be doing a number of other people that are looking for some efficiencies if you were to take a leadership position in this area and make some things happen.

Ms. DEPARLE. Well, I am taking a leadership position. I view this as my responsibility. The chief information officer is reporting directly to me, and I am managing that part of the operation.

Mr. CHRISTENSEN. Okay, I want to encourage you in the other area as well.

Let me get to another question: during the testimony of the Senate Aging Committee, Deputy Mike Hash, he talked about some different agencies, different programs, that were going to be getting some money, about $9 million—Mr. Chairman, may I continue another minute or two?—and I wanted to go over with you that $9 million and exactly who it was going to be going to if you had any knowledge of that area? During his testimony, he talked about 23 partners on a coordinating committee, 15 organizations on a task

force, 28 organizations helping as educational affiliates—and this kind of follows along the line of Ms. Johnson's query about the independent organizations, hoping that you would move towards that area. Are these the groups that he talked about that are getting some of this $9 million or all the $9 million in this area of outreach programs?

Ms. DEPARLE. Primarily, sir, I believe the people who will be getting money are what are called the State Health Insurance Advisory Programs that used to be known as the Information Counseling and Assistance Programs that provide one-on-one counseling to Medicare beneficiaries, and I believe that's primarily what he was talking about. He may have also been referring to some of the State aging offices that will be getting some funding from this.

Mr. CHRISTENSEN. Well, I just want to, for the record, Nancy, most of these organizations in here seem to be of the type that I saw in commercials or paying for commercials against a lot of my fellow Members of Congress in 1994 and 1996. The AFL–CIO, the AARP, the Medicare Rights Center, the National Council of Senior Citizens, which is an arm of the AFL–CIO, the Visiting Nurses' Association, the American Nurses' Association. I could go on and on, but I think this would lend some credibility to the question that Nancy was asking about, we need to have more of an independent agency that's out there disseminating information and educating the seniors on Medicare Plus and most of the money that I see earmarked in this $9.9 million is going to rather suspect organizations with very left-leaning credentials, and I'd like to see a little bit more equalization if we're going to be spending money in this area. I'm sorry I'm out of time, but maybe you want to respond?

Ms. DEPARLE. I would like to look into that and get back to you.

Mr. CHRISTENSEN. Thank you.

[The following was subsequently received:]

There are 80 partner organizations in the National Medicare Education Program. This is not a partisan effort; any organization can participate. Organizations as diverse as the AARP, AAHP, HIAA, and the U.S. Office of Personnel Management are all participating in this effort to educate their members who are Medicare beneficiaries. These partners do not receive any funding from HCFA. Funding dedicated to this part of our National Medicare Education Campaign is spent on printed materials and the costs of delivering the materials to our partner organizations.

Chairman THOMAS. I believe Members want to go through and ask some additional questions, and we do have Members who are not Members of the Subcommittee, and I will try to accommodate you.

Briefly—and this has been a discussion privately, and I do want to get it on the record. I want to indicate a degree of concern, because, frankly, it's coming up now with other members—your point number eight in terms of beneficiary feedback and assessment, I was recently sent, on June 24th, a packet from the chairman of the Veterans' Affairs Committee, Bob Stump, which contained a survey from one of his constituents, and it was to evaluate the quality of the Medicare health plan, and there was a cover letter from you: "Dear, Medicare beneficiary, As a Medicare beneficiary, you deserve the highest quality medical care, et cetera, and would you please fill out the questionnaire?" It's the questionnaire with a number of seniors on the front in individual photos. The concern that was expressed by the constituent—and I know this is difficult,

and is going to be an ongoing concern, and it's why we need to review the material that we send out very, very carefully—there was a question which was highlighted in the questionnaire which was, "These questions are about how you feel and things that have been with you during the past four weeks—these questions are about how you feel and how things have been with you during the past four weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past four weeks, A, did you feel full of pep? B, have you been a very nervous person? C, have you felt so down in the dumps that nothing could cheer you up? D, have you felt calm and peaceful? E, did you have a lot of energy?" Obviously, these are so subjective, and I know that sometimes you can, from a subjective choice, come up with—I mean, the choices were "all of the time, most of the time—as you might expect—a good bit of the time, some of the time, a little of the time, none of the time. Have you felt downhearted and blue?" This is over a four-week period, so if anybody's like me, I've already recorded four different attitudes. "Do you feel worn out? Have you been a happy person? Do you feel tired?" Now that's differentiating from feeling worn out.

The problem is that when you get these kinds of things sent, I'm sure there is a clear analysis in an objective way that, perhaps, is available to this, but this is what people are going to be getting in terms of beneficiary feedback. This is what they focus on, and they're trying to say, because we're not going to be able to go out with an education program that will give them the full benefit of it, but we're going to be doing follow up, because, frankly, this is not based narrowly on the Medicare + Choice. This is based on the current Medicare risk contracts that are out there in terms of managed care. We know we're not doing these same kinds of things with fee-for-service, because, in part, you can't do them, but no one, I believe, has tried to create some kind of measuring tool there.

All of the focus is on the 15 percent of the program. The 85 percent of the program where the dollar is being spent, nobody ever does a follow up to ask you if you've been cheerful over the last four weeks. So, I just have a concern that if this is what people are seeing and it's coming to members already and this is—I want to underscore—this is not on the Medicare Plus Choice—this is on, I believe—if I'm correct—on the ongoing current evaluation of the current managed care program, 15 percent of the program is what we're faced with.

Ms. DEPARLE. I think it went out in January, and, Mr. Chairman, I totally agree with you that we need to be focusing on the fee-for-service side of the program, and we are working on developing a measurement of satisfaction there too.

Chairman THOMAS. But if these are measurements of satisfaction, they are so subjective, unless, of course—I'm willing to listen to whoever designed this matrix—that they are going to get valuable information out of it. I know sometimes when you ask similar questions you mark to see if they answer it the same way.

Ms. DEPARLE. I'd like to get you the information. I don't remember which academic institution it was that worked with us and the Agency for Health Care Policy Research in designing it, and some of the questions—part of it is that it's designed at a fourth-grade

reading level, and there are all sorts of things like that, but I'd like to get you some background on it, and I totally agree with you that we should be also measuring satisfaction and results on the fee-for-service side.

[The following was subsequently received:]

The Health of Seniors survey was designed in collaboration with the National Committee for Quality Assurance (NCQA). It was developed as the first HEDIS health status outcome measure and adopted by NCQA's Committee on Performance Measurement for inclusion in the HEDIS 3.0 for Medicare. The Health of Seniors Survey is designed to measure how well managed care plans are taking care of Medicare beneficiaries. It measures both physical and mental health functioning. The questions cited are components of a well-tested scale which validly measures an individual's mental health status. It asks people whether they feel tired and blue because some would never say they are depressed due to the social stigma attached to mental illness. The questions come from an instrument known as the Short Form 36 (SF–36). Early versions of the tool were used by RAND as part of the landmark Health Insurance Experiment research. For over nearly twenty years a team of researchers led by John Ware at the Health Institute, New England Medical Center/Tuffs University has tested, improved and validated the instrument. This survey is used as a measure of the health status of the general population and in patients with specific disease conditions (i.e. diabetes, hip fracture, etc.) both in the United States and internationally. The most well known test of the SF–36 in the general U.S. population is the Medical Outcomes Study. Results of this work have been published in the Journal of the American Medical Association (JAMA), a highly regarded, peer reviewed journal.

[An attachment is being retained in the Committee files.]

Chairman THOMAS. What we're hearing at the same time is that we didn't give you enough money; you only had $95 million; $95 million with a full 48-State roll-out; you're only doing 5 States at a time, but the problem is we don't have enough money. It is very difficult to sustain a drive which I'm committed to get you enough money when these things keep popping up. That's a concern, and that gets back, in part, to that original question about management; about culture; about the way you approach your testimony in front of Senate committees, material coming in. I'm very concerned about our ability to get a fundamental seed change in the Health Care Financing Administration of a consumer-oriented education program.

Does the gentlewoman from Connecticut wish to inquire briefly?

Mrs. JOHNSON of Connecticut. I just have to say the questionnaire that the chairman just used, it's truly an outrage. I hope you will provide the committee with the rationale as to why this went out and what it's supposed to accomplish and how it will help us? For an agency that can't afford to send out the basic information that would really help seniors; those are the questions I'm getting. I mean, this is what makes people really angry about Government, and I'm just glad it wasn't one of my constituents who came up to me and showed me that questionnaire.

I mean, first of all, what business is it of ours if people feel tired? I don't know a senior that isn't going to answer yes to that question, and what does it have to do with managed care; with Medicare choices; with fee-for-service medicine or not? So, I'll tell you, I'm looking for that rationale, because if we don't have money enough to educate our seniors about the choices that they—I've got seniors in my district living on $7,000 a year and struggling to make some little payment so they get some Medigap insurance. Those folks need and deserve to know that there are plans in the

market now that will cover their copayments; cover them, help them out. So, anyway, I really want the committee to get the rationale for that, because that strikes me off the top of my head as indefensible.

I also do want to say that Mike Hash's testimony is inaccurate, inaccurate. We spent a very long time making sure that in every single State any Medicare recipient who went from fee-for-service to managed care—first of all, under the bill, for the first three months, they have the absolute right to go back to exactly the same Medigap program they were in, but down the road apiece in every single State, there is at least one and usually at least two Medigap policies that have no preexisting conditions, exclusions, and have open enrollment. So, in fact, if they don't like their managed care program and they want to go back to Medicare, they do have an open enrollment, no discrimination for preexisting conditions option. It may not be exactly the plan they wanted, but when you look at the variation of Medigap plans, they all cover certain basics. So, I really regret—when you read the whole thing of Mike's testimony, it is very negative. It doesn't make a clear differentiation between when the program is fully implemented and what the choices of being on. This is why this is going to be hard.

You're right, this is the biggest educational challenge we've ever undertaken, and we've got a long way to go, but we have to really be much more careful about not scaring the seniors and giving them the information they need.

Let me just conclude with the two things that I wanted to bring up. You know, one of the problems in implementing this whole new program and particularly the reimbursement rate is that we are back to a one-size-fits-all policy; that's the nature of Medicare. But in these new reimbursement systems, the vulnerability of small agencies is far greater than in the old payment system, and so we see that in the efficient small home health systems. But I would tell you that I'm going to be contacting you about the Little Sisters of Mercy Nursing Homes that have one or two or three Medicare patients; less than 5 percent of their whole load, and they're having to—they're facing just an accounting challenge that is, frankly, absurd, and they couldn't be servicing more than a tiny percent, and I—just as you have deferred some of the new billing changes in the nursing home area—which, frankly, I don't regret; I think we're going to need some experience before we get into that—I think we've got to look at implementing even what we're going to do with the bigger ones; maybe exempt the little tiny ones until we get the system straightened out and see what we really need, because we're going to do—in sector after sector—we're going to put out of business the most kindly; the ones supported by the local church; the most human providers, and what we're going to get is a system of chain nursing homes. I don't want that to be the outcome of reform. So, I'll send you more information on that.

And the last thing that I want to just mention that I'm going to bring up to you is that your ambulatory surgical center reimbursements that you're going to use in developing the outpatient reimbursements are based on very old data, 1993 data. So, and the odd thing is the discriminatory impact it has on women services v. men services, because prostate testing and things like that, some of

those things are more recent, it's a reasonable reimbursement. There was no 1993 data. In some of the other areas, the more modern technology, the modern diagnostic approach, we don't have realistic reimbursements under your system because the data wasn't there. So, we need to look at how do we assure state-of-the-art access to high quality health care, and I'll give you some specifics on that, because it's just recently come to my attention.

But I'll tell you, this is a mine field, and we all need to work together to make sure that the little guys get addressed that; that change gets addressed, and that we do make good on our promise to improve the quality of Medicare for our seniors. Thanks.

Ms. DEPARLE. Thank you.

Chairman THOMAS. The gentleman from Louisiana wishes to inquire.

Mr. MCCRERY. Thank you, Mr. Chairman. Ms. DeParle, on your website, medicare.gov, a person can go to a site that explains the provisions of plans that are available in their area.

Ms. DEPARLE. Yes, sir. Medicare Compare is what it's called.

Mr. MCCRERY. Right. I was struck by the fact that the first real item of information regarding these plans on your website is whether the plan is a profit or a non-profit plan. Why is that on there? What does that have to do with information that's about the plan to the potential patient?

Ms. DEPARLE. I noticed the same thing, and I asked the same question. In focus group testing of this site last year, that was one thing that seniors wanted to know. They wanted to know whether the plan was for profit or not. It surprised me, because it wouldn't occur to me to ask that, but that was one thing that came back in the focus groups.

Mr. MCCRERY. Did you discover in your focus groups why they wanted to know that?

Ms. DEPARLE. I can probably get you some more information about that. I don't remember specifically what—I think they felt it was some sort of proxy for something, but, obviously, some of them are in for-profit ones, and some are in not-for-profit, and I don't know the exact details of it, but I'd like to get back to you on it.

Mr. MCCRERY. Yes, I don't see the value in that for a number of reasons, but I wish you would get back to me on the rationale for including that.

[The following was subsequently received:]

Beneficiaries in focus groups expressed a strong interest in knowing whether health plans are for-profit because they perceive that for-profit plans are more cost conscious, and that non-profit plans focus more on patients.

Mr. MCCRERY. It would seem to me to bias the choice even though the cost to the patient might be lower for a for-profit plan than in a not-for-profit plan. So, I question the soundness of that decision even in light of focus groups in which people said that's something they would like to know. I just don't know that it adds any value to their decision-making process.

John Ensign had to leave, but he asked me to ask you a question which I will do for him, and it concerns the hospital wage index. Evidently, HCFA was supposed to make an adjustment to the hospital wage index based on labor costs, regional or local labor costs, and include it in the Fiscal Year 1999 PPS rule, but for some rea-

son the adjustment was left out; it was not included in the rule. Do you know anything about that? Can you expand on that a little bit for us?

Ms. DEPARLE. The rule hasn't come out yet. We're trying to get it finalized by the 1st of August, and I am aware that a problem has arisen. I learned about this in a meeting with the American Hospital Association that there are some—and this is one of those things that affects different regions of the country differently, and we are working with them to see what can be done about it.

Mr. MCCRERY. Okay. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you. Briefly, some Members who are not members of the subcommittee, first, someone who is a member of the Full Ways and Means Committee, the gentleman from Ohio, Mr. Portman, wishes to inquire briefly.

Mr. PORTMAN. Thank you, Mr. Chairman, and thank you for allowing me to be here today. My question is related, indirectly, to the subject today of expanding Medicare Plus options and getting that message out to recipients. Ms. DeParle, I've already written you about this topic, and I think you're familiar with it, but it has to do with the situation where roughly 22,000 seniors have lost their coverage in rural counties in Ohio; 22 counties were affected. My own district is affected. I have 2 counties—Brown County and Warren County—that are part of the 22. Anthem Blue Cross and Blue Shield had a Senior Advantage Medicare HMO Program that was quite attractive to many of my constituents. What's particularly disturbing to me is that based on what my constituents tell me, a lot of folks were aggressively marketed, by Anthem just prior to its dropping. In fact, even more disturbing, is that some of have said that Anthem continued to market the program after it had made its decision to pull out of these markets, and the two counties I represent as well as many of the other 22, there are no alternatives. There are no other HMO products out there for Medicare recipients. Many, of course, left their supplemental plans to join the HMO and are now concerned as to whether they can get back into their Medicare supplemental plans on favorable terms.

So, it's a major concern, and I guess my questions to you are twofold: first, whether HCFA can do anything—and I've, again, sent you a letter in this regard, and I've not heard back yet—but with regard to facilitating other HMOs going into these rural areas, particularly where there's no other option of a HMO product.

Ms. DEPARLE. Yes, and you did mention two of the counties where I think there isn't another option, and I appreciate your bringing this to my attention, and the chairman also mentioned it to me. We are working with some other companies that have expressed a desire to go into Ohio and to some of the counties to try to make sure we quickly get them approved if that's possible.

Unfortunately—and we've looked into, at your request, the issue of the marketing to beneficiaries right when they knew they were going to move out of the Medicare market. Under the current law and regulations, it appears that what they did was all right. I must tell you, I don't like it from the standpoint——

Mr. PORTMAN. Because HCFA had approved the plan, and once the plan is approved they would have the ability to leave those counties whenever it was in their interest to do so.

Ms. DEPARLE. Under the law, they can leave, and there are some marketing standards, and we're in the process now of looking at updating our marketing standards, but the existing standards say that if they know they're going to go out of the business there, they have to quit marketing by October of the year when the following year they would be out of business. It's not October yet—so, technically, they've already told the beneficiaries, but I agree with you——

Mr. PORTMAN. Because it's in place until the end of the year.

Ms. DEPARLE. Sir?

Mr. PORTMAN. Because the program is in place until the end of the year.

Ms. DEPARLE. That's right, but if it were my parent or grandmother there who had been marketed to, I wouldn't have been happy about it, and I think we'd like to work with you on that.

Mr. PORTMAN. The other question I guess I would have is to the extent HCFA does approve these plans, do you look at the feasibility of the plans? What Anthem has told me is that reimbursement's a big issue which is my second question really, and the other issue is that there were not adequate health care facilities, clinics, and so on, so that health care costs were, indeed, higher in these rural areas than they were in the urban areas where, ironically, the reimbursement rate was higher. And, also, that there were other factors that they, perhaps, hadn't considered. I guess my question is does HCFA look at those factors—the reimbursement rate, the availability of health care, the other factors that would affect productivity—as HCFA approves or disapproves plans?

Ms. DEPARLE. Well, certainly, the reimbursement rate is something that is set under law, and it's out there for the plans to decide whether they want to come in. We review the marketing materials; we look at the plan solvency. There are changes in all of this as a result of the Balanced Budget Act, and we're looking at making some changes in the regulation on marketing.

Mr. PORTMAN. My final question is—I know the balanced budget agreement that got through the subcommittee I think made major improvements to Medicare and helps in terms of rural areas. Should we back up now, given this experience and other experiences around the country, and look at that formula. Again, Anthem is in business to make money, ultimately, and they're telling us that the formula doesn't work; that, in fact, ironically, the urban areas get the higher reimbursement rate—there's roughly a $64 difference on average in Ohio between the rural and urban areas—as lower costs for their recipients for this particular HMO product. Should we be looking at either a regional or maybe even more aggressively look at the national aspect being a bigger part of the formula?

Ms. DEPARLE. I certainly think we should continue to look at it. I think that it's not clear whether the changes that we made last year to try to give the rural areas a floor have had the effect that the Congress intended.

Chairman THOMAS. Tell the gentleman it's a problem that we're going to be addressing, because I have two counties in my district that have more than $100 difference between the 2 of them. The plan didn't pull out; the key providers simply couldn't get value for

it, and there is no plan, it was the single one available. His concern is not a unique one. It is, unfortunately, under the old system, and the checks that created were in the Medicare Cost Plus. It is an area we have to address. We are not now providing the opportunity for managed care that we had anticipated.

Mr. PORTMAN. I appreciate the chairman's thoughts on that, and I look forward to working with him and with HCFA to try to do just that.

Chairman THOMAS. And I did want to recognize that we have with us someone who is not a Member of the Subcommittee or the Full Committee, the gentleman from Texas, Mr. Lampson. I will say that this is technically in recess until 2:15. I want to thank you for coming, but the gentleman does wish to inquire, and if you'll please act as though the subcommittee is still in session, he would like to get the words and maybe have to follow up with some written information, and we will be back at 2:15 at which time we'll hear Bill Scanlon.

Ms. DEPARLE. Thank you.

Chairman THOMAS. Well, he'll submit them in writing then? The gentleman wishes to submit them in writing.

[Questions from Congressmen Cardin and Lampson submitted to Ms. DeParle and her responses follow:]

Prepared by the office of Rep. Benjamin L. Cardin
July 30, 1998

QUESTION FOR NANCY-ANN MIN DEPARLE ON HOME HEALTH:

My understanding is that one key goal of home health reform was to increase efficiency in the industry, and that the IPS and PPS systems are intended to accomplish this. Under the current Interim Payment System, however, it is entirely possible for an agency to continue to operate quite inefficiently and perpetuate its wasteful practices, yet stay in business (and prosper) by taking on less sick patients.

In fact, if we continue to set limits at a blend of 75% agency-specific/25% regional, we are only rewarding those agencies that have been inefficient in the past, and penalizing those who have responsibly contained costs. Furthermore, our hardest hit agencies will face an additional 15% cut on October 1, 1999.

Our number one priority must be to ensure that Medicare beneficiaries have access to the care they need. The current system makes a focused hit on the patients who need home health care the most.

What do you propose as the best way to help these patients and ensure that our efficient agencies can continue to operate?

QUESTION FOR NANCY-ANN MIN DEPARLE RE: $1500 OUTPATIENT THERAPY CAP

Providers are concerned that they will risk fraud accusations if HCFA cannot track the $1500 annual payment limits due to Y2K problems. One facility may have no record of prior outpatient rehabilitation services provided by another facility, yet HCFA will hold that facility accountable if the limit is exceeded. Based on your concerns about Y2K, is HCFA equipped to track the implementation of the annual $1500 payment limit imposed on outpatient rehabilitative services? And if not, what safeguards can be put into place to assist providers in complying with the payment limits?

QUESTION FOR NANCY-ANN MIN DEPARLE RE: TRANSITION TO PPS FOR SKILLED NURSING FACILITIES

Congressional intent with a transition to a new SNF PPS was to ease facilities into the new system with minimal disruption to the Medicare population. Congress used the only data available, which was from the 1995 cost reports. It has become clear that some skilled nursing facilities will actually be disadvantaged by the transition because they have increased the volume and acuity of their residents. What steps can HCFA take to ensure that facilities are not disadvantaged by the transition and patient access to SNF services will not be disrupted?

How will HCFA address the care of certain outlier patients when skilled nursing facilities incur

costs far in excess of what they are reimbursed?

QUESTION FOR NANCY-ANN MIN DEPARLE RE: PHYSICIAN PRACTICE EXPENSE IMPLEMENTATION

HCFA has moved forward with timely implementation of the practice expense provisions in the BBA. However, some specialists are concerned about a substantial site differential between procedures performed in physician offices and those performed in ambulatory surgical centers or outpatient departments of hospitals. For example, a colonoscopy will be reimbursed $208 if done in an ASC or hospital outpatient department, but doctors performing this procedure in an office setting would receive $292.

Congress did not specifically direct HCFA to establish a site of service differential. Could you explain how the differential was determined? What quality judgements and medical standards of care did HCFA use?

QUESTION FOR NANCY-ANN MIN DEPARLE RE: SOCIAL HMOs

I understand that while HCFA is proposing a delay in the implementation of certain provisions in the BBA, you intend to keep on track with implementation of much of the legislation, including the Medicare+Choice program. Since the process for mainstreaming the Social HMO demonstration into the Medicare program is linked to the Medicare+Choice program, I assume that HCFA will move forward in developing the integration plan--that this feature of BBA will not be affected by the Y2K program. Is this correct?

September 25, 1998

The Honorable Benjamin L. Cardin
Committee on Ways and Means
U.S. House of Representatives
Washington, D. C. 20515

Dear Congressman Cardin:

As requested, listed below are HCFA's answers for the record to questions from the July 16, 1998 hearing on BBA Implementation.

1) Helping Home Health Patients and Efficient Agencies.

The home health interim payment system (IPS) was intended as an interim measure while the Health Care Financing Administration works to develop the home health prospective payment system (PPS). In the first year of its operation, the IPS was expected to save Medicare about $1.4 billion dollars. We know that in order to achieve these savings home health agencies will be faced with many challenges. We believe agencies can meet these challenges by returning spending and the average number of home visits to fiscal year 1994 levels. Agencies can achieve this by combining visits, eliminating unnecessary visits, and/or reducing overhead expenses while continuing to provide patients with the medically necessary services they may need.

The aggregate per beneficiary limit, as part of the interim payment system, includes an agency-specific component as a rough proxy for an agency's case mix. By basing part of the limitation on an agency's own historical cost experience, we believe that the aggregate per beneficiary limit should reflect the mix of patients an agency is currently caring for since the agency's mix of patients is unlikely to have changed dramatically. As part of our efforts to develop the home health prospective payment system, we are working diligently to create a case-mix adjustment system that would more accurately relate payment to the resources involved in providing care.

I also share your concerns about Medicare beneficiaries' access to home health care. We are working within the limitations of the statute so that agencies can continue to provide the necessary care to beneficiaries. We recently published the notice for the per visit and aggregate per beneficiary limits under IPS for fiscal year 1999. In that notice, we have

increased the aggregate per beneficiary limits for inflation, and rebased the per visit limit using more recently settled cost reports and updated it for inflation as well, both of which has had the effect of increasing these limits.

However, we do understand that there is considerable interest to provide for modifications or alternatives to the interim payment system. In keeping with this strong interest from Members of Congress, we have been providing technical assistance to Members and their staff on an ongoing basis. We want to continue to express our willingness to you and other Members to help you work through a feasible and administrable option that achieves a consensus in Congress and remains budget neutral.

2) Outpatient Rehabilitation Therapy Cap

We recognize that we must help beneficiaries and providers track spending under the cap. However, implementing the cap requires extensive computer system programming that conflicts with our Year 2000 renovations and testing. We are continuing to evaluate whether partial implementation is possible. We recognize that providers cannot be expected to know the services a beneficiary received at another facility and would not hold them accountable for this information.

3) Skilled Nursing Facility Prospective Payment System

SNF PPS is designed to ensure adequate payment levels by recognizing differences in resource use among patients with different clinical and functional characteristics. As specified by the BBA, the rates were based on 1995 allowable costs. Thus, a facility's historical costs were captured in these cost reports and reflected in both the Federal and facility specific transition rates.

The Balanced Budget Act did not authorize an outlier policy for SNF PPS. There is, however, a three-year transition period where the rates will include a certain percentage of each SNF's historical allowable costs so that SNFs will have time to assess their efficiency and adjust to PPS. Furthermore, HCFA has funded research to examine the potential for refinements to the system.

4) Practice Expense Site-of-Service Differential

The site-of-service differential is a long-established policy that was first authorized in the Omnibus Budget Reconciliation Act of 1981. We reduce practice expense payments to physicians by 50 percent when they furnish services in a facility, such as a hospital

outpatient department, rather than in their own office. This policy recognizes that physicians incur some expenses when performing procedures outside their offices, but that we pay these facilities separately for staff and supplies they furnish in support of these procedures. The Balanced Budget Act requires that we begin moving to a resource-based practice expense system for physicians on January 1, 1999. Under our proposal for such a system, published in the *Federal Register* on June 5, 1998, we would base the site-of-service differential on the actual resources needed for a given procedure in a given setting. If a procedure is provided in a facility rather than a physician's office, we would eliminate payment for clinical staff, supplies and equipment typically provided by the facility. This proposal is based on resource utilization, and does not involve quality judgments or medical standards of care.

5) Social HMOs

We are moving forward to integrate Social HMOs into the Medicare+Choice program. The Balanced Budget Act extended these demonstration projects until January 2001. We expect to have the integration plan ready by January 2000, and to bring these plans into the Medicare+Choice program before the demonstration authorization expires so that there is no disruption of service to enrollees. In the meantime, we must complete development of risk adjustment payment policies for the Medicare+Choice program overall so that payment to these unique plans reflects the greater needs of their enrollees.

I hope you find this information helpful. Please contact me if you have questions.

Sincerely,

/s/
Nancy-Ann Min DeParle
Administrator

Congress of the United States
House of Representatives
Washington, DC 20515–4309

NICK LAMPSON
9TH DISTRICT, TEXAS

COMMITTEE ON
TRANSPORTATION

COMMITTEE ON SCIENCE

July 17, 1998

Ms. Nancy-Ann Min DeParle, Administrator
Health Care Financing Administration
200 Independence Ave., SW
Washington, D.C. 20201

Dear Ms. DeParle:

Thank you for testifying at yesterday's Ways and Means Subcommittee on Health hearing on the Balanced Budget Act of 1997 and its effects on the health care industry. While I am not on this committee, I definitely appreciated the opportunity to attend the hearing and hear your views on a number of issues raised.

As I said to you while walking out of the hearing room, I look forward to a timely response to the following questions:

(1) Home health care benefits have been cut dramatically. Some agencies are closing because the real cost of providing services is no longer being reimbursed. I am concerned about the actual recipients of these benefits. When the companies are not there, who will care for those in need? Nursing homes and hospitals? For example, doing away with the venipuncture benefit removed approximately 35,000 Texans for service. An additional 100,000 Texans are going to be in need of home health but will not receive services because of cuts. Without Medicare reimbursement for venipuncture, many of these people will become sicker and require long term care. What do you project the additional cost for long term/institutional care to be and will Medicare have the money to pay for it? Will we ultimately spend more or less?

(2) The Interim Payment System was originally created to address the problems of fraud and abuse in the home health care industry. Unfortunately, more problems have been created with agencies being reimbursed the lowest of (a) actual allowable costs, (b) aggregate per-visit-cost limits, (c) or a new aggregate per-beneficiary limit using Fiscal Year 1994 dollars (which actually hurts agencies that were already attempting to lower their costs back in 1994).

(a) Is the real goal to correct the proliferation of HHC licenses (provider numbers)?
(b) Is there a better way to accomplish this goal?
(c) What costs would be necessary to move more quickly to the PPS system?

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(3) Why don't we use qualified health care professionals from the health care community to police the industry instead of the Justice Department?

(4) It is disgraceful that our Nation's Medicare beneficiaries and intermediaries are not receiving notification of changes in the payment system. I have been informing agencies in my district about the stay of the regulation for surety bonds. How do you explain the lack of information being sent to our seniors and homebound?

(5) New billing policies addressing the shift from Part A to Part B are creating hardships for the agencies. Financial data will then be flawed due to delays in claim submissions. How does HCFA intend to fix these problems?

(6) What is HCFA proposing to ensure that those home health care agencies that have been careful and not abusive, aren't penalized?

Again, thank you for your attention to these questions. I'm sure that you will agree with me that certain types of providers and certain geographic areas are affected differently by the above-stated limits. Changes in Medicare payments have had the unintended consequences of reducing access to services for our Nation's oldest, poorest, and sickest Medicare beneficiaries. I will be submitting my questions to the Ways and Means Committee for the Record and would appreciate HCFA doing the same.

Sincerely,

NICK LAMPSON
Member of Congress

cc: The Honorable Bill Thomas, Chairman of Ways and Means Subcommittee on Health
The Honorable Pete Stark, Ranking Member of Ways and Means Subcommittee on Health

NVL/ah

The Honorable Nick Lampson
House of Representatives
Washington, D.C. 20515-4309

Dear Congressman Lampson:

Thank you for attending the July 16, 1998 hearing on Balanced Budget Act implementation, and for your letter regarding concerns about the effects on home health agencies. As requested, listed below are HCFA's answers for the record to your questions.

1) Venipuncture.

Beneficiaries do not appear to be losing access to care because of reforms in Medicare's home health benefit, according to a draft report of a General Accounting Office study that was done in part in Texas. The study found that access problems, if any, are limited to costly beneficiaries, and that those problems also involve issues unrelated to reforms, such as a shortage of qualified personnel to deliver the care. Most agency closures have been in states that had the most growth in the number of agencies since 1994. In fact, growth in the number of agencies in just the last two years has been such that, despite closures, there are still more agencies in Medicare now than there were in October, 1996. And, according to the draft General Accounting Office report, agencies that have closed this year tended to be less efficient. The interim payment system is a step towards a prospective payment system, and it includes incentives to provide care more efficiently. These incentives are essential to stem the tide of unsustainable growth in Medicare home health spending. Home health care accounted for just 2.9 percent of all Medicare benefit payments in 1990 but now accounts for nearly 9 percent. Total home health spending rose from $4.7 billion (in 1997 dollars) in 1990 to $17.2 billion in 1997. During the same period, the number of beneficiaries receiving home health doubled from two million to four million, and the average number of visits per beneficiary jumped from 36 to 80. The number of home health agencies providing services to Medicare beneficiaries has grown about 10 percent each year, from 5,656 in 1990 to 10,500 in 1997. While some of this growth is due to changing demographics and medical advances, studies by the HHS Inspector General and the General Accounting Office document that a significant amount is due to waste, fraud and abuse. Also, the old cost-based reimbursement system gave home health agencies few incentives to be efficient. Other reforms are also affecting the home health industry. Standards for entry into the program have been raised, controls against waste, fraud and abuse have been tightened, and a new site-of-service billing rule has reduced the financial benefit of maintaining branch offices. All of these changes may be contributing to the moderate increase in agency

closures, and it is possible that the closure rate would be the same even without the interim payment system.

The venipuncture provision should not increase the need for nursing home care. A homebound beneficiary can still have blood drawn at home. The Balanced Budget Act did eliminate venipuncture as a qualifying criterion for home health services. This was done because patients who only needed blood drawn were receiving the full range of home health services, including such things as help with bathing. The Medicare home health benefit was designed to provide care related to treatment of a specific illness or injury in response to an acute episode. Personal care services by home health aides, such as help with bathing, are covered under the home health benefit only to augment treatment of a beneficiary who needs skilled care. The Medicare home health benefit was never intended to provide personal care services unrelated to skilled treatment of an illness or injury. Homebound beneficiaries who need intermittent skilled nursing care, physical therapy, speech language pathology services, or who have a continuing need for occupational therapy, will continue to receive blood draws at home through the home health benefit. Beneficiaries who do not need such skilled services can continue to have blood monitored at home, but as a lab benefit. Medicare Part B will pay for a qualified person to travel to their home and draw blood. We recently increased the travel allowance for home blood draws. Our new policy gives a flat rate travel allowance of $7.50 one way for trips less than 20 miles round trip and the minimum of $.75 per mile for trips longer than 20 miles round trip.

2) Interim Payment System.

The interim payment system is designed to control spending and introduce additional incentives to provide care efficiently. It may discourage proliferation of agencies where utilization and costs are already high by requiring that "new" home health agencies -- any that did not submit a full cost report during FY 1994 -- have an aggregate per beneficiary limit under the interim payment system that is the national median of these limits.

We are taking several actions to weed out unscrupulous agencies and raise the bar so that only reputable and qualified home health agencies serve Medicare beneficiaries. We have doubled the number of cost report audits and increased medical review of claims by 25 percent. We established new minimum capitalization requirements to ensure that new agencies have enough funds to operate responsibly. We began requiring agencies to treat at least 10 patients before they enter Medicare so we can make sure they provide quality care. We increased survey frequency for problem agencies. We implemented new authority to exclude providers convicted of fraud, and to require disclosure of related party ownership so we can determine whether any principals have a history of questionable practices. We also are developing proposed regulations to require agencies to be recertified every three years, and to submit an independent audit of records and

practices. And we have proposed new Conditions of Participation which would set additional appropriate standards for home health agencies, and clarify HCFA's unequivocal authority to decertify those found out of compliance with any Federal, State, or local law or regulation.

The delay in moving to a prospective payment system is not related to costs. The delay is necessary because implementing the system would conflict with efforts to fix computer systems so that we can continue processing claims in the year 2000. The Year 2000 problem is and must be the agency's highest priority. We are making every effort to minimize the delay in implementing the home health prospective payment system. We plan to continue development of all aspects of this project which are not computer systems-dependent so that we can promptly make needed changes as soon as Year 2000 priorities are met.

3) Policing the Industry.

We do use health care professionals, employed by our claims processing contractors, as the first line in reviewing claims. The Department of Justice becomes involved when, and only when, there is evidence of intent to commit fraud.

4) Notification of Changes in the Payment System.

Medicare claims processing contractors receive copies of every program memorandum issued regarding changes in the payment system. These contractors share this information in newsletters regularly sent to home health agencies. Beneficiaries receive information about any changes to the home health benefit.

5) Shift from Part A to Part B.

A new sequential billing policy was implemented to facilitate the shift of home health services unrelated to hospital stays to coverage under Medicare Part B. This policy requires claims to be paid in the order the services were delivered, and is the most accurate and timely administrative means of implementing the shift. It also means that, if an individual beneficiary claim is suspended for medical review, no further claims for that beneficiary can be paid until the suspended claim is resolved. The combination of increased medical review and sequential billing may contribute to cash flow problems for some smaller agencies. We therefore instructed contractors to: limit the number of claims suspended for random medical review for any individual provider to no more than 10 percent; limit the overall level of random medical review in any one state to no more than 10 percent; and, consider constructive alternatives, such as expedited reviews, for providers without a history of billing problems who may be having cash flow problems because of random medical review. The majority of medical review funds are for

focused medical review of providers with aberrant billing patterns or repeated billing problems. This focused scrutiny is necessary to 1) maximize program protection against inappropriate payment; 2) decrease claim denials by educating providers to bill properly and to improve the quality of care; and 3) minimize inconvenience to providers who have not had repeated billing problems.

Delay in claims submission should not cause financial data problems because claims-based financial data, such as that found in the National Claims History Database, are supplied from claims approved for payment through HCFA's Common Working File.

6) Ensuring that Careful Agencies are Not Penalized.

Studies by the HHS Inspector General and General Accounting Office have documented widespread waste, fraud, and abuse in home health care, estimating respectively in 1997 reports, that 40 percent and 43 percent of claims reviewed should not have been paid as submitted. The HHS Inspector General further documented that inappropriate payments are skewed to providers with repeated instances of abusive billing and cost reporting practices. We therefore have instituted focused medical review to target our program integrity efforts on agencies with aberrant billing and cost reporting patterns and not unduly increase scrutiny of agencies without such patterns. To limit the impact of program integrity activities on careful agencies and, as mentioned above, we have instructed claims processing contractors to: limit the number of claims held for random medical review for an individual provider to no more than 10 percent; limit the overall level of random review in any one state to no more than 10 percent; and, consider constructive alternatives, such as expedited reviews, for providers without a history of billing problems who may be experiencing cash flow problems as a result of claims Page reviews. Also, we have instructed home health claims processing contractors to grant extended repayment schedules of up to 12 months to make sure that repayment of any overpayments under the Interim Payment System does not cause undue hardship.

I appreciate your interest in the Medicare home health benefit and your willingness to work with us as we attempt to develop ways to deal with the problems in the program while strengthening the benefit for current and future beneficiaries. Please let me know if I can provide you with further information.

Sincerely,

Nancy-Ann Min DeParle
Administrator

[Recess.]

Chairman THOMAS. The subcommittee will reconvene. I want to thank Dr. Scanlon for, once again, attending to provide us a context and a perspective on the subcommittee's deliberations, and any written testimony you have will be made a part of the record, and you can address us in any way you see fit, doctor.

STATEMENT OF WILLIAM J. SCANLON, DIRECTOR, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, GENERAL ACCOUNTING OFFICE

Mr. SCANLON. Thank you very much, Mr. Chairman, and I'm very happy to be here today as you discuss HCFA's implementation of the more than 200 Medicare provisions contained in the Balanced Budget Act. Combined, these changes should help to control the growth of expenditures while moving the program closer to a model of consumer driven competition among health plans that's similar to how other parts of the health care system have been evolving.

You asked me to provide you an overview of how HCFA's implementation has progressed since our testimony earlier this year and more detailed comments on two key elements that have been the subject of extensive GAO work—the information campaign associated with Medicare Plus Choice and the new payment system for skilled nursing facilities.

As you've heard, HCFA is making some progress in meeting the BBA implementation schedule. We believe the implementation of a large number of the mandates with the July 1998 deadline including the recent Medicare Plus Choice and SNF PPS rules is significant. However, the prospect that many BBA provisions will not be implemented on time because of the year 2000 computer requirements and the content of some of the elements already implemented raise some concerns.

When I appeared before you in January, I indicated our review of HCFA's organizational capacity and processes had revealed that the agency had adopted a very systematic approach to identifying, tracking progress, and fulfilling the requirements of the BBA. We were then concerned, however, about the multiple challenges besides the BBA which HCFA faced, including improving its effectiveness in combating fraud and abuse; updating and enhancing its computer systems in the wake of the demise of the MTS, and completing a major staff reorganization. Now, unfortunately, it seems, collectively, these challenges are going to delay portions of the BBA. While HCFA indicates that these delays will have minimal impact on program savings, some, as you indicated, however, involve significant provisions such as prospective payment for hospital outpatient services.

Keeping the BBA implementation efforts on track while integrating them with other agency priorities is clearly important, but ensuring that those efforts also achieve congressional objectives to the fullest extent possible should be a primary focus. The Medicare Plus Choice information campaign and the skilled nursing facility prospective payment illustrate the latter. In implementing Medicare Plus Choice, HCFA must give beneficiaries the tools to make informed plan choices, a significant new task. Unlike many large

employers, HCFA has played almost no role in helping beneficiaries to evaluate their health plan options. Now, it must assemble comparative information about the expanded array of choices and find means to disseminate it to beneficiaries. Adequately informing beneficiaries about health plan options is likely to be a key to the success of Medicare Plus Choice; it will foster genuine performance-based competition that can result in greater beneficiary satisfaction and increased enrollment.

Our work on disenrollments from current HMOs has revealed a very disturbing fact that some plans can continue to operate with 40 percent of their members disenrolling over the course of a year. The longer term impact is most likely a greater reluctance of some of these disenrollees or others to participate in HMOs. HCFA intends to pilot key components of the information campaign, namely the toll free number and the beneficiary handbook. This cautious approach is, perhaps, warranted given its inexperience in such an endeavor.

Questions have been raised by health plan representatives and others about the estimated cost of the campaign. We are conducting a review of these costs at your request and that of the Senate Finance Committee. Our preliminary work indicates that the toll free number is both the most expensive component and the most difficult cost to estimate given the lack of experience. HCFA does seem to be trying to control the cost of the toll free number operation by providing only certain information on the phone and using other means for more extensive inquiries. We will be comparing HCFA's estimated costs to those of similar toll free number operations. However, until HCFA actually gains experience, we will have a somewhat limited basis to judge precisely either the efficiency or the effectiveness of its plans. Ultimately, the design of this and other aspects of the information campaign should be determined not only by the cost but how effective they are in contributing to the intended transformation of the Medicare Program.

With respect to the new SNF prospective payment system, effective 16 days ago, it represents a major step in gaining control over rapidly increasing SNF expenditures. However, we are concerned that elements of it could compromise the anticipated savings. Specifically, we have concerns that the system's design offers some opportunities for providers to increase their compensation by potentially supplying unnecessary services; that it's rates were computed using data that likely overstate the reasonable cost of providing care, and that the published regulation gives the impression of creating a new automatic means of determining eligibility for coverage that could both expand the number of beneficiaries and days covered.

Finally, we think there is insufficient planned oversight for this system that will increase the potential for all of the above factors to reduce expected savings. We do believe, though, on the positive side, that some short-term modifications to the rule and longer term efforts to refine the system could ameliorate our concerns.

In conclusion, I'd like to reiterate that we find the challenges created by the Balanced Budget Act, both in terms of the number of the changes and the complexity of some of them, very daunting. HCFA's normal workload and internal factors that compromise its

capacity compound the problem. In this context your oversight and assistance in setting priorities and selecting among options are essential to the fulfillment of the goals underlying the Balanced Budget Act. We will be very happy to continue to gather information and conduct analyses to assist you in these tasks. Thank you very much, Mr. Chairman.

[The prepared statement follows:]

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Health, Committee on Ways and Means, House of Representatives

For Release on Delivery
Expected at 11 a.m. EST
Thursday, July 16, 1998

BALANCED BUDGET ACT

Implementation of Key Medicare Mandates Must Evolve to Fulfill Congressional Objectives

Statement of William J. Scanlon, Director
Health Financing and Systems Issues
Health, Education, and Human Services Division

GAO/T-HEHS-98-214

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the Health Care Financing Administration's (HCFA) implementation of Medicare provisions contained in the Balanced Budget Act of 1997 (BBA).[1] Taken together, the more than 200 BBA Medicare mandates amount to what are probably the most significant modifications to the program since its inception 30 years ago. For example, the new Medicare+Choice provisions of BBA will enable beneficiaries to enroll in different types of health plans previously excluded from the Medicare program, while the introduction of prospective payment systems will alter how reimbursements are made to skilled nursing facilities (SNF), home health agencies, hospital outpatient departments, and inpatient rehabilitation facilities. Collectively, the objective behind these changes is to better control the growth in Medicare expenditures while simultaneously moving the program away from its fee-for-service orientation and toward greater acceptance of the different types of managed care already available to those with private health insurance. You asked me to give an overview of how HCFA's implementation has progressed since our testimony earlier this year.[2] In addition to this overview, my testimony will provide more detailed comments on two key program elements scheduled for implementation this year that have been the subject of extensive GAO work: (1) the efforts to inform Medicare beneficiaries about the expanded health plan choices available to them in 1999, commonly referred to as the "information campaign," and (2) the prospective payment system (PPS) for SNFs, which began a 3-year phase-in this month.

To prepare this testimony, we analyzed HCFA reports that track the implementation of BBA mandates and discussed their status with HCFA officials. We also drew on our previous as well as ongoing work assessing the information HCFA and health plans provide to beneficiaries; HCFA's responsibilities under BBA for a new, annual information campaign; and the financing for that campaign. Finally, we analyzed HCFA's interim final rule dated May 12, 1998, that describes the new PPS and consolidated billing for SNFs. Our analysis relied on (1) discussions with HCFA officials and Medicare contractor staff; (2) the lessons learned from implementing the PPS for inpatient hospital services, which has been in place since the mid-1980s; and (3) our prior work on SNF services.

In summary, HCFA is making progress in meeting the legislatively established implementation schedules. Since the passage of BBA in August 1997, almost three-fourths of the mandates with a July 1998 deadline have been implemented. HCFA's recent publication of the Medicare+Choice and SNF PPS implementing regulations demonstrate

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[1]P.L. 105-33 became law on August 5, 1997.

[2]Medicare: HCFA Faces Multiple Challenges to Prepare for the 21st Century (GAO/T-HEHS-98-85, Jan. 29, 1998).

that progress. However, HCFA officials have acknowledged that many remaining BBA mandates will not be implemented on time. In particular, they point out that achieving compliance with Year-2000 computer requirements, a critical agency priority, competes with BBA mandates for computer system resources and, as a result, implementation of a number of BBA mandates will be delayed. HCFA maintains that these delays will have a "minimal" impact on anticipated Medicare program savings.

Given the concurrent competition for limited resources and the differing importance and complexity of the many BBA mandates, the success or failure of HCFA's implementation efforts should not be judged solely on meeting deadlines. Rather, any assessment should consider whether the agency is meeting congressional objectives while taking a reasoned management approach to identifying critical BBA tasks, keeping them on track, and integrating them with other agency priorities. Continued involvement by high-level agency officials in this process as well as ongoing legislative oversight should enhance the likelihood of success.

Complying with the BBA mandate to conduct an information campaign that provides beneficiaries with the tools to make informed health plan choices poses significant challenges for HCFA and participating health plans. In the past, HCFA played almost no role in helping beneficiaries to evaluate their health plan options–that is, in deciding whether to remain in fee-for-service Medicare or switch to participating HMOs. In implementing the Medicare+Choice program, HCFA must now assemble the necessary comparative information about these options and find an effective means to disseminate it to beneficiaries. A parallel goal of the information campaign is to give beneficiaries information about the quality and performance of participating health plans to promote quality-based competition among plans. The lack of standardized information from health plans about their benefits and the imperfect state of quality and satisfaction measures have made HCFA's efforts to assemble this information more difficult. HCFA has accelerated its goals for obtaining standardized information from plans, and we believe health plan disenrollment rates provide an acceptable short-term substitute measure of plan performance. HCFA's cautious approach to implementing the information campaign is probably warranted, given its inexperience in such an endeavor and the campaign's important role in creating a more competitive Medicare market.

Questions have been raised by health plan representatives and others about the estimated cost of the information campaign. The campaign is to be financed primarily from user fees–that is, through an assessment on participating health plans. We recently began a review of HCFA's plans for the information campaign at your request and that of the Senate Committee on Finance. Since the start of our work, HCFA modifications to its plans for the information campaign have significantly affected the estimated costs of different components.

Finally, HCFA has met the July 1, 1998, implementation date for phasing in a new payment system for SNFs. We are concerned, however, that payment system design flaws

and inadequate underlying data used to establish payment rates may compromise the system's ability to meet the twin objectives of slowing spending growth while promoting the delivery of appropriate beneficiary care. Insufficient planned oversight of the new payment system may compound these shortcomings and further jeopardize the potential for cost savings. In the short term, the new payment system could be improved if HCFA clearly stated that SNFs are responsible for insuring that the claims they submit are for beneficiaries who meet Medicare coverage criteria. In the longer term, further research to improve the patient grouping methodology and new methods to monitor the accuracy of patient assessments could substantially improve the performance of the new payment system.

BACKGROUND

Medicare is the nation's health care program for the elderly and disabled, covering about 38 million people. While the organization and delivery of care has evolved considerably since the 1960s, Medicare beneficiaries are still overwhelmingly enrolled in a fee-for-service delivery system in which medical services can be obtained from any participating provider. Although private, employer-based coverage shifted decisively away from fee-for-service toward networks of providers, only a small percentage of Medicare beneficiaries are enrolled in such networks--and, almost exclusively in health maintenance organizations (HMO) that typically offer a more limited choice of providers. In contrast, many individuals with employer-based coverage are enrolled in other types of network plans that offer a broader choice of physicians. While employers migrated toward competing network-based managed care plans to help control health care costs, Medicare focused on fee-for-service payment innovations that moved from retrospective, cost-and-charge-based reimbursements to prospective systems and fee schedules designed to contain cost growth.

The August 1997 passage of BBA dramatically changed the existing paradigm, setting Medicare on a course toward a more competitive and consumer-driven model. HCFA, the agency charged with administering the program, must accomplish this transition while continuing to oversee the processing of an about 900 million claims annually. BBA contained over 350 separate Medicare and Medicaid mandates, the majority of which apply to the Medicare program. The Medicare mandates are of widely varying complexity. Some, such as the Medicare+Choice expansion of beneficiary health plan options and the implementation of PPSs for SNFs, home health agencies, and hospital outpatient services, are extraordinarily complex and have considerable budgetary and payment control implications. Others, such as updating the conversion factor for anesthesia payments, are relatively minor. Although most implementation deadlines are near term--over half had 1997 or 1998 deadlines--several are not scheduled to be implemented until 2002.

PROGRESS MADE IN MEETING BBA MANDATES, BUT FUTURE DELAYS EXPECTED

Overall, BBA required HCFA to implement about 240 unique Medicare changes. Since August 1997, about three-quarters of the mandates with a July 1998 deadline have been implemented. HCFA's recent publication of the Medicare+Choice and SNF PPS regulations are examples of progress HCFA has made in implementing key mandates. Approximately 25 percent missed the BBA implementation deadline, including establishment of a quality-of-care medical review process for SNFs and a required study of an alternative payment system for certain hospitals. It is clear that HCFA will continue to miss implementation deadlines as it attempts to balance the resource demands generated by BBA provisions with other competing objectives.

Implementing BBA provisions would be daunting under the best of circumstances, and the task is further complicated for HCFA by other, concurrent challenges, including new antifraud provisions and other responsibilities contained in the Health Insurance Portability and Accountability Act of 1996[3] and BBA's creation of a new program to reduce the number of uninsured children. Moreover, HCFA has just completed a major reorganization and is attempting to recruit and train staff with the skills needed to transition the agency from a passive purchaser of health care to an active manager of the competitive market being created by BBA-mandated changes. Finally, the need to modernize its multiple automated claims processing and other information systems, a task complicated by the Year-2000 computer challenges, is competing with other ongoing responsibilities.

HCFA has proposed that the Department of Health and Human Services seek legislative relief by delaying implementation of certain BBA provisions--those requiring major computer system changes that also coincide with Year-2000 computer renovations.[4] According to HCFA's computer contractor, simultaneously pursuing both BBA implementation and Year-2000 system changes risks the failure of both activities and threatens HCFA's highest priority--uninterrupted claims payments. The contractor advised HCFA to seek relief from competing requirements, which could allow the agency to focus instead on Year-2000 computer system renovations.

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[3]P.L. 104-191.

[4]Any change in payment policy requires computer system changes. HCFA has proposed delaying system modifications required by BBA so that resources can be focused on Year-2000 priorities. Contractors are required to be Year-2000-compliant by December 31, 1998. After compliance is achieved and remaining problems are fixed, resources will be redirected to meeting delayed BBA requirements.

The BBA provisions to be delayed by the computer renovations include updates to the October 1999 inpatient hospital PPS rate and the January 2000 physician fee schedule, hospital outpatient PPS limits on outpatient therapy services, and billing changes for SNFs. Appendix I lists other BBA mandates that are being postponed.[5]

It is difficult to assess the impact of these delays. In some instances, the effects are direct. Postponing the outpatient PPS, for instance, means that Medicare will continue to have few controls over its outlays for these services. Similarly, delays in instituting per-beneficiary limits on the amount of outpatient therapy services covered by Medicare—a rapidly expanding source of expenditures—means that anticipated savings will be lost. Some delays involve mandates that are intended to complement provisions already being implemented. We may expect further increases in spending for outpatient therapy services because of newly implemented payment constraints on other therapy providers. As another example, consolidated billing makes SNFs responsible for virtually all Medicare-covered services that residents receive, rather than allowing other providers to bill directly. The consolidated billing provision's importance is heightened by the fact that SNFs are starting to be paid under the new PPS rates, which cover both services previously billed by the SNF and by certain outside providers. Without this provision, it may be more difficult to adequately monitor whether bills for SNF residents are being submitted appropriately.

ADEQUATE INFORMATION CRITICAL TO SUCCESS OF MEDICARE+CHOICE

BBA establishes a new Medicare+Choice program, which will significantly expand the health care options that can be marketed to Medicare beneficiaries beginning in the fall of 1998. In addition to traditional Medicare and HMOs, beneficiaries will be able to enroll in preferred provider organizations, provider-sponsored organizations, and private fee-for-service plans. Medical savings accounts will also be available to a limited number of beneficiaries under a demonstration program. The goal is a voluntary transformation of Medicare via the introduction of new plan options. Capitalizing on changes in the delivery of health care, these new options are intended to create a market in which different types of health plans compete to enroll and serve Medicare beneficiaries. Recognizing that consumer information is an essential component of a competitive market, BBA mandated a national information campaign with the objective of promoting informed plan choice. From the beneficiary's viewpoint, information on available plans needs to be (1) accurate, (2) comparable, (3) comprehensible, and (4) readily accessible. Informed beneficiary choice will be critical since BBA phases out the beneficiary's right to disenroll from a plan on a monthly basis and moves toward the private sector practice of annual reconsideration of plan choice.

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[5]Our list is based on provisions identified in a July 8, 1998, HCFA BBA Implementation Tracking Report.

The responsibility for informing beneficiaries about plan choices is dual, falling on both HCFA and participating Medicare+Choice health plans. In keeping with provisions of BBA to inform beneficiaries about new and existing health care options, HCFA is attempting to summarize health plan coverage information and make it accessible in a comparative format. To ensure accessibility, BBA requires that comparative information be available to beneficiaries via the Internet, through a toll-free telephone number, and in printed form by mail. Recognizing that expanding the array of health plan choices and organizing a top-notch information campaign is an enormous undertaking, BBA mandates a two-step phase-in. In 1998, HCFA is only responsible for a "special information campaign" that gives beneficiaries data on existing HMO options and any new Medicare+Choice plans. Only a few new options are expected to be available and, though not required to do so this year, HCFA is already providing comparative data via the Internet. Beginning in 1999, however, the agency is charged with the orchestration of a "nationally coordinated educational and publicity campaign" that includes comparative data on the available health plan choices. This publicity campaign will support what is to become an annual event each November–an open enrollment period in which beneficiaries may review the options and switch to a different health plan. As in the past, health plans will continue to provide beneficiaries with marketing information that includes a detailed description of covered services. In fact, HCFA comparative summaries will refer beneficiaries to health plans for more detailed information.

HCFA is taking a cautious approach and testing the key components of its planned information campaign. This caution is probably warranted by the important role played by information in creating a more competitive Medicare market and by the agency's inexperience in this type of endeavor. In March 1998, the agency introduced a database on the Internet called "Medicare Compare," which includes summary information on health plans' benefits and out-of-pocket costs. The toll-free telephone number will be piloted in five states–Arizona, Florida, Ohio, Oregon and Washington–and gradually phased in nationally during 1999. Because of some concerns about its readability, HCFA has also decided to pilot a new beneficiary handbook in the same five states instead of mailing it to all beneficiaries this year. The handbook, a reference tool with about 36 pages, will describe the Medicare program in detail, providing comparative information on both Medicare+Choice plans as well as the traditional fee-for-service option. For beneficiaries in all other states, HCFA will send out a five- to six-page educational pamphlet that explains the Medicare+Choice options but contains no comparative information. This schedule will allow HCFA to gather and incorporate feedback on the effectiveness of and beneficiary satisfaction with the different elements of the information campaign into its plans for the 1999 open enrollment period.

Lack of Standardized Comparative Data
Hampers HCFA and Beneficiaries

Until BBA, Medicare lagged behind other large purchasers in helping beneficiaries choose among plans. The Federal Employees Health Benefits Program, the California Public Employees' Retirement System, Xerox Corporation, and Southern California Edison all provide their employees with comparative information on premiums, benefits, out-of-pocket costs, and the results from member satisfaction surveys. HCFA, on the other hand, has not routinely provided plan-specific information directly to beneficiaries. In 1996, we reported that beneficiaries received little or no comparative information on Medicare HMOs. Among other things, we recommended that HCFA produce plan comparison charts and require plans to use standard formats and terminology in benefit descriptions.

In developing comparative information for Medicare Compare, HCFA attempted to use information submitted by health plans as part of the contracting process. Like beneficiaries, HCFA had difficulty reconciling information from different HMOs because it was not standardized across plans. HCFA's Center for Beneficiary Services, the new unit responsible for providing information to Medicare enrollees, has been forced to recontact HMOs and clarify benefit descriptions. Recognizing that standardized contract information would reduce the administrative burden on both health plans and different HCFA offices that use the data, the agency has accelerated the schedule for requiring standard formats and language in contract benefit descriptions. Although originally targeted by 2001, the new timetable calls for contract standardization beginning with submissions due in the spring of 1999. If available on schedule, standardized contracts should facilitate the production of comparative information for the introduction of the annual open enrollment period in November 1999.

While comparative data from HCFA will provide a starting point for selecting a health plan, beneficiaries will probably continue to rely on marketing information and detailed benefit descriptions provided by plans in making their ultimate choice. Such materials may be both difficult to use and misleading because plan marketing material is not standardized. In our recent review of marketing materials from Medicare HMOs in Tampa, Florida, we found that the formats and benefit categories varied considerably from plan to plan and sometimes omitted key details, as in the following examples:

- Marketing materials often failed to inform beneficiaries that they face higher out-of-pocket costs if they choose a brand-name drug over a generic.

- HMOs differed in the terms used to describe the same benefit or used technical terms but did not define them. Thus, some used the term "formulary" to describe

the prescription drug benefit but did not explain that the use of nonformulary drugs may result in substantially higher out-of-pocket costs.[6]

- Only five of eight Tampa plans mention mammograms in their benefit summaries--even though all plans covered mammograms. Most plans listed mammograms under the "preventive service" benefit category. One plan, however, included them under hospital outpatient services.

Consistent presentation is important because beneficiaries may rely on plans' benefit summaries when comparing coverage and out-of-pocket cost information. Federal employees and retirees can readily compare benefits among health plans in the Federal Employees Health Benefits Program because the Office of Personnel Management requires that plan brochures follow a common format and use standard terminology. It is encouraging that HCFA wants to accelerate a similar requirement for Medicare+Choice plans. In the fall of 1999, HCFA expects to require health plans to use standard formats and terminology to describe covered services in the summary-of-benefits portion of the marketing materials.

Reliable Plan Performance Data
Essential to Quality-Based Competition

Comparative data on quality and performance is a key component of the information campaign mandated by BBA and is an essential underpinning of quality-based competition. Recognizing that the measurement and reporting of such comparative data is a "work in progress," the act directed broad distribution of such information as it becomes available. Categories of information specifically mentioned by BBA include beneficiary health outcomes and satisfaction, the extent to which health plans comply with Medicare requirements, and plan disenrollment rates. While disenrollment rates could be prepared for publication in a matter of months, other types of quality-related information have accuracy or reliability problems or are still being developed.

The best-known quality-of-care measures available focus on a health plan's history in delivering preventive services such as mammography, flu shots, and eye exams for diabetics. These indicators, referred to by the acronym HEDIS (Healthplan Employer Data and Information Set), were jointly developed by a group of large purchasers, including HCFA, and health plans. HCFA has already collected data on many HEDIS measures from Medicare HMOs with the intent of publishing them. Since the HEDIS data are self-reported by plans, HCFA contracted for an audit to verify the accuracy. HCFA recently reported serious accuracy problems that it attributed to immature health plan

[6]In general, a formulary is a list of drugs that health plans prefer their physicians to use. The formulary includes drugs that plans have determined to be effective and that suppliers may have favorably priced for the plan.

information systems and ambiguities in the HEDIS measurement specifications. Though committed to making the HEDIS information available as quickly as possible, HCFA emphasized that its premature release would be unfair to both plans and beneficiaries. Finally, efforts have been under way for some time to develop measures that actually demonstrate the quality of the care delivered–often referred to as "outcome" measures. As noted, the current HEDIS measures look at how frequently a health plan delivers specific services, such as immunizations, not at outcomes. The development and dissemination of reliable health outcome measures is a much more complicated task and remains a longer-term goal.[7]

Before passage of BBA, HCFA had funded a survey to measure and report beneficiaries' satisfaction with their HMOs. For example, Medicare enrollees were asked how easy it was to gain access to appropriate care and how well their physicians communicated with them about their health status and treatment options. HCFA plans to make the survey results available on its Medicare Compare Internet site this fall and to include the data in mailings to beneficiaries during the fall 1999 information campaign. We believe that the usefulness of HCFA's initial satisfaction survey for identifying poor performing plans is limited because it surveyed only those individuals satisfied enough with their plan to remain enrolled for at least 12 months. HCFA is planning a survey of those who disenrolled, which could help distinguish among the potential causes of high disenrollment rates in some plans, such as quality and access issues or beneficiary dissatisfaction with the benefit package.

For the short term, disenrollment rates for health plans provide a broad indicator of satisfaction that has long been available through HCFA's enrollment database. Only since passage of BBA has HCFA begun to develop formats to make these data useful for public consumption. We have urged the dissemination of disenrollment rates in reports to the Congress over the past 3 years, and we have published comparative rates for individual markets to illustrate the wide variability in HMOs' ability to satisfy and retain enrollees. Our most recent report shows that many HMOs had relatively high voluntary disenrollment rates.[8] In many markets, the highest disenrollment rates exceeded the lowest by more than fourfold. In a few markets, the range in rates was even wider. For example, in Houston, Texas, the highest disenrollment rate was nearly 56 percent, while the lowest was 8 percent. The large range in disenrollment rates among HMOs suggests that this single variable could be a powerful tool in alerting beneficiaries about potentially significant differences among plans and the need to seek additional information before making a plan choice.

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[7]HCFA's current HEDIS initiative contains a single outcome measure that will require data collection and analysis over several years.

[8]Medicare: Many HMOs Experience High Rates of Beneficiary Disenrollment) (GAO/HEHS-98-142, April 30, 1998).

Estimating Cost of Information Campaign Complicated by Lack of Experience

Questions have been raised by health plan representatives and others about the estimated cost of the information campaign. The campaign is to be financed primarily from user fees--that is, an assessment on participating health plans. We are conducting a review of HCFA's information campaign plans at your request and that of the Senate Committee on Finance. Our work began recently, and since then HCFA has modified its plans significantly, affecting the estimated costs of different components. While we cannot yet make an overall assessment, it is clear that the operation of the toll-free number is the most expensive component and, because of a lack of prior experience, is the most difficult cost to estimate.

The cost of the toll-free number comprises 44 percent of the total information campaign budget. HCFA projects fiscal year 1998 costs of $50.2 million to support set up as well as operations during fiscal year 1999. All but $4 million will come from user fees collected from existing Medicare HMOs. For fiscal year 2000, operations costs are projected to grow to $68 million.[9]

As noted earlier, HCFA will gradually make the toll-free number available nationwide between October 1998 and August 1999. HCFA's approach to establishing the toll-free number appears to be geared toward controlling costs. Customer service representatives will attempt to handle straightforward information requests on the spot but will refer beneficiaries with more complicated or detailed questions to the Medicare+Choice plans or to state and local counselors.[10] This referral concept should limit the duration of calls and hence their cost. It is important that the toll-free number meet beneficiaries' reasonable needs or expectations. However, until HCFA actually gains

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[9]During its first operational year, the primary costs associated with the toll-free number will be for a contract to provide trained customer service representatives. Smaller contracts will support the leasing of phone lines and the provision of recorded messages; the mailing of requested printed materials and the processing of disenrollment requests; and referrals of complex questions to HCFA.

[10]The toll-free number will offer prerecorded information 24 hours a day with customer service representatives available from 8:00 a.m. to 4:30 p.m. weekdays. These representatives will answer basic questions about Medicare+Choice rules and the types of plans available in specific areas. In answering benefit questions, the service representatives will rely on the Medicare Compare summary data that are also available on the Internet. Finally, the service representatives will also refer requests for printed comparative information, disenrollment, or difficult policy issues to a separate contractor.

experience with the toll-free number, it has no firm basis to judge either the duration of the calls or the type of information beneficiaries will find useful. The phased implementation of the toll-free numbers should give HCFA a better idea of what beneficiaries want and may necessitate adjustments to current plans.

Ultimately, the design of this and other aspects of the information campaign should be driven less by cost and more by how effective they are in meeting beneficiary needs and contributing to the intended transformation of the Medicare program. Consequently, we will be looking at (1) whether the estimated cost of the planned activities is appropriate and efficient in the near term, and (2) whether, over the longer term, the impact and effectiveness of these activities might be increased.

ANTICIPATED SAVINGS AT RISK
WITH NEW SNF PAYMENT SYSTEM

On July 1, 1998, HCFA began phasing in a Medicare PPS for SNFs, as directed by BBA.[11] Under the new system, facilities receive a payment for each day of care provided to a Medicare-eligible beneficiary (known as the per diem rate). This rate is based on the average daily cost of providing all Medicare-covered SNF services, as reflected in facilities' 1995 costs. Since not all patients require the same amount of care, the per diem rate is "case-mix" adjusted to take into account the nature of each patient's condition and expected care needs.

Previously, SNFs were paid the reasonable costs they incurred in providing Medicare-allowed services. There were limits on the costs that were reimbursed for the routine portion of care, that is, general nursing, room and board, and administrative overhead. Payments for capital costs and ancillary services, such as rehabilitation therapy, however, were virtually unlimited. Cost-based reimbursement is one of the main reasons the SNF benefit has grown faster than most components of the Medicare program. Because providing more services generally triggered higher payments, facilities have had no incentive to restrict services to those necessary or to improve their efficiency.

Prospective payment is intended to slow spending growth by controlling the increase in Medicare payments per day of SNF care. Facilities that can care for beneficiaries for less than the case-mix adjusted payment will benefit financially. Those

[11]HCFA has had problems with computer system changes to implement the system. As a result, providers with cost reporting periods beginning July 1 through September 30, 1998, will receive interim payments based on the old payment system that will be adjusted retroactively on or about October 1. To avoid major disruptions to the industry, the PPS will be phased in. For the first 3 years, SNFs will receive a blended payment of old and new rates.

with costs higher than the per diem amount will be at risk for the difference between costs and payments. The PPS for hospitals is credited with controlling outlays for inpatient hospital care. Similarly, the Congressional Budget Office (CBO) estimates that over 5 years the SNF PPS could save $9.5 billion compared with what Medicare would have paid for covered services.

Although HCFA met the deadline for issuing the implementing regulations for the new SNF per diem payment system, features of the system and inadequate data used to establish rates could compromise the anticipated savings. As noted in previous testimony, design choices and data reliability are key to implementing a successful payment methodology.[12] We are concerned that the system's design preserves the opportunity for providers to increase their compensation by supplying potentially unnecessary services. Furthermore, the per diem rates were computed using data that overstate the reasonable cost of providing care and may not appropriately reflect the differences in costs for patients with different care needs. In addition, as a part of the system, HCFA's regulation appears to have initiated an automatic eligibility process–that is, a new means of determining eligibility for the Medicare SNF benefit, that could expand the number of beneficiaries who will be covered and the length of covered stays. Insufficient planned oversight increases the potential for these aspects of the rule to compromise expected savings. Immediate modifications to the rule and efforts to refine the system and monitor its performance could ameliorate our concerns.

Rates Paid for Many Patients Based on Service Use Instead of Need

To reflect differences in patient needs that affect the cost of care, the SNF PPS divides beneficiaries into 44 case-mix groups. Each group is intended to define clinically similar patients who are expected to incur similar costs.[13] An adjustment is associated with each group to account for these cost differences. A facility then receives the same daily payment for all of its patients in each group. The case-mix classification method used in this PPS relies heavily on service use, particularly rehabilitation therapy (physical,

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[12]Medicare Post-Acute Care: Home Health and Skilled Nursing Facility Cost Growth and Proposals for Prospective Payment (GAO-T-HEHS-97-90, Mar. 4, 1997); Medicare Post-Acute Care: Cost Growth and Proposals to Manage It Through Prospective Payment and Other Controls (GAO/T-HEHS-97-106, Apr. 9, 1997); Medicare: Recent Legislation to Minimize Fraud and Abuse Requires Effective Implementation (GAO/T-HEHS-98-9, Oct. 9, 1997).

[13]The groups are defined by a classification system developed by HCFA contractors. The categories in this system are known as Resource Utilization Groups. For the Medicare SNF PPS, version III of the classification system, commonly called RUGS-III, is being used.

occupational, or speech therapy), to assign patients to the different groups. Categorizing patients on the basis of expected service use conflicts with a major objective of a PPS–to break the direct link between providing services and receiving additional payment.

A SNF has incentives to reduce the costs of the patients in each case-mix group. Because the groups are largely defined by the services the patient is to receive, a facility could do this by providing the minimum level of services that characterize patients in that group (see table 1). This would reduce the average cost for the SNF's patients in that case-mix group, but not lower Medicare payments for these patients. For patients needing close to the maximum amount of therapy services in a case-mix group, facilities could maximize their payments relative to their costs by adding more therapy so that the beneficiary was categorized in the next higher group. An increase in daily therapy from 140 to 144 minutes, for example, would change the case-mix category of a patient with moderate assistance needs from the "very high" to the "ultra high" group, resulting in a per diem payment that was about $60 higher. By thus manipulating the minutes of therapy provided to its rehabilitation patients, a facility could lower the costs associated with each case-mix category and increase its Medicare payments. Rather than improve efficiency and patient care, this might only raise Medicare outlays.

Table 1: SNF Prospective per Diem System for Rehabilitation Groups

Rehabilitation groups	Average daily therapy (for 5 days per week)	Per diem payment (federal unadjusted rate for urban facilities)
Ultra high	144+ minutes	$345.90
Very high	100 to 143 minutes	286.30
High	65 to 99 minutes	249.64
Medium	30 to 64 minutes	238.87

Note: Rates listed are for patients receiving this amount of therapy who also need moderate assistance with personal care, such as getting in and out of bed, toileting, moving from a chair to a bed, and eating.

Source: GAO analysis of data from HCFA's May 12, 1998, interim final rule.

HCFA needs to continue research efforts to move away from a patient classification system so closely linked to service use. If the case-mix categories were more dependant on patient characteristics, the facility would have to improve the efficiency with which it provides care to maximize its Medicare payments relative to costs. We recognize that this will be a challenging task. It is difficult to group patients by the amounts of care needed using methods that are less susceptible to manipulation by

a SNF. Nevertheless, being able to classify patients appropriately is critical to ensuring that Medicare can control its SNF payments and that SNFs are adequately compensated for their mix of patients.

Inadequate Data Likely Inflate and Distort Payment Rates

We are also concerned that the data underlying the SNF rates overstate the reasonable costs of providing services and may not appropriately reflect costs for patients with different care needs. The rates to be paid SNFs are computed in two steps. First, a base rate reflecting the average per diem costs of all Medicare SNF patients is calculated from 1995 Medicare SNF cost report data. This base rate may be too high, because the reported costs are not adequately adjusted to remove unnecessary or excessive costs. Second, a set of adjustors for the 44 case-mix groups is computed using information on the costs of services used by about 4,000 patients. This sample may simply be too small to reliably estimate these adjustors.

Most of the cost data used to set the SNF prospective per diem rates were not audited. At most, 10 percent of the base year--1995--cost reports underwent a focused audit in which a portion of the SNFs' expenses were reviewed. Of particular concern are therapy costs, which are likely inflated because there have been no limits on cost-based payments.[14] HCFA staff report that Medicare has been paying up to $300 per therapy session. These high therapy costs were incorporated in the PPS base rates. Even if additional audits were to uncover significant inappropriate costs, HCFA maintains that it has no authority to adjust the base rates after the July 1, 1998, implementation of the new payment system.

The adjustors for each category of patients are based on data from two 1-day studies of the amount of nursing and therapy care received by fewer than 4,000 patients in 154 SNFs in 12 states. Almost all Medicare patients will be in 26 of the 44 case-mix groups. For about one-third of these 26 groups, the adjustors are based on fewer than 50 patients. Given the variation in treatment patterns among SNFs, such a small sample may not be adequate to estimate the average resource costs for each group. As a result, the case-mix adjusted rates may not vary appropriately to account for the services facilities are expected to provide--rates will be too high for some types of patients and too low for others.

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[14]Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes (GAO/HEHS-95-23, Mar. 30, 1995); Medicare: Early Resolution of Overcharges for Therapy in Nursing Homes Is Unlikely (GAO/HEHS-96-145, Aug. 16, 1996).

Automatic Eligibility Process Could Expand Medicare Coverage

Medicare's SNF benefit is for enrollees who need daily skilled care on an inpatient basis following a minimum 3-day hospitalization. Before implementation of the prospective per diem system, SNFs were required to certify that each beneficiary met these criteria.[15] With the new payment system, the method for establishing eligibility for coverage will also change. Facilities will assign each patient to one of the case-mix groups on the basis of an assessment of the patient's condition and expected service use, and the facility will certify that each patient is appropriately classified. Beneficiaries in the top 26 of the 44 case-mix groups will automatically be deemed eligible for SNF coverage. If facilities do not continue to assess whether beneficiaries meet Medicare's coverage criteria, "deeming" could represent a considerable new cost to the program.

Some individuals who are in one of these 26 deemed categories may only require custodial or intermittent skilled care, but HCFA's regulations appear to indicate that they could still receive Medicare coverage. Medical review nurses who work with HCFA payment contractors indicated in interviews that some patients included in the 26 groups would not necessarily need daily skilled care. This may be particularly true at a later point in the SNF stay, since SNF coverage begins after a 3-day hospitalization. Individuals with certain forms of paralysis or multiple sclerosis who need extensive personal assistance may also need daily skilled care immediately following a hospital stay for pneumonia, for example. After a certain period, however, their need for daily skilled care may end, but their Medicare coverage will continue because of deeming. Similarly, certain patients with minor skin ulcers will be deemed eligible for Medicare coverage, whereas previously only those with more serious ulcers believed to require daily care were covered. Thus, more people could be eligible and Medicare could be responsible for longer stays unless HCFA is clear that Medicare coverage criteria have not been changed.

Deeming eligibility would not be a problem if all patients in a case-mix group met Medicare's coverage criteria. To redefine the patient groups in this way would require additional research and analysis. However, an immediate improvement would be for HCFA to clarify that Medicare will only pay for those patients that the facility certifies meet Medicare SNF coverage criteria.

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[15]Medicare coverage criteria are that the patient required skilled nursing services or skilled rehabilitation services, that is, services that must be performed by or under the supervision of professional or technical personnel, that these skilled services be required on a daily basis; and, as a practical matter, considering economy and efficiency, that the services can be provided only on an inpatient basis in a SNF.

Lack of Stringent Oversight
Could Further Diminish Savings

Whether a SNF patient is eligible for Medicare coverage and how much will be paid are based on a facility's assessment of its patients. Yet, HCFA has no plans to monitor those assessments to ensure they are appropriate and accurate. In contrast, when Texas implemented a similar reimbursement system for Medicaid, the state instituted on-site reviews to monitor the accuracy of patient assessments and to determine the need for training assessors. In 1989, the first year of its system's operation, Texas found widespread over-assessment. Through continued on-site monitoring, the error rate has dropped from about 40 percent, but it still remains at about 20 percent.

The current plans for collecting patient assessment information actually discourage rather than facilitate oversight. A SNF will transmit assessment data on all its patients, not just those eligible for Medicare coverage, to a state agency that will subsequently send copies to HCFA.[16] However, the claim identifying the patient's category for Medicare payment is sent to the HCFA claims contractor that pays the bill. At the time it is processing the bill, the claims contractor will not have access to data that would allow confirmation that the patient's classification matches the assessment.

To some extent, the implementation of the SNF prospective per diem system reduces the opportunities for fraud in the form of duplicate billings or billing for services not provided. Since a SNF is paid a fixed per diem rate for most services, it would be fraudulent to bill separately for services included in the SNF per diem. Yet, the new system opens opportunities to mischaracterize patients or to assign them to an inappropriate case-mix category. And, as was the case with the former system, methods to ensure that beneficiaries actually receive required services could be strengthened. As with the implementation of any major payment policy change, HCFA should increase its vigilance to ensure that fraudulent practices discovered in nursing homes, similar to problems noted in our prior work, do not resurface.[17]

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[16]The assessment of all SNF patients is actually a requirement of Omnibus Budget Reconciliation Act of 1987 (OBRA 87), which established requirements for SNFs participating in Medicare and Medicaid. The SNF prospective payment system rule added a requirement that these assessment data be given to the appropriate state agency. Previously, they had remained with the SNF.

[17]Nursing Homes: Too Early to Assess New Efforts to Control Fraud and Abuse (GAO/T-HEHS-97-114, Apr. 16, 1997); Fraud and Abuse: Providers Target Medicare Patients in Nursing Facilities (GAO/HEHS-96-18, Jan. 24, 1996).

CONCLUSIONS

HCFA faces numerous concurrent challenges, many of them the result of significant changes to the Medicare program mandated by BBA. Given the BBA workload alone, implementation delays were probably inevitable. And now, HCFA has been advised by its contractor that its highest priority–uninterrupted claims processing through the timely completion of Year-2000 computer renovations–may be jeopardized by some BBA mandates that also require computer system changes. Though HCFA is implementing what will become an annual information campaign associated with Medicare+Choice, it has little experience in planning and coordinating such an undertaking. The ability of the campaign to provide accurate, comparable, comprehensive, and readily accessible information will help to determine the success of the hoped for voluntary movement of Medicare beneficiaries into less costly, more efficient health care delivery systems. While BBA computer system-related delays may jeopardize some anticipated program savings, slower Medicare expenditure growth is also at risk because of weaknesses in the implementation of other mandates. HCFA could take short-term steps to correct deficiencies in the new SNF PPS. However, longer-term research is needed to implement a payment system that fully realizes the almost $10 billion in savings projected by CBO.

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Mr. Chairman, this concludes my statement. I will be happy to answer any questions that you or Members of the Subcommittee may have.

BBA PROVISIONS DELAYED BY YEAR 2000 COMPUTER RENOVATIONS

BBA section	Provision	Required implementation date
4001	Collection of nonpatient encounter data from plans	No date specified
4011, 4012	Medicare+Choice competitive pricing demonstration	1/1/99
4014	HMO: Plan for integration of part C and SHMO	1/1/99
4015	Medicare subvention: Project for military retirees	1/1/98[a]
4103	Prostate cancer screening	1/1/00
4313	Reporting and verification of provider identification numbers (employer identification numbers and Social Security numbers)	No date specified
4402	Maintaining savings from temporary reductions in capital payments for PPS hospitals	10/1/97[b]
4403	Disproportionate share payment adjustment	10/1/97[c]
4432	Transitional and final case mix PPS: PPS rates for SNFs	7/1/98[d]
4432	SNF consolidated billing for Part B services	7/1/98
4441	Payment update for hospice services	10/1/97[e]
4502	Update to conversion factor	1/1/99[f]
4505	Implementation of resource-based practice expense RVUs	3/1/98[g]
4505	Implementation of resource-based malpractice RVUs	1/1/00

4523	Hospital outpatient PPS	1/1/99
4523	Prospective payment cancer hospitals	1/1/00
4531	Prospective payment fee for ambulance services	1/1/00
4541	Application of $1,500 annual limit to outpatient therapy rehabilitation services	1/1/99
4551	DME payment provisions	1/1/98[h]
4555	Ambulatory surgical center update *	10/1/97[i]
4602	Interim payment for home health services: per beneficiary limit	10/1/97[j]
4603	Prospective payment for home health services	10/1/99
4603	Requirements for home health payment information	10/1/98
4624	Payments to hospitals for direct costs of graduate medical education of Medicare+Choice enrollees	1/1/98

[a]Collection of encounter data may be delayed.
[b]October 1, 1999, updates and changes may be delayed.
[c]October 1, 1999, updates and changes may be delayed.
[d]October 1, 1999, updates may be delayed.
[e]October 1, 1999, updates may be delayed.
[f]January 1, 2000, update may be delayed.
[g]January 1, 2000, transition may be delayed.
[h]January 1, 2000, update for orthotics and prosthetics may be delayed.
[i]October 1, 1999, update may be delayed.
[j]Implementation of proration provision delayed.
[k]January change may be delayed.

(101757)

Chairman THOMAS. Thank you, Dr. Scanlon. No one said this was going to be easy. We're dealing with a set of data that had never really been brought forward in a way that most people would have expected. If someone said they were working in an area, for example, for 10 years, it's not comfortable dealing with interim payments and now having to change in the context that we're in.

What we hope you will continue to do—and in your testimony is a good example—of taking a look at something like the skilled nursing facility prospective payment system, for example—I believe it's on page 13. In which, if you shift just a couple of minutes a day—and we're not talking about really sophisticated stuff here—but if somebody gives you a rehab group definition based on the number of minutes and it's medium high, very high, and ultra high, and the difference between very high and ultra high is $286 v. $345 and the difference is literally 1 minute, I assume most folks are going to find the 1 minute. How do you go about trying to protect from that kind of gaming of a system? Have you looked at that? Do you have any initial suggestions as to how it might be done?

Mr. SCANLON. I think that we need to explore options to classify patients using criteria other than the minutes of therapy. We recognize that minutes are very easy to measure whereas qualitative factors such as the rehabilitation potential of an individual and the amount of therapy that may be appropriate for that rehabilitation potential are more subjective. With informed medical judgment that is appropriately reviewed, we may be able to have a better classification system that is less gameable.

At this point, one of the troubling things in this system is an attempt to limit the oversight being given to the determination of benefits. The system essentially allows a classification based on the minimum data set assessment to determine whether or not someone receives Medicare coverage. We think there is a need for clinical judgment, that take medical criteria into account to determine whether or not this person is covered for a portion of their stay.

Chairman THOMAS. Well, this is part of the concern I have in—for want of a better term—talking about the reculturalization of HCFA. Because it's easily measured, doesn't necessarily mean it's worth measuring or that it ought to be a criteria, and, oftentimes, it's simply turning in paper which allows me then to show that things are happening. We just don't have the money to do that sort of thing. The ability to move a bit more into a subjective definition—quality, improvement types of things—do you believe that the law as currently written affords sufficient leeway for the administration to make those kinds of changes themselves if they were interested in doing so or do you think that would require a legislative change?

Mr. SCANLON. I don't think it would require a legislative change. When you look at how the system treats therapies, differences are measured in minutes. However, when you look at the ability for an individual to care for themselves, the activities of daily living, there are subjective judgments based upon clinical observation used we are differentiate payment. So, clearly HCFA has the authority to establish a case mix system that is appropriate for these kinds of individuals and the care they're receiving. I think it has the lati-

tude under the law to extend that type of subjective clinical judgment to therapies as well.

Chairman THOMAS. Good. I, obviously, will be working with you on that.

You heard the earlier discussion, I believe, about the concern on the Y2K problem and the window that may be as small as three months or as large as five months. I'm concerned that there isn't enough creative thinking going on about how to deal with that lights out period either, in terms of being creative on frontloading with the settling later or some kind of a payment agreement which, obviously, doesn't leave people hanging or doesn't require institution of paper unless you think that may be one of the things that we could do. Because, frankly, a three or four-month period for payment and failure to do so in that period when you're use to an ongoing regular reimbursement claim structure has me worried a little bit, and I guess from your professional point of view, does it have you worried a little bit, and are you beginning to look at? Do you need additional instructions and direction to begin focusing on, perhaps, some attempt to find out what the private sector's doing—we don't need to reinvent the wheel? But I have very little comfort with what I heard today about where we are in dealing with this dark period except that we know what we're not going to be able to do.

Mr. SCANLON. The Information Systems Group at GAO has been working on the year 2000 problem for a considerable amount of time. One of the significant points that they make in that work is that it's not just a question of correcting a certain number of lines of computer code, whether it's 30 million or 50 million. It's an issue of also having planned for contingencies that if you cannot correct that code or if somebody you're dealing with wasn't able to correct their code, you may find your normal business processes disrupted. You have need to have that a contingency plan in place that provides you with the assurance that you're going to be able to operate over that three-month disrupted period.

Joel Williamson from GAO's Information Systems Group has testified before about HCFA lagging in development contingency plans. As HCFA pursues this now, I think it would be very important for us to be involved as well, because we're moving from a question that's a computer problem to a question that's a Medicare Program policy problem.

Chairman THOMAS. Yes, and gets into that general area of management that we talked about.

Mr. SCANLON. That's correct.

Chairman THOMAS. Okay, thank you very much. I look forward to hearing from you again. Let me see if any of my colleagues have questions they might want to ask. The gentlewoman from Connecticut.

Mrs. JOHNSON of Connecticut. I was interested in your testimony where you've entitled one section: Care on the Basis of Use Rather than Need. Under the old system, providing ancillary services in nursing homes, we at least knew what services were being provided. What was our capability at that time of evaluating need?

Mr. SCANLON. It was no different than it is today in terms of relying on clinical judgment. It's an issue of a clinician reviewing the

patient's status and feeling through their professional knowledge what services might be of benefit. In the old system, we did not have any oversight, though, I agree with you, in terms of the Medicare Program following up to understand whether that professional judgment was something program reviewers would agree with and whether they felt that it was an appropriate use of the benefit.

Mrs. JOHNSON of Connecticut. I think that's exactly my point is that it seems to me it would actually have been easier to implement a system of oversight when we had the specific bills for each action based on need than what we're going to have now which is—I mean, theoretically, one of the savings of the new system is that it won't be so costly administratively, but if we require reporting of every single thing and oversight, it will be just as costly.

Mr. SCANLON. We don't want to make it as costly, of course. We acknowledge understand that HCFA was dealing with the state-of-the-art in terms of research on patient classification when they developed this system, but we really need to do is to think about how to move this system or the state-of-the-art on patient classification to be able to, at one point in time, classify somebody in terms of their potential and the services that they're likely to benefit from and then use that for payment over a period of time. That's not going to involve tracking every service and justifying every service. Right now what we have is a situation where we've determined payment based on minutes which creates a perverse incentive that a few minutes can generate significant increases in revenue.

Mrs. JOHNSON of Connecticut. I just hope that as we think through under the new system how do we assure that the services that were delivered were, indeed, the ones that were needed and that service wasn't denied?

Mr. SCANLON. That's going to be a very critical factor as well as to ensure that the services that we paid for were delivered, because this is a system that is prospective, and we want it to be prospective, because that establishes good incentives, but, at the same time, we want it to be a system that's accountable; that we know that care was delivered appropriately when we paid for it.

Mrs. JOHNSON of Connecticut. I agree with that. I would hope that we would try to build that into the annual review process or something like that rather than a lot more paperwork and a lot more coding and this and that. So, I think we have to think about how we're going to achieve that goal since in the past system and since we had an easier task and didn't achieve it.

Mr. SCANLON. I think we fully recognize that with the administrative resources available and wanting to be very sensitive to the burden that we would impose upon providers, we need to find a way to do this in a very targeted and efficient manner but in a manner that we find to be effective and that gives us great confidence that services have been delivered appropriately.

Mrs. JOHNSON of Connecticut. Thank you.

Chairman THOMAS. Thank you very much.

Mr. SCANLON. Thank you.

Chairman THOMAS. And our last panel, if I could ask you to come forward, Bruce A. Davidson, who is the senior vice president of Blue Cross Blue Shield of Florida, on behalf of the National Association; Carol Raphael, president and chief executive officer of the

Visiting Nurse Service of New York; Mary K. Ousley, senior vice president, government and regulatory affairs, Integrated Health Services, on behalf of the American Health Care Association; Thomas Miller, chief executive officer of the Lutheran Hospital of Indiana, on behalf of the Federation of American Health Systems, and David Bernd, president and chief executive officer of the Sentara Health System, Norfolk, Virginia, on behalf of the American Hospital Association.

I just wanted the record to note that as the chairman is from California and the ranking member is from California, this is an east of the Mississippi panel. My assumption is as much for the economy of fair, I'm sure you're going to be able to represent that portion of the United States west of the Mississippi.

If you have written testimony, which I know you do, it will be made part of the record, and you may address us in any fashion you see fit in the time allotted to you, and let's start with Mr. Davidson.

STATEMENT OF BRUCE DAVIDSON, SENIOR VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD OF FLORIDA

Mr. DAVIDSON. Thank you, Mr. Chairman and Members of the Subcommittee.

I am Bruce Davidson, senior vice president of Blue Cross/Blue Shield of Florida. Thank you for the opportunity to testify on behalf of the Blue Cross/Blue Shield Association on two important points.

Let me address first the regulations implementing the Medicare+ Choice.

We are concerned that the recently released mega-reg will preclude HMO's from entering into the program, and, in fact, increase cost for participating HMO's to the extent that many will have to exit the program. Certainly this outcome would not produce the range of options for beneficiaries desired by Congress.

It is important to understand that the mega-reg is closely tied to a set of performance standards known as the Quality Improvement System for Managed Care, or QISMC, that was being designed for tightly-managed HMO's. The mega-reg and QISMC will require a significant increase in the level of clinical intervention and medical management by all health plans. All health plans would be required to measure a core set of clinical performance indicators, essentially physician clinical practices, and demonstrate a minimum level of performance. Plans would also be required to demonstrate annual, measurable improvements in physician practices.

Many HMO's are involved in this type of medical management already. However, the technology and knowledgeable resources are not available to support the level of activity contemplated by the mega-reg. Certainly the architecture of PPO's cannot support this level of measurement of medical practice patterns or clinical management of physicians.

PPO's meet a different demand of the market than HMO's. They offer a broad choice of physicians, ability to use physicians outside the network, and lower administrative cost. They are very popular products. However, to meet the QISMC standards, PPO's would have to assign beneficiaries to primary care providers, begin collecting detailed patient medical record information, restrict out-of-

network coverage, impose practice protocols and new payment incentives on physicians, and reduce the size of choice of their networks. In short, PPO's would have to redesign into a product closely resembling tightly managed HMO's.

We hope that this will not happen. The references in the mega-reg notwithstanding, we are encouraged that the preamble to the regulations state that HCFA does not intend to adopt a one-size-fits-all approach. Also, we have initiated discussions with HCFA to assure that broad access PPO's are viable in the Medicare+ program. However, at this point, our particular plan would not offer a PPO in Florida to Medicare beneficiaries because of the nature of the mega-reg.

Turning to the issue of Y2K compliance and contractor reform. A representative group of contractors and senior HCFA personnel are working collaboratively to ensure that the claims will be paid accurately and timely in the year 2000. My contacts with fellow contractor executives indicate that everyone is giving Y2K their utmost attention, and we believe that it is possible to complete basic testing by the end of 1998.

It is important that changes to the Medicare program be minimized during the last quarter of 1998 and the first months of 1999, which is when we will be doing most of our testing. Our technical experts advise us that if other complex programming changes are tested simultaneously with Y2K programming changes it will be difficult to determine whether problems are originating with Y2K programming or the other programming changes.

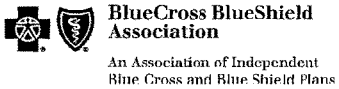
After Y2K testing is completed and problems are resolved, any further changes in 1999 would necessitate retesting and should be kept to a minimum.

In terms of contractor reform, we believe that HCFA currently has the authority to terminate a contractor for non-performance, including non-performance of Y2K responsibilities. We have serious concerns about the breadth of proposed contractor reform which appears to give HCFA the authority to hire, fire, with or without cause, and with or without competitive bidding for the replacement. All this without having a clear strategy of what is to be achieved with this new authority.

In summary, we advocate a less intrusive approach to the regulation of Medicare+Choice plans and a very careful approach to the Medicare program change burden while Y2K remediation is in progress.

Mr. Chairman, thank you for the opportunity to express our views.

[The prepared statement follows:]



TESTIMONY OF THE

BLUE CROSS AND BLUE SHIELD ASSOCIATION

ON

MEDICARE+CHOICE QUALITY REGULATIONS AND YEAR 2000 COMPLIANCE

FOR THE

SUBCOMMITTEE ON HEALTH
WAYS AND MEANS COMMITTEE
U. S. HOUSE OF REPRESENTATIVES

PRESENTED BY

BRUCE DAVIDSON
SENIOR VICE PRESIDENT
BLUE CROSS AND BLUE SHIELD OF FLORIDA

July 16, 1998

Mr. Chairman and members of the subcommittee, I am Bruce Davidson, Senior Vice President of Government Programs and Public Affairs for Blue Cross and Blue Shield (BCBS) of Florida. I am testifying on behalf of the Blue Cross and Blue Shield Association, the organization representing 54 independent Blue Cross and Blue Shield Plans throughout the nation.

The BCBS system is a major presence in the Medicare program. Collectively, BCBS Plans provide Medicare HMO coverage to more than three-quarters of a million Medicare beneficiaries, which makes the Blue system the second largest Medicare HMO provider in the country. BCBS Plans process 85 percent of Medicare Part A claims and about two-thirds of all Part B claims. BCBS of Florida itself is a major Medicare contractor: our Medicare risk HMO has approximately 105,000 enrollees, and we process about 4.7 million Part A claims and 50.4 million Part B claims a year.

I appreciate the opportunity to testify before the subcommittee today on two separate points:

I. The new Medicare+Choice regulations are likely to limit beneficiaries' options to tightly managed HMOs and deny access to popular PPO products.

II. The Medicare contractors have made Year 2000 compliance a top priority.

I. MEDICARE+CHOICE REGULATIONS ARE LIKELY TO LIMIT BENEFICIARIES CHOICES

In creating Medicare+Choice under the Balanced Budget Act of 1997 (BBA), the Congress sought to expand significantly the types of private health plan options that will be available to Medicare beneficiaries. Medicare+Choice is intended to reflect the health benefit design, delivery, and cost containment innovations that are features of the private sector health market and that, to a great extent, have been captured by the Federal Employee Health Benefit Program (FEHBP). Thus, Medicare beneficiaries

should have access not only to HMOs, as under the old Medicare risk program, but also other options such as PSOs, POS plans, private fee-for-service plans, MSAs, and Preferred Provider Organizations (PPOs).

However, we are concerned that Medicare beneficiaries may not actually have access to one of the most popular commercial and FEHBP choices: PPOs that have very large networks and that promote free choice of providers. The reason: HCFA's new standards for quality assurance and performance improvement, while intended for all managed care products, are only applicable to a specific type of product — tightly managed HMOs. Ironically, far from increasing choice to reflect options in the private sector, HCFA appears headed on a course that will limit choice for Medicare beneficiaries.

The QISMC and the Mega-Reg

During the past two years, HCFA has been working to develop a new set of quality standards for Medicare and Medicaid managed care organizations — the Quality Improvement System for Managed Care or QISMC. The QISMC is the basis for the quality assurance standards in the recently released Interim Final Regulations on Medicare+Choice (the so-called "mega-reg"). Even though the QISMC is not yet final — the most recent public draft is several months old — HCFA incorporated many QISMC standards directly into the rule, and HCFA indicates it will use QISMC as part of the contracting process to determine whether a managed care organization can meet the quality assurance requirements.

It is significant that HCFA's work on the QISMC started before the Congress passed the new Medicare Part C. Thus, as HCFA itself has stated, "QISMC deliberations focused chiefly on assuring quality in the types of entities that most frequently contract with HCFA and States under current law — that is, TEFRA risk HMOs under Medicare and risk-comprehensive contractors under Medicaid." But with the expansion of choices

allowed under Medicare Part C, we question whether QISMC's stated aim - "to establish a single standard of quality, regardless of plan structure or model" - is still appropriate.

HCFA's New Quality Assurance Standards are a Blueprint for HMOs

HCFA's quality assurance standards rest on two key components. These components — clinicial/non-clinical performance measures (e.g., HEDIS measures and health outcomes) and demonstrable performance improvement in clinical areas — are a design for a tightly managed HMO product. Industry standards in today's market (i.e., National Committee for Quality Assurance (NCQA) and the American Accreditation HealthCare Commission/Utilization Review Accreditation Commission (AAHC/URAC)) simply do not use such components for PPOs, for reasons that I shall make clear. But first, let me discuss the two components of HCFA's proposed quality assurance standards.

First, Medicare+Choice plans must measure performance for both clinical and nonclinical areas using standard measures required by HCFA, and they must meet minimum performance levels in these areas. (Initially these performance levels may be locally or regionally-based, but HCFA wants to move toward minimum uniform national performance standards.) HCFA will develop a core set of measures for all plans. The preamble states that for contract year 1999, performance measures will include most HEDIS 3.0 measures and data from the Consumer Assessment of Health Plans Survey.

HEDIS (the Health Plan Employer Data and Information Set) is controlled by the National Committee for Quality Assurance (NCQA), a private sector organization that accredits HMOs. NCQA exclusively accredits HMO-style health plans. HEDIS has become the standard benchmark for clinical quality indicators in HMOs. In contrast, the leading private sector organization for accrediting PPOs, the AAHC/URAC, does **not** collect HEDIS measures or HEDIS-type measures from PPOs.

Second, Medicare+Choice organizations must conduct "performance improvement projects" that achieve "demonstrable improvement" in the health or functional status of their enrollees across various clinical (e.g., prevention and care of acute and chronic conditions, high-volume services, high-risk services, and continuity and coordination of care) and nonclinical (e.g., appeals, grievances and other complaints, access to and availability of services) focus areas. As part of the contract, HCFA will set plan-specific obligations for the number and distribution of projects and the length of the performance improvement cycle (i.e., the number of years over which the project must continue to achieve improvement). Also, consistent with the QISMC, HCFA states in the mega-reg that it is considering requiring a 10 percent reduction in negative outcomes in each performance improvement project. Depending on how HCFA makes these final determinations, Medicare+Choice organizations could have to spread their resources over as many as 20 to 30 different projects.

HCFA's Quality Assurance Standards Create Serious Problems for PPOs

Blue Cross and Blue Shield is very concerned about the application of HCFA's new quality assurance standards to PPOs.

PPOs have a fundamentally different design than HMOs.

The key feature of an HMO is that it is accountable for the clinical care that its members receive. This means that HMOs are structured to support measurement of health indicators and improvement in enrollees' health status. HMOs can achieve these goals by assuring a central point of management for every individual's health care, controlling the physicians that their enrollees use (i.e., limited access to physicians in the network), and assuring (by contract) that physicians will participate in the HMOs medical management and information collection program.

HMOs achieve improvement in health outcomes by measuring individual physician performance, assuring that physicians are following professionally accepted practice

protocols, and using payment arrangements and incentives that foster improvement in patient outcomes (i.e., capitated and payment incentives). Also, HMOs are dependent on information abstracted from patient medical records; health plan nurses work with physicians to collect the information.

PPOs are structured to meet a different demand of our subscribers and employers.

PPOs' key feature is a broad choice of physicians at a reduced cost to enrollees (i.e., negotiated payment rates and protections against balanced billing). Enrollees have an incentive to use providers — hospitals and physicians — under contract (the negotiated rates are based on the promise of volume for providers). However, enrollees can go outside the network and pay a higher level of cost-sharing.

Unlike HMOs, PPOs do not expect an enrollee to select a single primary care physician to manage all their health care needs. An enrollee can see any physician or specialist in the network or an enrollee can elect to go outside the network and the health plan will make a lower level of payment.

PPOs do not have the level of clinical oversight of physician care that is present in an HMO. Physicians are generally paid on a discounted fee-for-service basis and their contract is generally limited to a requirement to accept the health plan payment as payment in full (i.e., not bill the enrollee for any extra cost).

Importantly, PPO utilization review and quality assurance programs are based on information generated from claims (bills for care provided). PPOs do not perform the routine patient medical record abstraction the HMOs require to assess medical outcomes.

It is important to note that employers and enrollees are asking for both types of products. They are very different products: HMOs offer a tightly controlled care

management style with a relatively restricted network of physicians; PPOs offer broad choice, the benefit of discounted payment rates, and the option to use any provider of the individual's choice.

PPOs are very popular products. One in three working Americans is currently enrolled in a PPO, attracted in part by the broad choice of network physicians and open access to non-network providers. Some of the larger BCBS Plans, for example, have PPO networks that include 10,000, 20,000, or even 30,000 or more physicians. BCBS Plans serving the FEHBP together have 400,000 physicians in the BCBS PPO.

Problems with "One Size Fits All Standards"

Broad access PPOs are simply not set up to monitor, measure, and assure improvement in enrollee health status and physician outcomes. This level of clinical management requires (1) limiting the physicians that enrollees can use (i.e., network physicians); (2) assuring that enrollees have a single point (physician) of accountability for their care; (3) having in place physician payment arrangements that support the desired impact or clinical status of enrollees, (4) assuring access to all medical records information on patients; and (5) a major investment in systems to track and analyze the collected information. <u>These are fundamental characteristics of HMOs</u>.

These characteristics do not appear in broad access PPOs. PPOs are structured to allow enrollees to use the provider of their choice. This freedom to choose and change providers permits enrollees to use providers that satisfy their needs and expectations. Because PPOs are designed to promote free choice of providers, they have limited ability to intervene in providers treatment decisions. PPOs generally allow participating providers to practice independently and do not have mechanisms for oversight of providers (other than basic credentialing requirements such as licensure or certifying hospital privileges). PPOs usually do not maintain mechanisms (e.g., medical management programs, primary care physician programs, or referral requirements) to manage and oversee the provision of care. Nor do PPOs have the ability to exert

significant leverage over provider performance, since PPOs usually do not put providers at financial risk.

Finally, performance measures nearly always depend on supplementation of administrative information with medical records data. On-site medical chart review is simply not feasible for large network, broad access PPOs.

The Effects of QISMC on Product Design

PPOs could comply with the QISMC's "one-size-fits-all" standards only by eliminating the very features that make them popular products in the private sector. PPOs would have to:

- restrict beneficiaries' open access to non-network providers in order to track and improve outcomes.
- introduce mechanisms for coordinating and managing care (e.g., an assigned primary care provider).
- recontract with providers so as to enter into a much more information-intensive and management-based relationship.
- reduce significantly the number of physicians and other health care professionals in their networks.

In essence, PPOs would have to be fundamentally redesigned to become tightly-managed health plans.

Future of the QISMC Standards

As I stated in the beginning of my testimony, the QISMC standards are not yet final, although they are in the final stages of development. Thus, BCBSA has the opportunity to work with HCFA to ensure that beneficiaries have as many Medicare+Choice options available as possible — including the broad access PPOs that are so popular in the

commercial sector and in the FEHBP. Moreover, we are encouraged that HCFA has expressed some awareness of our concerns by inserting this statement in the preamble:

> We do not intend to adopt a "one size fits all" approach that assumes that reporting under all types of managed care plans will be possible in the same manner for all measures. We will balance our efforts to increase uniformity to facilitate consumer comparison of plans with sensitivity to the different organizational structures of plans and their different abilities to affect provider behavior.

Nonetheless, the standards that are actually embodied in the regulation, and the underlying QISMC document, still have a long way to go before they will encourage a wide range of Medicare+Choice plan choices. BCBSA hopes that HCFA will encourage innovation and flexibility by permitting a variety of approaches to quality assurance and performance improvement. We look forward to a continued dialogue with HCFA to ensure the viability of PPOs in the Medicare+Choice program.

II. MEDICARE CONTRACTORS' COMMITMENT TO BECOMING MILLENIUM COMPLIANT

Since its inception, the traditional Medicare fee-for-service program has been administered through a successful partnership between private industry and the Health Care Financing Administration (HCFA). Blue Cross and Blue Shield Plans and commercial insurers contract with HCFA to handle much of the day-to-day work of paying Medicare claims accurately and in a timely manner. Nationally, Blue Cross and Blue Shield Plans process 85 percent of Medicare Part A claims and about two-thirds of all Part B claims.

Medicare contractors have successfully met many significant challenges over this thirty-three year partnership. These include:

- Handling a dramatic increase in workload that has grown from 61 million claims in 1970 to 889 million in 1998.

- Quickly implementing major programmatic changes under extremely tight time frames, such as the institution and refinement of the Medicare prospective payment system for hospitals and the physician resource-based relative value payment system for physicians.

We are very proud of our role as Medicare administrators and our record of efficiency and cost effectiveness for the federal government on contractor issues.

One of our next major challenges is to assure that Year 2000 computer adjustments are made accurately and in accordance with the timetable set out by HCFA. There are three specific points I would like to make today:

1. Year 2000 compliance is a top priority for Medicare contractors.
2. New contracting legislation is unnecessary, would jeopardize year 2000 compliance, and would create further delays in implementing new laws (e.g., Balanced Budget Act).
3. Stable and adequate funding for Medicare contractors is critical to administering the traditional Medicare program efficiently and effectively.

Year 2000 compliance is a top priority

Year 2000 compliance is a top priority for Medicare contractors. Despite the real challenges, let me assure you that Medicare contractors are working toward becoming compliant on a timetable that will meet HCFA's deadline of December 31, 1998, which is two months earlier than the government-wide target date set by the Office of Management and Budget (OMB).

Medicare contractors will make every effort to meet this challenge just as they have successfully met other challenges in the past. It is in everyone's interest – Blue Cross and Blue Shield Plans, the government, providers and beneficiaries – for contractors to

become millenium compliant on time. For Blue Cross and Blue Shield Plans, both their Medicare and private business depend on meeting this challenge.
I want to state clearly that Medicare contractors are committed to Year 2000 compliance. In recent congressional hearings and press reports, it has been suggested that contractors are not being diligent in their efforts to meet this requirement and that HCFA needs additional authority to assure compliance. Nothing could be further from the truth.

BCBSA and Medicare contractors have been working closely with HCFA on compliance issues. As part of this process, BCBSA has been working with HCFA to find an agreeable contract amendment related to Year 2000 compliance. Last fall, HCFA sent all Medicare contractors a contract amendment intended to assure Year 2000 compliance. BCBSA had several concerns with the amendment, including concerns that it would have required contractors to assume liability for compliance of all vendors (e.g., financial institutions, facilities managers who control elevator programming, etc.) or face civil and monetary penalties. HCFA acknowledged that it had drafted the amendment too broadly and agreed to work with contractors to rewrite the amendment. I am happy to report that two weeks ago, HCFA and BCBSA developed a contract amendment agreeable to both parties.

In addition to the work on the contract amendment, BCBSA has worked with HCFA on developing a regular, formal process to assure regular communication with HCFA. In response to a BCBSA recommendation, HCFA established a steering committee — chaired by HCFA's chief operating officer and vice-chaired by BCBSA — to facilitate communication. The committee established four working groups and has held several meetings over the past few months. We are very pleased with the progress that has been made at these meetings and with the constructive dialogue between HCFA and the contractors. We look forward to more of this type of cooperation.

In reviewing the issues related to Year 2000 compliance, the subcommittee should be aware of four additional issues that have made Year 2000 compliance activities even more challenging:

- **Significant Change in Direction:** Originally, many of the system changes that are necessary for compliance would have been accomplished by the conversion of all Medicare contractors to the Medicare Transaction System (MTS). As you know, the MTS initiative was dropped last year. As a result, contractors had to make significant changes that, in the absence of MTS, they would have been working on for a long time.

- **Transition to New Standard Systems:** Instead of converting to the MTS system, HCFA has now directed contractors to transition to a new single Part A and a new single Part B system. In some cases, this conversion to different systems has complicated efforts to focus on millenium compliance activities. As a result, several contractors requested HCFA to delay transition requirements so they could focus on Year 2000 issues. We are very pleased that HCFA recently agreed to delay transitions for some Blue Cross and Blue Shield Plans.

- **Adequate Funding is Absolutely Critical**: We anticipate Year 2000 compliance to be very costly. We were very pleased that Congress reprogrammed $20 million in the FY 1998 supplemental appropriations bill to cover contractor millenium costs. We also understand that HHS has taken administrative actions to allocate another $41 million to cover Year 2000 costs. However, to date, only $6 million has been made available to contractors. As a result, contractors have had to reallocate funding from other important activities on a temporary basis.

- **Numerous and Broad Programmatic Demands**: Numerous program, HIPAA requirements, and other initiatives will be implemented while Year 2000 modifications and testing are occurring. We recommended to HCFA that as many non-Year 2000 system changes as possible should be removed from contractor

workloads so that technical resources could be devoted to assuring Year 2000 readiness.

Contractor Reform is Not Necessary and Would Jeopardize Year 2000 Efforts and BBA Implementation

HCFA is seeking legislation that would dramatically restructure the contracting process for Medicare intermediaries and carriers. This effort to make broad changes in contract authority is not a new initiative. In fact, it has been argued that contractor reform is necessary to assure Year 2000 compliance.

Given our efforts to work proactively and cooperatively with HCFA on assuring millenium compliance and the broad authority HCFA already has under current contracts, we are perplexed why the need for contractor reform is being linked with Year 2000 compliance.

Contractor reform would not improve the Year 2000 problem, and, in fact, could make it much worse:

- Contractors unfamiliar with the Medicare program would have the added burden of having to learn its extremely complex and intricate rules and regulations, while simultaneously working to achieve millenium compliance.

- The new authority would take additional resources and focus away from HCFA's implementation of the BBA.

- HCFA potentially would have to manage many new contracts for claims-processing services with entities unfamiliar with Medicare at a time when HCFA has many other major responsibilities such as implementation of the Health Insurance Portability and Accountability Act and the new contracting provisions for the Medicare Integrity Program.

Importantly, HCFA already has broad authority to sanction contractors that are not in compliance. Contractor reform is not necessary to replace contractors that are not millenium compliant. HCFA can replace or terminate contractors for poor performance, including non-compliance for Year 2000. In fact, in a letter sent to contractors on November 17, 1997, HCFA indicated that "failure on the part of a [Medicare] contractor to bring its system into compliance will be considered a serous deficiency in contract performance." Moreover, the new contractor amendment clearly states that Year 2000 compliance can be a reason for contract nonrenewal.

The contractor reform legislation that HCFA has been seeking for several years would give the agency broad authority to fragment the functions of current contractors. We believe that contractor reform provisions: would jeopardize the continuity of Medicare claims payment to providers and service to beneficiaries; are ill-advised in the absence of HCFA articulating a new strategy for Medicare administration and of public debate on that strategy; are unnecessary for the continued smooth operation of the Medicare program; and would give HCFA extraordinary authority not needed in the current environment.

This proposal would have significant implications and unintended consequences for Medicare beneficiaries and providers. This subcommittee has reviewed and rejected similar proposals in the past.

Our specific concerns with the contractor legislation are as follows:

Current law gives the Health and Human Services Secretary authority to terminate Medicare contracts for lack of performance. Beneficiaries and providers have been well-served by this language. The so-called "reform" legislation would give the Secretary and HCFA a free-hand to terminate contracts at will, regardless of how efficiently and effectively the contractor has performed under the contract. Medicare

contractors' provider payments and services to beneficiaries thus would become subject to the whim of HCFA staff.

The "reform" legislation also would authorize the transfer of functions among fiscal intermediaries without regard to any provision of law requiring competitive bidding for awarding contracts. Transfer of functions could happen at HCFA's discretion, with no warning and no recourse for the contractor or providers affected by the transfer. This would create an unstable system and would prohibit contractors from investing in the technology and resources needed in top-flight organizations.

An additional major concern is the implication for other government business with contractors. As noted, this legislation would provide HCFA with expanded, unprecedented authority to terminate and debar contractors without due process or appeal rights. This language could be interpreted as precluding any terminated contractor from receiving other government contracts, such as FEP, CHAMPUS, Medicaid, and Medicare+Choice. The lack of due process and the de facto debarment provides HCFA with authority well beyond what is allowed by the Federal Acquisition Regulations (FAR).

In summary, the reform proposal would give HCFA the authority to completely restructure the current configuration of Medicare contractors within one year of enactment with no due process for current contractors, no competition, and importantly, no explanation to guess of its strategy for the future administration of the program. Taken together, these reform provisions would give HCFA the authority to cast out – with no recourse – Medicare contractors that have served the country faithfully for over 30 years, without stating the plan for future Medicare contractor administration. This authority and the possibility of an unplanned, behind-closed-doors use of it would impede Medicare contracting for many years to come.

Success in Medicare claims administration requires that HCFA and the contractors work together toward their mutual goal of accurate and timely claims payment. This partnership should extend to planning the future of Medicare contract administration.

We do not believe these legislative changes are necessary to assure efficiency and high performance levels.

Stable and adequate funding is critical

As Medicare's first line of defense against fraud and abuse, contractors need stable and adequate funding. We urge the subcommittee to support the Medicare contractor funding level approved by the Appropriations Labor/HHS Subcommittee for FY 1999. The subcommittee recommended appropriating $1.27 billion, without the user fees proposed in the President's budget. We fully support this funding level without the user fees. These user fees are hidden taxes that place additional burdens on physicians and other health care providers and should be rejected.

If a lower amount is provided, anti-fraud efforts will be weakened and other services will be threatened. In addition, without increased funding above the 1998 level, contractors will be unable to adequately handle the increase in beneficiary inquiries we anticipate contractors will receive due to the introduction of the new Medicare+Choice program. With the toll-free phone centers dedicated to Medicare+Choice limited to only five states, contractors are bound to be overwhelmed with calls from beneficiaries asking about their health care coverage options. HCFA has already instructed contractors to make greater use of phone mail. The new Medicare+Choice program will likely make this situation worse.

In addition, an independent study commissioned by BCBSA indicates that contractor funding will be significantly strained by the increased anti-fraud and abuse detection efforts under the newly enacted Medicare Integrity Program (MIP). The report shows that every 10 percent increase in the MIP funding will result in a $13 million increase in

contractor costs due to increased appeals, inquiries, and hearings. Without increased contractor funding, it will be impossible to handle additional appeals, without undermining the fight against Medicare fraud and abuse.

CONCLUSION

The new Medicare+Choice regulations and Year 2000 compliance issue pose monumental challenges. Blue Cross and Blue Shield Plans are committed to meeting these challenges just as they have done in the past, both as Medicare risk contractors and as Medicare claims contractors.

Let me reiterate that Medicare contractors are working diligently to become millenium compliant by December 31, 1998. We will continue to work with HCFA to resolve issues that arise and to ensure compliance. A cooperative approach between contractors and HCFA will achieve the best results.

Congress should reject HCFA's use of year 2000 compliance as a political reason for legislating far-reaching changes to the Medicare contractor program. Contractor reform raises fundamental issues and implications for the Medicare program. In fact, contractor reform would introduce change, confusion and diversion of resources at a time when experience and focus is important.

Let me also reiterate our concern that Medicare beneficiaries may not have access to PPOs that have very large networks and that promote free choice of providers. We hope that HCFA will permit a variety of approaches to quality assurance and performance improvement so as to encourage innovation and flexibility. We look forward to a continued dialogue with HCFA to ensure the viability of PPOs in the Medicare+Choice program.

Thank you for the opportunity to speak with you on these important issues.

July 7, 1998

Nancy-Ann Min De Parle
Administrator
Health Care Financing Administration
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Ms. De Parle:

We are writing in our capacities as the contractor members of the Joint HCFA/Contractor Y2K Steering Committee to comment upon the "HCFA Year 2000 Fact Sheet" which describes the priorities HCFA has established to balance the resource requirements demanded by:

- Y2K modifications to the numerous inter related systems;
- Testing the systems against one another to assure Y2K readiness; and
- Managing the numerous program, HIPAA change requirements and initiatives which will be implemented while these Y2K modifications and testing are occurring.

As you know, we have been working with senior HCFA management to help develop the HCFA/Contractor collaboration which will assure that fee for service Medicare claims will be processed timely and accurately on January 1, 2000.

A substantial portion of our advisory work with HCFA has been devoted to examining the critical processes in assuring Y2K readiness. We concluded, and recommended to HCFA, that as many non Y2K system changes as possible should be removed from contractor workloads so that technical resources could be devoted to assuring Y2K readiness. Non Y2K systems development work should be added back only after HCFA is satisfied that the contractors' and HCFA's systems are certified Y2K ready. We also recommended that no material system changes be introduced between October 1, 1999 and February 1, 2000.

The priorities described in the HCFA Year 2000 Fact Sheet are consistent with advice from our technical experts that resources must be focused on the Y2K effort. We believe that prioritization established by HCFA is an aggressive but feasible workload that is consistent with the availability of systems technicians and Medicare "subject matter

experts." However, there is little doubt that even these priorities will require HCFA and its Medicare contractors to manage resources to very high levels of productivity. Also, additional funding for contractors will be necessary to assure that sufficient resources can be acquired, and we appreciate the progress HCFA has made in acquiring that funding.

We appreciate the difficult decisions involved in HCFA's prioritization effort, and look forward to a collaborative and intensive working relationship to assure that claims are paid accurately and timely in the Year 2000.

Sincerely,

Bruce A. Davidson
Blue Cross & Blue Shield of Florida

Harvey Friedman
Blue Cross & Blue Shield Association

Barbara Gagel
Administar Federal, Inc.

Gil R. Glover
Blue Cross & Blue Shield of Texas

George Garcia
Transamerica Occidental
Life Insurance Company

Edward Burrell
CIGNA

Chairman THOMAS. I thank you very much, Mr. Davidson.

Ms. Raphael.

STATEMENT OF CAROL RAPHAEL, PRESIDENT AND CHIEF EXECUTIVE OFFICER, VISITING NURSE SERVICE OF NEW YORK; ON BEHALF OF VISITING NURSE ASSOCIATIONS OF AMERICA

Ms. RAPHAEL. Thank you.

Mr. Chairman and members of the subcommittee, I am pleased to be here today to speak to you. My name is Carol Raphael. I am the president and CEO of the Visiting Nurse Service of New York which is the largest not-for-profit home-health care agency in the Nation. It is also one of the oldest with over 100 years of experience in providing home care, an important option for people who want to leave hospitals as quickly as possible, avoid unnecessary institutionalization and remain active, independent members of their community.

My theme today is "no good deed goes unpunished." And basically, I want to focus on the Interim Payment System which has had a very harsh effect on particular agencies. And who might these agencies be? I think they fall into two categories: those who did what the Balanced Budget Act tried to accomplish. These agencies kept their costs low, controlled their costs before there was legislation, and in addition, those agencies are most impacted who have experienced increased severity in their case mix. And it is ironic that the prospective payment system couldn't be implemented because it didn't have a case mix adjuster, and now we have a system that, in fact, also doesn't have such an adjuster and seems to be taking its course of action without it.

I think that you need to understand what the impact of the Interim Payment System has been on the Visiting Nurse Association of America and its members. As of now, six VNA's have closed including the VNA of southeast Indiana and the VNA of Palm Beach. Yesterday, the VNA of Medford, Massachusetts shut its doors. Dozens of others are on the brink of closing. The VNA of St. Louis will no longer admit any Medicare recipients because their reduction under the Interim Payment System was 45 percent. Many other VNA's are laying off staff, shutting down services; this will affect the access of beneficiaries to what has been an essential range of services in many communities in this country. And I would like to say that, in general, the effect has been a 25 percent reduction in reimbursement.

And I think that I speak for all organizations in this Nation who have been cost efficient and have tried to produce good care whether they are for profit, not-for-profit, rural, urban, large, small, community-based, hospital-based, or public health departments. We really believe that it is essential that this committee take action this year. We think that it is imperative because if action does not occur, you will end up seeing a system of health care dismantled that will be very difficult to rebuild down the road. And we have several steps that we think that you should consider taking.

First of all, I want to recognize the efforts of Senator Collins and Congressman Pappas who spoke to you this morning because they have really tried to address our issues.

We believe there are three key things that need to be done. Change the formula. And we believe that Congressman Pappas and Senator Collins have proposed the most effective blend which is 75 percent national and 25 percent regional data.

Secondly, move the base year forward. There is now a huge gap between the base year's cost and the cost we're experiencing today.

And thirdly, raise the per-visit limits to 112 percent of the mean. We understand that it isn't increased costs-per-visits that have really driven expenditures in home health care. In fact, costs have remained fairly constant over the last seven years. And this would help agencies in States like California where there is high penetration of managed care and where agencies have low costs per case but high costs per visits.

And lastly, we heard confirmed for us this morning that HCFA is not going to implement prospective payment by October 1999. So what we thought was an interim, short-term system is no longer an interim, short-term system. And Congress had enacted an additional 15 percent cut in the event that PPS does not come to pass. We would very much urge you to reconsider putting us under the knife even further and making the cuts deeper given that PPS is not likely to be implemented.

So, I think that we want to say that we have addressed what we think are key issues: budget neutrality, equity across the Nation, and lastly, paving the way to prospective payment. And we look forward to working with you, Mr. Chairman, and the committee members to try to find a workable and doable solution to a very, very serious set of issues.

Thank you so much.

[The prepared statement follows:]

STATEMENT OF THE VISITING NURSE ASSOCIATIONS OF AMERICA

TO THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON WAYS AND MEANS

UNITED STATES HOUSE OF REPRESENTATIVES

PRESENTED BY

CAROL RAPHAEL

PRESIDENT AND CHIEF EXECUTIVE OFFICER

VISITING NURSE SERVICE OF NEW YORK

JULY 16, 1998

11:00 A.M.

11 Beacon Street, Suite 910, Boston, MA 02108
Tel: 617 523 4042 • 1 888 866 8773 • Fax: 617-227-4843 • E-mail: vnaa.org

Mr. Chairman and Members of the Subcommittee:

My name is Carol Raphael, and I am President and Chief Executive Officer of the Visiting Nurse Service of New York (VNSNY). VNSNY is the nation's largest not-for-profit home health agency. Based on over one hundred years of experience in serving the diverse populations of New York City, VNSNY has a real understanding of the needs of home care patients, and of the challenges of providing this care. This is an experience shared by my Visiting Nurse Agency (VNA) colleagues in cities as diverse as New Orleans, Atlanta, Bakersfield, and Omaha.

I am pleased to be here today to present the views of the Visiting Nurse Associations of America (VNAA) on the current challenges facing VNAA members as the Health Care Financing Administration (HCFA) implements the Interim Payment System (IPS) and to express our great concern about the possibility that implementation of a prospective payment system (PPS) may be significantly delayed.

VNAA is the national association of over 200 Visiting Nurse Agencies (VNAs) around the country. Our members created the profession of home health care over one hundred years ago, and it is our hope and intention to provide high quality home care for at least the next hundred years. Our members are not-for-profit, community-based agencies, and we are proud of the fact that VNAs are low cost, high quality providers of home health care services. Our members' costs are generally well below state, regional and national averages. It is this low cost profile that has made the IPS formula such a critical problem for our members, which I will discuss later in my testimony.

Last year Congress, following the lead of this Subcommittee, changed the face of Medicare home health reimbursement. As part of the Balanced Budget Act of 1997, Congress directed HCFA to establish a PPS for home health. Congress was reacting to the recent dramatic growth in Medicare home health spending and to persistent charges of abusive and fraudulent practices within the industry.

VNAA, and other thoughtful home health industry leaders, supported the move to a PPS as an essential step to change the incentives in the system. It was clear to all of us who cared about the future of this important Medicare benefit that radical change was needed. Prospective payment seemed to be the best answer. As cost effective agencies, VNAs believe that they can do well under Medicare PPS. We know from years of experience how to manage costs while providing medically necessary services to the full array of patients needing home health care. We worked with our industry colleagues to develop PPS recommendations to Congress. While Congress chose a somewhat different framework, the critical point is that we all agreed that prospective payment was the best way to change reimbursement for the Medicare home health benefit.

VNAA believes that Congress' action was not a repudiation of the importance of home health care for Medicare patients. We believe that no one would dispute the essential value of home health care. However, we agree that the problems that had developed in the system had to be addressed in a fundamental way if the benefit were to be saved for future beneficiaries.

VNAA members are looking forward to the opportunity to work with HCFA and Congress on the implementation of PPS. However, we are very concerned by recent suggestions that implementation of PPS may be delayed well beyond the statutory implementation date of October 1, 1999, because of the multiple challenges now facing HCFA to implement BBA '97 while dealing with the "Year 2000" computer problem.

While we fully understand the need to address the "Year 2000" problem, failure to act on the prospective payment system as planned would mean that the industry would have to labor under the IPS for an unknown length of time and would face an automatic 15% reduction in payments on Oct. 1, 1999. Unless Congress acts this year to change the IPS formula, and to respond to HCFA's dilemma, this will be an impossible financial burden for many VNAA members, and all other cost effective agencies. As an experienced VNA executive, I simply don't know how we would be able to meet the medical needs of our patients under such circumstances. More and more VNAs would be faced with the difficult choice of closure, as the VNA of Southeastern Indiana recently did, or elimination of Medicare services, the route chosen by the VNA in St. Louis. We do not believe that either pathway is the best one for our patients, nor do we believe that Congress wanted to place our members and their patients in such a situation. As you consider HCFA's request for delays in the implementation of home health PPS and other provisions in the BBA '97, we urge you to carefully consider the implications of the automatic 15% reduction in reimbursement and make an appropriate adjustment so that there will not be disruption in patient services.

I know that our members can provide high quality home health care under PPS; however,

I am deeply concerned about the ability of many of them to survive under the IPS as it is now written, particularly if it continues to be the payment framework for an indefinite time. Therefore, VNAA believes that action on IPS is critical now. Changing the IPS formula has been our number one legislative priority in 1998. The possibility that IPS might be in effect indefinitely only makes this need more compelling.

When Congress agreed to set up a PPS, it recognized that HCFA would need time to implement the new system. For example, one of the more difficult aspects of PPS is the need for a case mix adjustment so that agencies will not have incentives to drop difficult and more expensive patients. HCFA is working on a case mix adjuster, but the project is not complete. This is a key element to making PPS work effectively for patients and waiting for completion of this important step makes very good sense.

Accordingly, Congress deferred implementation of PPS and established the Interim Payment System as the bridge to PPS. Such a step was necessary to prepare the way for PPS by forcing agencies to become more cost effective and to rein in Medicare home health spending. The key elements in IPS were (1) the reduction in the per-visit cost limit from 112% of the mean to 105% of the median, and (2) the creation of the new per-beneficiary cost limit. In order to try to address overutilization, Congress based the per-beneficiary limit on fiscal year 1994 reimbursement, using a blend of 75% of an agency's costs and 25% of the average costs for all agencies in a HCFA region. New agencies were assigned a per-beneficiary limit equal to the national average cost per patient in FY 1994.

The need for an interim payment system is not disputed by VNAA, but the impact of the statutory formula for the per beneficiary limit is very harsh for our members and all other cost effective agencies. Because the formula is based primarily on an agency's FY 1994 costs, low cost agencies that have been careful users of Medicare resources now have very low limits. Many of these agencies, such as VNSNY, will actually be reimbursed on the basis of their calendar year 1993 costs. This magnifies the impact of the new per beneficiary limits for those agencies that were actively controlling costs during that period. Those agencies with high costs during the base year now receive much higher cost caps. Instead of rewarding efficiency, the formula rewards high costs. VNAA estimates that its members will experience average reductions in payment of 25%. For agencies that have traditionally been very cost effective, there is little room to find new efficiencies of that magnitude without affecting essential patient care services.

In anticipation of moving to the payment rates published in the March 31 Federal Register, our members have already begun to take difficult, but essential steps, to remain in business. Many VNAs have been forced to lay off staff at all levels. For example, so far this year, the Visiting Nurse Service, Inc., in Indianapolis has cut 32 jobs, causing a 30% decrease in services and patient volume.

To date four VNAs have closed, and other closures are pending. All these agencies were providing essential services in the community. They simply could not continue under the current IPS formula. As already noted, the St. Louis agency decided to stop treating Medicare beneficiaries because it could not sustain a 45% reduction in Medicare reimbursement. The loss of these services is a tragedy for the community. In addition,

the St. Louis VNA was the only home health agency in the community receiving United Way funding, which leaves a tremendous void for indigent patients.

When the House-Senate Conference was considering the home health provisions of the BBA '97, VNAA urged that the formula be based on a minimal blend of 50% regional or national data. We realized even then that a formula that used a significant portion of agency-specific data would penalize the historically low cost providers. However, in the context of that conference, our recommendation was not accepted. The Senate proposed a new limit based entirely on agency specific data, while the House position mirrored the final outcome. At that time, we could only anticipate the outcomes of the formula because reliable information was not yet available. Since the publication by HCFA of its new limits in the March 31 Federal Register, we have been able to assess the magnitude of the problem facing our members and other cost efficient home health agencies. I want to emphasize that this problem is not limited to VNAs, but affects all home health agencies that have an average cost per patient below the blended national/regional average cost per patient. This includes organizations such as Easter Seals, county public health departments providing home health care, hospital affiliated home health agencies and for-profit agencies that have been efficient in their use of Medicare funds.

VNAA's legislative priority for 1998 is to achieve a change in the formula for the per beneficiary limit and to restore the per visit limit to its pre-Balanced Budget Act level. We estimate that at least 50% of our members are affected by the new per beneficiary limit, while another 25% are subject to the lower per visit limit. It is urgent for our members that these changes be made now, not next year or the year after.

Here is what VNAA recommends. (1) Change the per beneficiary limit formula from one that is based on 75% agency specific/25% regional data to one that is based on 75% national data/25% regional data, using calendar year 1994 and 1995 data, respectively, as published in the Health Care Financing Review, 1997 Statistical Supplement, updated by a limited home health market basket index (HHMBI). (2) Restore the per visit limit to its pre-BBA level of 112% of the mean. These changes should be retroactive to October 1, 1997 so that the cost effective home health agencies are not penalized by the current formula. (3) Add an exceptions process. The use of any formula can be unfair to an individual agency, and we believe that agencies should be able to present their case to HCFA. If the data are persuasive, HCFA should have the clear authority to make an adjustment in rates for that agency. A process like this would address the concern that some agencies may have a skewed patient profile, thus experiencing unusually high costs.

We have tried to develop a proposal that is budget neutral, and Price Waterhouse was asked to review the budget implications of these recommendations. Their analysts concluded that the change in the per beneficiary formula using fiscal year 1994 data for the 75/25 national /regional blend created new savings of $5.5 billion over a five year period. HCFA has informally confirmed the fact that changing the per beneficiary formula generates additional savings which can be used in other ways to adjust home health reimbursement. In VNAA's recommendation, these savings are applied to increasing the per visit limit to a level that maintains budget neutrality. We have found that maintaining budget neutrality was critical to generating support for our position in Congress.

Increasing the per visit cost limit to a level that maintains budget neutrality while changing the per beneficiary formula will not lead to an increase in home health spending. The per visit costs have remained relatively constant under the previous limits, having increased less than 5% in the past seven years. Also, many experts have determined that past increases in Medicare home health spending in recent years were due to the dramatic growth in the numbers of visits provided to each patient. Controlling the number of visits is the essential step to curbing the growth in Medicare spending. Our recommended changes to the per beneficiary limit would be fully consistent with this goal.

We have been advised that CBO is reviewing H.R. 3567, the Medicare Home Health Equity Act of 1998, and S. 1993, the Senate companion legislation. These bills incorporate many of our recommendations. H.R. 3567 was introduced by Congressman Michael Pappas (R-NJ), and enjoys the bipartisan support of 81 other House Members. S. 1993 was sponsored by Senator Susan Collins (R-ME), and she has been joined by 21 of her Senate colleagues. VNAA deeply appreciates the support of Congressman Pappas, Senator Collins and the Members who have cosponsored this legislation. We are pleased that CBO is reviewing the fiscal implications of these bills, and we are prepared to work with this Subcommittee on any refinements that may be needed to assure budget neutrality. It is VNAA's goal to achieve a workable IPS formula so that our members can continue to serve Medicare patients without breaking the 1997 balanced budget agreement.

It has been argued that our proposed formula change will somehow harm patients served by high cost agencies. Some allege that high costs are not always a sign of inefficiency or inappropriate practices. It is argued that these high costs may reflect a more severe case mix than those experienced by the lower cost agencies. Let me respond by noting that neither the General Accounting Office nor the Inspector General for the Department of Health and Human Services has been able to attribute the vast disparity in Medicare home health spending to case mix or any other factor. Our own experience speaks for itself. VNAs throughout the country have provided high quality home health care for the full range of patients at very cost effective rates. Our patient outcomes are excellent. In most communities, we are the providers of last resort, taking the most difficult cases regardless of ability to pay. Frankly, we believe that any home health agency that exercises proper management and follows standard care protocols should be able to provide services at costs comparable to our own. However, we have included in our recommendations to Congress an exceptions process to address serious problems.

VNAA's recommended changes have been attacked as promoting a regional formula fight, one that pits states and regions against each other. However, our own analysis concludes that the average home health agency in 46 states would fare better under a 75/25 national/regional per beneficiary formula using the calendar year 1994/1995 average program payments per person served, as published in the Health Care Financing Review 1997 Statistical Supplement, updated by a limited HHMBI, than under the current IPS formula. Since all new agencies move to a national average per beneficiary limit, they would see improvement from our proposed formula since the national average would increase. States with many new agencies, like Texas, would benefit significantly

compared to the HCFA figures. Finally, the change in the per visit limit also helps agencies with high per visit costs, but with fewer visits per patient. This pattern is common in states like California where aggressive managed care plans have limited the number of visits that could be provided.

Our recommendations do not result in a regional battle. Any conflict would be between high cost and low cost agencies. We think Congress intended to put pressure on high cost agencies, and our recommended changes in the IPS formula would accomplish that goal. A criticism of this approach is that changing the per-beneficiary formula will create new "winners" and "losers". It is important to note that our recommendations would create far more winners than losers. As referenced earlier, we know that the average agency in at least 46 states would be better off under a 75% national/25% regional formula using the specified base period data than under IPS as now implemented. The losers under the current IPS formula are those agencies that have consistently been fiscally responsible providers in the Medicare program.

Congress has been inundated this year with proposals to revise the home health provisions in BBA '97 , and VNAA has been asked to support many of them. To date we have not done so, and I would like to explain this decision to the Subcommittee.

Our first principle was to identify the key problem facing our members and find a way to fix it as soon as possible. We quickly learned that the two major problems affecting VNAs' ability to provide appropriate patient care are the new per visit and per beneficiary cost limits. After consultation with a number of Congressional offices, including staff of

this Subcommittee, VNAA decided that our best chance to ensure the survival of our agencies this year was to pursue a very targeted effort that was budget neutral. Immediate relief through changing the cost limits will enable VNAs to continue to care for the full spectrum of Medicare patients.

Although VNAA members had questions and concerns about many of the BBA '97 home health provisions and their potential impact on their patients, the revised per visit limit and the new per beneficiary limit emerged as the critical issues for our members in 1998 because they have the greatest impact on VNAs' ability to serve patients. VNAA thus rejected the "laundry list" approach to addressing the challenges of the new home health reimbursement system. While surety bond and venipuncture issues are important to a small segment of our members, we are aware of only five of our members that have not yet been able to obtain surety bonds. Our Board also felt very strongly that it needed to maintain credibility with Congress and believed that a very targeted approach would contribute to that end.

VNAA has also not joined the ranks of organizations calling for repeal of the IPS provisions. We think it is unlikely that Congress will repeal a law enacted only last year; however, adjusting a formula to make sure it protects patients may be possible. We have been gratified that you, Mr. Chairman, and other Members of Congress have been willing to listen to VNAA's concerns about the IPS formula, and we look forward to developing a workable solution this year. While VNAA has strongly articulated its own views on how the formula could be improved, we are ready to work with the Members of this Subcommittee to find a formula that addresses the different concerns of each Member and

ensures that Medicare beneficiaries continue to have access to high quality home health care.

Finally, let me reiterate VNAA's position on the so-called "split cap" proposal, which divides the cost cap into one for short stay patients and another for long stay. This recommendation attempts to address the thorny problem of high cost, longer stay patients. We are all concerned that home health agencies may shun these patients unless the payment system sets up the right incentives that will ensure their continued access to home health care. However, we do not believe that the "split-cap" proposal is the answer to that problem. HCFA has raised a concern that it may not have the data to implement the proposal. If that is the case, then it cannot ease the current financial crunch and will prevent any progress on the changes to the cost limits this year that are essential to protecting patient care. Many of our members are afraid that some agencies might try to manipulate the caps to their own financial advantage. A proposal with that potential requires a much closer look before it is accepted. The final reason we do not support this recommendation is that it is complex and needs careful study by Congress. Time is a luxury our members do not have. Action to improve the IPS formula is needed this year, not at some future date.

If Congress acts this year on our recommended changes to IPS, VNAs and other cost effective agencies will be able meet the needs of all their patients, whether long or short stay, or high or low cost. We urge the Subcommittee to act soon, and we look forward to the opportunity to work closely with you on changes to IPS that will ensure that Medicare beneficiaries continue to receive medically necessary home health care.

This concludes my testimony. I will be happy to answer any questions the Members of the Subcommittee may have.

Chairman THOMAS. Thank you very much, and thank you for picking up on my comment and throwing a line about California in there. I appreciate that.

Ms. Ousley.

STATEMENT OF MARY OUSLEY, SENIOR VICE PRESIDENT OF GOVERNMENT AND REGULATORY AFFAIRS FOR INTEGRATED HEALTH SERVICES; ON BEHALF OF AMERICAN HEALTH CARE ASSOCIATION

Ms. OUSLEY. Thank you, Chairman Thomas and members of the subcommittee for the opportunity to share the views of skilled nursing providers.

My name is Mary Ousley, and I am the senior vice president of integrated health services. I also am an independent owner of nine facilities in Kentucky, a licensed nursing home administrator and registered nurse.

I am speaking today on behalf of the American Healthcare Association.

I first want to restate our support for the committee's work last year in enacting a prospective payment system for skilled facilities. And I also wish to commend the Healthcare Financing Administration for their willingness to sit down with the industry and work through the countless implementation issues.

We have identified three areas where we feel that the Balanced Budget Act and the prospective payment system could create access problems for America's seniors. Our list is short, but the concerns that we have, we think that they are critical.

First, as previously mentioned today, we oppose the $1,500 annual therapy cap. The Act created two annual caps in two categories, one for physical and speech therapy and additional for occupational therapy. These caps were imposed without the benefit of hearings or adequate data. MedPAC itself has indicated in its review of the impact of these caps that of the recipients that may be impacted approximately half of them would have needs that would be in excess of $1,000. We feel that, in fact, these caps are a reduced benefit.

We support the Ensign-Cardin bill, H.R. 3835. We feel that it is a very responsible solution that removes the caps and moves forward toward a more appropriate payment methodology based on diagnosis.

Additionally, again, as mentioned today, we are concerned about HCFA's ability to track the costs for these $1,500 caps in light of the Year 2000 problem.

Second, we are seeking relief for facilities that are disadvantaged by the PPS transition. The facility specific portion of the PPS transition rate is based on cost reports beginning in 1995. Facilities without Medicare experience during 1995 are considered newly participating and are not subjected to the transition. However, for facilities that increase their acuity level, increase the intensity and level of services that they have provided since 1965—1995, excuse me—for these facilities, instead of providing a gradual progression, as was the intent of Congress, toward the Federal rate, the transition actually serves to disadvantage them by providing rates during the transition below the Federal rate.

We have, and we would like to propose two solutions for this problem.

We propose that HCFA broaden the definition of new facilities to include a facility that has so dramatically changed its level of service during this period of time to be deemed newly participating.

Another option is to permit the fiscal intermediaries to allow facilities to merely opt into the Federal rate if they can, again, demonstrate that the level of care and services provided is so significantly than those provided in 1995.

We believe that both of these options could be done administratively.

Finally, and we urge—and I think that this is the most critical issue that I talk about today—that a policy be put in place to allow a budget-neutral pass through of certain ancillary services. This actual, we feel, is necessary to protect access to care for Medicare's sickest beneficiaries.

The skills prospective payment system utilizes reimbursement categories based on submission of the minimum data sets, specific patient information. These categories simply do not adequately handle the non-therapy ancillaries.

I want to share with you just this specific example. The Healthcare Financing Administration allocated about $47 per day into the rate for non-therapy ancillaries. The actual example: a patient is admitted to a nursing facility for care. This patient diagnoses included respiratory failure, pulmonary disease, depression, sepsis and pneumonia. These are not uncommon diagnoses for nursing facilities. This patient has tremendous need not only for nursing care, but the non-therapy ancillaries to meet their needs.

A couple—$74 this patient would require for respiratory therapy alone, and $170 for pharmacy. The total cost of non-therapy ancillaries would come to $272. And as I mentioned before, the PPS rate allocates only $47. HCFA has acknowledged the shortcoming of the RUG-III system, and, in fact, in the demonstration States, the non-therapy ancillaries were passed through. And we urge that Congress would take the necessary action to allow for a budget-neutral, temporary pass through until research and data can be completed to appropriately roll these into the overall cost.

We appreciate the opportunity to be here today, and I look forward to continuing to work with you on behalf of the American Healthcare Association.

Thank you.

[The prepared statement follows:]

AMERICAN HEALTH CARE ASSOCIATION

MEDICARE SKILLED NURSING FACILITY
PROSPECTIVE PAYMENT SYSTEM

TESTIMONY

before the

HOUSE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

July 16, 1998

MARY K. OUSLEY

Thank you Chairman Thomas and Members of the Subcommittee for the opportunity to share the views of skilled nursing facility (SNF) providers as we embark on the recently implemented prospective payment system (PPS) and other changes brought about by the balanced budget act of 1997 (BBA). My name is Mary K. Ousley, and I am the Senior Vice President of Government and Regulatory Affairs for Integrated Health Services. I am an operator of nine facilities in Kentucky that represent the entire range of long term care services for the elderly. I am a licensed nursing home administrator and a registered nurse. I am speaking today on behalf of the American Health Care Association (AHCA), a federation of 50 affiliated associations representing over 11,000 non-profit and for-profit assisted living, nursing facility, and subacute providers nationally. We recognize the primary focus of this hearing is on implementation delays of certain BBA mandates, so let me express our sincere appreciation for the opportunity to share with you our concerns regarding the actual implementation of the SNF PPS and related BBA provisions.

First, I want to restate our support of the Committee's work last year in enacting a PPS for SNFs. I also want to commend HCFA for their willingness to sit down with industry -- both before and after the passage of the BBA -- to work through the countless implementation and design issues. A change from cost-based reimbursement to a PPS is dramatic. With a transformation of that magnitude, the need for corrective adjustments along the way is inevitable. I come before you today to relay some of our remaining concerns and to propose solutions to address them. Our list is short, but the concerns that remain are very critical and require immediate attention.

We have identified three areas where we feel the BBA and SNF PPS is flawed and could create access and quality problems for America's seniors. We also recognize that the historic BBA achieved targeted savings. In our efforts to propose solutions, we have worked diligently to minimize any disruption to those savings. If there are costs associated with our solutions, we urge the Chairman to request that CBO reexamine their overall proposed savings attributed to the SNF industry. We believe a review of last year's estimated $9.2 billion in savings will show that this projection was low, and actual savings could be twice that much. We would look to that review as a way to give this Committee and HCFA latitude to provide the relief facilities and beneficiaries need within the savings you committed to achieve last year.

Our three major concerns are the following:

- We oppose arbitrary $1,500 payment limits on outpatient rehabilitation services;

- We are seeking relief for those facilities disadvantaged by the PPS transition period because the type and volume of services the facility provides has changed dramatically since 1995 -- the base year for the transition; and,

- We urge that a policy be put in place to allow a budget neutral pass-through of certain ancillary services until the Resource Utilization Group (RUG - III) improves the current distribution of resources among the 44 categories.

As I discuss further our three major concerns, let me reiterate that we have cautioned against dramatic repeal or restructuring of the BBA. Rather, we have attempted to identify constructive solutions with minimal disruption to the objective of a PPS and the savings achieved by it.

First, we oppose the annual caps of $1,500 per beneficiary on outpatient rehabilitation services.

As you know, the BBA created annual caps for two categories of therapy provided to residents under Medicare Part B: a $1500 annual cap on physical therapy and speech language pathology combined and a separate $1500 annual cap on occupational therapy. Arbitrary limits on medical services ignore a patient's clinical needs and carry serious consequences for Medicare beneficiaries. I recall last summer when the President claimed credit for reforming Medicare without any service reductions to the beneficiary. Senior citizens who suffer from common conditions such as stroke, hip fracture, and coronary artery disease, will tell you the President was mistaken. In fact, those patients may not be able to obtain the rehabilitative services they need to resume normal activities of daily living. The cap is, in fact, a reduced benefit.

A patient suffering from a stroke, hip fracture, Parkinson's disease or Alzheimer's disease typically will require more than $3,000 in therapy. The arbitrary cap truly penalizes the oldest and sickest Medicare beneficiaries and, in effect, is a cap on their potential to achieve activities of daily living and returning home. Without the necessary therapy services, patients will remain in institutional settings longer, be shifted to a higher cost hospital setting, or could go without necessary services.

The caps were imposed without the benefit of Congressional hearings or adequate data. As part of the Balanced Budget Act of 1997, the $1500 cap provision yielded savings of $1.7 billion over five years. However, the $1500 limits bear no relation to the medical condition of the patient nor the health outcomes of the rehabilitation services. This cap equates to health care rationing and, again, is a reduced benefit to the Medicare beneficiary.

MedPAC, itself, has said the caps could affect certain patients. According to the June 1998 *Report to Congress*, MedPAC claims that "some patients had only slightly more that $1,500 in payment per therapy type. For example, 10% of those affected exceeded the limits by less than $150. On the other hand, half of patients affected by the limits exceeded them by $1,000 or more."

Relevant to the major focus of this hearing, we question whether or not HCFA is adequately prepared to track the annual payments per beneficiary through the different categories based on other fiscal year 2000 concerns.

We support Congressman John Ensign's bill, H.R. 3835 -- a fiscally responsible solution that repeals arbitrary caps, while at the same time, borrows from the BBA provision, itself, by moving forward to January 1, 2000 a self-implementing payment policy for outpatient rehabilitation services based on diagnosis, functional status, and prior use of service. In addition, Congressman Ensign's proposal requires that any savings lost in 1999 because of the repeal of the cap need to be reflected in the new payment methodology.

Second, We are seeking relief for those facilities that are disadvantaged by the PPS transition period because the type and volume of services the facility provides has changed dramatically since 1995 -- the base year for the transition

The facility-specific portion of the SNF PPS transition rate is calculated from historical cost report periods beginning in fiscal year 1995. Facilities without Medicare experience during the base period are considered "new" facilities and are not subject to the transition at all and go directly to the federal rate for payment. The blend for those facilities subject to the transition starts with 75% facility-specific and 25% federal rate for the first period, moves to 50% and 50% for the second period, and 25% and 75%, respectively, for the third period. By the fourth period, the transition is complete and the facility is paid on the basis of 100% of the federal rate.

If the facility has changed its operation significantly since its base period, its current costs of operation are likely to be substantially different from those of its base period. For example, many facilities after 1995 have substantially increased the acuity level of their patients and have begun providing a level and intensity of services that are far above those represented by the 1995 base period. For these facilities, not only are their current costs very high relative to their base period costs, but their blended rates will be below the federal rate. This means that for these facilities the transition, instead of providing a gradual progression toward the federal rate, actually serves to seriously disadvantage them by providing payments during the transition that are below the federal rate.

Let me give you an actual example:

Hillebrand Nursing Home, a 120 bed independently operated nursing facility in Cincinnati, Ohio, expanded their facility in 1997 by doubling the square footage of the facility that existed in the 1995 base year. Hillebrand was prepared to increase its participation in the Medicare program and take on the added responsibility of more acute patients. This effort raised the property expenses from $5.86 per day to $22.82, and, in terms of total dollars, raised the property expenses by almost $45,000 per month.

In spite of this, Hillebrand's current daily Medicare rate is $231.00 and it feels that it can cope with the Medicare federal rates once the transition period is complete. However, the facility-specific rate imposed by the PPS during the transition period is only $182.43. Therefore, the transition period, instead of providing a smooth transition from the old rate to the PPS federal rate, actually penalizes Hillebrand for upgrading the physical plant and providing care to more acute patients since the base year.

To address this problem, we propose that HCFA broaden the definition of "new" facility in the SNF portion of the BBA to include facilities that can adequately demonstrate a significant change in the type and volume of services provided since 1995.

Another option would be to permit the fiscal intermediary to allow facilities to opt into the federal rate if they can demonstrate, again, a substantial change in the level and intensity of services provided to residents.

We believe either of these options can be done administratively and would provide a limited form of relief while minimizing access disruptions to SNF services.

Finally, we urge that a policy be put in place to allow a budget neutral pass-through of certain ancillary services until the Resource Utilization Group (RUG - III) improves the current distribution of resources among the 44 categories. This action is necessary to protect access to care for the very sickest Medicare patients.

The SNF PPS utilizes reimbursement categories based on the submission of the minimum data set (MDS). The 44 Resource Utilization Group III (RUG III) categories are insufficient from a nursing perspective and do not have adequate provisions for handling the non-therapy ancillary costs required for patients with medical complexities and co-morbidities. For example, SNFs will incur costs of respiratory therapy, prescriptions, wound care, chemotherapy, and lab services, but will not be adequately reimbursed for those services. HCFA allocated about $47 per day for all of these services into the nursing component of the rate, which is then allocated among the 44 patient categories using the nursing case mix index. For certain medically complex patients, the RUG III rate will not cover the costs of caring for certain patients. Here's an actual example:

Patient X was admitted to a facility for subacute nursing. Patient X's admitting diagnosis included respiratory failure, pulmonary disease, diabetes, shoulder and rib fractures, hypothyroidism, depression, peripheral vascular disease, sepsis, and pneumonia. This is not an uncommon diagnosis for patients in our facilities. This patient required extensive nursing care for tube feedings, ventilator dependency for breathing, suctioning, tracheostomy care, medication delivery, monitoring of vital signs, pulsed oximetry for oxygen levels, I&O monitoring, and physical therapy. Speech therapy was necessary for the dysphagia to accomplish weaning from the tube feedings.

The cost to the facility to fully comply with this patient's diagnosis and care plan includes the following:

- $74.35 per day for respiratory therapy
- $170.34 per day for pharmacy
- $22.06 per day for ventilator rental; and,
- $6.71 per day for lab services.

The costs of these services alone equals $273.46 per day. As I mentioned before, the PPS rate allocates only $47 per day for all of these non-therapy services. As this example demonstrates, high cost services to patients are not accounted for by the RUG III system. Clearly, facilities cannot afford to treat this type of patient. Unless relief is provided, Congress has unintentionally created a disincentive for facilities to provide these necessary and life saving Medicare services. In other words, Congress has induced providers to no longer participate in the Medicare program. This could have two negative effects: 1) It could create under-served areas and limited access to SNF services, or 2) patients will remain in a higher cost hospital setting longer, which will disrupt the flow of the patient back to his/her community. This is problematic, and we seek relief.

I am including as an appendix to my testimony additional case studies that demonstrate the inadequacy of the PPS rate structure as it pertains to certain non-therapy ancillaries.

HCFA has acknowledged the shortcomings of the current RUG - III system. The RUG - III demonstration project had treated these costs as pass-through. Although in-depth research by AHCA and HCFA is now underway to identify these costs, this research will not be completed in time for the first PPS year.

We urge Congress to take action to ensure that HCFA will allow a budget-neutral temporary pass-through for limited ancillary services until sufficient research is completed as to the proper handling of these costs. This would be a redistribution of existing dollars, so there will be no additional costs to the Medicare program. Since HCFA agrees the current distribution is inadequate, we, simply, recommend that clinicians -- not reimbursement specialists -- decide the distribution of the existing dollars.

Conclusion

In closing, I would like to convey to the Committee that we have worked hard to put forth solutions that are reasonable and consistent with the aim of the BBA.

We believe we need legislative help in resolving our concerns regarding the $1,500 cap on outpatient rehabilitation services and hope the Committee will look favorably upon our best attempt at budget neutrality. H.R. 3835 reflects those efforts and we strongly urge the Committee's support.

Regarding the problems associated with the 1995 base year for the transition and the need for a pass-through for non-therapy ancillary services, we know it was never Congress' intent to disadvantage facilities and patients. We recognize that 1995 data were all that were available last year. Additionally, the existing RUG system used in demonstration states had limits. We believe that HCFA has the administrative authority to make the proposed changes, which would provide some relief to both providers and patients.

Mr. Chairman and Members of the Committee, I thank you for the opportunity to be here today. On behalf of AHCA, I want to make clear our commitment to providing high quality care to America's frail and elderly. We look forward to working with you and your staff on these and other issues that will surface as we move through implementation.

Appendix A

Case Studies of Medically Complex SNF Patients

Case Study #1

Admitting Diagnosis: Respiratory Failure, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, Shoulder Fracture, Rib Fractures, Hypothyroidism, Depression, Peripheral Vascular Disease, Sepsis, Pneumonia.

Clinical History: Patient admitted from local hospital for sub acute nursing. Upon admission patient was ventilator dependent with the goal of ventilator weaning. Patient was receiving nutrition through a G-feeding tube. Patient required trachea care daily as well as Accu Checks for the unstable Insulin Diabetes. Care planning goals of the interdisciplinary treatment plan were centered upon the following:

Nursing Diagnosis	Disciplines
Activity Intolerance	Nursing, Rehabilitation
Altered Nutrition	Nursing, Dietary
Self Care Deficit	Nursing, Occupational Therapy
Impaired Gas Exchange	Nursing, Respiratory Therapy
Impaired Physical Mobility	Nursing, Physical Therapy
Inability to Sustain Spontaneous ventilation	Nursing, Respiratory Therapy
Knowledge Deficit	Nursing, Therapies, Social Work
Pain	Nursing, Physical Therapy
Risk for Aspiration	Nursing, Speech Therapy
Risk for Pneumonia	Nursing, Respiratory Therapy
Risk for Infection	All Disciplines
Impaired Skin Integrity	All Disciplines
Risk for Suffocation	All Disciplines
Risk for Fluid Volume Deficit	Nursing, Dietary
Feeding Self Care Deficit	Nursing, Speech Therapy, Dietary
Fear, Hopelessness	Nursing, Recreation Therapy, Social Work, MD

Medications: Patient was concurrently on the following medications:

Ascorbic Acid	Certagen	Coumadin	Colace
Lasix	K-Dur	Reglan	Miacalcin Nasal
Prednisone	Synthyroid	Zinc Sulfate Zoloft	
Insulin	Albuterol	Cromolyn	

Special Services: Patient required extensive nursing care hours for tube feedings, ventilator weaning, suctioning, tracheostomy care, medication delivery, monitoring of vital signs, pulsed oximetry for oxygenation levels, I&O monitoring, and total physical care secondary to the extremely high level of physical dependency. Patient also required the services of Occupational Therapy for the severe ADL deficits. Physical Therapy Services were required for the highly impacting activity intolerance level. Speech Therapy was required for the dysphagia to accomplish weaning from the G-Tube feedings. Social work involvement included assisting the patient and family members through the recovery process, and in discharge planning. Recreation Therapy played a significant role in the isolation and depression component of the patient's medical history. Dietitians monitored the caloric and fluid intake to nutritionally stabilize this patient through the treatment of the dysphagia.

Cost of Non-Therapy Ancillaries:

Ancillary Component	Cost per Patient Day
Respiratory Therapy	74.35
Pharmacy	170.34
Rental-Ventilator	22.06
Labs	6.71
Total:	**$273.46**

Under Medicare's Prospective Payment System, this patient would classify into the RUGS III Rehabilitation Category as an **RHC** which provides a national average Federal payment rate of approximately $272.00 per patient day, and an average nursing component payment of only $138.00.

Case Study #2

Admitting Diagnosis: Coronary Artery Disease, Sciatica, Arrhythmia, Renal Insufficiency, Lumbar Fracture

Clinical History: Patient admitted from local hospital for sub acute nursing and rehabilitation care. Upon admission, patient was dependent with mobility skills and required more extensive rehabilitation to enable discharge to home. Care planning goals of the interdisciplinary treatment plan were centered upon the following:

Nursing Diagnosis	Disciplines
Activity Intolerance	Nursing, Rehabilitation
Altered Health Maintenance	Nursing, Dietary, Rehabilitation
Self Care Deficit	Nursing, Occupational Therapy
Anxiety	Nursing, Recreation Therapy, Social Work
Impaired Home Maintenance Management	Nursing, Rehabilitation
Impaired Physical Mobility	Nursing, Rehabilitation
Impaired Skin Integrity	Nursing, Dietary
Knowledge Deficit	All disciplines
Pain	Nursing, Rehabilitation
Risk for Injury	All Disciplines
Risk for Disuse Syndrome	Rehabilitation
Toileting Self Care Deficit	Nursing, Rehabilitation

Medications: Patient was concurrently on the following medications:

Dyazide	Zestril	Digoxin	Coumadin
Curdorone	Zinacef	Granulex	

Special Services: Patient required nursing care hours to monitor for the potential medical complications which include infections, Pneumonia, Thrombophlebitis, Embolism, and Vascular Compromise. Patient was also receiving oxygen and nursing time was spent to insure adequate oxygenation with activity tolerances. Patient also required a special air mattress and special skin care procedures for impaired skin integrity of bilateral heels. Occupational Therapy was required for the patient's ADL deficits. Physical Therapy was required to assess the patient's level of confusion to safely plan for discharge to the most appropriate setting. Social Work was actively involved in predischarge planning with the patient and family members, to provide for the continuum of care that would be required after discharge from the center. Recreation Therapy assisted in the care planning of the patient's isolation and associated depression. Dietary provided for this patient's nutritional needs and addressed the concerns associated with renal insufficiency.

Cost of Non-Therapy Ancillaries:

Ancillary Component	Cost per Patient Day
Pharmacy	100.79
Labs	4.02
Total:	**$104.81**

Under Medicare's Prospective Payment System, this patient would classify into the RUGS III Rehabilitation Category as an **RHB** which provides a national average Federal payment rate of approximately $250.00 per patient day and an average nursing component of only $116.00.

Case Study #3

Admitting Diagnosis: Respiratory Failure, Congestive Heart Failure, Hypertension, Renal Failure, Arteriosclerotic Cardiovascular Disease, Glucose Intolerance, Osteoarthritis, Dementia.

Clinical History: This 58 year old patient was admitted for follow-up care after hospitalization for respiratory failure and hypoxemia. Upon admission, the patient was alert, oriented only to self, and could could follow simple commands. Patient required physical therapy to improve strength, range of motion and endurance; needed assistance with bed mobility, transfers, ambulation and ADL's; received respiratory therapy for pulse oximetry, nebulizer treatments, 3 times day and chest phsiotherapy to promote recovery from pulmonary infection; and required speech therapy for dysphagia (swallowing). Care planning goals of the interdisciplinary treatment plan were centered upon the following:

Nursing Diagnosis	**Disciplines**
Psychiatric Mood Deficit	Activities, Nursing, Social Services
Sensory Deficit	Nursing, Activities, Social Services
Self-Care Deficit	Nursing, PT, OT
Alteration in Bowel and Bladder	Nursing
Impaired Skin Integrity	Nursing, Dietary, PT
Behavioral Meds	Nursing, Pharmacy
Impaired Physical Mobility	Nursing, PT
Alteration in Nutritional Status	Nursing, Dietary
Risk for Aspiration	Nursing, Speech Therapy
Feeding Self Care Deficit	Nursing, Speech Therapy, OT

Medications: Patient was concurrently on the following medications:

Lasix	Cardizem	Xalation eye drops
Prednisone	Nitropaste	Tylenol
Axid	Digoxin	Insulin

Special Services: Patient required nursing care for medication delivery, monitoring vital signs, assistance with ADL's, I & O monitoring, pulse oximetry, mobilization, ambulation. Patient had high level of physical dependency due to dementia and decreased strength. Required PT/OT for ADL's/strengthening. Speech Therapy was required for dysphagia which had a high impact on her nutritional status. Respiratory Therapy was needed for Chest Physiotherapy and recovery from pulmonary infection. Social Service worked with family and patient to promote transition. Dietitians monitored caloric intake throughout the treatment for dysphagia.

Cost of Non-Therapy Ancillaries:

Ancillary Component	Cost per Patient Day
Respiratory Therapy	173.15
Pharmacy	32.83
Labs	6.96
Rental	1.07
X ray	15.59
Total:	**$229.60**

Under Medicare's Prospective Payment System, this patient would classify into the RUGS III RehabilitationCategory as an **RLB** which provides a national average Federal payment rate of approximately $213.00 per patient day and an average nursing component payment of only $122.00.

Case Study #4

Admitting Diagnosis: Severe exacerbation COPD, Pneumonia, osteoporosis, Dementia, Pericardial Effusion, Asthma.

Clinical History: Patient admitted from hospital for severe exacerbation of COPD and pneumonia. Patient has a history of pulmonary problems. Upon admission, the patient had greatly diminished breath sounds, mildly labored breathing with use of accessory muscles. Mobility and ADL's were diminished. Patient also had a left ankle sprain which significantly affected mobility. Care planning goals of the interdisciplinary treatment plan were centered upon the following:

Nursing Diagnosis	Disciplines
Activity Intolerance	Nursing, PT
Self-Care Deficit	Nursing
Impaired gas exchange	Nursing, Respiratory
Impaired Skin Integrity	Nursing, Dietary, PT
Impaired Physical Mobility	Nursing, PT
Pain	Nursing, PT
Risk for Infection	Nursing, Physician, Respiratory

Medications: Patient was concurrently on the following medications:

Prednisone
Flovent MDI

Special Services: Patient required extensive respiratory therapy to relieve dyspnea and increase oxygenation, nebulizer treatment three times a day, seven days a week, chest physiotherapy and instruction in breathing patterns. Patient also required PT to improve severely decreased functional abilities, ADL's and mobility. Left ankle sprain contributed to difficulty in regaining strength and mobility. Social Services worked with family and patient to promote transition.

Cost of Non-Therapy Ancillaries:

Ancillary Component	Cost per Patient Day
Respiratory Therapy	204.12
Pharmacy	27.10
Rental	6.46
X-ray	15.59
Total:	**$253.27**

Under Medicare's Prospective Payment System, this patient would classify into the RUGS III Rehabilitation Category as an **RMB** which provides a natioanl averageFederal payment rate of approximately $239.00 per patient day and an average nursing component payment of only $119.00.

Case Study #5

Admitting Diagnosis: Cancer of breast with Bone Metastasis, Diabetes, Rheumatoid Arthritis

Clinical History: Patient admitted from local hospital for sub acute nursing. Upon admission patient was alert and oriented x3, and was undergoing radiation therapy five times a week. Patient was debilitated with significant functional deficits secondary to clinical condition; and had a port-a-cath which required care. Patient was very depressed over medical condition and situation. Care planning goals of the interdisciplinary treatment plan were centered upon the following:

Nursing Diagnosis	**Disciplines**
Activity Intolerance	Nursing
Impaired Mobility	Nursing
Self Care Deficit	Nursing
Pain	Nursing
Alteration in Mood	Nursing, Medical

Medications: Patient was concurrently on the following medications:

Decadron	Paxil	Vancomycin
Coumadin	Xanax	Insulin
Pepcid	PeriColace	Percocet
Restoril	Talwin	Flonase
Compazine	Zafron	

Special Services: Patient required nursing services at a moderate care level for assistance with all care and ADL's due to patient's weakness and debilitation due to medical condition. Patient required monitoring of Diabetes including Accuchecks twice a day with insulin coverage. Patient received radiation therapy five times a week. Patient received blood work daily to monitor and regulate Coumadin.

Cost of Non-Therapy Ancillaries:

Ancillary Component	Cost per Patient Day
Pharmacy	109.32
Medical Supplies	0.37
Labs	18.28
Total:	**$127.97**

Under Medicare's Prospective Payment System, this patient would classify into the RUGS III Category **CB1** which provides a national average Federal payment rate of approximately $159.00 per patient day and an average nursing component of only $92.00.

Chairman THOMAS. I thank you very much, Mrs. Ousley.

Mr. Miller.

STATEMENT OF THOMAS MILLER, CHIEF EXECUTIVE OFFICER, LUTHERAN HOSPITAL OF INDIANA

Mr. MILLER. Thank you, Mr. Chairman, and members of the committee.

My name is Tom Miller. I am the Chief Executive Officer of Lutheran Health System in Fort Wayne, Indiana. I appreciate the opportunity to talk to you today concerning the Balanced Budget Amendment and its implementation by the Healthcare Finance Administration.

Lutheran is owned by Quorum Health Group, and through its affiliates and subsidiaries, Quorum owns 18 hospitals and manages approximately 240 non-profit hospitals throughout the country. Lutheran is an active member of the Federation of American Health Systems, and Mr. Jim Dalton, the president for Quorum and Chief Executive Officer is chairman of the Federation.

By background, I would like to let you know that I spent the last 17 years in healthcare management. I've had the opportunity to run great hospitals in Tennessee, Texas, Virginia, and Indiana. I'm sorry that I have not run good hospitals in Louisiana and California, but look for the opportunity in the future.

Let me give you a glimpse of Lutheran hospital so that you can understand the commitment that our staff has to the seniors and the amount of community support that we offer. We have a 100 year tradition in providing healthcare in the Fort Wayne community. Lutheran is part of a two hospital MedServe system both with skilled nursing facilities. We have a free-standing rehab hospital, a home health agency. We have performed 150 transplants. We are full-service tertiary care provider, and we've had the opportunity to take care of 21,000 inpatients this past year and over 250,000 outpatients in our facilities.

We feel like we have to have a partnership with our largest payer, and that is the Federal Government, and that is why we are here today. We're trying to build and maintain a healthy partnership with the Government and understand your commitment and those of the committee as well as those of the Congress as well as an important relationship with Administrator DeParle and all of HCFA both in the regional office and nationally.

I can tell you from my seven years in Tennessee that I had the opportunity to know Administrator DeParle, and I will tell you that she is well thought of amongst the healthcare field and through the Federation has done an excellent job in her role in HCFA.

However, running the Agency has a lot of difficult challenges, and the collision of the millennium bug and the mandates under the Balanced Budget Act against the back drop of swift changes all have come together and have made her job significantly difficulty. Still, as good as she is, the local healthcare people—from a local healthcare viewpoint, we have major challenges on our hands.

Hospitals and health systems like Lutheran are dismayed on the current course that HCFA appears to have chartered to address these complex issues. We are particularly by the Agency's an-

nounced plans to delay the hospital update for the Fiscal Year 2000.

You've heard much talk about Y2K and all associated with that. As an administrator of a hospital, I will tell you that January 1, 2000 our patients will not have a problem with computers. Every system will be in place. We cannot afford not to be ready. And we expect the same from the Healthcare Finance Administration.

This is not a new problem although it gets a lot of play today. It is a problem that has existed for awhile, and the delay in the fiscal update that has been discussed is something that HCFA has had experience with for the last 15 years. We don't necessarily, in the healthcare field, understand why these two issues. We'd ask for your help to make sure that the interim payments are appropriately paid in many different fashions. But, from our standpoint, we believe that these two issues perhaps are not related.

Equally as much as we look at Y2K from the healthcare field, we have a hard time understanding how ill-advised transfer policy can also be implemented at the same time that the Y2K problem exists. And the transfer policies—I know that you have heard about them—I can tell you that the provisions are going to be an administrative nightmare, and I suspect it will be a serious problem and demand on all of HCFA.

I project to you that the problems that we are having today will be magnified sevenfold in five years, and I want to give you a very specific example.

In Virginia, as I was the hospital administrator, I received one of the letters from HCFA in regard to the 72 hours rule indicating that we needed to make payments related to overpayments of patients. The systems related to this were not in place when the 72 hour rules were implemented. As we move forward with the transfer policy where hospitals are going to have to find ways of tracking home-health patients that were discharged within three days, the systems are not in place, and when asked that we look at a delay related to that transfer policy, let's fix the Y2K problems, let's look at opportunities that we have to put the systems in place, and seven years down the road let's not monitor these and find out that we had a huge mistake.

In regard to home health, we have an agency that treats 600 new patients each year with 50 employees. Plan delays will handicap Lutheran's ability to provide seamless, quality care to our seniors. The delay is moving toward a perceptive payment for home-health agencies and is particularly troubling for two reasons.

First, it means that the interim-payment system already emplaced with devastating consequences for home-health providers and the clients they serve will remain in place indefinitely.

Second, at additional 15 percent reduction in payments scheduled for September 1999 will take effect with or without the implementation of the home-health PPS system.

I would point out that the interim-payment system already is projected to save $10 billion more than what was initially sought for in the Balanced Budget Amendment of $16.5 billion savings. In that light, it would be unfair and unjust to reduce payments another 15 percent under those circumstances.

One delay in the home-health area of which we applaud the Agency involves the deadline for securing surety bonds. Recently the Agency responded to the course of congressional concerns and agreed to suspend until mid-February as well as the GAO oversight role. Notwithstanding this extension, which, when it is formally issued, will be the fourth Federal Register publication this year. We continue to believe that the Agency is going in the wrong direction on the surety bond issues.

For example, the Agency's insistence on a ceiling of 15 percent of revenues, its rejection of other equally reliable forms of securities such as irrevocable letters of credit, and its refusal to combine Medicare and Medicaid bonds strikes us as arbitrary and inconsistent with the intent of Congress when it established the Balanced Budget Amendment. We hope that the Agency will use this opportunity to revisit these fundamental policy issues.

With regard to skilled nursing facilities, our understanding is that HCFA intends to proceed as planned with the July 1 implementation of the skilled nursing facility PPS except for the consolidated billing and requirements under part B.

Our chief concern is that only after several major policy twists and turns to HCFA ultimately arrive at the policy that is in place today. The difficulty that we have is that hospitals and skilled nursing facilities can't properly plan to implement these radically new systems. This type of uncertainty places hospitals at risk and not just in terms of fiscal exposure, but in the current fraud and abuse environment, hospitals can't be legally held at risk.

Mr. Chairman, last year's Balanced Budget Act contained unprecedented levels of combined Medicare and Medicaid reductions across the provider spectrum that fell especially hard on the hospital community. The uncertainty that we have faced, however, in trying to determine the best way to comply with the host of new policies has made our job of managing these reductions much more difficult.

As noted in the testimony, I fully understand the tremendous pressures and the tight deadlines facing HCFA today, and I'm not here to attack the Agency. It is clearly at the crossroads to change, and in that context, some uncertainty even delay is inevitable. But at the same time, as a hospital administrator, I must tell you that my compassion is tempered by the reality that hospitals, including mine, are at the frontier of healthcare and in a regulatory climate that has become decidedly more complex over the years. It is virtually in an arena.

Lutheran Hospital delivers competent and quality patient care to hundreds of people everyday with thousands of bills and annually prepares several incredibly detailed cost reports numbering hundreds of pages. Still, we can't afford to make a single mistake without risking major, adverse legal and fiscal consequences. Put another way, we are held fully accountable for every act of commission or omission. In this setting our biggest enemy is uncertainty.

In closing, I would ask that we ask you to try to set a course for healthcare. We spend a significant amount of money changing and rechanging to meet the needs of HCFA. It appears that hospitals and health systems are at the end of the feeding chain and that you establish the policies and the laws and that HCFA interprets

those policies and laws and tries to implement them and gives hospitals days, weeks or a few months notice to implement these and these hospitals are held totally accountable on day one as in the skilled nursing facility proposals that are held out for comment—I think they close today—that were implemented on July 1.

We ask for your help in establishing a course and plain be reasonable with our hospitals.

Thank you.

[The prepared statement follows:]

Federation of American Health Systems

Statement of

Thomas Miller

Chief Executive Officer

Lutheran Hospital of Indiana

Delay of Implementation of the
Balanced Budget Act of 1997

before the

Subcommittee on Health

House Committee on Ways & Means

July 16, 1998

Mr. Chairman, Members of the Committee. Good morning. My name is Tom Miller. I am the Chief Executive Officer of Lutheran Health Systems in Ft. Wayne, Indiana, and it is indeed a pleasure to be with you here this morning. Lutheran is owned by an affiliate of Quorum Health Group, Inc. Through its affiliates and subsidaries, Quorum owns 18 hospitals and manages approximately 240 nonprofit hospitals. Lutheran is an active member of the Federation of American Health Systems. Jim Dalton, Quorum's President and Chief Executive Officer, is the Chairman of the Federation.

By way of background, prior to my current position at Lutheran, I have been a senior hospital administrator for nearly 20 years in various hospitals throughout Tennessee, Texas, and Virginia.

I appreciate the opportunity to testify on the Balanced Budget Act and its implementation under the Health Care Financing Administration.

Let me begin by giving you a glimpse of Lutheran so that you can get a sense of the broad spectrum of health care services we offer to seniors and others, as well as the deep roots we have in the Ft. Wayne community.

The Lutheran system includes 3,400 employees in the Ft. Wayne area and anticipates total revenue of approximately $250 million in 1998. Nearly one-half of this amount comes through Federal health programs, mostly Medicare. We have two acute care hospitals in addition to a rehabilitation hospital, a skilled nursing facility, and a home health agency, among other community and public health services. In 1998 we expect to serve 21,000 patients.

Mr. Chairman, in order for us to honor our community commitment, we need to build and maintain a healthy partnership with our largest payer, the government. And not just with you, your colleagues on this committee, and other Members of Congress, but also with Administrator DeParle and the thousands of dedicated people at HCFA, both in Baltimore and regionally, who have such a major impact on our lives.

I know from my years in Tennessee and from the Federation's leadership that Administrator DeParle is held in the highest regard by hospitals for her work in Tennessee and, most recently, at HCFA.

Running that Agency would be a difficult challenge under any circumstances. The collision of the millenium bug and the mandates under the Balanced Budget Act, all against the backdrop of the swift currents of change in the health care market, makes her job incredibly

challenging. Still, as good as she is, from the local health system viewpoint, we still have a major challenge on our hands.
Hospitals and health systems are dismayed over the current course HCFA appears to have charted to address these complex issues. We are particularly troubled by the Agency's announced plans to delay the hospital update for Fiscal Year 2000. Notwithstanding HCFA's intent to "make hospitals whole" by adjusting the update to compensate for lost revenues, to the best of my knowledge, the agency has not committed to paying interest on the lost revenue – which we believe is a matter of simple fairness. Indeed, it is not clear just how HCFA intends to adjust payments because the issue is not as straightforward as it may seem. For example, how would HCFA adjust payments to account for the seasonal variation in volume that hospitals commonly experience?

Nor are we convinced that the delay is even necessary. Now, I am not by any stretch of the imagination a computer systems expert. But I *do* know a little bit about the hospital business. And I *can* tell you how critically important it is for the typical community hospital such as Lutheran to be able to plan for reimbursement changes and for strategic capital purchases. Though Congress did reduce the market basket inflation update for Fiscal Year 2000 to approximately 1.0 percent, even that modest increase would help hospitals offset the rise in input prices for hospital care. Without it, our ability to deal with rising costs and to continue to meet the health care needs of our seniors becomes that much more tenuous.

HCFA has some 15 years of experience in implementing PPS payment updates. Adjusting the information systems to reflect annual updates should, by now, be a fairly routine maintenance issue, not the complete overhaul that is required when, for example, a payment system undergoes a major policy transition from cost-based to prospective payment.

Not only does HCFA have considerable experience in implementing updates, it has had ample time to prepare for one in the year 2000. We do not understand Agency claims that it cannot adjust its payment system to either accommodate the scheduled update, or, in the alternative, pay hospitals prospectively an amount that is equal to the revenue that would be withheld by delaying the update, with interest. We are sympathetic to the government's difficulties regarding its information systems -- but we fail to see why providers and patients should have to pay a price.

Indeed, HCFA's insistence that the millenium bug requires a delay in the update, which seems fairly routine, begs the question why the Agency isn't seeking a delay in its implementation of the ill-advised transfer

policy, which will place much greater systems demands on HCFA and providers. For example, the Agency is proposing that the transfer policy be applied to a qualified discharge (one of the 10 DRGs selected by the Secretary) when the patient receives home health services within three days of the discharge that relate to the condition or diagnosis for which the patient received hospital care. I can tell you that this provision will be an administrative nightmare for hospitals, and I suspect it will also impose serious systems demands on HCFA as it must ultimately reconcile all patient claims to ensure that the hospital billed correctly.

Home Health

Our home health agency treats 600 patients and employs 50. Planned delays will handicap Lutheran's ability to provide seamless, quality care to senior citizens. The delay in moving towards a prospective payment system for home health agencies is particularly troubling for two reasons. First, it means that the interim payment system, already in place with devastating consequences for home health providers and the clients they serve, will remain in place indefinitely. Second, an additional 15 percent reduction in payments scheduled for September 30, 1999, will take effect with or without implementation of home health PPS. I would point out that the interim payment system already is projected to achieve more than $10 billion over the $16.5 billion in home health savings contemplated by BBA. In that light, it would be unfair and unjust to reduce payments another 15 percent under any circumstances, especially in the absence of a prospective payment system.

One delay in the home health area on which we applaud the agency involves the deadline for securing surety bonds. Recently, the Agency responded to a chorus of congressional concerns and agreed to a suspension until at least mid-February as well as a GAO oversight role. Notwithstanding this extension, which, when it is formally issued, will be the fourth Federal Register publication this year on this one issue, we continue to believe the Agency is going in the wrong direction on the surety bond issue. For example, the Agency's insistence on a ceiling of 15 percent of revenues, its rejection of other equally reliable forms of security such as irrevocable letters of credit, and its refusal to allow combined Medicare and Medicaid bonds strikes us as arbitrary and inconsistent with the intent of Congress when it established this BBA requirement. We hope the Agency will use this opportunity to revisit these fundamental policy issues regarding surety bonds.

Skilled Nursing Facilities

Our understanding is that HCFA intends to proceed as planned with the July 1 implementation of SNF PPS, except for the consolidated billing requirement for Part B residents. Our chief concern is that only after several major policy twists and turns did HCFA ultimately arrive at the policy that is in place today. The difficulty we have is that hospitals and SNFs cannot properly plan to implement these radically new systems and policies until they know for certain what they will be. With respect to consolidated billing, we still don't know for sure the ultimate policy, and it has been a moving target all year. And for hospitals, the policy that is in place today still leaves many unanswered questions as to precisely which services hospitals may continue to bill to Part B and which services it furnishes to SNF residents for which it must bill the SNF. This type of uncertainty places hospitals at risk not just in terms of its fiscal exposure, but in the current fraud and abuse environment; hospitals could be at legal risk as well.

Hospital Outpatient Services

I am told that HCFA has announced it expects a one to two year delay in the implementation of a prospective payment system for hospital outpatient services that BBA called for beginning January 1, 1999. The system that HCFA is expected to propose will, at a minimum, require a fundamental restructuring of our information, billing, and administrative systems. In light of the massive changes that this PPS system would require, January 1 is right around the corner. Yet a proposed rule, originally expected in April, is nowhere in sight. And while the Agency has briefed hospital groups on the broad contours of the system, we know next to nothing about the operational details. While we support the move to outpatient PPS, under the circumstances we may indeed welcome a delay.

However, a delay may not come without fiscal consequences and administrative uncertainty. For example, under the current complex payment methodologies, most hospital outpatient services are paid on the basis of a formula that blends the costs of care in the hospital with the fee schedule payment when those same services are provided in settings outside the hospital, for example in an ambulatory surgery center (ASC) or a physician's office. Under ASC proposed rules that are scheduled to become final in the next few months, payments in that non-hospital setting would decrease. That, in turn, would lead to a decrease in hospital payments for those same services because of the blended payment formulas that would remain in effect if outpatient PPS is delayed. For some high-volume, high-cost services, the payment decrease could be significant. Reductions in the physician fee schedule

for radiologists would have a similar effect. Timely implementation of the outpatient PPS system, however, would avoid these kinds of payment reductions. Each of these policy delays has a ripple effect – generating uncertainty and financial complications.

Mr. Chairman, last year's Balanced Budget Act contained an unprecedented level of combined Medicare and Medicaid reductions across the provider spectrum that fell especially hard on the hospital community. The uncertainty we have faced, however, in trying to determine how best to comply with a host of new payment policies has made our job managing those reductions much more difficult.

I'll give you one example, one that I know you are quite familiar with. Some time after the BBA was enacted, HCFA issued instructions to deny Medicare reimbursement for part of the unpaid cost-sharing obligations of indigent elderly. This was clearly not what Congress intended when it enacted the provision giving state Medicaid programs the option to reduce its payment to hospitals for services provided to these individuals. To her credit, Administrator DeParle reexamined the issue and had the wisdom to recognize the Agency's error and adjust the policy. Yet for months, hospitals were in payment limbo. It was only after your intervention that we ultimately succeeded in fixing this flaw. While we are grateful for the remedy, this situation added an unexpected and enormous financial question mark for hospitals serving poor patients for nearly six months.

Mr. Chairman, as noted earlier in this testimony, I fully understand the tremendous pressures and tight deadlines facing HCFA today, and am not here to attack the Agency. It is clearly at the crossroads of change, and, in that context, some uncertainty, even delay, is inevitable. But at the same time, as a hospital administrator, I must tell you that my compassion is tempered by the reality that hospitals, including mine, are on the frontlines of health care in a regulatory climate that has become decidedly more complex over the years in virtually every arena. Lutheran Hospital delivers complicated quality patient care to hundreds of people every day, submits thousands of bills and claim forms, and annually prepares several incredibly detailed cost reports numbering hundreds of pages. Still, we cannot afford to make a single mistake without risking major adverse legal and financial consequences. Put another way, we are held fully accountable for every act of commission and omission. In this setting, our biggest enemy is uncertainty.

That is why we need to know with a reasonable degree of certainty what the payment rules of the road are. Further, we need to know well in advance of their being put into place, so we can plan accordingly. And finally, we need to know that once they are put into place, they will, for

the most part, remain constant. Regretably, that does not appear to have been our experience since the BBA became law. Y2K may be a complicating circumstance, but I cannot believe that it is the root cause. Nor should Y2K exonerate the agency from meeting its obligations under BBA anymore than it would exonerate hospitals from meeting our obligation to provide patient care.

We think of the Federal Government, and HCFA in particular, as our biggest partner, and as such, we would like to work to achieve mutual support, sharing, and reliance. While we have worked closely with the Agency, especially under its new leadership, it remains an unpredictable and uncertain partner. Too often the Agency culture seems to focus more on how a policy or action will impact Baltimore headquarters, the regional offices, and the contractors who carry out HCFA's marching orders, and not enough on how it impacts the site where health care is actually delivered, the hospital.

We look forward to working with Congress and HCFA in a continuing dialogue and expanding our partnership to provide the finest in patient care.

Thank you for the opportunity to testify, Mr. Chairman, and I will be happy to answer any questions you or the Committee might have.

Mr. McCrery [presiding]. Thank you, Mr. Miller.

Mr. Bernd.

STATEMENT OF DAVID L. BERND, PRESIDENT AND CHIEF EXECUTIVE OFFICER, SENTARA HEALTH SYSTEM; ON BEHALF OF AMERICAN HOSPITAL ASSOCIATION

Mr. Bernd. Thank you, sir.

Mr. Chairman, I am David L. Bernd, the Chief Executive Officer of Sentara Health Systems which is a six-hospital system and not-for-profit located in Norfolk, Virginia.

I am here today as a member of the board of directors of the American Hospital Association which represents nearly 5,000 hospitals, health systems, network providers and other providers of care.

First, Mr. Chairman, I would like to commend your work as administrative chairman of the National Bi-Partisan Commission on the Future of Medicare. As you know, we cannot continue to shore up the trust fund by relying solely on reductions to providers.

Like you, we believe that we must change the basic structure of the program. We support your efforts to strengthen Medicare for generations to come.

We are here today to talk about the Balanced Budget Act and the Year 2000. Hospitals and health systems agree that Y2K demands the immediate attention of everyone in healthcare. We applaud HCFA's recognition that Y2K must be dealt with now. However, we are disappointed that HCFA plans to do so by delaying the Year 2000 payment updates.

Across the Nation, hospitals are preparing for the date change and making a commitment to do whatever is necessary to avoid any disruptions in patient care. Sentara, for instance, has budgeted $10 million for this effort, and it is 35 percent Y2K compliant as of today.

The hospitals and health systems like mine are also trying to cope with the Balanced Budget Act spending reductions. Delay in the Year 2000 update adds to the burden. We still must pay the bills associated with providing care, and those bills will keep coming during HCFA's computer update.

Even if HCFA is confident that its computers are compliant, problems could crop up. It is imperative that HCFA establish a fail-safe contingency plan. We would like to work with HCFA to create that plan including a provision to pay interest. At the same time, if payment systems are impeded by the millennium bug, hospitals and patients would be severely affected. A system to provide periodic payments based on past payment levels can prevent this. We urge Congress to enact legislation to authorize such a system.

HCFA's decision to delay PPS for home-health care also concerns us because it extends the interim-payment system another year. The IPS freezes historical base payments, as we've heard, locking lower cost efficient providers into payments that are well below their costs. This penalizes efficient agencies like hospital based and visiting nurse association providers.

Moreover, 15 percent automatic reduction is scheduled for the Year 2000 whether or not PPS is implemented. This reduction, in the absence of PPS on the heels of deep IPS reductions hits effi-

cient hospital based and visiting nurse association home-health care agencies harder than others. We strongly urge Congress to revisit the IPS.

We also disagree with HCFA's proposed delay with outpatient PPS. The existing array of payment systems for outpatient services is complex, expensive, and a large administrative burden. A simple means of payment would simplify the system and could help bring more efficient outpatient care.

I would also like to cite two issues unrelated to Y2K that are part of the Balanced Budget Act.

First, is transfers. The act changed the definition of transfers to include patient sent from acute care hospitals to a rehabilitation or skilled nursing facility or a home health care agency. Efforts to coordinate patient care are frauded because the transfer provision penalizes hospitals for sending patients as soon as possible to the healthcare site that best meets their needs. In addition, the prospective payment assessment commission found that on average, patients who used post-acute care stay in the hospital stay in the hospital longer than those who do not shining doubt on HCFA's claim that hospitals are pushing patients or rushing them into post-acute care to receive extra Medicare payments.

Making the situation worse is HCFA's decision to include swing beds. These are acute-care beds in rural hospitals that are used for post-acute services. Congress did not intend for them to be included in the transfer position as Mr. Thomas noted in a letter to HCFA. HCFA's decision was arbitrary and must be reconsidered.

We urge you to support H.R. 2908 and S. 1604, legislation to repeal the entire transfer position.

Finally, we have concerns about the PPS for skilled nursing facilities. Our key concern is that the case-mix measure under SNF PPS, the resource utilization groups, doesn't reflect the resources needed for hospital based SNF patients whose conditions are usually more complex than those of patients with free-standing SNF's.

In conclusion, hospitals and health systems know that HCFA has a big job ahead of it preparing a complex computer system for the Year 2000. We are doing the same job, however, hospitals cannot simply shut down their systems to prepare for Y2K, nor can they delay the care that has been demanded by them daily by the patients and communities that they serve. The needs of Medicare beneficiaries will not be delayed either. That is why HCFA must meet its obligations to beneficiaries and hospitals and systems that serve them.

We want to work with HCFA to find a way to continue critical payment updates, and we want to help HCFA appropriately implement PPS for outpatients and SNF services. Y2K is a tremendous challenge, but it is a challenge that all of us in healthcare must face together.

Thank you.

[The prepared statement follows:]

Testimony
of the
American Hospital Association
before the
Subcommittee on Health
of the
Committee on Ways & Means
United States House of Representatives
on
The Administration's Plan to Delay
Implementation of the Balanced Budget Act of 1997

July 16, 1998

Mr. Chairman, I am David L. Bernd, President and Chief Executive Officer of Sentara Health system in Norfolk, Va. I am here today as a member of the American Hospital Association (AHA), which represents nearly 5,000 hospitals, health systems, networks, and other providers of care. We appreciate this opportunity to present our views on an issue that is of critical importance to our members and the patients they care for: the Health Care Financing Administration's (HCFA) implementation of the Balanced Budget Act (BBA), including the agency's decision to delay several provisions in order to prepare for the Year 2000.

First, Mr. Chairman, because we are speaking today about preparing for the future, I would like to commend and encourage you for your work as administrative chairman of the National

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Bipartisan Commission on the Future of Medicare. The AHA last year called for creation of a commission to make recommendations to Congress on how to ensure the financial solvency of Medicare. However, we cannot continue to shore up the trust fund by relying solely on reductions to providers. We must make changes to the underlying structure of the program. The AHA believes that fundamental reforms in program structure, financing, and benefits are needed. And we strongly support your efforts to craft recommendations that will bring about these changes, and strengthen Medicare for generations to come.

We are also here today to talk abut the Balanced Budget Act and the Year 2000 issue. Hospitals and health systems agree that the Y2K issue demands the immediate attention of everyone associated with health care. Across the nation, more and more hospitals are preparing for the date change, and making a commitment to take all appropriate steps to avoid any disruption in patient care. The AHA and its state hospital associations are working together to inform and educate hospitals and health systems about the Year 2000 issue.

And while we applaud HCFA's recognition that the Y2K issue must be dealt with, we have several concerns about the agency's decision to do so by delaying routine Year 2000 payment updates, as well as putting off new prospective payment systems. I will address these concerns, and then move on to several other concerns we have with the BBA, including HCFA's implementation of some of its provisions.

DELAYING THE YEAR 2000 UPDATE

We are disappointed that HCFA has decided to delay routine Year 2000 payment updates. In addition, the agency apparently plans to do so without making any provision to pay interest for that period. Hospitals are already trying to cope with the BBA's dramatic changes, including significant spending reductions. A delay in the Year 2000 update adds to their burden and causes unpredictability for them and their patients.

While HCFA may have stated reasons for delaying the update in order to tend to Y2K issues, the consequences of that decision for hospitals is quite significant. HCFA's actions could affect hospitals' ability to provide the highest-quality care possible not just to Medicare beneficiaries, but to our other patients as well. Hospitals still must pay the bills associated with providing that care, and those bills will keep coming throughout HCFA's effort to update its computers.

While we can understand HCFA's need to look carefully at implementing new, complex prospective payment systems (PPS) for outpatient and home health care, the fact is that routine updates in current PPS payments are not complex. If they cannot be provided as scheduled, then HCFA must quickly create an alternate payment method that ensures the smooth flow of funds even as it updates its computer systems, including paying hospitals prospectively.

PREPARING FOR THE WORST

On average, America's hospitals and health systems receive roughly half of their revenues from government programs like Medicare and Medicaid. If that much revenue were to be suddenly cut off, hospitals and the patients they serve could be at risk. Hospitals would not be able to pay vendors. They would not be able to purchase food, supplies, laundry services, maintain medical equipment -- in short, they would not be able to do the job their communities expect of them. All this would occur even as hospitals and health systems faced the substantial costs of addressing their own Year 2000 system needs, costs not recognized in the calculation of current Medicare updates.

HCFA must make sure its contractors -- including Medicare+Choice plans -- have taken steps to ensure that their performance will not be interrupted by Year 2000 problems caused by the millennium bug. HCFA should make readily available its work plan for bringing the contractors and Medicare+Choice plans into compliance and monitor their efforts. Letting providers know what changes may be required of them is also important. This would allow providers, contractors and plans to prepare simultaneously and ensure that their systems are compatible.

Even if HCFA, its contractors and the plans express confidence that their payment mechanisms will not be affected by the millennium bug, the possibility remains that unforeseen problems could crop up. Therefore, it is imperative that HCFA establish a fail-safe contingency plan in case HCFA or its contractors' payment mechanisms somehow fail at the turn of the century. We

would like to work with HCFA to ensure that these short- and long-term concerns about the Year 2000 are adequately addressed.

Medicare beneficiaries' health care needs will remain constant, regardless of how well we are prepared for Year 2000 problems. If carrier and fiscal intermediary payment systems are clogged up by the millennium bug, hospitals' ability to continue providing high-quality health care could be severely affected. A system to provide periodic payments, based on past payment levels, is one way that this could be done. It would ensure that hospitals have the resources necessary to care for Medicare patients. We urge Congress to enact legislation to authorize such a system, and require that HCFA subject such contingency plans to public scrutiny.

Let me add that similar payment delays could occur if private health insurers and, in the case of Medicaid, individual states, have not addressed their own Year 2000 problems. The federal government has the power to prevent this from happening, and we urge you to use that power.

DELAYING HOME HEALTH PPS

HCFA's decision to delay implementation of PPS for home health care has the unfortunate consequence of extending the interim payment system (IPS) for another year. The IPS freezes historical base payments, locking lower cost, efficient providers into payments well below their costs, while historically high-cost home health agencies will continue to be paid at substantially higher rates. This further penalizes efficient home health agencies such as hospital-based and

visiting nurse association providers. The IPS is problematic for the two years it is scheduled to be in effect until the changeover to PPS. Three years of the IPS would only magnify the problem.

Moreover, a 15 percent automatic reduction is scheduled to occur in the Year 2000 whether or not PPS is implemented. We believe that this reduction, in the absence of PPS and coming on the heels of already-deep IPS reductions, hits efficient hospital-based and visiting nurse association home health agencies harder than others.

Prior to the BBA, hospital-based home health agencies were paid actual costs subject to a per-visit limit. Under the interim payment system, HCFA has reduced payments in two ways: a lower per visit payment limit; and a new per-beneficiary cost limit. The particular formula for calculating the per beneficiary limit allows payment disparities across agencies, even in the same market area.

The IPS also fails to recognize changes in the mix of patients served over the past several years as more complex patients are now treated successfully at home. On the basis of these changes, researchers from Georgetown and George Washington Universities who studied the effects of the BBA on home health care beneficiaries, warn of potential access problems for the very frail elderly.

We strongly urge Congress to revisit the IPS and address its unintended consequences that are harming competition between similarly situated agencies, and penalizing efficient hospital-based

and visiting nurse association agencies. If an artificially low per-beneficiary payment limit affects access to the frailest beneficiaries, the resulting cost of admission into hospitals or nursing homes will ultimately be borne by the Medicare system, raising overall costs and limiting beneficiaries' ability to be treated in their own homes.

THE DELAY IN OUTPATIENT PPS

We also are concerned about HCFA's proposed delay in the implementation of PPS for outpatient hospital services. The existing array of payment systems for outpatient services -- cost reimbursement for some, a blend of cost and freestanding facility rates for others, a fee schedule for still others -- is a complex administrative burden, and is expensive to maintain. Moving to a single, procedure-based payment methodology under outpatient PPS offers significant simplification of this system and establishes incentives to provide efficient outpatient care.

Moreover, we are extremely concerned that, in addition to delaying implementation of outpatient PPS, HCFA may delay publication of the proposed and final rules for the system. This delay may eliminate much-needed time to understand the new system, to work with HCFA and, if needed, the Congress, to address deficiencies before the final rule is issued, and to make the necessary changes in coding, billing and other record-keeping that must be in place when outpatient PPS finally does take effect.

TRANSFERS

Currently, cases that are transferred from one acute care hospital to another are defined as transfers and are paid a per-day rate, up to the full diagnostic-related group (DRG) amount. The BBA amended the definition of transfers to include patients sent from an acute care hospital to a rehabilitation facility, a skilled nursing facility, or a home health agency for 10 DRGs that typically result in the use of post-acute care.

The problem with the provision is that it effectively lowers payments to hospitals for the 10 DRGs HCFA has identified -- which make up nearly 10 percent of all Medicare inpatient cases. The result: reductions in hospitals payments in FY 1999 of $422 million. At the same time, efforts to coordinate patient care are thwarted because the transfer provision penalizes hospitals for sending patients as soon as possible to the health care site that best meets their needs.

We support H.R. 2908 and S. 1604, legislation to repeal the transfer provision of the BBA, because the provision is not in the best interest of patients, undermines PPS incentives, and is unfair to hospitals. In addition, the Prospective Payment Assessment Commission found that, on average, patients who use post-acute care stay in the hospital longer than patients who do not use post-acute care, shining doubt on HCFA's claims that hospitals are rushing patients into post-acute care in order to receive extra payments from Medicare. We are further concerned that, under the BBA, HCFA has the power to expand the provision even beyond the 10 DRGs already slated for inclusion.

Making a bad situation worse is HCFA's announcement that a transfer to a skilled nursing facility will include swing beds. Swing beds are beds in small acute-care rural hospitals that are used to provide post-acute services. This is allowed by Medicare because many rural patients do not have access to post-acute services. It is clear that Congress did not intend for these beds to be included in the transfer provision -- as Chairman Thomas noted in a letter to HCFA — yet HCFA has deemed that swing beds will be included. This decision was arbitrary, was wholly inappropriate, and must be rescinded.

SKILLED NURSING FACILITIES

Many of our member hospitals established their own skilled nursing facilities after the onset of inpatient PPS, when freestanding SNFs were unable or unwilling to admit post-acute patients who needed such services as catheters, tube feeding, intravenous drugs, chemotherapy, or ventilators. However, the case-mix measure under SNF PPS -- the resource utilization groups -- is based predominantly on nursing staff time and, as a result, fails to adequately reflect the resources that are required in caring for hospital-based SNF patients.

As a result of the BBA, those same hospitals are being doubly penalized, once under the inpatient PPS transfer provision, and again due to the case-mix measure's failure to appropriately adjust payments for such complex SNF patients.

Hospitals without SNFs may also face difficulties in placing their post-acute patients in SNFs. We have already heard reports from some of our members that SNFs to which they discharge patients

have begun asking to do on-site patient evaluations and requesting more patient information, especially about high-cost drugs and other special needs, prior to admitting patients. We are concerned that such behavior may impact post-acute patients with the most complex care needs, patients who, because of their frailties, are at added and unnecessary risk of infection and other complications if forced to stay in the acute care setting longer than necessary.

PPS-EXEMPT HOSPITALS

The BBA will hurt hospitals that are exempt from PPS — namely, rehabilitation and psychiatric facilities. Prior to the BBA, Medicare gave these hospitals economic incentives to control their costs. Payments were based on reasonable costs and subject to a per-discharge limit, or "target" amount. For example, when reimbursable costs were below the provider's target amount, Medicare reimbursed the fully allowed cost of providing services, plus half of the difference between that cost and the target amount, or 5 percent of the target, whichever was less.

The BBA reduced payments to these hospitals by $4 billion over five years. The reductions occur in a number of ways, but all limit providers' incentives to contain costs. Among them: capping target amounts at 75 percent of all users' costs within each facility class (rehabilitation, psychiatric, long-term care); freezing 1998 target amounts at the 1997 level; reducing capital payments by 15 percent; and severely reducing bonus payments. These cuts are especially hard on facilities that care for severe cases, such as burn victims.

We would ask Congress to revisit this issue. PPS-exempt hospitals such as these are an increasingly important of America's health care system. They cannot afford to shoulder such deep reductions and continue to meet the growing demands being placed on them.

PROVIDER SPONSORED ORGANIZATIONS

By including provider sponsored organizations (PSO) in the BBA, Congress took a huge step toward ensuring greater choice for Medicare beneficiaries. PSOs are locally based organizations of hospitals, physicians and other local providers working together to provide high-quality care. We commend Mr. Thomas and other members of the subcommittee for their vision in adopting PSOs, and we applaud HCFA for allowing providers and others to work together in helping the agency create its rules for implementation of this historic provision of the BBA.

We are concerned about one issue in particular, however. In HCFA's interim rule on PSOs, it appears that the agency may be interpreting the BBA incorrectly and, in doing so, is granting states rights that they are not granted under the BBA. More specifically, HCFA's interim rule refers to "the state's right" to require PSOs to "comply with consumer protection and quality standards ..."

Mr. Chairman, during congressional debate on the issue there was an explicit decision to incorporate compliance with certain state requirements as a matter of contract between the Secretary of HHS and the PSO. While HCFA might use contracts with states to monitor

compliance, only HCFA can take enforcement actions. Under the BBA, states were not given any independent rights or jurisdiction to take action against a PSO, based on their own state sanctions.

We recommend that HCFA undertake an approach under which the agency would:

- In order to avoid delays in the processing of PSO applications for federal waivers, clarify that the basic requirement of a PSO is the assurance of compliance with consumer protection and quality standards, while still establishing the legal basis for federal sanctions if that compliance does not materialize.
- Enter into contracts with all states to provide a state-specific document identifying state requirements; provide for the state to receive beneficiary complaints related to the applicable state standards, the investigation of the complaint, and the transmittal of the resulting analysis; and provide for state monitoring of consumer protections or quality requirements that states identify as significantly greater than or different from federal standards.

RURAL ACCESS TO MEDICARE+CHOICE PLANS.

Another area of concern is whether the just-published Medicare+Choice Part C regulation is workable. The short answer is that it remains to be seen. It is an enormous rule that incorporates many changes in Medicare risk contracting practices that will affect health plans, providers, and beneficiaries. Our members (both those that offer Medicare plans and those who do not) are evaluating these changes as part of the public comment process.

The combined effect of the service area, access, and benefit requirements are that a Medicare+Choice (M+C) plan's service area must generally follow natural health care delivery patterns and networks, and the benefits, premiums, and cost-sharing must be identical throughout the entire service area. Given that Medicare capitation rates vary (often significantly) from one county to another and most service areas include more than one county, there is a readily apparent problem: It is difficult to provide the same benefit throughout a service area without getting the same payment for everyone in that area.

Plans have three approaches to resolving this problem under the new rules: reduce benefits in higher-rate areas to cross-subsidize lower-rate areas; pull out of lower-rate areas; or seek HCFA approval of multiple M+C plans offered by the same M+C organization.

The first of these approaches is not viable from a marketing perspective. Plans will have to offer benefit packages that are competitive in the highest-rate county within their service area. With respect to the second approach, we are already hearing reports from around the country that major HMOs are either pulling out of Medicare altogether or are pulling out of rural portions of their service area. The third approach is one that is newly available under the Part C rules, and it is subject to a great deal of HCFA discretion. It remains to be seen whether HCFA will allow the use of this approach to enable a reflection of payment levels in defining service areas or in setting benefit, premium, and cost-sharing levels. It also remains to be seen whether organizing multiple plans to overcome this problem ultimately results in unworkably high administrative costs.

While we believe that these requirements were intended to avoid discrimination against certain Medicare beneficiaries, our fear is that their effect may be much broader -- hurting access to health plan alternatives in rural areas.

BLENDING MANAGED CARE RATES

Medicare managed care has enrolled more than 10 percent of Medicare's beneficiaries and is commanding an increasing share of the Medicare budget. However, especially in rural areas where managed care plans are not as likely to exist, beneficiaries may not have the benefit of managed care plans. This could be especially true as Medicare+Choice programs become available. As a result, we urge you to increase payments to low-utilization areas by blending average per capita cost, which is based on fee-for-service, with a national rate adjusted for local price differences.

The BBA originally intended to do this in three steps: a minimum floor payment of $367 to help rural counties with low Medicare utilization rates; a blended rate to bring equity to low- and mid-level payment counties; and a minimum 2 percent increase in current payment rates for all counties. However, only the blend has not been implemented.

We need to ensure that, as Congress intended, payments actually made to health plans will be based on a phased-in 50/50 blend of local area and national price-adjusted payment rates. To do this, we support, S. 2227, bipartisan legislation introduced by Sens. Ron Wyden and Gordon

Smith of Oregon. This legislation would implement the original intent of Congress: to fund the full blend of local and national rates.

USER FEES

The BBA reduced Medicare spending by $116 billion over five years — including $44 billion in direct reductions to hospitals. The administration now wants to add to those reductions by implementing a new tax on providers, a tax that is disguised as user fees.

Mr. Chairman, we strongly urge you and your colleagues to oppose this burden on the health care community. It would take another $660 million from hospitals and other providers in 1999 by forcing them to shoulder Medicare's administrative costs. The AHA believes that hidden cuts such as these proposed user fees are unfair and ill-advised -- especially in the wake of the BBA's severe spending reductions. Medicare's administrative costs should be funded by those who benefit from the program -- society as a whole -- through general revenues.

CONCLUSION

Mr. Chairman, hospitals and health systems are acutely aware that HCFA has a big job ahead of it: preparing a complex computer system for the Year 2000. We are in the midst of doing the same job. However, hospitals cannot simply shut down their systems in order to make the fix. Nor can they delay the care they must provide to the patients and communities they serve.

The needs of Medicare beneficiaries will not be delayed either. That is why we believe strongly that HCFA must meet its obligations to Medicare beneficiaries and the hospitals and health systems that serve them. We would like to work with HCFA to find a way to continue critical payment updates, including those slated for the Year 2000. We want to work with HCFA as well on ways to implement the important PPS systems for outpatient and skilled nursing facility services. And we want to work with HCFA and with you and your colleagues, Mr. Chairman, to improve the provisions of the BBA that I have addressed today.

I thank you for the opportunity to appear before you.

Chairman THOMAS [presiding]. Thank you all very much.

If you were here for the earlier testimony, you know that one of the difficulties is that we don't know that it is the Y2K and our current problems are significantly related either except for the fact that they occupy the same moment in time. And that for changes that we think make sense—and frankly there are a number of ways to adjust. For example, the interim payment, changing the percentage mix and doing some other things as well as the Pappas bill and the Collins bill indicate, simply aren't going to be executed because of the decision by HCFA.

So, what we need to do, as I indicated to HCFA, is get creative in figuring out what it is that we can do. Obviously that means that we don't do our first choice, but frankly doing something is more critical than getting our first choice because we're not going to be able to make some of the adjustments that you would think would be relatively obvious. For example, as was mentioned by Ms. Raphael on the changing of the formula, move the base year, none of that is available to us.

So it is becoming a bit of a challenge as to just exactly what it is that we are going to be able to come up with that will remedy the discrepancies and can be done by HCFA in the time frame we're dealing with. And we're committed to working with all parties to make sure that we find whatever that is.

Let me ask a general question and probably direct it to Mr. Davidson, but open to any who can respond. As you might guess, the argument from HCFA has been that if we're going to get into more of this Medicare+Choice, we need more tools available to deal with Medicare contractors. In fact, it has been stated that it is virtually, if not impossible, to terminate a contract with a contractor.

Does anyone just off hand know of anyone that has been terminated? And if so, are you aware of the—in terms of the law, what the mechanics are so we can at least get on the record if it is true that they simply don't have the tools to deal with contractors up to and including terminating?

Mr. DAVIDSON. Mr. Chairman, my understanding——

Chairman THOMAS. And I would prefer if you can also react to some kind of disciplining within the law short of terminating. I'll take either.

Mr. DAVIDSON. My understanding of the termination abilities of HCFA is that they have the authority to non-renew a contract upon its anniversary date with or without cause. They also have the authority to terminate a contract during its period for substantial non-performance. I am not aware that they have ever exercised the latter action.

In terms of disciplining, I am aware that when contractors have performance difficulties of one sort or another, performance improvement plans and adherence to them is required as a condition of continuing the contract.

Chairman THOMAS. Does anyone else want to respond? As I have indicated there is an argument that they need greater flexibility. In fact, my colleague from California, Mr. Stark, has introduced legislation, H.R. 4186, I believe it is—it is called the Medicare Contracting Flexibility Act. Are you familiar with it?

Mr. DAVIDSON. I am somewhat familiar with it, sir.

Chairman THOMAS. Well, for example, it allows HCFA to use non-insurance companies as Medicare contractors. The Part A would be carriers, Part B would be fiscal intermediaries. Any reaction to that part of it?

Mr. DAVIDSON. We don't have a problem with that.

Chairman THOMAS. You don't have a problem with that.

The second part of it is that it permits providers of medical services to choose their Medicare carrier or fiscal intermediary.

Mr. DAVIDSON. We think that there is a strategy that HCFA has either explicitly or implicitly started to employ which breaks up the contractor functions in a given geographic area between so-called "fraud abuse contractors"—the MIP contractors, claims payment contractors, other specialty contractors. Our view is that this is not wise having one contractor who is responsible for both claim payment and fraud abuse activities in a given medical geographic area given market is, in our opinion, the most effective way to get good administration and good fraud and abuse protection for the program.

And we disagree with HCFA's progress in breaking this up the way they are doing.

Chairman THOMAS. Does anyone else want to react briefly?

Then the other one that I assume that you have some reaction to is that Mr. Stark's bill repeals the cost reimbursement system giving HCFA greater authority to set payment rates.

Mr. DAVIDSON. We would be very, very much in favor of having something besides the cost-reimbursement system for payment. I think that it would put HCFA in a position to induce contractors to better performance.

Chairman THOMAS. Is there any other reaction?

Ms. Raphael, just briefly, all of us are concerned about the Interim Payment System, and you have given graphic evidence of how Visiting Nurses Associations are closing. Let me ask the question a slightly different way.

Forget the intermediate payment system. If we could have implemented initially the prospective payment system as it is structured, do you think those visiting nurses programs would have closed anyway, or do you think that that structure would have provided a minimally reasonable amount?

Ms. RAPHAEL. I think that the Visiting Nurses Associations would have fared very well under a prospective payment system because that kind of pricing system actually reward efficiency and encourages efficiency and that is what we had hoped that any revised reform payment system would, in fact, do.

Chairman THOMAS. And without significant change in the intermediate payment system, if, in fact, it's going to be present for a longer period of time, which is my greater concern, we have got to create some kind of an adjustment which allows incentives.

Last question. I don't have an answer to this, and I would like to try it out on you to help explain to me why in, for example, 1990, the visits on a per-beneficiary using home-health services was 36 and by 1997 those visits had gone up to 80. What occurred in roughly the decade of the 1990's? In 1983 on the data I have—and this is from a MedPAC information packet—in 1983 the per-beneficiary number was 28 home visits. Over that decade it went to 36.

But between 1990 and today it has gone from 36 to 80. Since almost half, or about 48.9 percent are aid visits, does the relationship—and maybe, Mrs. Raphael, you might want to begin the comment on it—does the relationship between home visits in terms of aids versus other skilled or particular needs, does that reflect a little bit in that structure? I have not been able to break it down in terms of the number of visits that were strictly for aid or whether they were partial.

Ms. RAPHAEL. I think that the reasons for the increase in utilization are multiple. I think that it certainly has to do with the fact that there was a court decision which liberalized the Medicare benefit. I think that it had to do with changes in technology. It had to do with what was happening in the hospital sector and with State policies in some cases trying to manage the supply of nursing homes as well as other factors in Medicaid expenditures in different States.

But I also do believe that like all insurance programs, if you look at the Medicare home-health program, 10 percent of the beneficiaries use 43 percent of the resources. And who are they? They tend to be people who fall into two categories. Either they are very medically complex, (for example, they have cancer.) They have a lot of hospitalizations, and they have a lot of episodes of home health. Or they tend to be over 85, and they have functional impairments. And to some extent, what they do need is a more supportive, long-term care benefit. And this second group tend to be the ones who are diabetics with complications who may have come out of a hospital with bedsores, who may be incontinent, and therefore, it is true that the ratio of aid visits in those cases is higher than is true overall.

So, I think that you see the results of many forces at work here.

Chairman THOMAS. Does anyone else wish to react?

Mr. BERND. I think from running an integrated delivery system, we have a number of hospitals and a home-healthcare agency. The time frame that you talked about, probably the average Medicare length of stay in a hospital went down by 50 percent. And that was on probably providing more efficient patient care, but also at the insistence of third-party payers and HCFA. It has driven up the use of outpatient services.

Mr. MILLER. And I would agree with that. I think that the number of procedures that have been done on the outpatient basis, complicated procedures, have grown significantly. A lot of patients don't even get into the hospital and are treated on the outpatient basis. Our home-health agency sees about 45 patient on the average today, and I will speculate that our average age of the patient that we admit is, during this same time frame from 1990 to 1997, is approximately four years older.

Chairman THOMAS. Are there additional reactions?

Thank you. Your answer was excellent. It is fairly obvious that there were a number of changes in the system. I believe that the primary problem was that they had no place else to go. In fact, government, I believe, created the skilled nursing facility universe, and the decisions made in other areas drove the home healthcare and that the real answer is, create what it is that people are trying to get out home healthcare, which is a long-term care benefit, and

you will see a readjustment in terms of the numbers. Of course, a long-term care benefit is not now part of that package, and the Medicare Commission is looking at that as a significant solution to individuals needs in the next century with a more reasonable response on a need profile.

Thank you very much. The gentleman from Louisiana.

Mr. MCCRERY. Just one question for Mr. Miller and Mr. Bernd.

As you know, we're going to be considering the HHS spending bill here in the House. The White House proposed, as part of their budget, funding certain HCFA functions by levying $650 million in fees on providers, hospitals. The biggest provider fee would have been about $395 million worth of charges on hospitals and Part A providers.

What are your thoughts on the administration's proposals for implementing user fees to pay for some of HCFA's functions?

Mr. MILLER. I'll give you a quick answer. Take the $650 million and put it where it needs to be which is taking care of patients.

Mr. BERND. I think that it is rather difficult to put that burden on the healthcare providers. We've talked about the issues of decreased payments and what is going to happen with Y2K. It is just another tax on the healthcare system.

Mr. MILLER. We have had so many changes and so many reductions over the last few years. How much more can hospitals afford to fund?

Mr. MCCRERY. So, you don't approve of that part of the President's budget?

Mr. MILLER. No, sir.

Mr. BERND. No.

Mr. MCCRERY. Thank you.

Chairman THOMAS. Let me ask one additional question because it is out of that broad discussion that we had, and it was mentioned. And I want to get as fulsome an answer as I can. And it has to do with the caps on the skilled nursing facility payments.

My understanding is that they will be delayed. In part the argument is because of the Y2K.

Ms. Ousley, on page two of your testimony, you state that, "a patient suffering from a stroke, a hip fracture, Parkinsons, or Alzheimers disease typically needs more than $3,000 in therapy." If you include all of those in that structure—I'm trying to understand why it would be in all of those instances that that would be the case. For example, if you have a hip fracture—I mean typically, wouldn't they be first admitted to an acute care hospital? And then in a post-acute care structure, they have an opportunity to got to the skilled nursing facility for up to 100 days under Part A. They can go to a rehab hospital or unit. Obviously, we just discussed, they could be sent home, depending on the situation, they could be sent home to receive some home care. The Visiting Nurses Association could assist them. They might also, on an outpatient basis, receive therapy while they are still at home or some other kind of a combination of services such as that.

So, the question would be, in that kind of a context, using the one example that you provided, a hip fracture, how likely is it that a patient will need more than $3,000 in SNF—a skilled nursing facility—therapy services after they have had an inpatient, a possible

rehab hospital or unit admission, and 100 days of a skilled nursing facility care covered under Part A?

Ms. OUSLEY. Well, sir, you are making an assumption that as the patient transitions through each one of those levels of care that they would be staying under a Part A care, and that is not necessarily the case.

Chairman THOMAS. But could it be the case?

Ms. OUSLEY. Under—it could be the case, but under most circumstances what our review and analysis predicts is that there will be about 10 to 15 percent of the patients that would not follow that course of therapy, and, in fact, they would be the ones that would fall into the area that would need additional therapy that would not be covered by the $1,500 cap. We think that that would translate into about 750,000 individuals that would not be able to access the necessary care and services that they would need to achieve their rehab potential.

Chairman THOMAS. My only concern is that as we were looking for alternatives to try to slow down—I gave you an indication of the growth of home-healthcare visits over the decade of the 1990's. And I think that the answers that were provided were excellent ones. I think that they happen to represent a good rationale for why that occurred in a number of different ways.

But in trying to examine a growth rate in the therapy services, it was very difficult for us to put some kind of a demographic factor price on what was occurring on the Part A. And on the Part B, when you've got a growth from 151 million to 827 million within a 5 to 7 year period at an average annual growth rate of 41 percent, and that is after they have exhausted the 100 SNF days, do you have an ability to explain why there was that kind of a growth rate tied to demographic or other factors?

Ms. OUSLEY. Well, I think that the demographics do come into play there, but I also think that, especially in the skilled nursing facility during this period of time, we have been seeing an intense increase in the acuity level of patients that are transferred into the facilities for our care.

Additionally, in 1990——

Chairman THOMAS. Yes, but isn't it after they have had 100 days of skilled nursing benefits that this kicks in?

Ms. OUSLEY. Pardon?

Chairman THOMAS. Isn't it true that this is after 100 days of SNF?

Ms. OUSLEY. Sir, the average utilization for——

Chairman THOMAS. I'm trying to understand what you're saying. You said that in terms of the acuteness of patients coming in. So the acuteness carries through the 100 day SNF benefit and then has to be treated with the therapy benefits on the other side of the 100 days?

Ms. OUSLEY. They—a patient does not necessarily always meet the skilled, Part A criteria for a full 100 days. I think that the average utilization is about 22 days. So, when the patient is out of their Part A, yes, the need for a continuing level of service, based on their Part B, absolutely exists. And you certainly cannot assume—because most patients do not receive that covered 100 days of service.

Chairman THOMAS. It is just that we are looking for ways to try to explain significant increases in dollar amounts. Any help that you can provide us in alternatives other than simply delaying—the kinds of controls unfortunately that are available to us are not as sophisticated as we would like, but we would love to sophisticate them as rapidly as we can.

Ms. OUSLEY. Well, you know, I think that one of the things that the Senator—that Ensign's bill that I referred to, it does move us toward a PPS-like system for rehab services that would be based on diagnosis. I think that that is critical to being able to have responsible use of the resources, but also to continue to meet the resident's needs.

Chairman THOMAS. Well, I appreciate that, and obviously we are working with it. Our problem is, again, that this occurrence of two events in time, one a desire to change some of the structures that we put in on an interim basis, and HCFA's indication that they aren't doing anything for awhile makes it very, very difficult to bring about changes. But I can assure you that on a bi-partisan basis we will work with you to come up with—and I am looking for some really creative ways to get around the Y2K argument. And I will tell you that one of those that we are looking at, as I mentioned earlier, is the potential of a copay which we did not want to deal with earlier, but it is something that could provide an adjustment on an interim payment since we now have a whole new world that we hadn't anticipated. We thought that we were going to be able to adjust the formula rates, move the year around, do some other things to come up with adjustments that would be relatively easy to do through computers. Apparently we are back to paper and abacuses trying to figure out how to make this system work.

So, any ideas you have would be greatly appreciated.

And I do want to thank you, on behalf of the subcommittee, for your willingness to testify, and most importantly, for the content of your testimony. Thank you very much.

[Whereupon, at 3:35 p.m., the hearing was adjourned subject to the call of the Chair.]

[Submissions for the record follow:]

Statement on Implementation of the Balanced Budget Act of 1997

For the Written Record

July 16, 1998

Submitted by the American Association of Health Plans

to the Ways and Means Health Subcommittee

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I. Introduction

The American Association of Health Plans (AAHP) appreciates this opportunity to comment on implementation of the Medicare+Choice provisions of the Balanced Budget Act of 1997. The AAHP represents 1,000 HMOs, PPOs, and similar network health plans. Together, AAHP member plans provide care for over 140 million Americans nationwide.

With last year's passage of the Balanced Budget Act, Congress made the goal of expanded choice a reality. Over the past several years, we have supported efforts to modernize Medicare and give beneficiaries the same choices that are available to working Americans. Today, more than 16 percent -- or 6.1 million beneficiaries -- are enrolled in health plans, up from 6.2 percent five years ago.[1] Approximately 90,000 Medicare beneficiaries are joining health plans each month, selecting among the more than 330 health plans available.

This written statement addresses a range of specific issues related to implementation of the Medicare+Choice program, including the beneficiary information campaign, risk adjustment and payment, service area designation, post-stabilization care, provider relations, HCFA's Quality Improvement System for Managed Care, and preemption of state laws and regulations.

II. Beneficiary Information Campaign

AAHP supports efforts to ensure that beneficiaries receive information that will enable them to make informed decisions about coverage options. AAHP and its member plans are working with the Health Care Financing Administration (HCFA), beneficiary groups and others as the beneficiary education and information dissemination campaign moves forward. The central goal of this initiative, to provide more and better information to beneficiaries about all of the options available to them, is critical to permitting beneficiaries to take advantage of the expanded range of choices envisioned under the new Medicare+Choice program. As health plans participating in the Medicare program today know well, there are significant challenges in reaching out to Medicare beneficiaries and ensuring that the information they receive is useful and understandable. AAHP's member plans have a great deal of experience in communicating with beneficiaries and are constantly working to refine and improve our outreach and communications efforts.

The Balanced Budget Act of 1997 (BBA) instructs the Secretary to use a variety of approaches to educating Medicare beneficiaries about their choices including a handbook, toll-free number, an internet website, and community outreach. To finance these activities, the BBA authorizes HCFA to charge each Medicare+Choice organization and Medicare risk contractor a fee equal to the organization's pro rata share of HCFA's estimated costs of enrollment and information dissemination activities. Congress appropriated $95 million for these activities in 1998 and suggested that HCFA focus first on developing and publishing the comparative

[1] Includes enrollees in risk, cost, and HCPP contractors.

information booklet. In December 1997, HCFA announced its intent to assess all Medicare risk contractors a fee equal to 0.428 percent of their monthly Medicare payments beginning in January and continuing through September 1998 until it collects the fiscal year 1998 assessment of $95 million. AAHP is concerned that the FY1998 user fee represents more than 20 percent of the 2 percent minimum payment update that applied to rates in the vast majority of counties in 1998.

In June 1998, HCFA announced that it would scale back plans to distribute Medicare handbooks to 38 million beneficiaries and instead pilot test the Medicare handbook in 5 states, reaching only 5.5 million beneficiaries. In addition, HCFA is phasing in over 12 months implementation of the toll-free call center. Yet HCFA has collected close to its full 1998 assessment of $95 million from health plans. The 1998 assessment of $95 million was intended to educate all beneficiaries about their options under the Medicare+Choice program, not just a subset of these beneficiaries. While we are supportive of a scaled-back, more thoughtful process for the distribution of the handbook and recognize the value of phasing in the call center, a significantly scaled-back education campaign raises questions about HCFA's use of the full 1998 assessment. HCFA needs to be held accountable for its use of the FY1998 assessment collected from health plans especially since the reduction in scope of HCFA's activities should also be reflected in reduced FY98 expenditures. To date, HCFA has not provided detailed information on the budget, resource allocation, or expenditures for the beneficiary education campaign.

While it is reasonable for health plans and their enrollees to contribute to funding HCFA's enrollment and information dissemination initiatives, their contribution should be in proportion to their participation in the Medicare program. Last year, Medicare risk HMOs and their enrollees represented 14.3 percent of the program but shouldered 100% of the cost of the information campaign.[2] The burden of this fee directly affects the premiums and benefits that health plans can offer to their Medicare members.

In FY 1999, the organizations participating in the Medicare+Choice program and their members will again bear a disproportionate share of the costs of an initiative designed to reach all 39 million Medicare beneficiaries and educate them about all of their options, including the Medicare fee-for-service program and Medigap coverage. We support the dissemination of information to all beneficiaries that will permit them to make informed choices but believe that an equitable funding mechanism is critical to the success of this effort. It will not serve the goals of the Medicare+Choice program if the burden of funding the program-wide information campaign reduces the attractiveness to beneficiaries of the coordinated care and other options that the program is designed to make more widely available.

Furthermore, comparative information on Medicare+Choice plans will be disseminated as part of an expanded Medicare handbook. However, the handbook is a HCFA publication whose production and dissemination were previously funded from sources other than the new user fee.

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[2]Includes enrollees in risk contracts only.

The funds that would otherwise have been allocated to updating the handbook should have been taken into consideration in determining HCFA's cost for producing the new publication, now called Medicare & You. It is not clear that this has been the case.

III. Risk Adjustment and Payment

The BBA requires HCFA to develop a risk adjustment method based on beneficiaries' health status for implementation beginning in the year 2000. In addition, the BBA authorizes HCFA to collect, beginning in January 1998, retroactive hospital encounter data from health plans dating back to July 1997. The aggressive timeframe stipulated by the BBA for implementation of a risk adjuster has challenged both health plans and HCFA. We are working with HCFA to address a wide range of complex, technical issues related to implementation of risk adjusted payments. In addition, our member plans have undertaken major systems modifications to prepare for submission of hospital encounter data which contains all of the elements HCFA requires and can be submitted electronically in the required format. The collection of retroactive data, from July 1, 1997 through December 31, 1997, has been particularly problematic, because plans had no opportunity to put necessary systems in place prior to the period for which data must be reported. Many problems remain to be resolved by health plans and HCFA under the hospital encounter data collection initiative.

AAHP has consistently supported the goal of ensuring that Medicare payments to health plans are accurate and that they fairly reflect the health care service needs of the Medicare beneficiaries who enroll. Risk adjusting Medicare+Choice payments should be implemented in a manner that will improve payment accuracy and result in the least disruption possible to beneficiaries and plans participating in the program. AAHP believes that the risk adjustment methodology developed by HCFA should be implemented without a further aggregate reduction of payment to the Medicare+Choice part of the program as a result of risk adjustment. As discussed below, growth in Medicare+Choice payment rates will not keep pace with growth in FFS payments over the next five years. Using a risk adjustor to further reduce payments would make plans hesitant to enter certain market areas and leave beneficiaries with fewer Medicare+Choice options, reduced benefits, and higher premiums.

A recent study by Price Waterhouse illustrates that the BBA dramatically reduces the growth in capitation rates to health plans compared to pre-BBA payment levels. The study found that prior to the BBA, the average payment would have risen from $553 in 1998 to $746 in 2003 and would have remained at 95 percent of the fee-for-service program. After the BBA, the average payment rate is reduced to $530 in 1998 and $658 in 2003. The study found that enactment of the BBA reduced average payments relative to the fee-for-service program to 0.94 in 1998 and 0.89 in 2003. It is our understanding that HCFA plans to implement risk-adjusted payments in 2000 using a methodology that will further reduce capitation payments relative to the fee-for-service program.

The combined effects of the substantial reduction in payment growth contained in the BBA and HCFA's proposed risk adjustment methodology will be to further reduce

Medicare+Choice payments relative to FFS. Overall these changes will reduce the competitiveness of Medicare+Choice plans as the gap between these payments widens. These changes, combined with the myriad of other potentially costly changes under the new Medicare+Choice program, may lead many plans to cut benefits, raise premiums or both.

We encourage HCFA not only to monitor the effects of implementation of a risk adjuster, but also to assess the overall performance of the Medicare+Choice program under the new payment methodology. The changes made by the BBA are significant and the impact on plans is complex. For the future success of the program, HCFA needs to evaluate the impact of this new methodology on beneficiaries, and on health plans and other Medicare+Choice options. Some plans have already begun to modify their benefit packages and premiums and trends in enrollment growth and market expansions are among other areas that should be examined.

IV. Service Area Designation

Prior to the BBA, Medicare HMOs had flexibility in defining their service areas and in varying the premiums and benefits offered on a county-by-county basis. The BBA and the Medicare+Choice regulations are both more restrictive than HCFA's previous "flexible benefits" policy. The BBA discontinues this policy by requiring that Medicare+Choice plans offer uniform benefits and uniform premiums across a plan's total service area without regard to different county payment levels. For 1998, HCFA developed a transition policy for existing contractors which allows Medicare+Choice organizations to segment service areas and offer multiple plans in an effort to mitigate the effect of moving away from the flexible benefits policy.

The policy contained in the Medicare+Choice regulation, however, appears to be more restrictive than even the transitional policy allowed by HCFA during 1998. We are in the process of analyzing the anticipated impact of the regulation and it is unclear whether health plans that serve a mix of both high- and low-payment counties may still be forced to make difficult decisions about whether their organization can viably continue serving low-payment areas.

V. Post-Stabilization Care

The BBA introduced a new requirement that health plans cover care out-of-network following stabilization of an emergency medical condition. Under the Medicare+Choice regulation, post-stabilization care means medically necessary non-emergency services needed to ensure that an enrollee remains stabilized until the enrollee is discharged or a plan physician assumes care for the enrollee. AAHP and its members first expressed strong concerns about this provision during the drafting of the BBA, and we remain concerned about whether it is a workable requirement that will benefit Medicare+Choice enrollees. We remain concerned that requiring Medicare+Choice organizations to cover non-emergency care provided by out-of-network providers does not promote care coordination by providers within the organization who provide ongoing care to the enrollee. The fact that the patient is stabilized and no longer has an

emergency medical condition means that there is no medical reason why the plan should not resume responsibility for that patient's care in the plan's network. The provision has the potential to undermine the continuity of care that health plans provide enrollees and may delay placing responsibility for that care in the hands of health plans and their network providers.

VI. Provider Relations

The Medicare+Choice regulation significantly expands the scope of the BBA provisions related to provider relations. While the BBA requires Medicare+Choice organizations to develop numerous new physician participation procedures, including a process for allowing physicians to appeal adverse participation decisions, the Medicare+Choice regulation dramatically expands the scope of these requirements to encompass all health care professionals. AAHP has serious concerns regarding these requirements which now encompass not only physicians, but also dentists, podiatrists, optometrists, nurse practitioners, chiropractors, licensed social workers, and all other health care professionals either participating or desiring to participate in a network. HCFA's statutory authority to expand these provisions is unclear. Moreover, appeals rights are not commonly available to other professionals as a right accompanying their employment. Given the administrative burden that these provisions will impose on health plans, it remains to be seen whether the provisions are workable as expanded by the Medicare+Choice regulations.

VII. Quality Improvement System for Managed Care

The Quality Improvement System for Managed Care (QISMC) is designed to establish a consistent set of quality oversight standards for health plans for use by HCFA and state Medicaid agencies under the Medicare and Medicaid programs, respectively. AAHP has long advocated coordination of quality standards for health plans in order to maximize the value of plan resources dedicated to quality improvement. While we believe that QISMC holds the promise of contributing to this important goal, we have a number of serious concerns regarding QISMC and its implementation. We urge HCFA to engage in an intensive dialogue with health plans contracting under the Medicare and Medicaid programs to permit full consideration of their outstanding concerns about the QISMC standards and guidelines.

One of our primary concerns is that QISMC lacks clear coordination with existing public and private sector accreditation and reporting standards. Health plans currently meet voluntary private accreditation standards, such as those developed by the National Committee for Quality Assurance, in order to satisfy requirements of private sector purchasers and some states. Rather than coordinate with these existing standards, QISMC appears to establish a new system of outcomes-based requirements and "demonstrable improvement." In addition, QISMC fails to establish realistic goals for QISMC-related health plan activities and performance that take into consideration available resources and health plan responsibilities for the delivery of quality care to beneficiaries.

VIII. Preemption

The BBA supersedes state law to the extent that state laws and regulations applying to Medicare+Choice organizations are inconsistent with federal Medicare+Choice rules and standards. Specifically, inconsistent state laws are preempted for three areas of Medicare+Choice requirements: plan benefits, participation of providers and suppliers, and coverage determinations, including those related to appeal and grievance processes. This provision is beneficial to the Medicare+Choice program because it makes clear that consistency in health plan standards for plans that operate as Medicare+Choice organizations is important for the Medicare program and its beneficiaries. In the Medicare+Choice regulation, HCFA states that it has chosen to interpret narrowly the preemption provisions of the BBA. AAHP is concerned that this narrow interpretation of the preemption provisions may undermine Congress' intent in developing these provisions. In addition, it remains unclear from the Medicare+Choice regulation how HCFA will monitor and implement the preemption provision of the BBA.

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Health plans have valuable experience to share with Congress and HCFA on implementation of many of the provisions in the Balanced Budget Act of 1997. AAHP appreciates this opportunity to comment on the BBA and its implementation to date. We look forward to continuing to work with members of the Subcommittee, other members of Congress, and HCFA to ensure the successful implementation of the Medicare+Choice program.

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July 14, 1998

FOR IMMEDIATE RELEASE
CONTACT: Barbara Lauter, 202/261-4560, Washington office
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Y2K Physician Payment Delays Will Adversely Affect Delivery of Primary Care Services to Medicare Patients

WASHINGTON, D.C.–The American College of Physicians–American Society of Internal Medicine (ACP–ASIM), which represents the doctors who treat more Medicare patients than any other medical specialty, is concerned about the effect on physicians' ability to provide appropriate care to elderly and disabled patients that might result from a delay in making Medicare fee schedule updates and other changes already mandated for payments for physician services in the year 2000 (Y2K).

According to a recent General Accounting Office (GAO) report, the Health Care Financing Administration (HCFA) will be responsible for processing more than a billion Medicare claims amounting to $288 billion in benefits by the year 2000. The GAO report then warned of dire consequences that would result if HCFA's computer systems are not Y2K compliant by that time. A recent HCFA memo expressed concern about its ability to meet competing resource demands from congressional mandates, such as those included in the Balanced Budget Act of 1997 (BBA'97), and already planned computer system changes and transitions by its contractors. As a result, the memo said, HCFA will seek to delay implementation of certain BBA'97 provisions *as well as already scheduled and mandated physician payment updates* in Y2K.

–more–

ACP–ASIM is seeking clarification and assurances on:

- precisely what updates and payment changes would be delayed and, most important, the impact that any delay in implementation of annual fee schedule updates and resource-based practice expenses would have on the cash flow and other operations of physicians' offices— particularly for those of primary care physicians in general and those in rural areas especially.
- how physicians will be held harmless from the cumulative impact of the delay, i.e., if an increase in payments for office based primary care services is delayed months or a year, how the compounding effect will be made up to physicians at a later date.

"This issue is more than one about dollars," ACP–ASIM President Harold C. Sox, MD, FACP, pointed out. "It involves questions of whether or not physicians and beneficiaries can have confidence that the Medicare program will be able to— and *will*— meet its obligations to physicians and Medicare patients in the year 2000 and beyond. Any delay in payment updates and other promised program changes is acceptable only if it can be clearly justified on the basis of technical issues beyond HCFA's control. And even so, such disruptions must be kept to an absolute minimum or patient care will surely suffer as a result."

Headquartered in Philadelphia, ACP–ASIM is the nation's largest medical specialty organization. ACP, founded in 1915, and ASIM, founded in 1956, merged July 1, 1998. Membership is composed of more than 100,000 internal medicine physicians and medical students. Internists provide the majority of health care to adults in America.

# # #

STATEMENT SUBMITTED FOR THE RECORD
Hearing of July 16, 1998
Delay of Implementation of the Balanced Budget Act of 1997
House Ways and Means Committee
Subcommittee on Health

The American Occupational Therapy Association is pleased to present a statement for the record on issues related to delays and problems with implementation of the Balanced Budget Act of 1997 (BBA).

AOTA represents 60,000 occupational therapy practitioners. As the professional association representing occupational therapy practitioners we are committed to the provision of those services by properly trained professionals and to assuring that those professionals are able to practice within an ethical framework which services the best interests of patients and supports best practice.

Occupational therapy is an important component of both Medicare Part A and Medicare Part B.

Occupational therapy is a health and rehabilitation service provided by licensed or certified professionals, which uses goal-directed activity in the evaluation and treatment of persons whose ability to function is impaired by illness, injury, disability or normal aging. Treatment goals in the post-acute setting include maintaining, regaining or improving maximum function, adjustment to impaired function, prevention of further injury or complications, and increase in independent activity.

Occupational therapy is provided in hospitals, home health agencies, rehabilitation hospitals and agencies, skilled nursing facilities, outpatient clinics and other settings.

While AOTA believes that many sections of BBA should be reviewed more fully and implementation should be monitored closely by the Congress, this statement will address three issues in regard to BBA implementation:

--the cap on outpatient therapy services imposed by Sec. 4541 of the BBA;
--the implementation of the prospective payment system for skilled nursing facilities imposed by Sec. 4432 of the BBA;
--the changes to payment for and provision of home health services.

The Cap on Outpatient Therapy Services

One of the most egregious portions of the BBA is the imposition of the $1500 annual cap on outpatient occupational therapy services. AOTA continues to firmly believe that this cap is wholly inappropriate from both a clinical standpoint and a policy perspective. It is also unlikely to achieve the presumed level of budgetary savings, particularly in light of expected inability of the Health Care Financing Administration (HCFA) and its contractors to implement it in a timely manner.

The limit completely ignores the beneficiary's rehabilitation needs as regards their individual health and functional status, and inhibits the provision of services at what could be the optimal stage in the continuum of care. Moreover, it will significantly disrupt continuity of care for beneficiaries whose condition requires care beyond the limit. **There is no allowance in the BBA for any medical exceptions, including multiple episodes of need during a single year.**

This limit creates a serious impediment to patient access to necessary rehabilitation services, particularly in rural or other underserved areas of the country where independent practitioners or other non-hospital providers are the only accessible sources of therapy.

The limit is a crude and ineffective design for controlling utilization and limiting inappropriate cost growth. **The Medicare Payment Assessment Commission in its June 1998 Report to the Congress: Context for a Changing Medicare Program, raised several concerns about the impact on patients. It summarizes cost issues but also confirms that many patients will need therapy services beyond the cap to achieve full recovery. (See Chapter 5: Outpatient Rehabilitation).**

AOTA is supporting legislation, H.R. 3835, the Reinstatement of the Medicare Rehabilitation Act, introduced by Subcommittee members Mr. Ensign and Mr. Cardin, to eliminate this cap and to move up by one year the requirement that HCFA develop a more appropriate system, based on patient classification, condition and functional status, to assure appropriate utilization and achieve cost growth control. We urge the subcommittee to consider this legislation at the earliest possible time.

In addition, from our view of HCFA's first steps toward meeting the January 1999 date, implementation may also be crude and ineffective. We are continuing to work with HCFA to assure that implementation is consistent with legislative intent.

The implementation must be carefully and correctly done in order to prevent providers and, more importantly, beneficiaries from incurring unexpected expenses if they go over the limits. Implementation may also require significant computer system retooling in order to track beneficiary utilization; such retooling will have to be done at the same time that HCFA is working to adjust for the year 2000 changes.

AOTA encourages the Subcommittee to continue its oversight of HCFA's implementation and to hold full and open hearings on this issue, as this did not occur during the reconciliation process.

Implementation of the Prospective Payment System for Skilled Nursing Facilities

AOTA supports the use of an appropriate and well-designed prospective payment system (PPS) for skilled nursing facility care under Medicare. However, AOTA has concerns about how such a prospective payment system will be implemented and urges the Subcommittee to carefully monitor HCFA's implementation, paying particular attention to quality. Sec. 4432(c) of the BBA does require that a medical review process be implemented. AOTA urges Congress to monitor HCFA's implementation of this requirement to assure that the system allows for appropriate and adequate utilization of services and does not have a negative impact on patient outcomes. Furthermore, we urge the Subcommittee to assure that the process developed under this section is based on national guidelines which reflect accepted clinical standards. Any efforts to assure quality is maintained should be applied equitably through such mechanisms as peer review as used in other areas of the Medicare program.

AOTA urges the Subcommittee to promote full attention to quality, adequacy and appropriate utilization of all services. In developing the process for monitoring, **as well as in developing the payment systems and amounts,** consideration must be given to the adequacy and appropriate utilization of ancillary services, such as occupational therapy.

AOTA has continually worked with HCFA on development of the PPS system that is being implemented. But we must reiterate that both the amounts of the payments to nursing homes and **how those payments are apportioned within the nursing facilities' patient management systems** should be of important concern to the Subcommittee. AOTA is already hearing from its members who practice in nursing facilities of limits on utilization, unprofessional requirements such as the use of stopwatches to control therapeutic intervention times, and presentation of ethical dilemmas with regard to how much service an individual patient is able to obtain. We will continue to work with the Subcommittee and provide further information on these developments.

For the present, we urge consistent and continuous oversight of the effect on beneficiary health, safety, and functional status of the prospective payment system.

Home Health Care Changes

Many issues have been raised with regard to the interim payment system that is being implemented for the Medicare home health benefit. AOTA is concerned about the impact of these changes on patient care and access to services.

But AOTA also wishes to bring to the attention of the Subcommittee an issue which the Association raised during the reconciliation debate. **AOTA would encourage the Subcommittee to require that HCFA study the coverage criteria for home health care.** AOTA has long been concerned that beneficiaries are not allowed to access occupational therapy services without first receiving skilled nursing, physical therapy or speech-language pathology services. AOTA has been concerned that this is an unwarranted restriction on access to a service which is targeted, as occupational therapy is, toward **achieving and maintaining functional independence.**

Furthermore, certain components of the current coverage criteria may be inappropriate and even counterproductive for use in a new payment system. The coverage criteria may in fact work against successful and efficient management of the benefit.

AOTA suggests that a study be conducted to examine more appropriate coverage criteria for home health. The study should emphasize examination of alternatives in use in other programs or of a new design that moves away from the "qualifying service" requirement and toward alternatives more appropriate for use under a prospective payment system. The study should also examine whether the current criteria is compatible with the move to increased monitoring of patient outcomes that HCFA is pursuing in home health.

Under the interim payment system and under any other prospective system, use of the existing criteria may limit choices and options for consumers and agencies, thus becoming counterproductive to achieving the best outcome in the least time for a reasonable cost. To establish a radically different system such as the interim payment system (IPS) or PPS while ignoring other problematic aspects of the current home health benefit, perpetuates the piecemeal approach that underlies many of the problems now facing the Medicare system.

The Prospective Payment Assessment Commission said in its March 1997 report that "(t)he Congress should more specifically define the scope of Medicare's home health care benefit. The absence of clear coverage constraints limits the program's ability to control home health utilization." The report goes on to say that the "lack of a clearly defined benefit compromises" the program's ability to pay only for services that are reasonable, necessary and medically appropriate.

Yet HCFA has not examined or studied any changes to respond to future needs for a different approach to the "qualifying service." (The BBA did require a study of the issue of the definition of homebound, however, which is only a portion of the coverage criteria.)

AOTA urges the Subcommittee to request that HCFA or some other agency conduct a study to examine alternative coverage criteria in use under private insurance plans, under Medicare HMO's, and as proposed by others who may have examined the benefit's structure. Such a study could inform future Congressional debate to assure the payment reforms in the BBA are implemented effectively.

Conclusion

AOTA is grateful for the opportunity to share its views on BBA implementation and looks forward to continuing to work with the Subcommittee to improve and enhance the development of a Medicare program for the 21st Century.

VIA HAND DELIVERY

Chairman Bill Thomas
Ways & Means Health Subcommittee
United States House of Representatives
1136 Longworth House Office Building
Washington, DC 20515

Dear Mr. Chairman:

On behalf of AmSurg Corp. ("AmSurg"), I am pleased to submit the following testimony for the record on the Subcommittee's hearing on the Administration's plan to delay implementation of the Balanced Budget Act of 1997 ("BBA"). AmSurg is a corporation based in Nashville, Tennessee and operates forty-six ASCs in twenty-one states and the District of Columbia.

While HCFA is delaying many aspects of the BBA, we want you to be aware of another troublesome area of activity by the Health Care Financing Administration ("HCFA"). Specifically, we have concerns about a rulemaking process underway at HCFA restructuring payments to ASCs. (The proposed rule was published by HCFA in the June 12, 1998 *Federal Register* and marked as HCFA-1885-P). HCFA has indicated that the reason for moving forward on the ASC regulations is because it needs to complete this process before December 31, 1998 for Year 2000 compliance purposes. If the proposed rule becomes effective in its present form on the stated October 1, 1998 effective date, it will have a significant adverse effect on many ASC operations and the Medicare beneficiaries that receive ASC services.

We believe HCFA's implementation of any changes to ASC payments must allow all affected parties to provide meaningful comments on the proposed rule. The proposed rule involves many substantive changes and is not merely periodic routine provider payment updates. Further, we question whether a proposed rule could have a predetermined effective date. More specifically, we believe that the effective date stated in the caption of the proposed rule (October 1, 1998) will not allow HCFA sufficient time to address comments and issue final regulations, particularly given other regulatory and operational priorities impacting HCFA.

We submit that an extension to the comment period and a postponement of the effective date is appropriate due to several reasons. First, we recognize the priority given by HCFA to ensure coverage for beneficiaries and payments for providers on January 1, 2000. We also understand that HCFA needs to complete systems changes before December 31, 1998. Given these important challenges, we believe that the proposed rule should not be rushed to

finalization inappropriately.[1] Further, the BBA only requires that the ASC payment rates be adjusted by the increase in the urban consumer price index minus two percentage points. *See* BBA § 4555. Accordingly, HCFA can comply with the BBA and simultaneously meet its Year 2000 priorities without implementing the proposed rule by applying the CPI adjustment to the current ASC payment system.

Second, the proposed rule did not include all material information needed to comment and, to date, we have not received the relevant cost data and other material information that HCFA used in crafting the proposed rule.[2] Although we have requested this data, we have been informed that we would need to submit a formal request to HCFA under the Freedom of Information Act ("FOIA"). While our counsel has submitted a FOIA request to HCFA on our behalf (*see* Exhibits A and B), there is insufficient time to go through the FOIA process and adequately comment on the proposed rule by the August 11, 1998 deadline.

Third, the interrelationship between payment of ambulatory surgical services across various outpatient settings suggests that hospital outpatient department ("HOPD") and ASC payment reforms should be considered by HCFA concurrently to minimize any inappropriate shifts in setting or compromises in patient access to ASC services. HCFA and the Medicare Payment Advisory Commission ("MedPAC") have each acknowledged the implications of this interrelationship. In the proposed rule, HCFA states that the new APC surgical groups will be used in HCFA's development of the HOPD PPS. Further, MedPAC recently advised Congress that, while payment considerations do not presently unduly influence the setting in which an ambulatory service is provided, the magnitude of the changes to payment policy being implemented as a result of the BBA create a risk of inappropriate shifts in setting and compromises in beneficiary access to ASC services. *See* MedPAC, *Report To Congress: Context for a Changing Medicare Program*, 74 (June 1998). Accordingly, we believe that concurrent consideration of the HOPD and ASC payment reforms is in the best interests of ASCs and the Medicare Program.

Finally, in other recent proposed rulemakings, HCFA has recognized that an extension of the comment period is essential to obtain meaningful input from the provider community. For example, HCFA recently extended the comment period for the interim final rule for the prospective payment system ("PPS") for skilled nursing facilities and the comment period for the Stark II proposed rule because of their "complexity." *See* 63 *Fed. Reg.* 37498 (7/13/98); 63 *Fed Reg.* 11649 (3/10/98). We believe the proposed changes in this rulemaking are similarly complex and are not merely periodic routine provider payment updates. Accordingly, the sixty

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[1] We note that HCFA's proposed 1998 payment rates in the proposed rule are based upon a small number of certain types of ASCs in operation in 1991 with 1992 and 1993 fiscal year data. As of the date of the 1994 survey, the number of Medicare certified ASCs in the United States has almost doubled, and the ASC community now includes a wider variety of types of ASCs. This significant fact raises legal questions as to the "representativeness" of this survey data.

[2] In the proposed rule, HCFA specifically requests "arguments for changes in payment rates be supported by data." *See, e.g.*, 63 *Fed Reg.* 32294.

days in the ASC proposed rule and the predetermined October 1, 1998 effective date are insufficient to evaluate meaningfully these significant policy and payment changes.

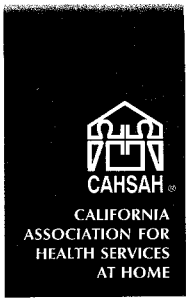
In conclusion, we believe that an extension of the comment period and a postponement of the effective date for the proposed rule impacting ASCs will enable a cooperative and productive dialogue between the ASC community and HCFA regarding this significant rulemaking.

Thank you for your consideration of this testimony. If you have any questions please call me at (615) 665-3525.

Sincerely,

Ken P. McDonald /cw

Ken P. McDonald
President and Chief Executive Officer
AmSurg Corp.
One Burton Hills Boulevard
Nashville, TN 37215



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July 15, 1998

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

Re: Subcommittee on Health of the Committee on Ways and Means Hearing on Administration Plan to Delay Implementation of Provisions of the Balanced Budget Act of 1997.
Thursday, July 16, 1998.

Dear Sir:

The California Association for Health Services at Home (CAHSAH), on behalf of its eleven hundred (1,100) home care offices in California, thanks the **Subcommittee on Health of the Committee on Ways and Means** for convening this hearing to examine issues related to the possible delay of a per episode Prospective Payment System (PPS) for home health providers. We are very concerned that delay of the PPS may extend the duration of the seriously defective Interim Payment System (IPS).

BACKGROUND

The Balanced Budget Act of 1997 (P.L. 105-33), referred to as the BBA, has many provisions related to home health, specifically home health payment, with a stated goal of containing growth and decreasing costs to the Medicare program for home health services. The ultimate method to contain growth is the projected transition to a Prospective Payment System (PPS) from a cost based reimbursement system which has, since its inception, paid providers the lesser of agency cost or charges.

While there is near universal agreement on the need to move from cost-based reimbursement to PPS, the transition established by the BBA is problematic for a number of reasons.

First, there is a good deal of uncertainty about what PPS will look like. The Health Care Financing Administration (HCFA) is currently funding Phase II of a project to demonstrate per episode prospective payment. Preliminary results from this project indicate that per episode prospective payment (with a rudimentary case-mix adjustment system):

- produces substantial Medicare savings;
- allows providers to break even; and
- does not result in reduced patient outcomes.

HCFA is funding a second research project, the Medicare Home Health Case-mix Project, to develop an improved case-mix adjuster. Preliminary results from this project are not due until January 1, 1999.

There is an expectation that these two projects will ultimately result in a per episode prospective payment system with an adequate case-mix adjuster. It should be recognized that this expectation may not be met and that the October 1, 1999 implementation date for PPS is the earliest possible date such a system could be ready.

A second reason why the BBA transition is flawed is the Interim Payment System(IPS) itself. The IPS has many problems of which these are the most severe:

- By limiting and reducing both per visit cost and per beneficiary cost, the IPS threatens the viability of the most efficient providers. Providers who reduce their visits per beneficiary will see an increase in their per visit costs, putting them in an impossible bind.
- By providing a higher per beneficiary limit to agencies with higher base year per beneficiary costs, the IPS discriminates against agencies with low base year per beneficiary costs.
- By providing a fixed per beneficiary limit, the IPS provides agencies with a disincentive to serve patients who require more than the average number of visits per beneficiary.
- By limiting costs per beneficiary rather than per episode, the IPS is inconsistent with the expected per episode PPS.

A third major problem with the IPS is that it arbitrarily reduces payment rates by 15 percent on October 1, 1999, regardless of whether PPS is implemented or not. Taken on top of the 20 to 40 percent reductions in payments caused by other provisions of the IPS, this additional 15 percent reduction will threaten the viability of virtually every agency in the country.

RECOMMENDATIONS:

In order to deal with these problems, we recommend the following:

1. Allow agencies participating in either the Phase II Per Episode Demonstration Project or the Medicare Home Health Case-mix Project to continue on these projects.
   This will allow these approximately 160 agencies from across the country to continue to test prospective payment and gather data necessary for prospective payment.

2. Allow agencies which can demonstrate budget neutrality to immediately advance to PPS.
   As an alternative to IPS, allow agencies which can demonstrate that a prospective per episode rate would be lower than their base year per episode costs to be paid prospectively using the same methodology used in the Phase II Per Episode Demonstration Project.

   The prospective per episode rate could be set in either of two ways:
   a. Based on the per episode rate for the nearest agency in the demonstration project or the average of rates in the state.

   b. Based on the agency's base year per episode actual cost.

3. Revise IPS to avoid the conflict between the per visit cost limits and the per beneficiary limit, and provide the same limits to all agencies within a geographic area.
   A number of bills have been introduced which either fully or partially restore the per visit cost limits to previous levels and/or modify the formula for calculating the per beneficiary limit. We support provisions which eliminate the conflict between reducing per visit costs and per episode costs at the same time.

4. Establish a methodology to account for long-stay or high-cost patients.
   The per beneficiary limit does not account for the costs of long-term or high-cost patients. Under the Phase II Per Episode Demonstration Project, agencies are paid per visit for patients whose stay exceeds 120 days.

   We propose a simple system be established to pay for patients whose stay exceeds 120 days. Based on data collected by the demonstration project, fixed monthly payment rates could be established for the long-stay patients with diagnoses such as diabetes, congestive heart failure or wound care. Such patients would be subject to random 25 percent medical review as in the demonstration.

5. Eliminate automatic 15 percent reduction scheduled for October 1, 1999.
   As previously discussed, this additional reduction is not needed to achieve the savings target established by the BBA and therefore should be eliminated.

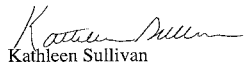
6. Other provisions.
   There are a number of other provisions of the Balanced Budget Act and other HCFA initiatives which are causing severe problems. At a minimum, these include the proposed elimination of Periodic Interim Payment (PIP), Sequential Billing and the proposed mandate to collect and electronically report the Outcome and Assessment Information Set (OASIS).

   We propose a task force of industry, fiscal intermediary and HCFA staff be immediately convened to analyze and present recommendations to deal with these problems.

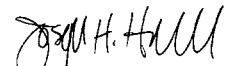
   The Medicare home health benefit is in immediate jeopardy because of the unintended consequences of provisions of the Balanced Budget Act and HCFA's limited ability to implement these and other initiatives. However, many of the problems could be alleviated relatively quickly along the lines suggested above.

We thank the Chairman and the Subcommittee for considering these suggestions.

Sincerely,



Kathleen Sullivan
Chair, Board of Directors



Joseph H. Hafkenschiel
President

MERRILL COOK
2ND DISTRICT, UTAH

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TRANSPORTATION
AND INFRASTRUCTURE

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FINANCIAL SERVICES

SCIENCE

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TESTIMONY OF CONGRESSMAN MERRILL COOK (R-UT)
BEFORE THE HOUSE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH
HEARING ON THE ADMINISTRATION'S PLAN TO DELAY IMPLEMENTATION OF THE BALANCED BUDGET ACT OF 1997
JULY 16, 1998
SUBMITTED FOR THE RECORD

Mr. Chairman I want to commend you for holding this hearing on the Health Care Finance Administration's (HCFA) plan to delay implementation of provisions of the Balanced Budget Act of 1997.

I share your concerns with this plan. I was alarmed to learn that HCFA is considering delaying implementation of the per episode prospective payment system (PPS) for home care. Like many of our colleagues, I have been contacted by numerous constituents who are struggling to survive under the Balanced Budget Act's Interim Payment System (IPS) for home care providers. In Utah alone, 27 home care agencies and branches have closed their doors since January. The IPS has driven more out of business since May, and more will follow.

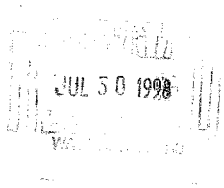
Mr. Chairman, I appreciate that the IPS is a separate issue, and that you are carefully examining the impact of the IPS. I hope to work with you to develop changes to the IPS to ensure that it does not drive honest efficient home care providers out of business.

However, I raise the difficulties caused by the IPS today to emphasize the catastrophic implications of delaying the shift from IPS to PPS. It is inconceivable to me that HCFA would consider extending the life of this fatally flawed system. It would be devastating for seniors and home care providers if HCFA kept the IPS in place beyond its statutory sunset date of October 1, 1999. Any delay in implementation would obviously violate the intent of Congress. And, as you have pointed out Mr. Chairman, it is inexplicable that the Clinton Administration would feel the need to delay implementation of a prospective payment system that it proposed in February, 1997. In effect, HCFA is saying that nearly three years of lead time is not enough to put in place a prospective payment system for home care.

Mr. Chairman, I also share your concern with HCFA's plan to delay implementation of the outpatient prospective payment system, and to postpone fiscal year 2000 updates for the hospital prospective payment system and for the physician fee schedule. These delays will add more headaches to providers who already must deal with tight reimbursement caps and HCFA's paperwork requirements. To me, these proposed delays are yet another indication that HCFA is becoming the health care equivalent of the IRS: unresponsive and unaccountable.

Thank you for allowing me to submit this testimony Mr. Chairman. I look forward to assisting you in developing solutions to these problems.

CORNERSTONE
HEALTH MANAGEMENT
GERIATRICARE SPECIALISTS



July 29, 1998

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

Re: **Written Comments Concerning the Administration's Plan to Delay Implementation of the Balanced Budget Act of 1997**

For distribution to the Members

Cornerstone Health Management manages inpatient geriatric psychiatric units, skilled care programs, and geriatric outpatient programs known as senior health centers for a wide variety of proprietary and non profit hospitals throughout the nation.

Our hospital clients have chosen to operate their outpatient senior health centers as a means to serve the specific medical problems of the elderly. Many physicians are unwilling to accept new geriatric patients and many of those who do accept new patients have no particular expertise in treating the elderly. Senior health centers provide both the professional (physician) component and the technical (nursing, testing, supplies, etc.) component of outpatient care to geriatric patients. These centers are established as a means of meeting community need for specialized outpatient treatment of the geriatric patient and ensuring that the geriatric patient receives prompt, effective treatment that may lessen the need for long, expensive inpatient hospital stays. The senior health center represents an important new trend that can maintain and improve the health of senior citizens.

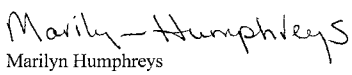
Our senior health center client hospitals are very concerned about the implementation of the prospective payment system for outpatient services. So few details have been released concerning either the method of calculating these rates or the amounts to be paid that these hospitals are considering closure of their specialized outpatient geriatric services due to the uncertainty of the method of payment. Additionally, some hospitals are putting on hold plans for the establishment or expansion of various other outpatient departments which provide less age-specialized treatment, but nevertheless treat large numbers of geriatric patients and the general public.

The outpatient Prospective Payment System is scheduled to begin on January 1, 1998. That date is now only five months away. In order to make rational decisions concerning the expansion or continuation of outpatient hospital services in 1999, the hospitals need publication of HCFA's proposed rates as soon as possible. In the event that HCFA is unable to publish these rates in a timely manner, then the implementation of outpatient PPS should be delayed for another year. To do otherwise would result in needless disruption of the outpatient healthcare delivery system.

5080 SPECTRUM DRIVE ■ SUITE 920 WEST ■ DALLAS, TEXAS 75248 ■ (972) 715-1200 ■ FAX (972) 715-1299

Thank you for the opportunity to comment on this important legislation.

Sincerely,



Marilyn Humphreys
Director of Reimbursement
Cornerstone Health Management

HEALTH INDUSTRY DISTRIBUTORS ASSOCIATION
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JUL 20 1998

Statement for the Record of the Ways and Means Subcommittee on Health

Submitted by: Health Industry Distributors Association
Balanced Budget Act Implementation
July 16, 1998

The following statement is submitted to the House of Representatives Ways and Means Subcommittee on Health on behalf of the Health Industry Distributors Association (HIDA). HIDA is the national trade association of home care companies and medical products distribution firms. Created in 1902, HIDA represents more than 700 companies with approximately 2000 locations nationwide. HIDA members provide value-added services to patients in their homes as well as virtually every hospital, physician office, and nursing home in the country. HIDA is pleased to be able to provide the Committee with our evaluation of the Health Care Financing Administration's (HCFA's) implementation of the Balanced Budget Act of 1997 (P.L. 105-31).

HIDA's home medical equipment (HME) providers are an integral component of the home health delivery chain. Home medical equipment (HME) providers supply the equipment and related services that help consumers meet their therapeutic goals. Pursuant to the physician's prescription, HME providers deliver medical equipment to a consumer's home, set it up, maintain it, and educate and train the consumer and caregiver in its use. HME providers also interact with physicians and other home care providers (such as home health agencies and family caregivers) as the consumer improves and his/her needs evolve. Specialized home infusion providers manage complex intravenous services, including chemotherapy, in the home.

These providers and the beneficiaries that they serve are at a great risk for negative consequences resulting from HCFA's implementation of Balanced Budget Act (BBA). Although a great number of provisions in the BBA have the potential to impact HME providers, our testimony will focus just one issue - HCFA's competitive bidding demonstration program.

Competitive Bidding

HIDA is concerned about the Health Care Financing Administration's implementation of a competitive bidding demonstration program for DMEPOS authorized by the BBA (Section 4319). Mr. Chairman, it is important to remember that although the term "competitive bidding" may sound attractive, this

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program will actually stifle the existing free market competition that encourages the provision of high quality medical services to Medicare beneficiaries. Once this demonstration program is under way, only a very limited number of HME providers in three demonstration areas will be reimbursed by Medicare for home oxygen services, hospital beds, wound care supplies, enteral nutrition, and incontinence supplies. The fact that the vast majority of providers will be excluded from providing these services will create monopolistic forces that will eliminate the existing market competition. In addition, by radically reducing the number of providers of HME services consumer access may be threatened (especially in rural areas) and beneficiaries' in the demonstration areas will lose their important right to choose their own healthcare provider.

HIDA is concerned that HCFA's current competitive bidding plan also threatens access to important health services. Home medical equipment (HME) such as oxygen equipment cannot be drop-shipped to patients because the therapeutic support services offered by HME providers are crucial to positive health outcomes. History shows that once an artificially low bid is awarded and the winning bidder faces budget pressures, the first thing the provider eliminates are these therapeutic services (e.g., preventative maintenance, patient education, 24-hour on call service, the professional care of respiratory therapists, and the furnishing of supplies). Once these services are eliminated, the beneficiary is much more likely to experience health problems.

In addition, HIDA is concerned that the competitive bidding demonstration program may place a serious strain on the Medicare's computer systems. We are all aware of the urgent need for the Medicare Program to focus resources on updating their systems to accommodate the change to the year 2000. HIDA understands that a number of provisions included in the Balanced Budget Act of 1997 (P.L. 105-31) will be delayed in order to allow these updates to occur. We are concerned that HCFA is underestimating the systems resources that will be required by this competitive bidding demonstration, and urge this Subcommittee to investigate whether this demonstration should be also postponed.

This competitive bidding demonstration program has already placed a considerable burden on Medicare's resources. Originally scheduled to be implemented in the late 1980's, this demonstration has been repeatedly postponed due to the complexities of designing a program that can encourage competitive bids and meet the statutory requirements of the Medicare Program. HIDA has remains in contact with HCFA on this issue and has participated in the Technical Experts Panel convened by HCFA to provide input the development on the demonstration plan. Through these contacts, we understand that the current plan will require the Medicare Carrier administering the program to:

1. develop and circulate a request for proposals that encourages HME providers to provide bids, while maintaining high quality services, limiting Medicare expenditures, and guaranteeing beneficiary access
2. educate beneficiaries, physicians, aging organizations, home health agencies, and other affected parties about this considerable change in the Part B benefit (HCFA estimates that there are 91,000 Medicare beneficiaries in the chosen demonstration area)
3. finalize and implement standards designed to assure that the participating HME providers meet quality guidelines
4. educate HME providers about the bidding process
5. receive bids for more than 70 product codes
6. evaluate the billing history of each bidder for each code that they have submitted a bid on to determine the service capacity of the bidder
7. project the future demand for each item put up for bid in the demonstration area through the end of the demonstration

assure that the cumulative capacity of the 'winning' bidders for each of the more than 70 products codes will meet the projected demand for that product/service
9. conduct a site visit of each 'winning' bidder's facility to assure that they meet quality standards
10. evaluate each winning bidder's history of Medicare Program compliance
11. organize a local demonstration work group and ombudsman
12. implement systems edits that will reject claims from 'losing' providers for demonstration items, while accepting claims for certain demonstration items submitted by 'losing' bidders who are fulfilling rental agreements signed prior to the demonstration, and allowing all Medicare Part B HME providers to submit claims for other, non-demonstration items
13. provide ongoing evaluation of beneficiary access to services, the quality of services provided, the effectiveness of transition policies, the bidding process, bidder conduct, and beneficiary reactions to these changes

HIDA urges the Subcommittee to investigate the resources required to conduct these numerous and complicated activities. If the Subcommittee determines that this demonstration program will deplete the systems resources, we recommend that you contact HCFA in support of a delay.

Conclusion

HIDA appreciates the opportunity to provide the Subcommittee with our views on HCFA's implementation of the BBA, and the year 2000 computer problem. We are concerned that HCFA has opted not to delay the resource-intensive competitive bidding demonstration program in order to focus on year 2000 computer compliance. HIDA is concerned that the dual objectives of BBA implementation and needed computer upgrades may result in a hastily and poorly designed competitive bidding demonstration program. As this demonstration program has the potential to directly impact the healthcare services of thousands of Medicare beneficiaries, it is urgently important for HCFA to conduct a well-reasoned, responsive program. We urge the Subcommittee to investigate the systems resources required by the demonstration and to request a delay in implementation if it is determined that the two programs can not be conducted simultaneously.

The following statement is for submission to the written record for the July 16, 1998 Committee on Ways and Means Subcommittee on Health hearing.

This story is submitted on behalf of the patients and their families of Kent County Visiting Nurse Association. Confidentiality prohibits us from using actual names.

THE FACE OF HOME CARE: "Home Care does not make it easy, it makes it possible."

Susan M., of Warwick Rhode Island is a wife and mother of three sons, 18, 16 and 12. She also cares for her 77 year-old mother, Hannah, who suffered a stroke in 1991. This stroke left her paralyzed on the left side. She is also a diabetic. Susan is part of what we have come to know as the "sandwich generation." Many members of the sandwich generation are frantically trying to care for their own children and homes, maintain their marriages, juggle careers, and meet the demands and challenges of caring for an aging, and many times chronically ill parent.

Hannah lives with Susan and her family in a modest, three bedroom, ranch style home. In 1991, after Hannah's stroke, her husband, David, cared for her at their home in New Hampshire with the help of visiting nurses. When David experienced an aneurysm, he and Hannah came to live with Susan. He was later diagnosed with cancer.

David and Hannah lived in their daughter's home for close to two years before David passed away. It was during this time that Susan first experienced the world of home care and what it may do for a family and its sickest members. During this time, David received Hospice Care from Kent County Visiting Nurse Association while his wife received home care from this same agency.

Currently, Hannah receives nursing and home care aide visits from Kent County Visiting Nurse Association. Her fragile physical condition has fluctuated throughout the years. At times, her condition has warranted home care services and at other times, although sick, she has not met the Medicare guidelines to receive home care.

She requires monitoring and periodic medication adjustments and treatments to prevent hospitalization. Susan attributes the recent lack of hospitalizations to the nursing and home care aide visits that have allowed Hannah to remain living with her daughter and her family. Her emotional state has deteriorated somewhat and Susan believes this is due to her total dependence on others to perform even the most basic tasks. Hannah has experienced a tremendous loss of dignity. She is completely immobile and must receive help to perform all activities of daily living. She cannot move from her bed to a chair by herself, she cannot get a book or magazine on her own and she cannot go to the bathroom without assistance. She is completely dependent on others 24 hours a day each and every day.

Besides Susan, the others in Hannah's life are her son-in-law, three grandsons and the visiting nurses and home care aides that care for her. Susan has no siblings that may assist with Hannah's care. Currently, the nurse visits with Hannah one time every two weeks. The nurse checks her vital signs, skin integrity, respiratory function, nutrition, bowel function, mobility, medications, and how she is coping with her limitations. The nurse is also responsible for developing and maintaining her care plan in conjunction with her physician and communicates her personal care needs to the home care aide. The home care aide visits three times weekly to bathe Hannah and help her with other personal care needs. On a daily basis, her personal care needs are left to Susan and her family.

In a recent interview, Susan commented that "Home care does not make it easy, it makes it possible." Susan and her family made a life-altering decision to take both of her parents into their home and care for them when they both became ill. The easy answer would have been to put both Hannah and David into a long-term care facility where around-the-clock care is available. However, Susan's value system and great respect for her parents prevented her from doing this. The decision was made to keep her parents in the family home as long as possible and to care for them with the help of the visiting nurses.

The help of the visiting nurses and home care aides provides some relief for both Hannah and Susan. Hannah looks forward to her care and the interaction with her nurse and home care aide. She can share her fears and frustrations with these individuals and know that her confidentiality and dignity will be maintained. Susan is relieved because she knows that trained professionals are looking after her mother's physical and emotional condition. She is not a trained medical professional, but has learned a lot from

the VNA staff. The nurses have educated her on what changes to look for in her mother's condition that would indicate a problem. Without this ongoing education and assessments from the nurses, Susan may miss a critical change in Hannah's condition and she could end up hospitalized. Hannah has been hospitalized in the past for a severe urinary tract infection. Her nurses perform periodic urine and blood tests to ensure that she does not develop another infection and require another hospital stay.

The nurses and home care aides help to keep Hannah as well as she can be, given her limitations, and they provide the essential education that Susan and her family need to keep Hannah home. This is what Susan means when she says, "Home care does not make it easy, it makes it possible."

While Susan does not like to use the word "sacrifice" in reference to keeping Hannah with her family, the reality is that both she, her husband and three sons have made significant sacrifices. She and her husband cannot go away together. They cannot take a family vacation, because Hannah is home bound and unable to travel. Her three sons have been forced to share one bedroom for the past seven years. There is nothing called "privacy" for any members of this family. Financially, Susan and her family have sacrificed. This is a time when Susan would like to be working. She would like to bring in extra income to help support her family and pay for college tuition bills. Her oldest son will begin college in the Fall. However, if she goes to work, there will be no one to care for Hannah.

Again, the simple solution would be to put Hannah in to a long-term care facility. While Susan cannot say with full certainty that this will not happen someday, she is not willing to do this yet. Her philosophy is "People are not disposable, we cannot get rid of them when it becomes a little difficult." Susan feels this is a valuable lesson for her sons to learn and believes that this experience will make them better people. In a society where we read and hear so much about family values, this is a family that has established a strong set of values to live by.

However, it is difficult. It is difficult to be part of the sandwich generation and try to juggle multiple priorities. It is difficult to reverse the mother/daughter role and have your parent completely dependent on you. Finally, it is very difficult to think that new Medicare reimbursement guidelines under the Balanced Budget Act of 1997, Interim Payment System may make Hannah's visiting nurse and home care aide visits even less frequent than they are now and possibly non-existent all together.

Susan is willing to do her part. She is willing to care for Hannah as long as she is able to in her own home. All she is asking for is a bit of help from the visiting nurses and home care aides to ensure that her mother stays as well as she can and maintains some level of dignity. Without this help, this little bit of professional care; Susan would be forced to put Hannah into a long-term care facility.

While this would devastate the family unit that has been developed, it also would be another admission to a long-term care facility. It would mean an increase in overall health care expenditures for an already financially overburdened health care system. It is a simple comparison that can be made quite quickly without any dollar amounts being used. Two nursing and twelve home care aide visits per month to be paid by Medicare versus the daily cost of a long-term care facility for the rest of Hannah's life. It is that old adage; "We are not comparing apples to apples." Certainly we are not even close if you choose to do the real cost comparison.

Hannah is not alone. There are millions of individuals across the nation that are only a few home care visits away from becoming another admission to a long-term care facility. There are young and old individuals that rely on home care each and every day. There are newborn babies and frail, elderly 100-year-old seniors relying on that visiting nurse to come and provide that essential, professional care. We are all only one accident or one illness away from this happening to us.

The financial implications of reduced home care and visiting nurse services are tremendous. The dollars are in the billions. The real questions here are "Does it make sense to take away home care?" "Does it make sense to drive visiting nurse services out of business by continuing to reduce their Medicare reimbursements so they are forced to close their doors?" "Does it make sense to continue to destroy families across the nation who have made a value choice in attempting to keep their loved ones at home?"
The answer is simply no.

Remember, as Susan has said, "Home care does not make it easy, it makes it possible." Let us all hope that home care may continue to make it possible for Susan, Hannah and her family and families throughout the country.

Respectfully submitted by Lisa M. Scott, Manager of Public Information and Community Relations at Kent County Visiting Nurse Association, 51 Health Lane, Warwick, Rhode Island, 02886, 401-737-6050, or 1-800-348-6417. *Family and patient names have been changed to protect confidentiality.*

Kent County Visiting Nurse Association celebrates its 90th anniversary this year. The Agency is dedicated to providing quality health care and developing programs and resources to benefit the community.

Mary Suther
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TESTIMONY
SUBMITTED FOR THE RECORD

BEFORE THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

JULY 16, 1998

ON BEHALF OF

NATIONAL ASSOCIATION FOR HOME CARE
228 Seventh Street, S.E.
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Mr. Chairman,

The National Association for Home Care appreciates the opportunity to provide comments for the record on the issue of the Health Care Financing Administration's plan to implement a prospective payment system (PPS) for home care.

The National Association for Home Care is the largest national organization representing home health care providers, hospices, and home care aide organizations. Among NAHC's nearly 6000-member organizations are every type of home care agency, including nonprofit agencies like visiting nurse associations, for-profit chains, hospital-based agencies and freestanding agencies.

HCFA's latest move to delay implementation of PPS by at least six months comes as no surprise to the home care community, and makes it even more imperative that Congress move to fundamentally reform the interim payment system (IPS) in this legislative session.

NAHC is deeply appreciative of the support this Subcommittee has shown for the development and implementation of a prospective payment system. We also greatly appreciate the attention the Members of this Subcommittee have shown to the problems created for the Medicare home care benefit. We are pleased to have the opportunity provided by this Committee to express our concerns about the devastating impact this new system is having on home health agencies and the patients they serve, and the importance of moving home care to a prospective payment system by no later than October 1, 1999, as mandated under the Balanced Budget Act of 1997.

Benefit Reductions Go Far Beyond the Rate of Growth

The BBA cut home health spending by much more than the $16.2 billion over five years. Although home care represents only 9% of Medicare, it was slated for about 14% of the cuts in Medicare spending. What many Members of Congress may not have been aware of is that the Congressional Budget Office (CBO) anticipated that these provisions would actually produce home care savings of $48.6 billion; however, the savings were reduced by a 2/3 "behavioral offset" under which CBO expected home care providers to dramatically "game" the system.

CBO recently rescored the BBA home care provisions using actual, lower home care growth rates. According to this more recent baseline, BBA will result in additional home care savings of $9.7 billion over five years. From 1990 to 1995, average annual Medicare home health expenditures increased by more than 30%. However, home care growth fell dramatically to only 4.8% prior to enactment of the BBA. Current HCFA projections show home health spending will decline through fiscal year (FY)2000.

In fact, HCFA's latest figures show that far from "reducing the rate of growth," the BBA home care provisions have resulted in a dramatic reduction in the home care benefit itself. According to figures from the Office of the Actuary, Medicare home health expenditures for FY1997 totaled $17.799 billion ($17.589 billion in Part A, $210 million in Part B.) HCFA now expects that home health spending will decline in FY1998.

Projected Medicare home health expenditures for FY1998 total $17.266 billion ($9.938 billion in Part A, $7.328 billion in Part B). Once the rates are recalculated using the BBA lower limits, spending may be even lower than projected.

Based on an analysis provided for NAHC by The Lewin Group, an estimated 92% of agencies will be faced with reimbursement cuts that average 32% in FY1998. A reduction of this magnitude could result in Medicare home health expenditures falling to $12-$13 billion for this fiscal year.

Prospective Payment For Home Care

The BBA requires HCFA to implement a prospective payment system for home care by October 1, 1999. All indications are that HCFA will fail to meet this statutory requirement, which will mean that home care providers and patients must continue to live under the flawed IPS for much longer than Congress anticipated. Additionally, on October 1, 1999, the BBA subjects home care to a further 15% reduction.

To meet the aggressive deadline for implementing PPS, HCFA is required to complete within 17 months what it took years to do for hospitals and skilled nursing facilities. These tasks include:

- the completion of the PPS per episode demonstration;
- the completion of the PPS case mix study;
- synthesis of the PPS research into an operational PPS with adequate case mix adjustment;
- a fully implemented and operational OASIS data collection system;
- an audit of home health agency cost reports to form the basis of PPS payment rates;
- development of an adequate outlier policy;
- training of FIs on the new payment system; and
- education of home health agencies and patients about the new system.

Even before HCFA's admission that it needs to request a delay in the required implementation date, NAHC expressed serious reservations that HCFA would be able to complete these tasks within the given time frame.

The unfeasibility of this requirement now is even more evident and makes immediate reform of the IPS more urgent than ever.

Problems Created by the Interim Payment System

BBA made dramatic changes in the reimbursement system for Medicare home health services. These changes became effective for cost reporting periods beginning on or after October 1, 1997, and are intended to remain in effect until October 1, 1999, when Congress has mandated the implementation of a new PPS for cost reporting periods beginning on or after that date.
Under the new IPS, agencies are reimbursed the lowest of their (1) actual allowable costs; (2) aggregate per-visit cost limits; or (3) a new aggregate per-beneficiary limit. A number of significant problems have emerged as a result of the IPS, and we urge Congress to fundamentally reform the system in this legislative session.

Reduced Per Visit Cost Limits -- 21% Reduction

IPS reduced the per-visit cost limits in two ways. First, the limits are calculated based on 105% of the median per-visit costs of freestanding home health agencies, rather than the previous method of 112% of the mean. Second, the new cost limits do not take into account the market basket price increases that occurred between July 1, 1994 and June 30, 1996.

The combined effect of these two provisions represents a 21% reduction in the cost limits. HCFA estimates that 65% of all providers will be over these limits. NAHC's data indicates that the percentage of those over the limits is even higher.

The New Per-Beneficiary Limits Are Inequitable

The per-beneficiary limit is a blended limit -- 75% agency-specific data and 25% census region data -- with FY1994 as the base year. The idea behind the agency-specific component of the limit was that it would serve as a proxy for case-mix. The problems with the per-beneficiary limit are many.

The new per-beneficiary limit has been of tremendous concern because of the inequities it creates. The per-beneficiary limit has been an extremely divisive issue in the home care community because certain types of providers and certain geographic areas are affected differently by these limits.

Many agencies that have been in existence for years that have worked to get their costs down and become more efficient in anticipation of a PPS have been harmed by the per-beneficiary limits. They end up with lower limits, based on the agency-specific data, and are penalized for their own efficiency.

First, the limit is based on data (costs of care and type of patients) that a home care agency had four or five years ago (FY1993/1994). The per-beneficiary limit does not reflect any changes that occurred from the base year to today.

As in all segments of the economy, costs increased in the last four to five years. Many home care agencies provide a wider range of services in 1998 than they did in 1993 or 1994. Many home care agencies serve a very different type of patient -- sicker, more high tech, more complex cases -- than they did in 1993 or 1994. None of these changes are reflected in the limit.

While in theory the per-beneficiary limit is supposed to allow home care providers to "balance" their sicker patients with lighter care patients, because the limit does not adequately reflect case mix, providers are finding it increasingly difficult to adequately serve patients with heavier care needs.

Combined Effect of the Per-Visit and Per-Beneficiary Limits

HCFA estimates that 93% of all Medicare home health providers will have their reimbursements reduced by one of the limits. For comparison, only about one-third of home health agencies incurred costs exceeding the per visit cost limits in FY1997.

Additional 15% Reduction in Limits

On October 1, 1999, regardless of whether HCFA has developed PPS, home health expenditures are to be reduced by an additional 15%. This further reduction would be devastating to providers and would severely jeopardize the ability of beneficiaries to access care and restrict the level of care they could receive in their homes. The additional 15% reduction is unnecessary because the budget target will be achieved without it. Although the CBO estimated that the BBA would cut Medicare home care expenditures by $16.2 billion over five years, the reductions in per-visit cost limits and the per-beneficiary limits will likely cut home care expenditures by close to $50 billion over the same period.

Lack of Case Mix Adjuster

The primary impediment to developing a full PPS has been the lack of a case-mix adjuster to account for patient characteristics that influence an agency's cost of providing services to patients. Case-mix adjustment is necessary to ensure that agencies are not penalized for serving patients whose care needs are more expensive and to eliminate the incentive for agencies to reject patients who have heavier care needs.

No Appeals or Exceptions Mechanisms

Further, there is no mechanism under which providers can appeal the limit calculations or otherwise ensure that they can accommodate the care needs of the sickest patients.

"New Provider" Rates and Definition

Under the BBA, new providers, those who do not have a full base year ending in FY1994, are to receive the "median of these limits," which HCFA has interpreted to mean national averages rather than census division limits. Since nearly one-half of all providers under this definition are new providers, this leads to inequitable results.

Some new providers who deliver care in census regions with limits which are below the national average will have higher limits than existing agencies in the census division. In other areas, the

opposite effect results. In Louisiana, we are told, one agency has a per-beneficiary limit estimated to be $3000 per year, and a competing agency in the same city has a limit of $13,000.

Late Publication of Per-Beneficiary Limits

It is important to remember that HCFA did not publish the new per-beneficiary limits, which went into effect on October 1, 1997, until April 1998. Nearly 2/3 of all home health providers were on IPS before the actual limits were published. In effect, they have been "flying blind," making business and care decisions on best guesses. Many agencies expected higher limits than they were actually given and based their business decisions on inaccurate best guesses.

Beneficiary Impact

The most devastating impact of the IPS, however, is on beneficiaries. IPS is reducing access to home health services significantly and restricting the level of care received by patients in their homes.

The inadequacy of the new reimbursement limits leaves providers with the choice of restricting access to their services or financially destroying the agency by delivering care to patients that push the agency's operating costs above the reimbursement limits. Patients who need the most care are most at risk for cutbacks or being denied access to care.

These beneficiaries tend to be the oldest, sickest, poorest, and most frail Medicare beneficiaries. With too-low Medicare payments, providers have cut back on staff, leaving them unable to care for all who need home care. Patients who need care the most either are not receiving care, or are being cared for in more costly settings like emergency rooms, hospitals, and nursing homes.

It is important to note that although the reimbursement system has dramatically changed, the Medicare coverage criteria (except for the venipuncture exclusion) have remained the same. Providers must lower both their costs and their utilization rates in order to remain viable under IPS. Lowering either of these without adversely affecting patient care or the quality of services, however, is proving extremely difficult.

Home health costs have grown much more slowly than both the health care market basket and the consumer price index (CPI). Therefore, it is nearly impossible for many providers to reduce only their costs of care, while continuing to comply with quality standards, and staying under the new cost limits.

Providers must also reduce utilization levels which could have a drastic impact on beneficiary care. Cutting the number of home care visits could place some Medicare beneficiaries at risk of receiving less care than they need to remain in their homes. Lower utilization also requires family caregivers, who already provide a majority of home care services, to carry an even larger burden.

To lower utilization and costs, some home care providers are being forced to selectively admit patients. Beneficiaries who require high-intensity services for a short period (e.g. infected wound patients who require two or three dressing changes a day) or long-term patients who require services over an extended period (e.g. a multiple sclerosis patient with limited skilled care needs, but who requires extensive home health aide services for help with activities of daily living) are no longer "desirable" types of patients. Without home care, these patients could end up with increased numbers of acute-care episodes, increasing costs to Medicare, or end up in nursing homes at higher costs to state Medicaid programs.

HCFA has failed in its duty to educate beneficiaries and guide home care providers on the issue of appropriate versus inappropriate discharges from care. Because of a complete failure to address this important issue by HCFA, NAHC has attempted to develop educational materials for both providers and beneficiaries. Our best efforts, however, cannot take the place of guidance from HCFA since this is an unclear area of the law which calls for official explanation of responsibilities.

It is critical that providers understand how to appropriately discharge patients from service, should that be necessary, and that beneficiaries understand how IPS affects them and their home care benefits.

IPS Studies

Two recent studies on IPS echo many of home care's concerns about the impact of IPS on beneficiaries and providers. A recent study commissioned by The Commonwealth Fund found that changes in Medicare payments for home health care resulting from the BBA have the unintended consequence of reducing access to services for the oldest, poorest, and sickest Medicare beneficiaries. These individuals tend to need the most home care, for the longest periods of time. The report also found that:

- IPS places new financial pressures on home care providers to reduce high volume, or longer-stay, episodes of care.

- Most longer-stay patients are not using the Medicare home health benefit solely or predominantly for long-term care. These individuals tend to have substantial acute care needs as well.

- The home care agencies most affected by IPS will not necessarily be the most inefficient. Agencies serving more patients with greater care needs than they served in FY1994 will likely have difficulties maintaining the provision of appropriate care.

A study by The Lewin Group, entitled "Implications of the Medicare Home Health Interim Payment System of the 1997 Balanced Budget Act" concluded that:

- The sickest and most fragile patients may have difficulty accessing services, experience reductions in service, or be shifted to less appropriate care settings as a result of the per-beneficiary limit, which is based on 1993-94 cost data.

- The IPS was enacted to restrain growth of the Medicare home health benefit. However, growth in the benefit has already been restrained without the implementation of IPS. The growth rate in home care for 1996 to 1997 sharply decelerated, changing from a projected 13.8% to only 4.8%.

- Agencies most affected by the new per-beneficiary limit include: 1) those that have had an increase in severity in their case mix since 1994; 2) small agencies serving a large number of high-use patients; 3) rural agencies where alternative sources of care are less likely to be available; 4) agencies that have added services since 1994, the cost of which will not be included in the per-beneficiary limit calculation; and 5) new providers and agencies resulting from mergers or acquisitions.

- The IPS requires agencies to hold down their costs without regard to past efficiency or current patient mix. Agencies that cannot make cost reductions in the short time frame will likely experience financial losses and potential closure.

Specific IPS Reforms

The impact of IPS is so devastating that the ideal solution would be to repeal it and to require HCFA to meet its October 1, 1999, implementation date for a full PPS for home care. Absent a full-scale repeal, there are specific issues that must be addressed to adequately reform the interim payment system. NAHC urges Congress to act quickly and comprehensively in enacting legislation to address these concerns.

- **Restore cost limits to 112% of the mean.** Until BBA, the cost limits were set at 112% of the mean. BBA altered calculation to 105% of the median.

• **Delete the application of extending the savings from the freeze to the per-beneficiary limits.** Congress should allow the full market basket increase in calculating the per-beneficiary limits.

• **Delay implementation of the per-beneficiary limits.** Congress should delay the implementation of the per-beneficiary limits until FY1999.

• **Change the base year for calculating the IPS per-beneficiary limits.** Congress should change the base year from "12-month cost reports ending fiscal year 1994" to the 12-month cost reports ending in calendar year 1995. Congress should also change the per-beneficiary limit calculation in IPS from 98% to 100% of the base year cost per patient.

• **Eliminate the mandatory October 1, 1999, 15% reduction in home health reimbursement.** Congress should eliminate the mandatory October 1, 1999, 15% reduction in the limits to a reduction of up to 15% based on the targeted expenditures for home health during that year.

• **Restrict the proration of the per-beneficiary limits to when patients are served by more than the one agency to circumvent limits.** Congress should require that HCFA use the prorating provision only in situations where agencies are transferring or prematurely discharging patients for purposes of intentionally circumventing the limits.

• **Extend authorization for exemptions and exceptions to the per-beneficiary limits.** Congress should extend authorizations for exemptions and exceptions to the per-beneficiary limits.

• **Assign the median of the cost limits for the census division for new providers.** Congress should assign new providers a per-beneficiary limit that is the median of the limits for the census division where the agency is located.

• **Maintain periodic interim payment for home health agencies.** Congress should, at a minimum, maintain periodic interim payments (PIP) until a prospective payment system for home health is enacted.

Administrative Fixes

Some of the issues listed above can be resolved administratively by HCFA, and do not need a legislative fix. The Small Business Administration's Counsel of the Office of Advocacy issued an opinion which agrees that HCFA overstepped its bounds in several key areas of IPS implementation, and took administrative actions which dramatically worsen the effect of IPS on patients and home care providers. Specifically, HCFA should immediately reverse their actions in the following areas:

• HCFA chose to **apply the "recapture the savings of the freeze" provision to the calculation of the new per-beneficiary limits,** in addition to the per visit cost limits, setting the per-beneficiary limits at artificially lower levels. The new limits did not even exist at the time of the original rate freeze.

• HCFA assigned **new providers the median limit** that reflects national home care data, rather than census division data, giving some "new providers" much lower, and others much higher, reimbursement levels than other HHAs in the same geographic areas.

• HCFA also applied a **much broader definition of "new providers" than was required in statute,** making more than half of all HHAs in the nation "new providers" with reduced reimbursement limits that vary widely from other providers in their areas.

• HCFA chose to **prorate the per-beneficiary limit in all cases,** rather than only in cases where home care agencies act to circumvent the per-beneficiary limits. This approach ignores the long-standing rights of patients to choose any HHA they wish.

- HCFA is not **allowing any exceptions to the per-beneficiary limits**, even though using a five-year-old base year does not account for many changes in the amounts and types of services provided to clients by an agency.

We urge the Committee to insist that HCFA immediately reverse its decisions in each of these areas. While resolution of these issues would not adequately address all the difficulties in IPS, it would certainly address some important points. Furthermore, administratively addressing these issues would help Congress develop a legislative solution to IPS that fits within the required budget parameters.

Surety Bonds

Included in BBA was a requirement that each home health agency participating in Medicare and/or Medicaid secure a surety bond of at least $50,000 on a continuing basis. Agencies participating in both programs are required to secure two separate bonds. As Members of the Committee are aware, the recommendation for this proposal came out of the Health and Human Services Inspector General's Office, based on the Florida Medicaid program's experience with a surety bond requirement for home health agencies and durable medical equipment suppliers.

In Florida, HHAs are required to purchase a bond of $50,000 in value; agencies in good standing with the Medicaid program that had participated for at least one year were permitted to forgo the requirement; and once a new agency has proven itself reputable, it no longer must purchase a bond.

Unfortunately, the manner in which HCFA tried to implement the federal requirement went far beyond the Florida model, and provides a prime example of bureaucratic overkill.

NAHC is deeply grateful to the Chairman and members of the Subcommittee, especially Representatives Thurman and Stark for their attention to this matter. As you know, HCFA recently agreed to reconsider its regulatory decisions on surety bonds. This development would not have occurred without the strong signals from this body that the surety bond issue must be addressed.

NAHC looks forward to working with the Committee to ensure that any new regulatory efforts fully reflect NAHC's concerns with the previous surety bond regulations.

Surety Bond Recommendations:

1. HCFA should develop the surety bond regulations based on the intended principle and purpose of screening out inappropriate HHAs rather than as an insurance policy against overpayments.

2. Legislation should be enacted to allow recognition of the costs of a surety bond.

3. The bond amount should be reduced below $50,000 for small HHAs.

4. HCFA should reduce the bond amount to no greater than $50,000.

5. HCFA should establish standards for waiver of the bond requirement for any HHA in good standing.

6. HCFA should establish objective criteria for the eligibility of an HHA for a Medicare repayment plan.

7. HCFA should postpone the bond compliance date for new subunits so that it is consistent with the time standard for existing HHAs.

8. **HCFA should modify the regulations to eliminate or limit any risk of cumulative liability for the surety.**

9. **HCFA should not implement or enforce the surety bond regulations until the completion of the notice and comment procedures under the APA.**

10. **HCFA should comply with all procedural requirements of SBREFA including Congressional notice and the exploration and evaluation of alternatives.**

Sequential Billing and Medical Review

To manage the Part A to Part B shift, HCFA has instituted a policy known as sequential billing and payment. This policy has caused serious problems for home health agencies and is completely unnecessary. In fact, the FIs have clearly indicated that A and B expenditures can be calculated retrospectively, making sequential billing unnecessary.

Not only has the sequential billing policy created severe financial hardship for home health agencies, but financial data for A to B expenditures will be seriously flawed due to delays in claim submission and processing. In addition, these delays will have a negative impact on timely calculation of agencies' per-beneficiary expenditures.

Under this policy, HCFA has instructed fiscal intermediaries (FIs) to only process and pay claims submitted in chronological order according to when the services were performed, and only those claims for which any previous claims for provided services have already been settled. Previous claims for the same beneficiary may be unsettled for a variety of reasons, including medical review and common working file and Medicare secondary payor edits.

In recent years, HCFA and the office of the Inspector General (IG) have significantly increased the number of prepayment home health medical reviews being conducted (currently at 7% of all home health claims nationwide). Individual agency claims under review can be anywhere from 0% to 100%; despite the fact that the Administrator recently limited random review to 10%, many agencies average somewhere between 10 to 20% of claims under review. The process for reviewing and settling claims under this type of review takes somewhere in the neighborhood of 90 days (30 days for the agency to submit additional documentation, 60 days for FI review).

Because claims cannot be paid until previous claims are settled, the sequential billing and payment policy is having a cumulative, negative effect upon home health agency cash flow. For example, an agency that is serving 120 patients and is subject to 20% review beginning in March would be limited to submitting claims for only half (60) of those patients by June.

According to HCFA analysis, home health agencies are already under severe financial pressures (under the home health interim payment system, nearly all agencies will have costs for delivering care that exceed the level of Medicare reimbursement).

NAHC recommends that HCFA withdraw the policy for sequential billing. The Part A to Part B shift in home health is an accounting function designed to help shore up the Part A trust fund; the appropriate charging of home health services to Part A or Part B can be most accurately done on a retrospective basis.

CONCLUSION

The Medicare home health benefit is a vital part of the fabric that protects our nation's most vulnerable individuals.

NAHC, along with many Members of this Subcommittee, has long pressed for the development and implementation of an episodic PPS for home health that would include an adequate case mix adjuster to account for the costs of care of intensive care patients. This system would create important incentives for efficient delivery of services, while ensuring that high-cost chronically-ill patients can continue to receive needed services.

We urge the Subcommittee to fundamentally reform the IPS this year and to take decisive measures to ensure that HCFA meets the statutory requirement for implementing PPS in the BBA. NAHC appreciates the opportunity to submit our views to the Subcommittee. We look forward to working closely with you to resolve these issues, and ultimately to making PPS for home care a reality.

Written Statement of Susan Morris

On behalf of
The National Association for the Support of
Long Term Care

Submitted to

House Ways and Means Committee
Subcommittee on Health

July 16, 1998

Dear Chairman Thomas:

On behalf of the National Association for the Support of Long Term Care (NASL), I am pleased to submit the following testimony to you and the Members of the House Ways and Means Subcommittee on Health. This testimony is provided in response to the public hearing held by your Subcommittee on July 16, 1998 to examine recent policy decisions by the U.S. Department of Health and Human Services to delay implementation of certain provisions within the Balanced Budget Act of 1997. NASL is a trade association representing approximately 200 companies involved in the provision of services and supplies to the long term care industry. We are the only national organization that concentrates exclusively on legislative and regulatory matters regarding the professional services and supplies provided to beneficiaries in post-acute care programs.

We share the Subcommittee's concerns regarding the problems the Health Care Financing Administration (HCFA) is currently experiencing in implementing the computer system changes required by the Balanced Budget Act of 1997 (BBA), while also addressing the "Year 2000" or "Y2K" computer problems. The resulting confusion would put at serious risk the delivery of crucial services to Medicare beneficiaries. ***We therefore believe it is imperative that decisions regarding BBA implementation delays be made through a thoughtful and deliberative process which would ensure that no beneficiary services are put in jeopardy.***

In this regard, we applaud HCFA's prioritization in its recent decision to delay, until further notice, the implementation of consolidated billing for skilled nursing facility beneficiaries. The consolidated billing requirements require a tremendous amount of change to the computer systems of the multiple entities (HCFA, fiscal intermediaries, suppliers and providers), they also raise significant unanswered logistical questions. The resulting problems could therefore jeopardize necessary patient care. It was a decision that was welcomed by our members which, like HCFA, are also struggling to modify computer systems to comply with BBA requirements while addressing potential Year 2000 problems. We support this decision as the implementation of consolidated billing, absent administrative coordination, would result in confusion over rules, delay in payments and reductions in services that are necessary for beneficiaries.

As previously stated, NASL represents 200 companies that provide services and supplies to beneficiaries in skilled nursing facilities. ***Since the services of our members have a direct impact upon beneficiaries, it is imperative that decisions made by HCFA to delay implementation of some of the BBA provisions, be made known in an official capacity as soon as possible, to the provider community***. Inconsistent communications from the fiscal intermediaries, and last minute actions by HCFA will only result in additional burdens upon the industry's computer systems.

Another BBA provision that poses tremendous systems change, potential claims processing problems and a negative impact on beneficiaries is the proposed implementation of the $1,500 therapy cap provision. Section 4541(c) of the BBA imposed an annual, per-beneficiary limitation of $1,500 for the reimbursement of certain rehabilitation services. This limitation, or cap, is scheduled to become effective on January 1, 1999 and will affect all outpatient rehabilitation services, excluding those expressly excluded. In addition, the language has been interpreted as establishing dual caps; one for occupational therapy, and one cap for physical therapy and speech-language pathology services combined. Some therapy claims are paid by intermediaries, some by carriers. By its own admission, HCFA acknowledges that implementation of the provision, along with the necessary systems to track the financial limits of each beneficiary as they move through the system, will be extremely difficult at best.

The tremendous negative impact this cap will have on beneficiaries, however, is of more importance than the problems associated with the computer implementation problems. The arbitrary limitation was introduced without the benefit of research, public hearing or provider involvement. For these reasons, NASL has completed three studies that comprehensively document the negative effects of this cap. Your staff has received two

reports, and the third is attached.[1] This study confirms that one out of seven beneficiaries requiring therapy will incur costs exceeding the $1,500 cap.

The attached report responds to a question asked at the July 16th hearing. The question asked was "why the average length of stay in a skilled nursing facility is only 26 days, when the beneficiary has a 100 day benefit?" The attached report, *An Analysis of Rehabilitation Services "Flow" Patterns and Payments by Provider Setting for Medicare Beneficiaries* tracks Medicare beneficiaries through the complex, pluralistic American health care system. According to the study, there is no typical "flow" pattern of beneficiaries by care setting. Only *two percent* of all Medicare beneficiaries requiring rehabilitation care services follow the most common sequence of encounters by service setting (i.e. short term hospital inpatient to skilled nursing facility to home health agency.)

NASL opposes the imposition of the cap as its implementation will harm the oldest and sickest Medicare beneficiaries. For these reasons, we support H.R. 3835, the "Reinstatement of Rehabilitation Benefits for Seniors Act of 1998." This bill introduced by Congressman Ensign, repeals the arbitrary $1,500 cap and requires HCFA to implement a budget neutral alternative payment system no later than January 1, 2000.

We thank you for the opportunity to submit comments on this extremely important issue, and ask that our testimony be included in the hearing record.

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[1] In accordance with the Committee's formatting requirements for the submission of testimony for the record, we have attached to these comments a summary of the referenced report. We will also include a copy of the entire report which we understand will not be part of the official hearing record, but will be maintained in the Committee files for review and use by the Committee.

Attachment to NASL Testimony

Summary Analysis of the Flow Patterns and Payments by Setting for Medicare Beneficiaries Who Used Rehabilitation Services During 1996

This is a summary analysis of the attached study, *AAn Analysis of Rehabilitation Services "Flow Patterns and Payments by Provider Setting for Medicare Beneficiaries—1996"*

Do the findings from the 1996 study confirm the findings from the original 1994 "flow" analysis?

- Yes, in fact the 1996 report confirms both conclusions drawn from the 1994 study that: 1) Medicare beneficiaries do not flow through the rehabilitation services system in a similar manner and 2) the $1,500 annual per discipline cap is not adequate to meet the needs of most beneficiaries.

How many Medicare beneficiaries received rehabilitation services during 1996 and how many encounters did they have with the rehabilitation services care system?

- 5.6 million Medicare beneficiaries received rehabilitation services in 1996, resulting in approximately 8.9 million encounters with the rehabilitation services care system during the calendar year.

What percent of Medicare beneficiaries received rehabilitation services beyond a first encounter?

- 2.1 million, or 37 percent of Medicare beneficiaries receiving rehabilitation services, required more than a single encounter with the rehabilitation services care system.

What is the typical "flow" pattern by care setting of Medicare beneficiaries receiving rehabilitation services?

- There is no typical Aflow@ pattern by care setting. Medicare beneficiaries choose a highly varied matrix of care settings. No one provider setting accounts for more than 33 percent of services for the first three encounters. Only *two percent* of all Medicare beneficiaries requiring rehabilitation care services follow the most common sequence of encounters by service setting. (Short Term Hospital Inpatient to Skilled Nursing Facility to Home Health Agency)

What percent of Medicare beneficiaries who will need rehabilitation services outside a hospital setting in 1999 are projected to exceed the $1,500 benefit cap?

- Almost 13 percent, or about 1 in 7 Medicare beneficiaries who need rehabilitation services care will exceed the $1,500 benefit cap.

Will the $1,500 benefit cap reduce the choice of provider setting for the projected 13 percent of Medicare beneficiaries needing more intense rehabilitation care?

- Yes. Logically, the sickest and oldest Medicare beneficiaries require more intense, and more expensive, rehabilitation services care than healthier and younger beneficiaries. The 13 percent of Medicare beneficiaries exceeding the cap will be forced to seek rehabilitation services in inpatient or outpatient hospital settings if they want Medicare to pay for their rehabilitation services care.

BACKGROUND

During March 1998, NovaCare, the rehabilitation services company and National Association for the Support of Long Term Care (NASL) member, commissioned a study to update and further explore the use and costs of rehabilitation services in the Medicare program by analyzing the 1996 Medicare 5% Standard Analytical File. This report is the third in a series of studies on service, utilization and costs for Medicare beneficiaries receiving rehabilitation services.

In June 1997, NASL commissioned Muse & Associates to determine the number of Medicare beneficiaries who were receiving rehabilitation services in different provider settings and to assess the potential impact of changes in capping payments for rehabilitation services for beneficiaries using the 1994 Medicare 5% sample Standard Analytical Files. By July of that year, Muse released its report titled, The Impact of the $900 Therapy Cap on the Provision of Part B Therapy Services. This report examined the types of patients utilizing Part B therapy services and quantified the potential impact of a proposed reimbursement limit on the provision of rehabilitation services. The report also discussed the differences in costs incurred in the provision of therapy services in different settings. Data developed in this first report were one of several influences leading to a change in the proposed and subsequently approved annual service limit from $900 to $1,500.

In November 1997, Muse & Associates released a follow-up study for NASL that focused on the flow of patients through the rehabilitation services system titled, An Analysis of Rehabilitation Services "Flow" Patterns and Payments by Provider Setting for Medicare Beneficiaries During 1994. The major findings of the study were twofold: 1) the rehabilitation services delivery system is extremely complex and, therefore, it is virtually impossible to predict how a beneficiary will flow through this lattice-like system and 2) about 13 percent of Medicare beneficiaries are projected to exceed the $1,500 annual per discipline cap in 1999. Data from this analysis were instrumental in raising awareness of the possible effects of the $1,500 cap.

This current study builds on the previous work completed for NASL. It examines usage patterns of rehabilitation services during 1996 and investigates the number of beneficiaries expected to exceed the rehabilitation services cap during 1996. The same methodology was used for both flow reports (see Method Section). This analysis found that during 1996, an estimated 5.6 million Medicare beneficiaries received about 8.9 million rehabilitation service encounters paid by the federal government. Only 2 percent of all Medicare beneficiaries requiring rehabilitation services care follow the most common encounter "flow" pattern of rehabilitation services care (Short Term Hospital Inpatient, to Skilled Nursing Facility Inpatient, to Home Health Agency).

In June 1998, MedPac issued a report stating, "About one-third of patients in the dominant non-hospital settings (rehabilitation agencies and CORF's) exceeded either $1,500 of outpatient physical and speech therapy or $1,500 of occupational therapy. Since most outpatient rehabilitation patients receive those services in hospital OPDs, though, the affected patients represented only 10 percent of all physical and speech therapy patients in hospital OPDs, agencies, and CORFs in 1996..."[1] The current Muse study confirms MedPac's findings, estimating that about 13 percent of Medicare beneficiaries will exceed the therapy services cap in 1999.[2]

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[1] MedPAC Report, *Report to Congress: Context for a Changing Medicare Program, June 1998, p.86.*

[2] The Muse estimate is slightly higher because costs have been inflated to 1999 dollars. We estimate that Medicare beneficiaries will continue to exceed the therapy services cap at this rate and higher until 2002 when the $1,500 cap is set to be indexed for inflation.

METHOD AND STATEMENT OF ASSUMPTIONS TESTED

This study employed the same rigorous methodological standards that were established during the first "Flow" report (See Appendix I). As in the previous study, criteria were instituted to match encounters across multiple data sets[3] and an algorithm defined for tracking claims records on the 1996 5% public use file. Protocols were established to avoid double counting of rehabilitation services. Edits were applied to eliminate extreme outliers and to identify likely reporting errors. Results were carefully cross-walked to ensure data validity. Using established statistical standards, findings from the 5% sample were extrapolated to the universe of Medicare beneficiaries.

This report evaluates *two assumptions made by advocates of the $1,500 per discipline cap on rehabilitation services* during the debate leading up to the passage of therapy cap in the Balanced Budget Act of 1997. First, Medicare beneficiaries requiring rehabilitation therapy services flow through the system in similar manner (i.e., their service needs are similar, and, therefore, the costs of services should be similar). Second, that a $1,500 annual aggregate therapy limit per beneficiary provides sufficient resources to meet the rehabilitation needs of most Medicare beneficiaries (most defined as 90% of services).

ASSUMPTIONS TESTED

Assumption #1: *Medicare beneficiaries flow through the system in a similar manner.*

Data affirm this assumption to be false.

As in the previous study, the Medicare claims data were: (1) chronologically ordered across all settings, and (2) tabulated into data tables based on diagnoses, age, charges and payments. During 1996, the Short Term Hospital Inpatient (STHI) was the most common setting for Medicare beneficiaries needing rehabilitation therapy services. Skilled Nursing Facilities (SNF), Home Health Agencies (HHA), Physician Office Setting and Short Term Hospital Outpatient (STHO) settings were the four other most common settings for rehabilitation therapy services. These five settings accounted for more than 85 percent of all encounters for rehabilitation therapy services during 1996. Table 1 summarizes encounters by setting and sequence.

[3] An encounter was defined as a set of chronologically contiguous claim records occurring in a single setting (see Appendix 1 for a more detailed description of the method used to develop these data).

Table 1- Setting of Rehabilitation Services for Medicare Beneficiaries Receiving Services by Encounter During 1996

	First		Second		Third		Total	
	Encounter	%	Encounter	%	Encounter	%	Encounters	%
Short Term Hospital Inpatient	*1,851,340*	33%	389,500	19%	191,480	17%	2,432,320	27%
Short Term Hospital Outpatient	756,340	13%	159,960	8%	90,120	8%	1,006,420	11%
Skilled Nursing Facility: SNF File	331,940	6%	*541,000*	26%	*196,360*	17%	1,069,300	12%
Skilled Nursing Facility: Outpatient File	395,200	7%	88,840	4%	71,140	6%	555,180	6%
Home Health Agency	652,180	12%	*459,400*	22%	*354,460*	32%	1,466,040	17%
Outpatient Physical Therapy Service	311,900	6%	69,560	3%	39,820	4%	421,280	5%
Death *	69,420	2%	51,640	2%	31,220	3%	172,280	2%
Rehabilitation Hospital	63,300	1%	65,760	3%	30,820	3%	159,880	2%
Rehabilitation Unit	44,980	1%	122,180	6%	33,040	3%	200,200	2%
Psychiatric Unit	66,460	1%	15,880	1%	7,380	1%	89,720	1%
CORF	39,300	1%	10,740	1%	6,360	1%	56,400	1%
Psychiatric Hospital	12,920	0%	2,560	0%	1,140	0%	16,640	0%
Short Term/ Acute Care SB Hospital	12,980	0%	26,740	1%	9,960	1%	49,680	1%
Long Term Hospital	18,060	0%	17,720	1%	8,100	1%	43,880	0%
Physician	*994,580*	18%	76,400	4%	49,800	4%	1,120,780	13%
Other	10,140	0%	4,920	0%	2,400	0%	17,460	0%
Total	5,651,040	100%	2,102,820	100%	1,123,600	100%	8,877,460	100%

* Billable services provided before death

Note: Projections by settings are based on the Medicare 5% file. Caution should be taken for settings with low projections because they are based on sample sizes too small to provide projections as reliable as settings with higher projections. A larger projection reflects a larger sample size and, therefore, a more reliable projection.

An estimated 63 percent of Medicare beneficiaries receiving rehabilitation services did not have a second encounter with the rehabilitation care system. About 80 percent of Medicare beneficiaries receiving rehabilitation services did not have a third encounter with the rehabilitation care system during 1996.

Only 2 percent of all Medicare beneficiaries requiring rehabilitation services care follow the most common encounter "flow" pattern of rehabilitation services care from the Short Term Hospital Inpatient, to Skilled Nursing Facility Inpatient, to Home Health Agency setting. The "flow" patterns of encounters by setting for Medicare beneficiaries requiring rehabilitation services show great variation (Table 2). As was demonstrated in the 1994 study, the appropriate treatment for services appears to be related to medical acuity as represented by the differences in the average annual per capita payment for rehabilitation services by encounter (Table 3). These findings illustrate the difficulty of predicting the most prevalent encounter patterns. In fact, there are hundreds of different "flow" patterns that Medicare beneficiaries may follow as they receive rehabilitation therapy services during the course of a year.

Table 2- 1996 Most Prevalent "Flow" for Rehabilitation Services

Encounters	Setting	# of Beneficiaries	% of Total
First	Short Term Hospital Inpatient	1,851,340	33%
Second	Skilled Nursing Facility: SNF File	467,463	8%
Third	Home Health Agency	134,583	2%
Total Beneficiaries Receiving Rehabilitation Services		5,651,040	

As a way of illustrating the variations in flow patterns, the aggregate data were arrayed by encounter and services "flow" trees that map the progression of patient encounters across settings (see Appendix 2). Even limiting the number of trees to location of first and second

Table 3- Per Capita Payment of Rehabilitation Services by Setting for Medicare Beneficiaries Receiving Services by Encounter During 1996

	First Encounter Per Capita Payment	Second Encounter Per Capita Payment	Third Encounter Per Capita Payment	Overall Per Capita Payment
Short Term Hospital Inpatient	$276	$301	$320	$283
Short Term Hospital Outpatient	$233	$236	$307	$240
Skilled Nursing Facility: Inpatient File	$1,605	$2,073	$2,167	$1,945
Skilled Nursing Facility: Outpatient File	$1,413	$1,557	$1,452	$1,441
Home Health Agency	$1,102	$879	$1,035	$1,016
Outpatient Physical Therapy Service	$983	$1,287	$1,331	$1,085
Death *	$275	$432	$500	$363
Rehabilitation Hospital	$1,488	*$2,965*	*$2,557*	$2,294
Rehabilitation Unit	*$2,408*	*$3,104*	*$3,248*	$2,971
Psychiatric Unit	$534	$598	$691	$558
CORF	$1,555	$1,750	$2,170	$1,661
Psychiatric Hospital	$379	$426	$263	$379
Short Term / Acute Care SB Hospital	$347	$509	$512	$467
Long Term Hospital	*$1,722*	$2,867	$2,556	$2,338
Physician	$172	$200	$191	$175
Other	$1,124	$1,159	$1,667	$1,208
Total	$592	$1,246	$1,155	$818

* Billable services provided before death

service encounters, a very telling and varied "service delivery lattice" is evident. No setting accounts for more than 33 percent of the services at any stage of delivery. *Second and third encounters with rehabilitation services for Medicare beneficiaries appear to be more of a matrix of choices than a clearly defined continuum of care.*

Medicare beneficiaries needing rehabilitation services also require different intensities of care based on the acuity of their conditions, and appear to elect care setting based on this acuity factor. This is reflected in the variance of per capita payments for rehabilitation services across settings (see Table 3).[4] Per capita payments for rehabilitation services care are highest in rehabilitation units and long-term care hospitals. The physician and Short Term Hospital Outpatient settings have the lowest per capita payments for rehabilitation therapy services provided during a first encounter.

Assumption #2: A $1,500 annual per discipline cap[5] is adequate to meeting the needs of most beneficiaries.[6]

Data affirm this assumption to be false.[7]

Up to approximately 13 percent (see Appendix 3 and Appendix 4) of Medicare beneficiaries receiving rehabilitation services care are projected to exceed the $1,500 cap in 1999. This means those beneficiaries with higher acuity and need for rehabilitation services are more likely to be impacted by the therapy services cap. A Medicare beneficiary who needs two or more encounters of rehabilitation services can be expected to require more intense care than those needing only one encounter and are therefore more likely to exceed the cap. For instance, the average annual per capita Medicare payment for beneficiaries requiring only one encounter was approximately $592 during 1996. The average per capita Medicare payment for beneficiaries requiring three encounters was $592 for the first encounter, $1,246 for the second encounter, and $1,155 for the third encounter, with a total average annual per capita payment of $2,993. Many Medicare beneficiaries can be expected to have expenses in excess of the $1,500 cap by the second encounter with the rehabilitation services care system if they receive Part B services in more than one setting.

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[4] The 5% sample is based on interim not final payments. Intermediaries are penalized if the interim rate is less than 95% accurate. Source: HCFA Office of the Actuary.

[5] The $1,500 cap is the total charge amount that is subject to a 20 percent co-payment. Medicare total payment is $1,200.

[6] "Most" is defined as 90 percent of Medicare beneficiaries requiring rehabilitation services care.

[7] The cap does not apply to services billed in the STHI, STHO settings and to Part A skilled and home care services. The cap does apply to Part B services provided in SNFs, Rehabilitation Agencies, CORFs, and Part B home care (assumed to be 40% of beneficiaries who receive services in this setting).

received outside of the hospital setting. This study raise several additional questions about the effects of the $1,500 limitation on rehabilitation services for Medicare beneficiaries in need of such care including:

- Will the limitation of rehabilitation services setting choices for beneficiaries with rehabilitation payments in excess of $1,500 cause them to have longer and more frequent hospital stays?

- Will a beneficiary receive rehabilitation services care in the most appropriate and medically necessary setting due to the limitations that the $1,500 cap imposes?

- Does quality of care for beneficiaries with the most acute conditions suffer as short term hospital outpatient facilities transition from treating primarily the least acutely ill beneficiaries to treating the most acutely ill beneficiaries?

- What are the primary causes of payment growth for rehabilitation therapy services from 1994 to 1996? Do the trends support the policy rationale for a $1,500 per Medicare beneficiary coverage limit for rehabilitation therapy services?

National
Association of Health
Underwriters
Serving the public by promoting the activities and ethical conduct of insurance professionals through communication, education and legislative representation.

TESTIMONY OF

THE NATIONAL ASSOCIATION OF HEALTH

UNDERWRITERS

FOR THE RECORD

BEFORE

THE WAYS & MEANS HEALTH SUBCOMMITTEE

JULY 16, 1998

1000 Connecticut Avenue, NW• #810•Washington, DC 20036•(202) 223-5533•fax (202) 785-2274• www.nahu.org

My name is Diane Mahoney. I am an insurance agent specializing in senior products with Velco Insurance Agency in Randallstown, MD. These comments are presented on behalf of the National Association of Health Underwriters (NAHU), where I am the Senior Products Chair for the NAHU Legislative Council. NAHU's more than 15,000 members are insurance professionals involved in the sale and service of health insurance and related products, serving the insurance needs of more than 100 million Americans.

Last month the Administrator of the Health Care Financing Administration (HCFA) requested a delay in the implementation of the per episode home health prospective payment system and the outpatient prospective payment system provisions of the Balanced Budget Act. Furthermore, the agency is seeking a delay in the fiscal year 2000 updates for the hospital prospective payment and the physician fee schedule.

These serious steps preceded yet another HCFA announcement earlier this month, to curtail plans to distribute vital information regarding the Medicare+Choice options to all 38 million Medicare beneficiaries, another important component of the Balanced Budget Act. HCFA is now planning a sharply limited distribution to the 5.5 million beneficiaries living in Ohio, Florida, Arizona, Oregon and Washington.

Mr. Chairman, we hope you and your colleagues will critically review HCFA's plans because, we believe, the agency has failed to take advantage of a resource available to inform older Americans of their options: the health insurance professional.

Over the kitchen and family room tables of millions of Americans through the last several decades, the health insurance professional has been that trusted advisor who has "walked" wage earners and owners through health plan options and benefits, and not moved to the next topic until they understood what is important for them. Despite the complexity of the Medicare+Choice options, we are convinced that only an educational process that includes the personal, eye-to-eye dynamics of the client-agent relationship will succeed.

Instead, HCFA is relying on an impersonal strategy of using printed materials, the Internet, a toll-free telephone number, and community-based resources to help seniors make their choices. We share the concerns of you and your colleagues that these tools will prove inadequate to address the many questions older Americans will pose.

We believe the long-delayed handbook and other printed materials will be too thick and complex for beneficiaries to compare Medicare+Choice options and apply them to their specific needs. For example, HMOs, PPOs and PSOs might look the same but they are quite different, and MSAs are a new concept. For specific questions, beneficiaries will be directed to an 800-number, manned by individuals responsible for talking with hundreds of seniors daily. Anyone familiar with the delays in reaching someone on a toll-free

number can easily imagine the frustration seniors will face as they look for help with their Medicare choices.

People staffing these numbers, whose training has not been detailed and who apparently lack any public accountability, will have a limited time for each caller. This problem will be more acute for the senior who has several "what if" questions, the type likely to be raised. With others awaiting their turn, the 800-staffer will be anxious to get the caller off the phone. Seniors will have detailed questions these harried individuals will not have the time to answer. Rushed and confused, the senior will be inclined to select that which is familiar (and expensive), traditional fee-for-service Medicare.

We do not believe the impersonal Internet, with its required hardware, software, expertise, and small print, is widely enough available, sufficiently interactive and user-friendly to provide older Americans with the information they need to make these important health plan decisions. Furthermore, the monthly Internet access fees may be unaffordable for seniors on a fixed income.

For their part, community organizations may have the zeal and commitment to be of dedicated service, but they lack the knowledge, skills and accountability to advise seniors on this serious issue, and may actually do great harm in what they recommend.

In sum, NAHU believes there are two fatal flaws in the HCFA strategy. First, there is a complete lack of accountability to older Americans, the agency, Congress and the tax-paying public for the information and advice provided. Certainly the decisions seniors must make on their own behalf demand that responsibility be fixed for the success and effectiveness of this information campaign.

The second flaw, if addressed, will remove the first. Nowhere in the HCFA strategy is there a role for the health insurance professional. By virtue of their expertise, personal interaction with consumers, required state licensure, and public accountability, agents represent an untapped resource for older Americans. Because an agent would take the time to explain managed care and other options in detail, seniors would become more familiar with choices other than traditional fee-for-service Medicare. As a result, both seniors and the Medicare program would be able to enjoy the significant pricing advantages available only through many managed care plans.

Agents bring a valuable service to seniors by providing them with the wise counsel long enjoyed by millions of younger Americans. During their working years, many seniors had a trusted insurance agent they relied on to explain health plan provisions, help with the paperwork, contact providers, and represent their interests. Through their own personal experience, they know that an agent would be willing to take the time to explain in detail, and **in person**, how each Medicare+Choice option would work.

For example, an agent can help a senior on a limited budget identify an HMO plan offering a drug benefit, or describe the ease of a PPO plan to someone unlikely to adjust well to seeing a primary care physician when specialty care referral is needed. Once choices have been made, the insurance professional can serve as an intermediary helping with claims, benefits and billing.

Insurance agents must be licensed and satisfy continuing education requirements, which are important protections for the public, but lacking for those anonymous individuals and impersonal tools HCFA would employ for older Americans. In fact, agents are used extensively by the insurance industry to market insurance and related products, both to the benefit of the carrier AND the consumer and, we believe, would be of great value to the older American.

Since independent health insurance professionals are contractors and not employees, insurance carriers do not have such associated costs as benefits and reimbursement expenses to provide. They simply have the cost of the agent's commission. It is important to remember that the agent's commission **does not add any cost** to the Medicare program, for ALL health plans, public and private, have a marketing component built into their administrative fees.

In light of the budgetary restraints now claimed by HCFA for communicating Medicare+Choice information to limited numbers of seniors, ignoring such a cost effective and value added educational tool seems fiscally imprudent at best. Since most plans already use agents to market health insurance to those under 65, many insurance carriers will now use them for their Medicare products. Because of a directive HCFA issued in 1992 strongly discouraging the use of independent insurance agents for Medicare HMOs, however, many carriers have relied upon their own employees to explain the benefits of their HMO plans.

A recission of the 1992 directive would encourage carriers to increase the number of independent agents marketing their HMO plans. More importantly, it would provide seniors the benefit of viewing and comparing all plan choices with someone having no personal incentive to recommend one plan over another. We believe this independence is critical for both beneficiaries and HCFA. In a highly competitive market, the insurance professional working for the consumer, not the plan, will represent what is best for the client. Since the beneficiary can end the relationship at any time, it is in the agent's interest (and thus HCFA's and the client's), to help the senior decide on the most appropriate Medicare plan, and then provide meaningful service.

Once a beneficiary has selected the appropriate Medicare+Choice option, it would be the agent who would serve as the intermediary between the beneficiary and the plan, assisting

with questions or problems involving claims, plan benefits, and billing. This personalized local consumer service is strikingly different from HCFA's faceless, unaccountable strategy.

To encourage integrity in advising seniors, NAHU proposes the adoption marketing practice guidelines. First, these guidelines should be modeled after the marketing rules of Medicare Supplement plans. Well understood by insurance carriers and agents, these rules have worked well in this arena and would be readily adaptable to Medicare+Choice.

Second, marketers of Medicare+Choice plans must be licensed in the state where they do business. Currently insurance professionals must be licensed where they practice, and they must complete continuing education requirements annually in order to retain that license. In addition to a loss of license, some states provide criminal and monetary penalties if an agent is found guilty. Licensure assures public accountability while preventing the dishonest individual, who is only interested in an immediate gain, from having an incentive to market Medicare products.

Third, those who would market Medicare+Choice plans, independent agents and carrier representatives alike, must complete a training program. Regardless of their employment, all agents should be well versed in the choices available to seniors. Fourth, agent commissions for the sale of Medicare+Choice products should be level and paid monthly. At the same time, there should be no finder's fees or higher first year commissions. We join HCFA and private sector witnesses who have expressed concern about "churning" (moving beneficiaries from one plan to another) in order for agents to realize new commissions. The payment of level commissions, extending over the life of the health plan contract, would eliminate any incentive for this practice.

Fifth, contracts between carriers and agents should contain a clause stating that commissions on existing cases would continue in the event of termination of the contract, provided the agent remains licensed. Carriers entering a new geographic area sometimes contract with many agents in order to gain market share quickly. Over time, they may decide to continue contracts with only a handful of their "top producers." By continuing to pay commissions to those who are not "top producers" for plans written before contract termination, the incentive is eliminated to move beneficiaries from one plan to another. This recommendation also addresses concerns about churning.

Mr. Chairman, we urge that HCFA take advantage of the expertise, motivation, service, and advocacy that is provided by the professional insurance agent to help older Americans to select health plans under the Medicare+Choice options. Licensed agents provide accountability and the greatest assurance against fraud and abuse. Why, Mr. Chairman and members of the subcommittee, should 38 million Americans be denied the

right to consult with insurance professionals for their health coverage merely because they have turned 65?

NAHU appreciates the opportunity to provide our views to the members of the subcommittee on this important issue. We look forward to working with you and HCFA to maximize the choices available to older Americans under the Balanced Budget Act.

The PPS Work Group

A Nonpartisan Coalition of National and State Associations Committed to Prompt Implementation of Medicare Prospective Payment for Home Care

Statement of the Home Health PPS Work Group
On
" The Administration's Plan to Delay Implementation of the Balanced Budget Act of 1997"
Before The
House Ways and Means Health Subcommittee
July 16, 1998

The Home Health PPS Work Group is a coalition of national and state home health associations which have been working together to develop a consensus proposal for reforming the home health interim payment system ("IPS") which was enacted as part of the Balanced Budget Act of 1997 and became effective October 1, 1997. (See attached list of member organizations.)

The Adverse Impact of IPS

The Work Group was concerned about the unintended adverse consequences of IPS prior to its enactment on August 5, 1997. With a delay in implementation of the home health prospective payment system, we believe those adverse consequences will be exacerbated. The Work Group's concerns were confirmed in three studies that were issued in February and March of this year which independently found that:

1. IPS will deprive the sickest, most frail Medicare beneficiaries of access to home health services that meet all coverage requirements of the Medicare program.

2. IPS will create competitive disparities among agencies because agencies with lower base year costs per patient will have lower per beneficiary limits, and "new" agencies will have limits that are unrelated to their costs, quality, or patient mix.

3. IPS does not move the reimbursement system toward a prospective payment system.[1]

The members of the Work Group associations are finding that all of the above predictions are occurring under IPS and that the Medicare beneficiaries who are entitled to home health coverage and who need it the most are being denied access to those services. Accordingly, we request that Congress act this year to correct the defects in IPS and avoid action that would exacerbate the difficulty sicker patients are experiencing in gaining access to home health services.

Structural Defects in IPS

These adverse consequences of IPS are caused principally by the following three structural flaws:

1. The per beneficiary limit is based on an average cost per beneficiary which encompasses two patient populations with widely divergent costs. The home health patient population consists of at least two distinct subgroups—lower cost, short stay patients and higher cost, longer stay patients. See George

[1] Medicare Home Health Services: An Analysis of the Implications of the Balanced Budget Act of 1997 for Access and Quality, The Center for Health Policy Research, The George Washington University (March 1998).

The Balanced Budget Act of 1997: Effect on Medicare's Home Health Benefit and Beneficiaries Who Need Long-term Care, The Georgetown University Institute for Health Care Research and Policy on behalf of the Commonwealth Fund (February 1998).

Implications of the Medicare Home Health Interim Payment System of the Balanced Budget Act, The Lewin Group (March 13, 1998).

1875 Eye Street NW 12th Floor Washington DC 20006 P:202-466-6550 F:202-785-1756

Washington University study, Executive Summary at ii. By establishing the limit at a percentage of the average costs for all patients, the limit has the effect of eliminating coverage for patients whose costs are at the upper end of the range. Data show, for example, that about 10% of the home health population requires more than 200 covered visits each year and that these services account for 43% of total costs. Access to care for these patients is essentially eliminated by the use of a limit based on a single average cost per patient. Thus, the savings achieved under IPS come almost entirely from the longest stay, sickest patients.

2. The 75% agency-specific element of the per beneficiary limit is designed to reflect differences in case mix but is too imprecise. It is crucial for any limit to contain an element that reflects the agency's current case or patient mix in order to avoid an incentive to game the system by discharging or avoiding the sickest patients while retaining the same limit. The agency-specific element of the per beneficiary limit is not entirely effective, however, because it is impossible to know whether an agency's costs in the base year were high because it treated higher cost patients or because it was wasteful and inefficient.

   In addition, the per beneficiary limit for "new" agencies may result in either a windfall or a crippling economic hardship for an agency because it is unrelated to an agency's patient mix or efficiency. (See attached diagram.)

3. The per beneficiary limits (for both "old" and "new" agencies) under IPS do not change to reflect changes in patient or case mix. This provides an incentive for agencies to discharge or avoid the sickest, most costly patients so that the agencies can gain room beneath the per beneficiary limit.

Solution

The Work Group has developed the following solution to the above structural defects in IPS (See Medicare Beneficiary Access Act in attached diagram):

1. Eliminate the weak measure of patient mix represented by the 75% agency-specific element of the per beneficiary limit.

2. Replace this measure of patient mix with a methodology based on the average cost for providing services to short stay patients (0-120 days) and long stay patients (120 to 365 days). Each agency's aggregate per beneficiary limit for the year would be based on the total number of short and long stay patients actually treated in the current year multiplied by the average cost for that category of patients. (See attached diagram.)

3. The average cost per short stay and long stay patient would be based 50% on national data and 50% on regional data.

Advantages

1. Restores access to covered home health services for the sickest Medicare beneficiaries while only reimbursing agencies for the costs of efficiently providing services to both long and short stay patients.

2. Spreads the savings to be achieved more equitably over the entire home health patient population.

3. Removes the incentives to inappropriately shift patient mix by avoiding sicker patients or by adding short stay, less sick patients.

4. Eliminates competitive disparities unrelated to patient mix.

5. Eliminates the distinction between "old" and "new" agencies.

6. Moves the reimbursement system toward PPS by basing the limits on the two categories of patients which must be reflected in any case mix adjuster under PPS.

7. Establishes a system that self adjusts the limits each year to reflect each agency's mix of short and long stay patients. (In other words, agencies' limits are based on what they do rather than simply where they are located.)

Congress should not, under any circumstances, eliminate the only measure of patient mix in the current system without replacing that element with a patient mix measure that is at least as effective. The restoration of access for the sickest patients has been adopted as a top priority by the Consortium for Citizens with Disabilities and the Leadership Council of Aging Organizations.

Illustrative Examples

Under the current per beneficiary limits, agencies that provide the same services to the same type of patients may receive radically different limits. (HCFA data indicate that the average cost per beneficiary in the FY '94 base year ranged from $72,000 per beneficiary to $15 per beneficiary.)

Under a system that eliminates the agency-specific element of IPS and does not replace it with some other measure of patient mix, agencies that treat radically different patients and incur radically different costs will receive the same limit.

Under the Work Group proposal, agencies that provide the same services to the same patients will receive the same limit. Those that treat radically different patients and incur radically different costs will have different limits (although not so radically different because the limits are based on national and regional data rather than agency-specific data).

In summary, any revision to the IPS that eliminates case or patient mix, as would be the case under H.R. 3567 and S. 1993, will increase the discrimination against the sickest, longest stay patients. Such a revision would reward agencies that discharge or otherwise avoid the sickest patients.

The Medicare program is a program for beneficiaries. Accordingly, the Work Group believes that any solution should put the interests of the beneficiaries first.

PPS Work Group Participants

National Organizations:

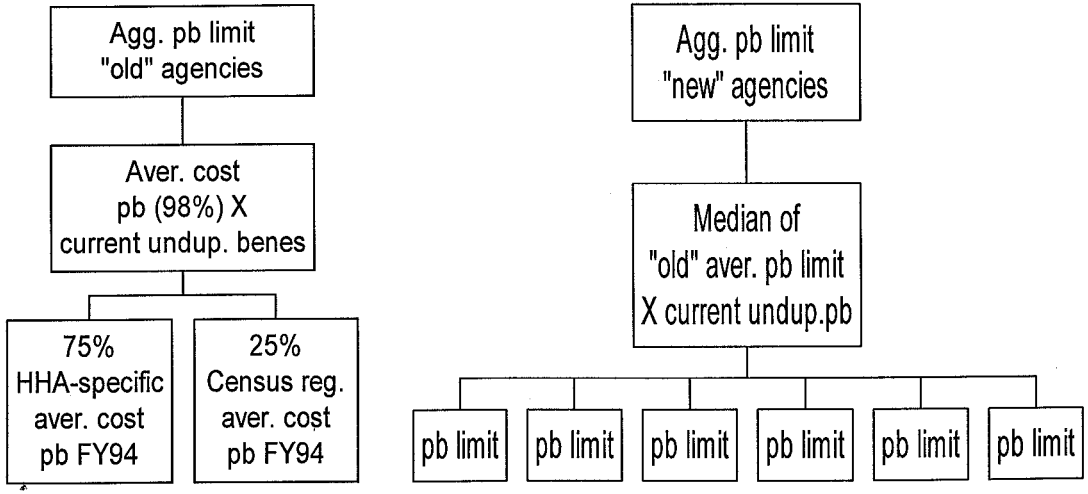
American Federation of Home Health Agencies
Home Health Services & Staffing Association
**Visiting Nurses Association of America

State Organizations:

Associated Home Health Industries of Florida, Inc.
California Association for Health Services at Home
Colorado Association of Home Health Agencies
Connecticut Association for Home Care, Inc.
Georgia Association of Home Health Industries, Inc.
Home Care Alliance of Maine
Homecare Association of Louisiana
Illinois Home Care Council
Indiana Association for Home Care, Inc.
Maryland National Capitol Homecare Association
Michigan Home Health Association
Mississippi Association for Home Care
New Mexico Association for Home Care
New York State Association of Health Care Providers
North Carolina Association for Home Care
Ohio Council for Home Care
Pennsylvania Association of Home Health Agencies
Texas Association for Home Care
Virginia Association for Home Care
Vermont Assembly of Home Health Agencies

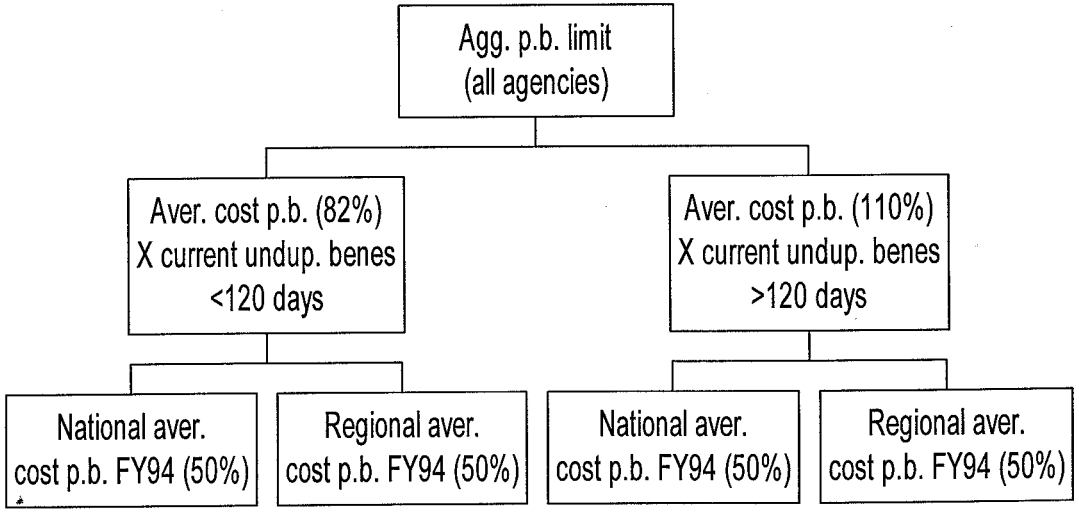
** Although the Visiting Nurses Association of America is a member of the PPS Work Group, they support their own proposal which is embodied in H.R. 3567 and S. 1993.

Interim Payment System
Balanced Budget Act '97



June 30, 1998

Interim Payment System
Medicare Beneficiary Access Act
PPS Work Group (Split Cap) Proposal



June 30, 1998

Congressman Jim Saxton (NJ)

Written Testimony submitted to the
Subcommittee on Health
Committee on Ways and Means

Thursday, July 16, 1998

Home Health Care and the Medicare IPS

Mr. Chairman, home health care for Medicare beneficiaries is undergoing serious changes. I have received thousands of letters from residents of my district sharing their concerns and fears about the future of the home health industry and informing me of the special care that these professionals bring to the sick and injured.

Mainly, these changes are occurring as a result of the Interim Payment System, a new formula developed to calculate Medicare reimbursement payments to home health agencies. The intent of the IPS was to reduce and hopefully eliminate fraud and abuse within this system. This I support whole heartedly.

However, New Jersey's home health agencies have consistently demonstrated a record of efficiency and exemplary care. In 1994, our state's agencies were providing on the average of thirty-nine annual visits per patient. At the same time, the national average was sixty-six visits.

Now, New Jersey's efficient providers are being treated equally to the most wasteful and fraudulent agencies around the country. This new provision does not target the worst offenders. It cuts everyone--including efficient agencies--from much needed home health dollars.

This policy must be altered so that wasteful and fraudulent agencies are forced to conduct business in a proper manner. At the same time, efficient agencies should not be penalized for their admirable efforts to provide the best care possible without jeopardizing the Medicare system.

For this very reason, I support the Medicare Home Health Equity Act of 1998 (H.R. 3567) introduced by Congressman Pappas. H.R. 3567 would reduce the spending of agencies with higher per patient visits without cutting into the reimbursements of effective agencies.

As the numbers show, New Jersey is not a state that has experienced exorbitant growth within its home health industry. Our citizens have received a superb level of care delivered to them in the comfort of their own home. These citizens--New Jersey's senior citizens--do not deserve to have their home care limited because of the careless or abusive actions of others.

Home health care is not only a less costly form of health care but also a more compassionate one. We all benefit from those that visit our homes to care for either our own ailments or those of our loved ones. Although, waste, fraud, and abuse are a constant threat to Medicare, there must be a **fair** and **equitable** way to rid them out. IPS is not the answer.

The bottom line here is to allow the most qualified and efficient agencies to continue to offer quality care to seniors. There is no logical reason why a credible provider should be penalized for the mistakes or abuses of others. Policies like these impact our seniors at a time when they need help the most.

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COMMISSION ON SECURITY AND COOPERATION IN EUROPE
CO-CHAIRMAN

Rep. Christopher H. Smith
July 16, 1998

Testimony before the Ways and Means Health Subcommittee

Congress Must Restore Fairness to Medicare's Home Health Care System

Mr. Chairman, today your Subcommittee will be examining the Health Care Financing Administration's (HCFA) proposal to delay -- until the year 2000 -- the legislatively mandated prospective payment system (PPS) for home health care services.

A delay in the PPS, Mr. Chairman, means an extension in the Interim Payment System (IPS). The IPS had only one saving grace: it was supposed to be "Interim" and temporary.

The IPS system was sold to Congress as a stop-gap measure to last no longer than 2 years while a PPS system was developed. Instead, HCFA appears to be giving Congress a lesson in the old Russian adage that "there is nothing more permanent than temporary."

Mr. Chairman, if home health agencies are going to be forced to live with the deeply flawed IPS system for longer than was contemplated under the Balanced Budget Act (B.B.A.), I believe Congress ought to consider how to reform the IPS so that home health agencies can survive until the year 2000.

I believe a good starting point for IPS reform is legislation that my good friend and colleague, Rep. Mike Pappas and I introduced to restore fairness and equity to the new Medicare reimbursement program for home health care. This legislation -- the Medicare Home Health Equity Act of 1998 (HR 3567) -- has been recently analyzed by the Congressional Budget Office (CBO) and it is definitely budget neutral. In fact, CBO believes it may even generate additional savings for the program. I strongly urge the Subcommittee to give HR 3567 the consideration it deserves, prior to adjournment this year. HCFA's plans to postpone PPS make the consideration of HR 3567 more pertinent than ever.

HR 3567 corrects the fundamental problem with the IPS, which is that current reimbursements are based on what agencies spent in the past. This means that agencies that were inefficient in the past get more money under the IPS than agencies that were conservative and well run. Waste is essentially hard-wired into home health agency future baselines under the IPS. Under HR 3567, however, per beneficiary spending formulas will be based on a combination of national and local costs that will reform payment variations across agencies while still allowing for peculiarities in their patient mix.

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Mr. Chairman, the cuts in reimbursement that the IPS has generated for well run, efficient home health agencies is wreaking havoc in my state and across the country. The Home Health Assembly of New Jersey estimates that if the IPS is not fixed during this legislative session of Congress, nearly a third of New Jersey's home health agencies will have to close. And if they have to live with IPS until the year 2000, as HCFA is now suggesting, the entire home health industry in New Jersey will be crippled by the steadily escalating cutbacks.

Already, NJ home care agencies -- all of which are nonprofit -- are losing money and many have laid off workers and reduced their patient visits. This is in spite of the fact that New Jersey's home health agencies continue to operate well below the national average in both numbers of visits per patient and cost per patient. The per beneficiary limits in the IPS have decreased the average New Jersey home health agency's reimbursement by nearly 36 percent.

The value of home health care to our seniors is obvious. All of us intuitively know that providing seniors quality, skilled nursing care in their own homes is preferable to other, more costly, sometimes isolated, settings. Seniors citizens receive the peace of mind from familiar settings and their loved ones close at hand. And the cost savings to Medicare from proper use of home health care are considerable.

Mr. Chairman, the legislation we have introduced is balanced and carefully crafted to make improvements to the Medicare Interim Payment System. It is budget neutral. It will enable our senior citizens to continue to receive high quality, medically necessary home health care services. It also will appropriately target federal efforts to reduce waste and fraud in the Medicare program. I urge you to consider this legislation and support our efforts to protect the homebound Medicare patients who are now at risk.

July 13, 1998

The Honorable Bill Thomas, Chairman, and Members
Subcommittee on Health, Committee on Ways and Means
1136 Longworth House Office Building
Washington, D.C., 20515

RE: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 1999; Proposed Rule, Health Care Financing Administration, 42 CFR Parts 405, 410, 413, 414, 415, 424, and 485.

Dear Congressman Thomas and Committee Members:

This letter is respectfully submitted on behalf of the membership and board of directors of the Society for Radiation Oncology Administrators (SROA), a national organization consisting of over 600 oncology program administrators, to address the public hearing on the "Administration's Plan to Delay Implementation of the Balanced Budget Act of 1997," specifically in regards to the fiscal year 2000 updates for the hospital prospective payment system and for the physician fee schedule.

The June 5, 1998, publication of the Federal Register regarding the proposed Resource Based Relative Value System (RBRVS) by HCFA jeopardizes the future of care delivery to cancer patients. While we applaud the federal government's increasing support of cancer research through National Cancer Institute (NCI) funding, we are somewhat baffled by this proposed legislation which will hinder the ability to provide current state-of-the-art care to the cancer population and inhibit the ability of providers to make available new treatments developed through this research funding. Although this may not be an intentional impact of the proposed legislation, the following points demonstrate the need to more fully research the RBRVS structure prior to its implementation.

- **The proposed ruling has a disproportionate impact on cancer patients.** Cancer is the second leading cause of death in the U.S., with more than 1,500 Americans dying each day from the disease ["Cancer Facts & Figures - 1998", American Cancer Society]. About 1,228,600 new cancer cases are expected to be diagnosed this year (not including basal cell and squamous cell skin cancer). At least sixty (60) percent of those diagnosed are Medicare beneficiaries. This means that nearly 750,000 Medicare beneficiaries will be diagnosed with cancer this year alone.

- **Radiation Therapy is a key component in cancer care, being one of the three principle means of treating cancer.** Radiation Oncology is currently utilized in over 50% of all cancer patients, and the NCI has commented that this figure should be closer to 70 - 80%. The proposed ruling decreases Medicare reimbursement to Radiation Oncologists by eight (8) percent, while reducing reimbursement to Radiation Oncology facilities by 24%. This drastic reduction occurred by "crosswalking" Radiation Oncology procedures into Diagnostic Radiology procedures. This methodology reduces the rate of reimbursement to a level which will not even allow for the recouping of costs associated with providing this care.

- **The data used by HCFA do not accurately represent the practice expense of Radiation Oncology** [Federal Register, June 5, 1998, p. 30,825; p. 30,829]. The methodology utilized by HCFA relies on statistical estimates in its "crosswalk" formula rather than concrete data for Radiation Oncology.

- **Although an adequate number of survey responses were obtained in the American Medical Association (AMA) Socioeconomic Monitoring Survey (SMS) from Radiation Oncology facilities (n=40), the actual data from these surveys were not considered as in other practices.** For example, the number of cases apparently acceptable for consideration as a separate specialty for the purpose of determining Relative Value Units (RVU's) was 27 for Medical Oncology, 31 for Allergy/Immunology, 42 for Neurological Surgery and 44 for Cardiac/Thoracic/Vascular Surgery [Table 2, Federal Register, June 5, 1998, p. 30,831]. Radiation Oncology facilities provided 40 cases, but these were instead grouped with 174 Radiology cases for development of the RVU's. This inequitably skewed the data utilized to develop the Radiation Oncology RVU's, since it is a field with higher capitalization costs and more costs associated with patient care management since Radiation Oncologists manage the care of patients throughout the course of their disease.

- **Cancer Care will be compromised by hindering the community-level introduction of new treatment technologies.** Over 50% of the radiotherapy equipment in current operation is 15 years of age or older. Reduction in the reimbursement for Radiation Oncology procedures will discourage the needed upgrading of this equipment, thereby increasing the incremental costs of care by precluding the introduction of more efficient technologies, by increasing maintenance costs, and by reducing the reliability of the equipment. More importantly, access to care for cancer patients will be reduced, since such a decline in reimbursement will render many clinics inoperable.

The bottom line created by the current proposal is a dramatic decline in the cancer care attainable by Medicare beneficiaries and all cancer patients throughout the U.S. The SROA recommends, on behalf of these millions of cancer patients, that the current proposal be modified prior to implementation or delayed until HCFA can establish a system which demonstrates equity across specialties utilizing statistically valid data and does not have a disparate impact on any particular group of patients.

Thank you for your consideration of these important issues. Good luck in your formidable task.

Sincerely,

Michael Franklin, President-Elect
Society for Radiation Oncology Administrators
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Oak Brook, IL 60523
630-368-3732

SOCIETY OF NUCLEAR MEDICINE
1850 Samuel Morse Drive / Reston, VA. 20190-5316 / (703) 708-9000 / FAX: (703) 708-9015

July 10, 1998

The Honorable William M. Thomas (R-CA)
Chairman
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Re: Hearings On HCFA's Proposed Delay In Implementation of
The Balanced Budget Act of 1997 - Hospital Outpatient APCs

Dear Chairman Thomas:

The Nuclear Medicine APC Task Force[1] thanks the Committee for this opportunity to comment on the Health Care Financing Administration's (HCFA) proposal to delay implementation of the hospital outpatient ambulatory payment classifications (APCs). The APCs were one of several provisions in the Balanced Budget Act of 1997, Pub. L. 105-33, (BBA) which Congress mandated be implemented by January 1, 1999. In brief, we support HCFA's request for additional time to develop the APCs, if that additional time is spent to work closely with affected parties to ensure the proposed APCs fulfill Congressional intent. We suggest that Congress urge HCFA to make available to affected parties relevant data being used to construct the APCs and that HCFA fully consider well substantiated data from the public to supplement HCFA data which may be flawed or inadequate to construct appropriate APCs. As discussed below, we are particularly concerned with APCs involving nuclear medicine/nuclear cardiology procedures and radiopharmaceuticals used in all these procedures.

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1 The Nuclear Medicine APC Task Force is an umbrella organization of groups involved in every aspect of nuclear medicine/nuclear cardiology. Its members include the American College of Nuclear Physicians (ACNP), the American Society of Nuclear Cardiology (ASNC), the Council on Radionuclides and Radiopharmaceuticals, Inc. (CORAR), the Society of Nuclear Medicine (SNM), and the Technologist's Section of the SNM.

The Nuclear Medicine APC Task Force commends the Committee for calling this hearing, and for its continuing oversight regarding the implementation of the Balanced Budget Act of 1997 by HCFA. Our members and Medicare patients will be significantly and directly affected by the nuclear medicine APCs, and we share your concern that delay not result in adverse impacts on patients or hospitals. The APCs are one of the most important changes in Medicare hospital payment policy. In addition, the many issues emerging for compliance with year 2000 changes could create substantial disruption if implementation is not smooth. It is in everyone's interest that the new APCs effectively achieve Congress' goals of fair and equitable payment for hospital outpatient services.

Support For Additional Time to Develop APCs

The Nuclear Medicine APC Task Force supports HCFA's request for additional time to propose the APCs, for the following reasons. The challenge facing HCFA is considerable in terms of the data, methodologies, and dynamic nature of hospital outpatient services. To finalize its APC proposal, HCFA must compress hundreds of thousands of clinical events into a manageable number of meaningful classifications that make economic and clinical sense. The Nuclear Medicine APC Task Force has been working with HCFA staff on the nuclear medicine/nuclear cardiology APCs for over two years. We appreciate that if the final stages of APCs are developed in undue haste, the APCs will not pay hospitals for services within clinically homogeneous and economically coherent classes. Section 4523 of the BBA requires no less. Accordingly, we believe that Congress should authorize HCFA to take an additional six months to finalize the APCs proposal.

Require HCFA to Make Radiopharmaceutical Data Available

Of course, if the APC proposal is to be delayed, this additional time must be put to good use. To this end, the Nuclear Medicine APC Task Force respectfully requests that the Committee recommends that HCFA make available to interested parties the data upon which the new APC proposal will be based, *before* the proposed rule is issued. These data are public data and we understand HCFA plans to make them available, although that may not occur until after the APC proposal is published.

As noted above, the Nuclear Medicine APC Task Force has been working with HCFA on the nuclear medicine APCs for over two years, and for the most part, our communications with the agency have been positive and productive. We have met with Janet Wellham and her staff on numerous occasions to share our perspectives on nuclear medicine APCs, present proposals and obtain feedback from HCFA. In March, 1998, we requested from HCFA data about radiopharmaceuticals, a key component of every nuclear medicine/nuclear cardiology procedure, but have received no reply as yet. These data on radiopharmaceuticals are critical to completing our recommendations to HCFA. We seek your support in encouraging HCFA to share these data with the Task Force. In so doing, we can use the additional time to

complete our analyses, further refine our recommendations to HCFA and better ensure that the nuclear medicine APCs will make clinical and economic sense.

Standards for Classifying Procedures in APCs - Recent Data

As you know, the BBA is quite specific in setting forth the parameters of the information that HCFA is to use in developing APCs. Section 4523(a)(2)(A) directs HCFA to develop a classification system for outpatient hospital services. Under subsection (B), HCFA may establish groups of covered OPD services within that classification system, "so that services classified within each group are comparable *clinically* and *with respect to the use of resources*." (emphasis added). Section 4523(a)(2)(C) then directs HCFA to set payment levels for these classifications, providing that:

> The Secretary shall, using data on claims from 1996 and using data from the most recent available cost reports, establish relative payment weights for covered OPD services (and any groups of such services described in subparagraph (B)) based on median hospital costs and shall determine projections of the frequency of utilization of each such service (or group of services) in 1999.

Unique Issues for Nuclear Medicine and Radiopharmaceuticals

Application of this requirement to nuclear medicine/nuclear cardiology and radiopharmaceuticals has proven particularly challenging for hospital outpatient procedures. There are over 120 nuclear medicine/nuclear cardiology procedures with widely varying technologies. Each procedure utilizes at least one radiopharmaceutical. Physicians must choose the radiopharmaceutical best suited for the patient. There are well over 50 radiopharmaceuticals with payment levels ranging from $9 up to over $2,000 per patient dose. For many years, it was unclear how hospitals were to bill for radiopharmaceuticals. In 1995 and 1996, HCFA's billing and payment policies made clear for the first time that radiopharmaceuticals could be billed and paid separately. Separate payment for the radiopharmaceutical enabled hospitals and physicians to select the product most appropriate for the patient.

However, during 1996, many hospitals did not report radiopharmaceuticals separately as allowed by the new policy. As a result, HCFA's data will present an incomplete and inaccurate record, for purposes of assessing costs and relative payment weights. This is especially important since HCFA has indicated to us that HCFA intends to bundle radiopharmaceuticals into the nuclear medicine APCs. HCFA has acknowledged there are anomalies in the classifications of nuclear medicine procedures and radiopharmaceuticals. Thus, our Task Force needs to understand, and if necessary supplement the data upon which HCFA relies, so that accurate information is used. For these reasons, our Task Force seeks reasonable access to HCFA's data. The availability of information is of particular significance to the Nuclear Medicine APCs in light of these data problems and section 4523(a)(2)(C) of the

BBA, which requires HCFA to use data from 1996 claims and the most recent cost reports to establish relative payment weights for covered services.

Furthermore, within the last year, hospitals have begun to use new radiopharmaceuticals, important for diagnosis and treatment of cancer. Data on these products will not be included in HCFA's 1996 reports, but should be considered in the formulation of the initial APCs. Looking ahead, HCFA needs to make clear how it will monitor the introduction of innovative new procedures and products to keep APCs up-to-date with advances in nuclear medicine.

Specific Data Sought from HCFA

Specific data which we would like HCFA to release include:

- The total number of nuclear medicine procedures in the hospital outpatient setting during 1996 used to construct the nuclear medicine APCs;
- The number of claims (or data records within a claim) for radiopharmaceuticals used in outpatient hospital nuclear medicine procedures in 1996;
- The range of Medicare payments for radiopharmaceutical;
- The standard deviation, median and average payment amounts for radiopharmaceuticals; and
- The methodology that HCFA proposes to use to monitor newly introduced radiopharmaceuticals for diagnostic and therapeutic nuclear medicine procedures, and the methodology to allow interim outlier payments and updates in APCs.

Release of these data will enable our Task Force to engage in much more informed dialogue with the agency. Also, HCFA should be instructed that with additional time, it should consider and allow data from 1997 and 1998, as well as other well substantiated data when anomalies exist.

In summary, the Nuclear Medicine APC Task Force supports HCFA's request to extend the date for issuing the APC's proposal. In order to assure that wise use is made of the additional time, and to make public participation more informed and productive, the Committee should urge HCFA to make rapidly available key information upon which it will base the determination of new APCs, such as data on nuclear medicine and radiopharmaceuticals. Similarly, HCFA should consider data from 1997 and 1998, including well substantiated hospital data.

With this information, our Task Force can better work with HCFA toward APCs that encourage high quality care and avoid a system that creates improper financial incentives to chose a product or procedure which is not in the best interests of the Medicare patient. We thank the Committee for this opportunity to present our views, and for your ongoing support in this important endeavor.

Sincerely,

Kenneth A. McKusick, MD

Kenneth A. McKusick, M.D., FACR, FACNP
Chairman
Nuclear Medicine APC Task Force

Enclosures - March 26, 1998 letter
April 17, 1998 letter

cc: Janet Wellham (HCFA)
Kitty Ahern (HCFA)

Robert E. Henkin, M.D., FACNP (ACNP)
Denise A. Merlino, M.B.A., CNMT, FSNMTS (SNM)
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July 1, 1998

Congressman Bill Thomas
Chairman, Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
Washington, DC 20510

Dear Chairman Thomas,

SUN Home Health Services is a mid-sized, traditional Visiting Nurse Association (VNA) serving a large portion of Central Pennsylvania for the last 30 years. We have built our reputation, as a traditional VNA who has always done whatever was necessary to ensure care for all those in need in Central Pennsylvania.

We are members of the National Association for Home Care and the Visiting Nurses Association of America, and are held in high regard by both industry organizations. We are one of 50 agencies selected nationwide to participate in the OASIS demonstration project, funded by Health Care Financing Administration (HCFA) through the Center for Health Policy and Research. This project has been ongoing for several years and is designed to measure patient care outcomes and set standards for all Medicare-certified home care providers in the coming months. We were selected because of our good provider reputation and demonstrated leadership in the industry. Our continued high-quality, effective and efficient outcomes have been commended by the Center for Health Policy, and a recent letter from project director Dr. Peter Shaughnessy is enclosed.

Because SUN Home Health Services is a community-based, not-for-profit provider, we have always provided care to all in need regardless of their financial situation in lieu of building financial reserves. That community mission almost got us dismissed from the Medicare program because we did not have the financial asset base required to obtain the $1,000,000 bond that was required of us by July 31st.

The reprieve from the bond requirements agreed to by HCFA is a good start to solving what is quickly becoming a homecare crisis, but we need to do more to secure and enhance the access to quality home health care services to seniors. As indicated earlier, our participation in the OASIS demonstration project speaks well of our organization's reputation, but more importantly we have helped to set the standards and benchmarks for medically necessary home care and the desired outcomes for Medicare expenditures.

In spite of our cost-effective quality care for 30 years our very existence is threatened because the current Medicare Interim Payment System (IPS) penalizes those that have been progressive and cost efficient while rewarding those who have historically drained the Medicare trust fund. IPS erodes our ability to continue meeting the very standards of care that we have participated in establishing. Our per beneficiary cap under IPS is nearly $1,000 less than the national average. Because we are a very cost-efficient agency, particularly in 1994, our IPS rates will make it impossible to continue achieving the results that we have been able to demonstrate through OASIS.

As you know, Pennsylvania has one of the lowest IPS calculations because costs have historically been lower than many other areas of the country. The fact is that most Pennsylvania agencies do not have the ability to survive IPS without significantly restricting care to patients.

The result will undoubtedly be limited access to homecare for the sickest patients. Patients will be forced to go without medical care or receive more costly and less desirable care in an inpatient setting.

I know that you and your staff have a good grasp of these important issues facing seniors and their access to health care in their homes. I am quite sure everyone agrees that the provision of medically necessary, physician-directed home health service is more cost effective than all other means of care, including acute and long-term care. Everyone understands that seniors respond better to care that is provided in their familiar home surroundings. And no one, absolutely no one, should be surprised that the use of home health care has grown by leaps and bounds over the past few years. Patients are discharged from hospitals much earlier with more complex medical conditions and treatments provided in a follow-up setting in the home. This is indeed a cost-effective alternative to hospitalization, emergency room visits, or long-term care and should be embraced as an appropriate public policy.

Chairman Thomas, we ask that the Subcommittee on Health of the Ways and Means Committee support efforts to hold the Health Care Financing Administration accountable for their actions aimed at undermining and destroying the home health care benefits that Congress has determined should be available to our senior citizens. HCFA should not be allowed to continue this devastating reimbursement methodology called IPS and certainly should not be allowed to extend it and delay implementation of a Prospective Payment System under the guise of the year 2000 problem. Be it ignorance or arrogance, HCFA is leading us down a path that is destroying the home health benefit and hurting seniors throughout our nation. We challenge HCFA to explain why it makes sense for funding levels to differ 5-6 times from one community to the next across this country. Why in the name of cost savings or fraud and abuse you reward the very agencies that have taken advantage of the system for years and stomp on the backs of providers who have provided cost-effective quality care.

SUN Home Health Services and many quality home care providers across the United States remain committed to our patients and our communities. We need your help to insure that our mission is not destroyed by bad health care policy at the national level.

Thank you for your assistance to this medical crisis.

Respectfully submitted,

Steven Richard

Steven Richard
Chief Financial Officer
SUN Home Health Services

The National Medicare Quality Assurance and Improvement Demonstration

June 26, 1998

Jane E. Hyde, COO
SUN Home Health Services, Inc.
61 Duke Street
Northumberland, PA 17857-0232

Dear Ms. Hyde:

The purpose of this letter is to acknowledge and compliment you on SUN Home Health Services' participation in the National Medicare Quality Assurance and Quality Improvement Demonstration since 1995. As you know, the purpose of this national demonstration program is to test and refine a methodology to evaluate and then improve the patient outcomes of home health care. This entails data collection on every adult patient, outcome reporting, and outcome enhancement. We at the University of Colorado who designed the approach and are administering the demonstration were extremely impressed that SUN Home Health Services lowered its hospitalization rate by over six percentage points within just one year after beginning participation in the demonstration – an indicator of potentially outstanding care and of dedication to positively impacting the well being of your patients.

This national demonstration project has been the precursor to and set the national standard for the soon-to-be-implemented approach Medicare is adopting to collecting Outcome and Assessment Information Set (OASIS) data and implementing a national approach to Outcome-Based Quality Improvement (OBQI) throughout the United States. SUN Home Health Services has played an important part in the demonstration by being one of the 50 original participating agencies, collecting and submitting data as required, and by developing and implementing pertinent quality improvement plans for SUN's targeted outcomes. Your agency's conscientious involvement in the demonstration reflects a clear and strong commitment to providing quality care to your patients.

Sincerely,

Peter W. Shaughnessy, Ph.D.
Professor and Director

Center for Health Policy Research - 1355 S. Colorado Blvd., Suite 306, Denver, Colorado 80222 - (303) 756-8350/Fax: (303) 759-8196

J.C. WATTS, JR.
4TH DISTRICT, OKLAHOMA

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Testimony by Congressman J.C. Watts of Oklahoma Regarding Home Health Care and the Interim Payment System

Before the House Subcommittee on Health, Rep. Bill Thomas of California, Chairman

July 16, 1998

Mr. Chairman, tens of thousands of elderly and disabled Americans depend on quality home care services to maintain a life of good health and dignity. It is a credit to you that this Committee is taking the time to review recent laws regarding home health care to make sure these laws are serving our constituents well.

As part of the Balanced Budget Act of 1997, Congress enacted reform of the rules by which home health care agencies are reimbursed by Medicare for the services they provide. This reform was designed to secure the financial health of the Medicare system and to encourage home health care agencies to provide more cost efficient service, thereby saving taxpayer dollars.

The Prospective Payment System, or PPS, is the ultimate reform Congress passed to make home health care more cost efficient. However, it is now clear that the Health Care Financing Administration, or HCFA, will not be ready anytime soon to implement PPS because HCFA's computer network is not yet ready to handle the Year 2000 problem. It is now estimated that PPS may not be ready for implementation until April of 2000. This is clearly an unacceptable delay.

In anticipation of a delay in implementing the new Prospective Payment System, HCFA established the Interim Payment System to bridge the old, cost-based system with the new PPS program. Under HCFA's Interim Payment System, or IPS, home care agencies will now receive Medicare reimbursements in the form of three possible amounts, whichever amount is the lowest — **one**, the actual cost of the service provided; **two**, a per visit limit, which is an amount calculated using the number of patients in an area and the services provided in that area; and **three**, a per beneficiary limit, which is a cap on how much a home care agency can be reimbursed during the course of a year for providing services.

Mr. Chairman, HCFA's Interim Payment System is a nightmare. I have heard from home care agencies across Oklahoma who have expressed grave concerns about the impact of the new IPS system. Sometimes when reforms are put into effect, there is some grumbling by those who are inherently resistant to change, no matter how beneficial that change may be, but the concerns expressed by these home care agencies are strongly merited. There are some potentially grave consequences surrounding HCFA's Interim Payment System to which we as Members of Congress must be sensitive and must address in a timely fashion.

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Simply put, HCFA's Interim Payment System does not ensure that home health care agencies will be adequately reimbursed for their services. It is wrong for home care agencies to receive too much money for their services, but it is just as wrong for home care agencies to receive too little money for their services. If home care agencies are forced to accept Medicare reimbursements for their services that are less than the costs of those services, those agencies will run deficits. Agencies cannot survive if they can't pay their bills. Under-reimbursed agencies will be not able to hire skilled staff and therapists, and the quality of the services they provide senior citizens will decline.

In a worst case scenario, home care agencies which are under-reimbursed stand a good chance of going bankrupt and closing their doors. Already in Texas, for example, we find that 815 home care agencies and branch offices have closed their doors in the first 10 months of fiscal year 1998, according to the *Dallas Morning News*.

Consider these numbers. HCFA estimates that for home care agencies across the country that receive Medicare reimbursements, **93 percent** of those agencies will be under-reimbursed. If these predictions are true, home care agencies across America may shut their doors for lack of adequate funding. The alternative to home health care for many disabled and elderly senior citizens is admittance into a nursing home. None of us want to rob senior citizens of their independence, so we must work to prevent good home care agencies from having to close their doors.

Particularly disturbing is the new per beneficiary limit HCFA established as a reimbursement option under IPS. According to HCFA, health care agencies nationwide are expected to receive a 31 percent drop in their total reimbursements under the per beneficiary limit reimbursement system. Home care agencies in Oklahoma are expected to average a 29 percent drop in reimbursements, so we are doing a little better than the national average. Many states are projected to do much worse. Home care agencies in California, for example, can expect to see a 37 percent drop in their Medicare reimbursements. Home care agencies in Connecticut are looking at 39 percent loss, while agencies in Illinois and Wisconsin can expect a 35 percent reduction. All of this translates into hundreds of home care agencies closing their doors. Clearly, this is a disparity which needs to be fixed sooner rather than later.

I am hopeful that Congress can repair the Interim Payment System. If IPS is to remain in place, it should at least provide a larger Medicare reimbursement for patients whose medical problems require more visits by a home care provider or more costly health care services. Currently, IPS would simply provide reimbursements for patients based on whatever cost is lower, the actual cost of services, a per beneficiary limit or a per visit limit. As you can imagine, the actual cost of services for patients require long-term or in-depth home health care is likely to be high. Therefore, under the IPS system, a home care agency probably won't be reimbursed for the full cost incurred while caring for patients needing long-term home care or many different care services.

Also, the IPS system should have been put into effect at the same time for all agencies, and not gradually phased into an area. One home care agency shouldn't be forced to linger under the old, cost-based system while another agency is put under the IPS system. This will hurt competition and force one agency to curtail services which it can no longer afford. All of us here today believe patients should be able to choose their health care provider. If the implementation of IPS is staggered in a region rather than implemented at once, competition will cease to exist, and patients may be forced to rely on a home care agency whose bedside manner is less than perfect.

These and other concerns are why this Committee should delay the implementation of the Interim Payment System until we can reform the system. If a good fix is not possible, then Congress should scrap IPS and replace it with a better system. Congress must help home care agencies receive a fair reimbursement, so they can keep their doors open and serve senior citizens who rely on their services.

Ultimately, our goal should be to press HCFA to implement the Prospective Payment System as soon as possible and to eliminate the need for a convoluted and potentially harmful interim system. The thought of two more years of the Interim Payment System is unacceptable. The time to act and solve the problems caused by the Interim Payment System is now.

Home care agencies in my District welcome efforts to make home health care more cost efficient, to save taxpayer dollars. Indeed, we can make home care more efficient without reducing the quality of health care and destroying the system. In the coming weeks, I look forward to working with this Committee and with all my colleagues as we work to protect the quality of home health care for senior citizens while making the home care system as efficient as possible.

Thank you, Mr. Chairman, for giving me time today to express my concerns about the future of home health care. I appreciate the efforts of this Committee to make sure my constituents and all Americans who need home health care can have access to a quality, cost efficient provider.

Statement for the Record

of

Congressman Bob Weygand
Rhode Island
District 2

Ways and Means Committee
Subcommittee on Health

July 16, 1998

Chairman Thomas, Congressman Stark and my distinguished colleagues. Thank you for providing me with this opportunity to present my thoughts to you on several home health care issues currently facing Medicare beneficiaries in this country.

Many throughout this nation recognize the value of home health care. Whether it is as a government official, a provider, a patient or a family member, home health care has made a profound impact on many of our lives. Home health care agencies help our elderly and disabled and their families bear the burden of financial costs and day to day care. They come into the home and assist the family in coping with illness, while providing their patients with something they cherish more than anything -- their independence.

Yet, as a result a provision of the Balanced Budget Act (BBA), our invaluable home care system, their employees and their patients, are in danger and on alert. In recent months we've watched agencies reluctantly lay off workers while one non-profit home health care agency in my state, the Visiting Nurse Service of Pawtucket, which has been providing quality care for over 87 years, closed its doors for good.

Since the passage of the BBA, it has become crystal clear that home health care agencies, which have been operating in a cost-efficient manner, have been unduly penalized while agencies with higher costs have been rewarded. The Interim Payment System (IPS), passed as part of the BBA, makes no adjustment on whether costs were artificially inflated and does not address waste, fraud and abuse. This is especially true for agencies in low cost regions, like New England because a portion of their reimbursement is based on regional costs.

This is not only true for cost-efficient agencies in New England and home health care agencies in other low-cost areas. The Visiting Nurse Association of Texas (VNA) recently wrote to me expressing their concern over the IPS. As they remarked in their letter to me, "VNA has been one of the most cost efficient home care agencies in the nation. Over the past six years, we have saved Medicare almost $21 million by providing care below the Medicare cost caps. In 1995, the VNA of Texas averaged 42 visits per patient while the average of all agencies in Texas was 128.6 visits per patient." I have included a copy of this letter with my testimony for the committee's information.

Due to the IPS, the VNA, which according to their accounting has saved Medicare $21 million for providing low cost service, is forced to compete with neighboring agencies which are receiving more from the federal government to provide home health care services.

Another portion of the IPS allows new agencies to be reimbursed at the national average, which in New England tends to be much higher than what older agencies are receiving to care for the same patients. This situation results in unfair competition between agencies, which could be as close as next door, by allowing agencies to receive more from the federal government to provide quality care than their well established and lower cost neighbor. We should not be punishing long standing agencies with low costs simply because they have been operating efficiently for years.

These are among the many unintended consequences of the inequitable IPS. We need to act now, prior to adjournment of this Congress, to restore equity and fairness into the home health care system.

To this end, I worked in the House Budget Committee to address this critical situation. I offered an amendment during the mark-up of the fiscal year 1999 Budget Resolution, which was passed unanimously. A copy of the amendment, Section 10 of the Budget Resolution as originally passed by the committee and the committee's modified language, as approved by the House, is attached for the committee's review.

It is clear that Congress wrote the language in the Balanced Budget Act to provide little administrative flexibility to HCFA, and is therefore incumbent upon Congress to enact needed reforms.

We need to act now to protect Medicare beneficiaries. Discussions of such things as "Interim Payment Systems", "per beneficiary caps" and "cost reporting periods" tend to illicit beltway responses with a sense that no real impact is felt outside of Washington. These changes in Medicare affect real people in our districts who are losing much needed home health benefits due to these changes.

In January, I accompanied a home health care nurse as he visited one of his patients, Genevieve Weeser. Gen, as she likes to be called, is 98 years-old and sharp as a tack. She currently lives in subsidized housing for the elderly in

Warwick, Rhode Island. As I sat in her cozy apartment, Gen told me without skipping a beat where she grew up, which happened to be the same neighborhood where I grew up, where she got married, which coincidentally happened to be the same church in which both my parents and my wife and I were married and all about her family, including her 102-year-old sister. But what Gen really wanted to talk about was her independence.

Gen relies on the home care services she receives. During the hours allotted by Medicare, Gen's home health aide assists her with the activities of daily living, while her nurse monitors her health condition. Gen told me she values this assistance, along with the friendships and continued independence that comes with it. She also told me she is afraid that the recent changes in Medicare may force her from her home and into a more expensive and medically-inappropriate nursing facility.

Above all else, during consideration of any bills to reform the IPS we must remember the human impact of the IPS. Patients come first.

Thankfully, there are many members of Congress who have recognized the problems with the IPS. Over 120 members of the House of Representatives have sponsored one or more pieces of legislation calling for reform of the Interim Payment System. I was heartened to hear that the Speaker of the House in a speech in New Jersey indicated that the House would keep its commitment to the Budget Committee Amendment that was adopted by the House calling for IPS reform. I also heard that the Speaker predicted that reform of the IPS will be enacted prior to the adjournment of the 105th Congress.

Without consensus, I fear that this issue, if not addressed properly, will cause battles -- between the North and East, between the West and South, between free-standing agencies and affiliated agencies, between non-profit agencies and proprietary agencies -- and, in doing so, scrap any hope for true IPS reform this year. I have been working diligently, with colleagues from both sides of the aisle, to forge a bi-partisan consensus on this most pressing issue. This working group is continuing to develop legislation to address the IPS and protect the sickest and neediest of Medicare beneficiaries.

I am also deeply concerned about the lack of progress in developing a prospective payment system for home health care. As we all know far too well,

in accordance with the Balanced Budget Act an additional reduction of 15% will automatically occur on October 1, 1999 if the Health Care Financing Administration has not fully implemented a PPS. Cost-efficient home health agencies in my district and yours are struggling to adapt to the dramatically lower rates due to the IPS. They cannot sustain any additional cuts -- much less one of dramatic proportions like 15%. In addition to addressing the problems associated with the IPS, Congress needs to lessen this automatic 15% cut and provide the resources to HCFA for the implementation of a PPS.

Soon, millions of Medicare beneficiaries will be faced with an overwhelming amount of choice for their health care. Although Congress authorized $200 million for an outreach effort for Medicare+Choice, only $95 million was appropriated for this initiative. I am weary of the Administration's decision to select specific markets to inform Medicare about their impending choice. I am particularly concerned that the state of Rhode Island, with the third largest percentage of citizens over the age of 65 is not slated to be among the markets chosen by HCFA. I believe all beneficiaries, as directed by the BBA, should be given all the information they require, in simple and easy to understand language, so they can make important decisions on their health care.

Finally, I recognize the amount of work the Health Care Financing Administration must perform to fully carry out its mandates. With the enactment of the Health Insurance Portability and Accountability Act and the Balanced Budget Act, HCFA has taken on an enormous amount of work. From keeping a watchful eye on waste, fraud and abuse which costs our nation over $23 billion each year to providing much-needed answers to Medicare beneficiaries, HCFA is swamped with work and may not have the needed resources to complete its work. I am hopeful Congress will recognize this situation and will appropriate adequate funds to HCFA to perform the mandates of Congress.

Above all else, I remain committed to ensuring that Medicare beneficiaries in this nation receive the information they need to acquire the quality of health they deserve.

Again, thank you for this opportunity to present my views on these important issues.

SEC. 10. SENSE OF CONGRESS ON THE INTERIM PAYMENT SYSTEM FOR HOME HEALTH BENEFITS UNDER MEDICARE.

(a) SENSE OF CONGRESS.—It is the sense of Congress that—

(1) the interim payment system for home health service has adversely affected some home health care agencies and medicare beneficiaries;

(2) if home health care is threatened and further reduced, health care costs to Federal and State governments, as well as families, may rise to cover more expensive post-hospital and long-term care;

(3) the committees of jurisdiction should initiate a revision of the interim payment system, paying particular attention to providing a more gradual reduction in home health care costs and additional time for home health care agencies to adjust to lower rates and reimbursements;

(4) due to the critical nature of this issue, Congress should enact an equitable and fair revision of the interim payment system before the adjournment of the 105th Congress; and

(5) the Health Care Financing Administration should fully implement by October 1, 1999, the prospective payment system that was enacted into law last year.

SEC. 9. SENSE OF THE CONGRESS ON THE INTERIM PAYMENT SYSTEM FOR HOME HEALTH BENEFITS UNDER MEDICARE.

It is the sense of the Congress that—

(1) there is concern that the interim payment system for home health service has adversely affected some home health care agencies;

(2) the Administration should ensure that the implementation of the interim payment system does not adversely affect the availability of home health services for Medicare beneficiaries;

(3) Congress should carefully examine the Adminstration's implementation of the home health payment system and make any necessary changes to ensure that the needs of Medicare beneficiaries are being met; and

(4) the Health Care Financing Administration should quickly implement the prospective payment system that was enacted into law last year.

O