

MEDICARE HOME HEALTH CARE INTERIM PAYMENT  
SYSTEM REFINEMENT ACT OF 1998

OCTOBER 5, 1998.—Ordered to be printed

Mr. ARCHER, from the Committee on Way and Means,  
submitted the following

REPORT

together with

MINORITY VIEWS

[To accompany 4567]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 4567) to amend title XVIII of the Social Security Act to make revisions in the per beneficiary and per visit payment limits on payment for health services under the Medicare Program, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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The amendment is as follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

**SECTION 1. SHORT TITLE.**

This Act may be cited as the “Medicare Home Health Care Interim Payment System Refinement Act of 1998”.

**SEC. 2. INCREASE IN PER BENEFICIARY LIMITS AND PER VISIT PAYMENT LIMITS FOR PAYMENT FOR HOME HEALTH SERVICES UNDER THE MEDICARE PROGRAM.**

(a) INCREASE IN PER BENEFICIARY LIMITS.—Section 1861(v)(1)(L) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)) is amended—

(1) in the first sentence of clause (v), by inserting “subject to clause (viii)(I),” before “the Secretary”;

(2) in clause (vi)(I), by inserting “subject to clause (viii)(II)” after “fiscal year 1994”; and

(3) by adding at the end the following new clause:

“(viii)(I) In no case shall the limit imposed under clause (v) for cost reporting periods beginning during or after fiscal year 1999 be less than the average of the limit otherwise imposed under such clause and the median described in clause (vi)(I) (but determined as if any reference in clause (v) to ‘98 percent’ were a reference to ‘100 percent’).

“(II) Subject to subclause (III), for cost reporting periods beginning during or after fiscal year 1999, in no case shall the limit imposed under clause (vi)(I) be less than the median described in such clause (determined as if any reference in clause (v) to ‘98 percent’ were a reference to ‘100 percent’).

“(III) In the case of a new home health agency for which the first cost reporting period begins during or after fiscal year 1999, the limitation applied under clause (vi)(I) (but only with respect to such provider) shall be equal to 75 percent of the median described in subclause (II) of this clause. This subclause shall not apply to a home health agency which filed an application for home health agency provider status under this title before September 15, 1998, or which was approved as a branch of its parent agency before such date and becomes a subunit of the parent agency or a separate agency on or after such date.

“(IV) The limits computed under subclauses (I) through (III) are subject to adjustment under clause (iii) to reflect variations in wages among different areas.”.

(b) REVISION OF PER VISIT LIMITS.—Section 1861(v)(1)(L)(i) of such Act (42 U.S.C. 1395x(v)(1)(L)(i)) is amended—

(1) in subclause (III), by striking “or”;

(2) in subclause (IV)—

(A) by inserting “and before October 1, 1998,” after “October 1, 1997,”; and

(B) by striking the period at the end and inserting “, or”; and

(3) by adding at the end the following new subclause:

“(V) October 1, 1998, 108 percent of such median.”.

(c) EXCLUSION OF ADDITIONAL PART B COSTS FROM DETERMINATION OF PART B MONTHLY PREMIUM.—Section 1839 of such Act (42 U.S.C. 1395r) is amended—

(1) in subsection (a)(3), by inserting “(except as provided in subsection (g))” after “year that”; and

(2) by adding at the end the following new subsection:

“(g) In estimating the benefits and administrative costs which will be payable from the Federal Supplementary Medical Insurance Trust Fund for a year for purposes of determining the monthly premium rate under subsection (a)(3), the Secretary shall exclude an estimate of any benefits and administrative costs attributable to the application of section 1861(v)(1)(L)(viii) or to the establishment under section 1861(v)(1)(L)(i)(V) of a per visit limit at 108 percent of the median (instead of 105 percent of the median), but only to the extent payment for home health services under this title is not being made under section 1895 (relating to prospective payment for home health services).”.

(d) REPORTS ON SUMMARY OF RESEARCH CONDUCTED BY THE SECRETARY ON THE PROSPECTIVE PAYMENT SYSTEM.—By not later than January 1, 1999, the Secretary of Health and Human Services shall submit to Congress a report on the following matters:

(1) RESEARCH.—A description of any research paid for by the Secretary on the development of a prospective payment system for home health services fur-

nished under the medicare care program under title XVIII of the Social Security Act, and a summary of the results of such research.

(2) SCHEDULE FOR IMPLEMENTATION OF SYSTEM.—The Secretary's schedule for the implementation of the prospective payment system for home health services under section 1895 of the Social Security Act (42 U.S.C. 1395fff).

(3) ALTERNATIVE TO 15 PERCENT REDUCTION IN LIMITS.—The Secretary's recommendations for one or more alternative means to provide for savings equivalent to the savings estimated to be made by the mandatory 15 percent reduction in payment limits for such home health services for fiscal year 2000 under section 1895(b)(3)(A) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(A)), or, in the case the Secretary does not establish and implement such prospective payment system, under section 4603(e) of the Balanced Budget Act of 1997.

(e) MEDPAC REPORTS.—

(1) REVIEW OF SECRETARY'S REPORT.—Not later than 60 days after the date the Secretary of Health and Human Services submits to Congress the report under subsection (d), the Medicare Payment Advisory Commission (established under section 1805 of the Social Security Act (42 U.S.C. 1395b-6)) shall submit to Congress a report describing the Commission's analysis of the Secretary's report, and shall include the Commission's recommendations with respect to the matters contained in such report.

(2) ANNUAL REPORT.—The Commission shall include in its annual report to Congress for June 1999 an analysis of whether changes in law made by the Balanced Budget Act of 1997, as modified by the amendments made by this section, with respect to payments for home health services furnished under the medicare program under title XVIII of the Social Security Act impede access to such services by individuals entitled to benefits under such program.

(f) GAO AUDIT OF RESEARCH EXPENDITURES.—The Comptroller General of the United States shall conduct an audit of sums obligated or expended by the Health Care Financing Administration for the research described in subsection (d)(1), and of the data, reports, proposals, or other information provided by such research.

## I. INTRODUCTION

### A. PURPOSE AND SUMMARY

The Committee bill refines the interim payment system for Medicare's home health care benefit as defined in the Balanced Budget Act of 1997 (P.L. 105-33). The bill is expected to provide equity to those agencies which have low-cost, low-utilization practices relative to other agencies. In addition, the bill increases payments to certain, new agencies and establishes payments for agencies that would receive Medicare payments until implementation of the new prospective system. Despite the increase in Medicare part B expenditures, the bill excludes these costs from the calculation of the beneficiary monthly premium. Finally, the bill requires several reports on the prospective payment system summarizing research conducted by the Secretary of Health and Human Services to be submitted to the Congress so that implementation of the new payment system is not further delayed. The policies contained in the bill were carefully designed to meet administrative restrictions relating to the Year 2000 as outlined by the Health Care Financing Administration in the Subcommittee on Health's August 6, 1998 hearing.

### B. BACKGROUND AND NEED FOR THE LEGISLATION

Last year, the Congress closely examined Medicare's home health care benefit to ensure that Medicare was providing appropriate and meaningful services to its beneficiaries and to rein in unsustainable growth in Medicare spending, approximately 40 percent of which was found by the Office of Inspector General for the Department

of Health and Human Services not to meet Medicare reimbursement requirements.

The Balanced Budget Act of 1997 included several changes in the payment of Medicare's home health care benefit. Primary among these changes was the creation of a new system of payment based on a standard prospective payment amount to be developed by the Secretary of Health and Human Services for implementation on October 1, 1999. Recently, the Congress learned the Administration would be unable to implement the prospective payment system on time, resulting in a prolonged interim payment system.

Under the Balanced Budget Act, the interim payment system was established for two years. The Administration's failure to implement the prospective payment system on October 1, 1999, will mean that it will be in place for a longer period than intended. The extension of the interim payment system will keep low limit providers under constraints that could affect their ability to respond to changes in patient-mix.

### C. LEGISLATIVE HISTORY

#### LEGISLATIVE HEARINGS

The Subcommittee on Health held a hearing on refinements to the interim payment system for Medicare's home health care benefit on August 6, 1998, that included testimony from the Health Care Financing Administration, the General Accounting Office, the Medicare Payment Advisory Commission, the Inspector General of the Department of Health and Human Services and many home health care agencies.

In the 105th Congress, the Subcommittee on Health held three hearings regarding the subject of the bill. The hearings were as follows:

On March 3, 1998, the Subcommittee on Health held a hearing on advisory reports regarding Medicare payment policies.

On July 16, 1998, the Subcommittee on Health held a hearing on the Administration's plan to delay implementation of the Balanced Budget Act of 1997.

On August 6, 1998, the Subcommittee on Health held a hearing on Medicare's home health care benefit.

#### COMMITTEE BILL

On September 15, 1998, the Subcommittee on Health ordered favorably reported to the full Committee, as amended, H.R. 4567, the "Medicare Home Health Care Interim Payment Refinement Act of 1998," by voice vote, with a quorum present. On September 18, 1998, the full Committee ordered favorably reported H.R. 4567 by voice vote, with a quorum present.

## II. EXPLANATION OF THE BILL

### 1. SHORT TITLE

*Present law*

No provision.

*Explanation of provision*

The Act is named the “Medicare Home Health Care Interim Payment System Refinement Act of 1998.”

## 2. INCREASE IN PER BENEFICIARY LIMITS AND PER VISIT LIMITS

*Current law*

Section 4602 of the Balanced Budget Act established interim payments for Medicare home health care agencies until implementation of the Prospective Payment System on October 1, 1999. Agencies are currently paid their costs up to two limits. The limits are applied when an agency settles its cost report with Medicare. The first limit—the per visit limit—is based on the mix of visits the agency provided to Medicare patients during the year. The per visit limits are based on 105 percent of the median costs by category of services. The second limit—the per beneficiary limit—is based 75 percent on an agency’s historical cost per beneficiary and 25 percent on the average per beneficiary historical costs for the region in which the agency is located (minus 2 percent), and are adjusted by the home health market basket. Agencies whose first full year cost report began after October 1, 1993 receive the national median of the per beneficiary limits.

*Explanation of provision*

H.R. 4567 increases the per visit limits to 108 percent of the national median costs. In addition, the bill increases the per beneficiary limit for those agencies whose per beneficiary limit is below the input price adjusted national median limit. The adjustment is equal to one half of the difference between the agency’s per beneficiary limit and the input price adjusted national median limit. Home health agencies who begin treating Medicare patients on or after October 1, 1998 will have per beneficiary limits equaling 75 percent of the input price adjusted national median limit. In the case of a home health care agency or home health care branch which exists as of September 15, 1998, the 75 percent of the national median rule would not apply if that branch subsequently becomes a subunit of its parent or a separate agency. Rather, the parent agency’s limit at the time the branch becomes a subunit or a separate agency would be used. These changes will have no impact on the Medicare part B monthly premium.

The bill also requires the Secretary of Health and Human Services to submit to Congress a report describing 1) all of the research to date on the development of a prospective payment system for Medicare home health services, 2) a schedule for implementation of the BBA mandated prospective payment system, and 3) the Secretary’s recommendations for one or more alternatives to provide savings equal to the estimated savings from the 15 percent reduction in payment limits scheduled for fiscal year 2000. The Secretary should consider, among her alternatives, the amount of co-payment that would provide the same level of savings. The Medicare Payment Advisory Commission (MedPAC) is required to submit a report to Congress no later than 60 days after the date that the Secretary submits her report. In addition, MedPAC shall include in its June 1999 report an analysis of whether changes in law

made by the Balanced Budget Act and amended by this section, impede access to home health services. The General Accounting Office is required to conduct an audit of the Health Care Financing Administration's expenditures for research related to the development of a prospective payment system for Medicare home health care services.

*Reason for change*

The Medicare home health care interim payment system per beneficiary limits are based on one year of historical cost data (from cost reporting period ending in fiscal year 1994). The rates are based on a blend of agency-specific data and regional data. While this blending reduces some of the variation among agencies, there still exists a more than ten-fold difference between the per beneficiary limits across agencies. Some agencies with very low historical costs have difficulty responding to changes in the mix of patients. This bill would assist the lowest cost agencies by increasing the per beneficiary limits for the agencies below the national median limit. The increase would equal half of the difference between the per beneficiary limit as established under the Balanced Budget Act and the national median limit (calculated without a two percent reduction).

Because of the Administration's recent announcement of a delay in implementing the prospective payment system on October 1, 1999, as required in the Balanced Budget Act, the Subcommittee is concerned about the impact of this delay on agencies and beneficiaries receiving home health care services. In order to ensure accountability, the Secretary is required to report back to Congress by January 1, 1999 with a detailed time line for implementation of the new system so that the progress may be carefully monitored by the Congress. The Administration must also propose recommended alternatives to the 15 percent across-the-board reduction in rates that will occur on October 1, 1999 because of the PPS implementation delay.

*Effective date*

Medicare home health agency cost reporting periods beginning on or after October 1, 1998.

### III. VOTES OF THE COMMITTEE

In compliance with clause 2(1)(2)(B) of rule XI of the Rules of the House of Representatives, the following statements are made concerning the votes of the Committee on Ways and Means in its consideration of the bill H.R. 4567.

#### MOTION TO REPORT THE BILL

The bill, H.R. 4567, as amended, was ordered favorably reported on September 18, 1998, by voice vote with a quorum being present.

#### VOTES ON AMENDMENTS

A roll call vote was conducted on the following amendment to the Thomas/Stark amendment in the nature of a substitute.

An amendment by Mr. Stark to include all policies in the underlying amendment in the nature of a substitute, to make certain payment provisions retroactive to fiscal year 1998, disallow adjustment in managed care payments, limit payments to mental health partial hospitalization services, require reporting of certain employment information, and reduce the number of individuals eligible to enroll under Medicare Medical Savings Accounts, was defeated by a roll call vote of 14 yeas to 23 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer .....		X		Mr. Rangel .....	X		
Mr. Crane .....		X		Mr. Stark .....	X		
Mr. Thomas .....		X		Mr. Matsui .....	X		
Mr. Shaw .....		X		Mrs. Kennelly .....			
Mrs. Johnson .....		X		Mr. Coyne .....	X		
Mr. Bunning .....		X		Mr. Levin .....	X		
Mr. Houghton .....		X		Mr. Cardin .....	X		
Mr. Herger .....		X		Mr. McDermott .....	X		
Mr. McCreery .....		X		Mr. Kleczka .....			
Mr. Camp .....		X		Mr. Lewis .....	X		
Mr. Ramstad .....		X		Mr. Neal .....	X		
Mr. Nussle .....		X		Mr. McNulty .....	X		
Mr. Johnson .....		X		Mr. Jefferson .....	X		
Ms. Dunn .....		X		Mr. Tanner .....	X		
Mr. Collins .....		X		Mr. Becerra .....	X		
Mr. Portman .....		X		Mrs. Thurman .....	X		
Mr. English .....		X					
Mr. Ensign .....		X					
Mr. Christensen .....		X					
Mr. Watkins .....		X					
Mr. Hayworth .....		X					
Mr. Weller .....		X					
Mr. Hulshof .....		X					

An amendment by Mr. Stark to add at the end of the bill, new sections consisting of the text of H.R. 4592, the "Home Health Patient Protection Act of 1998," was defeated by a roll call vote of 11 yeas to 17 nays, with one voting present. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer .....		X		Mr. Rangel .....	X		
Mr. Crane .....		X		Mr. Stark .....	X		
Mr. Thomas .....		X		Mr. Matsui .....	X		
Mr. Shaw .....		X		Mrs. Kennelly .....			
Mrs. Johnson .....		X		Mr. Coyne .....	X		
Mr. Bunning .....				Mr. Levin .....	X		
Mr. Houghton .....		X		Mr. Cardin .....	X		
Mr. Herger .....				Mr. McDermott .....	X		
Mr. McCreery .....				Mr. Kleczka .....	X		
Mr. Camp .....				Mr. Lewis .....			
Mr. Ramstad .....		X		Mr. Neal .....	X		
Mr. Nussle .....		X		Mr. McNulty .....	X		
Mr. Johnson .....		X		Mr. Jefferson .....			
Ms. Dunn .....		X		Mr. Tanner .....			
Mr. Collins .....		X		Mr. Becerra .....			
Mr. Portman .....		X		Mrs. Thurman .....	X		
Mr. English .....		X					
Mr. Ensign .....			X				
Mr. Christensen .....		X					
Mr. Watkins .....		X					
Mr. Hayworth .....		X					
Mr. Weller .....							

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Hulshof .....	.....	X	.....				

#### IV. BUDGET EFFECTS OF THE BILL

##### A. COMMITTEE ESTIMATE OF BUDGETARY EFFECTS

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the following statement is made:

The Committee agrees with the estimate prepared by the Congressional Budget Office (CBO) which is included below.

##### B. STATEMENT REGARDING NEW BUDGET AUTHORITY AND TAX EXPENDITURES

In compliance with clause 2(1)(3)(B) of rule XI of the Rules of the House of Representatives, the Committee states that the provisions in the Committee bill, if enacted, would decrease direct spending by \$1.3 billion over the budget period Fiscal Years 1999–2003.

##### C. COST ESTIMATE PREPARED BY THE CONGRESSIONAL BUDGET OFFICE

In compliance with clause 2(1)(3)(C) of rule XI of the Rules of the House of Representatives requiring a cost estimate prepared by the Congressional Budget Office, the following report prepared by CBO is provided.

U.S. CONGRESS,  
CONGRESSIONAL BUDGET OFFICE,  
*Washington, DC, September 24, 1998.*

Hon. BILL ARCHER,  
*Chairman, Committee on Ways and Means,  
House of Representatives, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 4567, the Medicare Home Health Care Interim Payment System Refinement Act of 1998.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Cyndi Dudzinski.

Sincerely,

JUNE E. O'NEILL, *Director.*

Enclosure.

##### *H.R. 4567—Medicare Home Health Care Interim Payment System Refinement Act of 1998*

Summary: H.R. 4567 would revise Medicare payment rates for services furnished by home health agencies during cost reporting periods beginning in or after fiscal year 1999. The revised rates would be the basis for Medicare payments until a prospective payment system (PPS) for home health services is implemented.

The bill would increase the per visit cost limits from 105 percent of the median per visit costs to 108 percent. It would reduce the per beneficiary limit from 98 percent of the national median per beneficiary limit to 75 percent for agencies whose first cost reporting period begins in or after fiscal year 1999. And it would estab-

lish a floor for the per beneficiary cost limits for agencies whose first cost reporting period began before fiscal year 1999.

For agencies that had a cost reporting period ending in fiscal year 1994, the per beneficiary limit would be the greater of the agency's current per beneficiary limit and the average of the agency's current per beneficiary limit and the national median per beneficiary limit. For home health agencies without a cost reporting period ending in fiscal year 1994, but with a cost reporting period beginning before fiscal year 1999, the per beneficiary limit would be the greater of the agency's current per beneficiary limit and the national median per beneficiary limit.

The change in Medicare Part B spending resulting from enactment of H.R. 4567 would not be included in the calculation of the Part B premium until a PPS for home health services is implemented.

CBO estimates that enacting H.R. 4567 would increase federal spending by \$0.2 billion in 1999 and \$1.3 billion over the 1999–2003 period. This legislation would affect direct spending; therefore pay-as-you-go procedures would apply.

The legislation does not contain any intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act. The bill would result in additional Medicaid costs to states of between \$1 million and \$14 million annually, totaling approximately \$75 million for the 1999–2008 period. However, states possess sufficient flexibility to alter their programmatic or financial responsibilities to offset these additional costs.

**Estimated cost to the Federal Government:** The estimated budgetary impact of H.R. 4567 is shown in the following table. The costs of this legislation fall within budget functions 550 and 570 (Health and Medicare).

[By fiscal year, in billions of dollars]

	1998	1999	2000	2001	2002	2003
<b>CHANGES IN DIRECT SPENDING</b>						
<b>Medicare:</b>						
Fee-for-service home health benefits .....	0	0.2	0.2	0.2	0.2	0.2
Payments to Medicare+Choice plans .....	0	0	( <sup>1</sup> )	0.1	0.1	0.1
Part B premiums .....	0	0	0	( <sup>1</sup> )	( <sup>1</sup> )	( <sup>1</sup> )
Subtotal .....	0	0.2	0.2	0.3	0.3	0.3
Medicaid .....	0	0	0	( <sup>1</sup> )	( <sup>1</sup> )	( <sup>1</sup> )
Total .....	0	0.2	0.2	0.3	0.3	0.3

<sup>1</sup> Costs or savings less than \$50 million.

Note.—Details may not add to totals due to rounding.

### *Basis of estimate*

**Medicare Fee-For-Service Home Health Benefits.**—Medicare pays home health agencies the least of three amounts: the agency's reasonable costs, a limit calculated on a per beneficiary basis, or a limit calculated on a per visit basis. H.R. 4567 would increase the per visit limit, and it would increase the per beneficiary limit for most agencies. The per beneficiary limit would be reduced for agencies that did not participate in Medicare before fiscal year 1999.

The higher proposed per visit and per beneficiary limits would result in higher rates of utilization and higher payments per beneficiary in agencies subject to those limits under current law. The reduction in the per beneficiary limit for agencies not already participating in Medicare would substantially reduce the entry of new firms. The estimate assumes, however, that existing agencies would expand to provide most of the services that would have been furnished by new entrants.

CBO analyzed the effects of changes in payment rates and utilization using data from a sample of cost reports for home health agencies. In aggregate, CBO estimates the bill would increase payments to home health agencies by \$0.2 billion in 1999 and \$1.1 billion over the 1999–2003 period.

Payments to Medicare+Choice Plans.—Higher Medicare spending for home health services in the fee-for-service sector would lead to higher capitated payments to Medicare+Choice plans beginning in 2000, because annual updates to Medicare+Choice payment rates are based on changes in per capita spending in the fee-for-service sector. CBO estimates that enactment of H.R. 4567 would increase Medicare fee-for-service spending by about 0.1 percent, which would increase payments to Medicare+Choice plans by \$0.3 billion over the 1999–2003 period.

Part B Premiums.—The Balanced Budget Act of 1997 (BBA) transferred coverage of certain home health services from Part A of Medicare to Part B. In general, the Part B premium would cover 25 percent of the additional Part B spending. However, the BBA also required that the effect on Part B premiums of the transferred home health spending be phased-in over a seven year period. Enactment of H.R. 4567 would increase Part B spending; however, the bill specifies that the effect of this increase not be incorporated into the Part B premium until a prospective payment system is implemented for home health services.

The BBA requires the Secretary of Health and Human Services to implement a PPS for home health services in fiscal year 2000. CBO assumes implementation of the PPS will be delayed because the analytic work needed to develop a system of categorizing cases that is clinically sound and that groups cases with comparable costs will not be completed in time. This analytic work will be further delayed by Medicare's Year 2000 computer problems. The estimate assumes that a PPS could be implemented as early as 2001 and will be implemented no later than 2004.

To estimate the effect of H.R. 4567 on Part B premium receipts, we first assumed implementation of a PPS for home health services and estimated the increase in Part B premiums that would result from higher Part B payments to home health agencies and Medicare+Choice plans. We then adjusted the estimated premium receipts to reflect the probability of implementation of a PPS. CBO estimates that Part B premium receipts would be unchanged in 1999 and would increase by about \$0.1 billion over the 1999–2003 period and by \$0.5 billion during 1999–2008.

Medicaid.—Medicaid pays the part B premium for beneficiaries enrolled in both Medicare and Medicaid. As a result of the increase in the Part B premium, CBO estimates that federal spending for Medicaid would increase by less than \$50 million over the 1999–

2003 period and by \$100 million during 1999–2008. The increase in Medicaid spending by states would total about \$75 million during the ten-year period.

Pay-as-you-go considerations: Section 252 of the Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays and governmental receipts that are subject to pay-as-you-go procedures are shown in the following table. For the purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

[By fiscal year, in millions of dollars]

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Changes in outlays .....	0	200	200	300	300	300	300	400	400	400	400

Intergovernmental and private-sector impact: H.R. 4567 contains no private-sector or intergovernmental mandates as defined in the Unfunded Mandates Reform Act. The bill would result in additional Medicaid costs to states of between \$1 million and \$14 million annually, totaling approximately \$75 million for the 1999–2008 period. However, states possess sufficient flexibility to alter their programmatic or financial responsibilities to offset these additional costs.

Estimate prepared by: Federal costs—Cyndi Dudzinski; impact on State, local, and tribal governments—Leo Lex; impact on the private sector—Pete Welch.

Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

**V. OTHER MATTERS REQUIRED TO BE DISCUSSED UNDER THE RULES OF THE HOUSE**

**A. COMMITTEE OVERSIGHT FINDINGS AND RECOMMENDATIONS**

In compliance with clause 2(1)(3)(A) of rule XI of the Rules of the House of Representatives, the Committee reports that the need for this legislation was confirmed by the oversight hearings of the Subcommittee on Health.

**B. SUMMARY OF FINDINGS AND RECOMMENDATIONS OF THE GOVERNMENT OPERATIONS COMMITTEE**

In compliance with clause 2(1)(3)(D) of rule XI of the Rules of the House of Representatives, the Committee states that no oversight findings and recommendations have been submitted to this Committee by the Committee on Government Operations with respect to the provisions contained in this bill.

**C. CONSTITUTIONAL AUTHORITY STATEMENT**

In compliance with clause 2(1)(4) of rule XI of the Rules of the House of Representatives, relating to Constitutional Authority, the Committee states that the Committee’s action in reporting the bill is derived from Article 1 of the Constitution, Section 8 (“The Congress shall have power to lay and collect taxes, duties, imposts and

excises, to pay the debts and to provide for \* \* \* the general Welfare of the United States \* \* \*.”)

**VI. CHANGES IN EXISTING LAW MADE BY THE BILL AS REPORTED**

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

**SOCIAL SECURITY ACT**

\* \* \* \* \*

**TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED**

\* \* \* \* \*

**PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED**

\* \* \* \* \*

**AMOUNTS OF PREMIUMS**

**SEC. 1839. (a)(1) \* \* \***

\* \* \* \* \*

(3) The Secretary, during September of each year, shall determine and promulgate a monthly premium rate for the succeeding calendar year that *(except as provided in subsection (g))* is equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1), for that succeeding calendar year. Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium rate for any period, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for enrollees age 65 and older as provided in paragraph (1).

\* \* \* \* \*

*(g) In estimating the benefits and administrative costs which will be payable from the Federal Supplementary Medical Insurance Trust Fund for a year for purposes of determining the monthly premium rate under subsection (a)(3), the Secretary shall exclude on estimate of any benefits and administrative costs attributable to the application of section 1861(v)(1)(L)(viii) or to the establishment under section 186(v)(1)(L)(i)(V) of a per visit limit at 198 percent of the median (instead of 105 percent of the median), but only to the extent payment for home health services under this title is not being*

*made under section 1895 (relating to prospective payment for home health services).*

\* \* \* \* \*

PART D—MISCELLANEOUS PROVISIONS

DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

Spell of Illness

(a) \* \* \*

\* \* \* \* \*

Reasonable Cost

(v) (1)(A) \* \* \*

\* \* \* \* \*

(L)(i) The Secretary, in determining the amount of the payments that may be made under this title with respect to services furnished by home health agencies, may not recognize as reasonable (in the efficient delivery of such services) costs for the provision of such services by an agency to the extent these costs exceed (on the aggregate for the agency) for cost reporting periods beginning on or after—

(I) \* \* \*

\* \* \* \* \*

(III) July 1, 1987, and before October 1, 1997, 112 percent of such mean, [or]

(IV) October 1, 1997, and before October 1, 1998, 105 percent of the median of the labor-related and nonlabor per visit costs for freestanding home health agencies[.], or

(V) October 1, 1998, 108 percent of such median.

\* \* \* \* \*

(v) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, *subject to clause (viii)(I)*, the Secretary shall provide for an interim system of limits. Payment shall not exceed the costs determined under the preceding provisions of this subparagraph or, if lower, the product of—

(I) \* \* \*

\* \* \* \* \*

(vi) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, the following rules apply:

(I) For new providers and those providers without a 12-month cost reporting period ending in fiscal year 1994 *subject to clause (viii)(II)*, the per beneficiary limitation shall be equal to the median of these limits (or the Secretary's best estimates thereof) applied to other home health agencies as determined by the Secretary. A home health agency that has altered its

corporate structure or name shall not be considered a new provider for this purpose.

(II) For beneficiaries who use services furnished by more than one home health agency, the per beneficiary limitations shall be prorated among the agencies.

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*(viii)(I) In no case shall the limit imposed under clause (v) for cost reporting periods beginning during or after fiscal year 1999 be less than the average of the limit otherwise imposed under such clause and the median described in clause (vi)(I) (but determined as if any reference in clause (v) to "98 percent" were a reference to "100 percent").*

*(II) Subject to subclause (III), for cost reporting periods beginning during or after fiscal year 1999, in no case shall the limit imposed under clause (vi)(I) be less than the median described in such clause (determined as if any reference in clause (v) to "98 percent" were a reference to "100 percent").*

*(III) In the case of a new home health agency for which the first cost reporting period begins during or after fiscal year 1999, the limitation applied under clause (vi)(I) (but only with respect to such provider) shall be equal to 75 percent of the median described in subclause (II) of this clause. This subclause shall not apply to a home health agency which filed an application for home health agency provider status under this title before September 15, 1998, or which was approved as a branch of its parent agency before such date and becomes a subunit of the parent agency or a separate agency on or after such date.*

*(IV) The limits computed under subclauses (I) through (III) are subject to adjustment under clause (iii) to reflect variations in wages among different areas.*

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## VII. MINORITY VIEWS

I was pleased to cosponsor H.R. 4567, which provides some meaningful help to the nation's better, more cost-conscious health agencies. It avoids throwing money at home health agencies that abuse the system.

I became a cosponsor with the commitment that the bill would not move forward without ways to pay for it. That did not happen. We are now told that a way to finance the bill's \$1.4 billion 5-year cost will be developed before the bill goes to the floor. My support on the House floor (and I am sure that this is the true for many other Democrats) depends on it being paid for in a fair and equitable way.

Democrats said repeatedly during the debate on the \$80 billion tax cut that we should not spend surpluses we do not have. We cannot drain away a surplus that should be saved for Social Security Medicare. The situation facing the home health industry should not be called an emergency in order to invade the budget rules. That would mean there is no budget discipline left: everything and anything will be classified as an emergency. Similarly, we cannot add to Medicare's deficits. The Medicare Part A Trust Fund sinks into the red in 2008. In 1997 the Medicare Trust Fund decreased \$9.3 billion and will decline another \$7.7 billion this year. Between now and 2008 we need to find about \$320 billion to keep a year's reserve in the Trust Fund. Clearly, we cannot add to the problems of the Trust Funds by the passage of an unfunded bill.

It should be easy to find \$1.3 billion. In the next five years, Medicare will spend over \$1.1 trillion. We can surely find \$1.3 billion—about 0.1%—in savings to pay for this bill.

Democrats on the Committee unanimously voted to support a way to pay for this bill through a series of fair and reasonable changes to Medicare. Our amendment would have expanded H.R. 4567 by making its benefits retroactive (as the home health industry says is desperately needed), and would actually raise an extra \$200 million for the Medicare Trust Funds.

Earlier in the summer, the Committee was considering revenue neutral changes to the home health program: that is, the plan to help some deserving home health agencies would be funded by money from some of the more questionable agencies. I regret we have not continued that approach, but instead are trying to find money outside of the home health sector. Why? The fact is fraud, waste, and abuse remains rampant in the home health sector. On its face, it is fraud when for-profit agencies provide twice the number of visits to the same type of patient as not-for-profits. It is either fraud, or waste, or abuse when home health agencies in the State of Washington can provide quality service with an average of 30 visits per user, but it takes 142 visits on average in Oklahoma

(1997 data). Hospital-based home health agencies allow hospitals to profit twice: they discharge patients quicker and provide home health services longer. H.R. 4567 should have been funded by setting the payment rate at the median of the not-for-profit cost per case and by capturing the profiteering by the hospital-based agencies. Because the Committee failed to address these issues of fraud, waste, and abuse, we are now in the position of trying to find funding from other sectors of Medicare.

Finally, this bill is a good band-aid. But it is only a band-aid. It does not address the fact that next October, all home health agencies, the good ones and the bad ones, will receive an across-the-board 15% cut.

It also does not begin to address the real issue. The real issue is long-term care and how to pay for it. We are in turmoil over home health, because it was rapidly becoming a long-term care program, attached to Medicare, which is an acute care program.

As a Member of the Pepper Commission in the 80s, I tried to develop a long-term care proposal, but no one wanted to pay for it. In Medicare Catastrophic, we moved toward better long-term care benefits, but no one wanted to pay for it, and it was repealed. Rather than sneak a long-term care policy into the backdoor of the acute care Medicare program, we should honestly propose and debate a long-term care social insurance program. If the public were fairly presented with the problems of long-term care and how they should be funded, we may find the support to pay for it. This would be a debate worth having, rather than tinkering with ways to squeeze down on the longest home health visits.

PETER STARK.

