HEARING ON RURAL HEALTH CARE SERVICES: HAS MEDICARE REFORM KILLED SMALL BUSINESS PROVIDERS?

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HOUSE OF REPRESENTATIVES

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HEARING ON RURAL HEALTH CARE SERVICES: HAS MEDICARE REFORM KILLED SMALL BUSINESS PROVIDERS?

WEDNESDAY, JUNE 14, 2000

HOUSE OF REPRESENTATIVES,
COMMITTEE ON SMALL BUSINESS,
Washington, DC.

The Committee met, pursuant to notice, at 10:04 a.m. in room 2360, Rayburn Office Building, Hon. James M. Talent (chairman of the Committee) presiding.

Chairman TALENT. Well, let's open the hearing. I will go ahead and give my opening statement and if the ranking member gets here, she can give hers. If not, we will recess just long enough for the vote.

Today the Committee will be examining the fate of small businesses health care providers three years after the Medicare reforms incorporated in the Balanced Budget Act of 1997. These reforms promised us an improved ability to reduce waste, fraud and abuse in the Medicare system and to achieve substantial savings. Certainly savings have appeared. Perhaps fraud and waste have been curbed but there are some concerns that service for Medicare recipients is suffering as a result.

Over the past two years, many of us have read the newspaper articles or seen the reports on television concerning the bankruptcies of major nursing home chains and the financial problems of HMOs that provide significant Medicare services. Most recently, we saw SIGNA Healthcare abandon Medicare services. The common reasons given revolve around the reimbursement and fee schedules established by the Health Care Financing Administration after the 1997 BBA changes.

However, as significant and oftentimes disturbing as those events were, a little noticed change was sweeping through the health care industry and devastating the provision of care available, particularly in rural areas. Small businesses involved in the provision of ancillary services to nursing facilities, hospices and home health care patients were failing or reducing service in rural areas at a record pace. These small businesses offered lab services, physical therapy, occupational therapy, wound care, intravenous therapy, portable electrocardiogram, x-ray, and pharmacy services to rural areas.

These providers offer a range of medical services that a rural nursing facility would find impossibly expensive to duplicate. Unfortunately, the providers are fast disappearing and it appears that

the reason may be the Medicare reforms enacted in 1997. Since the enactment of BBA '97, a number of previously covered ancillary services have been eliminated. In addition, many other Medicare services have been effectively eliminated in rural areas by the reduction or elimination of the transportation reimbursement rates. Ancillary service providers for Medicare patients at a rural facility now receive no reimbursement for travel to the facility and are forced to either provide services at a loss or suspend service to those facilities altogether.

At the same time, other provisions of BBA '97 are taking their toll. The Prospective Payment System was instituted in 1998 to consolidate the billing of Medicare A services through nursing facilities. Facilities are billed directly and then reimburse the ancillary care providers. Unfortunately, this has resulted in some facilities taking advantage of their position as "gatekeepers" to extract discounts from small providers. In addition, many facilities are increasingly slow in providing reimbursement.

This creates an addition strain on the system—ancillary providers faced with this situation refrain from providing service. While this could be considered by some as good because it prevents unnecessary use, it also creates a scenario for misuse. Services previously provided at bedside are now provided at hospitals, with the added cost of ambulance transportation and the added stress to the patient. We know these services are shifting to hospitals. Only last year Congress acted to increase reimbursement to rural hospitals in recognition of that added strain. The question is, have we only treated the systems?

Today we will discuss these problems and I hope begin a dialogue to restore the small business sector of the health care industry. We have a number of witnesses who will testify.

What I will do is recess the hearing so that we can go and vote and then come right back and we will start with our first witness.

[Recess.]

Chairman TALENT. I will recognize the gentlelady from New York for her opening statement.

Ms. VELÁZQUEZ. Thank you, Chairman Talent.

Today we examine the need for access to health care in rural America and the unintended consequences that the Balanced Budget Act of 1997 created. In study after study, it has been determined that those Americans living in rural areas tend to be poorer, older and less insured. Indeed, nearly 22 million Americans live in federally designated areas where there is complete shortage of adequate health care professionals or medical facilities. And to make that situation worse, those who often need health care the most—senior citizens—represent one-fifth of the total rural population.

This is without a doubt a travesty for this country. However, while the need is still great, the commitment by the federal government is diminishing. This is due in large part to the Balanced Budget Act of 1997 that has hit small rural health care providers especially hard.

Thus, small companies were paid through by a simple cost reimbursement system. Simply put, they were reimbursed for reasonable related to providing these services. In most cases, the costs often involve transportation of critical important to these remote

sites but these expenses are only reimbursed on a fixed basis, regardless of how far they travel to get to the facility they serve.

Unfortunately, these companies are now forced to carry an extra burden without proper compensation for reasonable costs of doing business and it is for this reason that we must take all of these issues into consideration, whether we are talking about patient care or protecting small business, to ensure that every American, no matter where they live, will have that continued access to basic health care.

I have looked forward to the start of this hearing. I believe it is important to reveal the unique issues revolving around access to quality rural health care or the lack thereof. We are all interested in hearing from the small businesses that provide health care services in rural areas and how we might be better able to continue their growth and success.

It is not in the spirit of equality that America has promised all of us to be denied the basic necessities shared by all only because of where you live. Many of these people in these rural areas who these companies service are farmers. Farmers have committed their lives and their families' lives to ensuring that each and every day all of us have food for our families.

I look forward to working with Chairman Talent and the other members of the Committee in seeking ways to mitigate the negative impact the Balanced Budget Act of 1997 has on our Nation's small businesses. We are faced with the serious dilemma with this issue and we must find a solution to prevent a serious problem from becoming a potential health care disaster for business and for to people they serve.

Thank you, Mr. Chairman, and I look forward to hearing from our panels today.

Chairman TALENT. I thank the gentlelady and without objection, anybody who wants to submit other statements for the record, they will be entered into the record. I have one from Mr. Manzullo and I am sure there are other members, as well.

[Mr. Manzullo's statement may be found in appendix.]

Chairman TALENT. We will go to our witness panel. The first witness is Kathleen A. Buto, who is the deputy director of health plans and providers for the Health Care Finance Administration. Thank you for being here.

STATEMENT OF KATHY A. BUTO, DEPUTY DIRECTOR, CENTER HEALTH PLANS AND PROVIDERS, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HEALTH SERVICES

Ms. BUTO. Thank you, Chairman Talent, Congresswoman Velázquez, for inviting us to participate in this hearing today to discuss our efforts to support small businesses that provide health care in America's rural areas.

We understand that rural providers face unique challenges in serving the medical needs of our beneficiaries. Assuring and enhancing access to quality care for rural beneficiaries is a priority for us and we are committed to continuing to work with you to ensure that these unique needs are met.

In fact, we have established a Rural Health Initiative Group within our agency to increase and coordinate attention to rural issues in all areas of our work. Each of our regional offices now has a rural issues point person and you and your provider constituents can call directly to raise and discuss issues, concerns and ideas. A list of these contacts is attached to my written testimony.

We are also working to enhance our relationship with the Small Business Administration and ensure our policies are responsive to the needs of small business communities, including those located in rural areas. This cooperative effort includes training sessions for our staff on small business issues—more than 100 staff were trained last year by the SBA—cross-agency review of regulations, and participation in forums that were held around the country by the SBA ombudsman.

Let me move to some of the issues directly under the jurisdiction of Medicare, because I know you are interested in those. We are proceeding with several projects to evaluate Medicare coverage for telemedicine services and, of course, this is particularly of interest in rural areas, to find ways to get some of the more sophisticated services available in urban areas more directly to rural beneficiaries.

For example, in February we initiated a project with Columbia University to explore how teleconsultations in urban New York City and rural Upstate New York affect patient care and outcomes.

Additionally, we are working with the Agency for Healthcare Research and Quality to assess the cost-effectiveness of telemedicine services and the need to expand telemedicine beyond current payment regulations. We are anxious to share our results with Congress and we look forward to doing that later this year.

We have already implemented the majority of provisions in the Balanced Budget Act of 1997 that assist rural providers. Working together, Congress and the Administration last year enacted the Balanced Budget Refinement Act, which includes a number of reforms and other changes to the BBA that address some of the BBA's unintended consequences. A number of these refinements are particularly helpful to providers in America's rural areas and their patients. We also have taken a number of important administrative actions to assist rural providers that complement the legislative changes included in the BBRA.

The BBRA allows more hospitals to be designated as critical access hospitals or rural referral centers. It holds rural hospitals harmless for four years during the transition to the new outpatient Prospective Payment System. It extends the Medicare-Dependent Hospital program, which assists small rural hospitals serving mostly Medicare patients, for five years. And it gives sole community hospitals an enhanced annual update for fiscal year 2001.

For skilled nursing facilities, it provides an immediate increase in payments for facilities that treat high-cost patients. It creates special payments to facilities that treat a high proportion of AIDS patients and excludes certain expensive items and services from the PPS consolidated billing requirements.

Importantly, BBRA provides an across-the-board increase of 4 percent in fiscal year 2001 and 2002 and gives nursing homes options on how their rates are calculated. It places a two-year mora-

torium on the physical and occupational therapy caps that were included in the BBA, which appeared to be presenting particular problems for patients in these facilities.

BBRA also delays a scheduled pay cut for home health agencies until after the first of the year 2001 under the Prospective Payment System for home health services. It provides an immediate adjustment to the per-beneficiary limits for certain agencies, and gives assistance payments to help cover some of the costs associated with collection of data as part of the home health PPS system. It excludes durable medical equipment from consolidated billing.

And we have taken a number of administrative steps to help rural and other providers. For example, we are making it easier for rural hospitals to be reclassified and to receive payments based on higher average wages in nearby urban areas. We are using the same wage index that is used to calculate in-patient rates for the Outpatient Prospective Payment System and we are postponing the expansion of the hospital transfer policy, which we understand has had an adverse impact on rural hospitals.

We are extending the time frame for repaying home health overpayments from one year to three, with the first year interest-free, and we are postponing the requirement for home health agencies to obtain surety bonds. We will refine the classification system for skilled nursing facilities in a budget-neutral way to increase payments for medically complex patients.

We are also redoubling our efforts to more clearly understand and actively address the special circumstances of rural providers and beneficiaries through our rural health initiative. We have been meeting with rural providers, visiting rural facilities, reviewing the impact of our regulations on rural health care providers, and conducting more research on rural health care issues.

We are participating in regularly scheduled meetings with the Office of Rural Health Policy in the Health Resources and Services Administration to make sure that we stay abreast of emerging rural issues and we are working directly with the National Rural Health Association on a number of issues and to evaluate rural access to care issues and policy changes.

Our goal is really to engage in more dialogue with rural providers and ensure that we are considering possible ways of making sure rural beneficiaries get the care they need. We are looking at best practices and areas where research and demonstration projects are warranted and we want to hear from those who are providing services to rural beneficiaries about what steps can be taken to ensure that they get the care they need.

We are committed to ensuring rural beneficiaries continued access to quality care and we are all concerned about the disproportionate impact that policy changes can have on rural health care providers.

We are grateful for the opportunity this hearing provides to discuss these important issues and to explore how we might address them in a better and more responsible manner.

I thank you again, Chairman Talent, for holding the hearing and I would be happy to answer your questions.

[Ms. Buto's statement may be found in appendix.]

Chairman TALENT. We will have questions in a few minutes, after the other witnesses have testified and I thank you for being here.

Our next witness is Zachary Evans, who is the president of Mobile Medical Services from St. Joseph, Missouri. Thank you for coming such a long way, Mr. Evans, and we would love to hear your testimony.

STATEMENT OF ZACHARY EVANS, PRESIDENT, MOBILE MEDICAL SERVICES, ST. JOSEPH, MO

Mr. EVANS. Thank you, Mr. Chairman and distinguished members of this Committee. I would like to request at this time that my entire written statement be entered into the record.

It is a pleasure to have the opportunity to testify before you today on an issue of great importance to our industry and small business owners nationwide.

As Chairman Talent said, my name is Zach Evans and I am the president of Mobile Medical Services, Incorporated. I am also the immediate past president of the National Association of Portable X-ray Providers.

My small business was established in 1992 and is located in St. Joseph, Missouri. I currently employ five individuals on a full-time basis.

I appear before you today to explain the dramatic impact upon my company and others like it across the country of severe cuts in Medicare reimbursement rates. These reductions, mandated by the Balanced Budget Act of '97, have hit small businesses the hardest and have, in turn, forced small businesses to cut back on nonprofitable services.

This impact is particularly alarming because it has ultimately led to a reduction in essential medical services for thousands of Americans, particularly those in rural areas.

In essence, what are seeing are the early symptoms of a potentially fatal disease that afflicts our Nation's health care delivery system. The reduction in Medicare reimbursement rates mandated by BBA '97 has resulted in the complete elimination of profit margins for small business providers of some vital services, particularly in the rural areas.

As a provider of medical services which are transported to the patient's bedside, reimbursement rate reduction has forced me to view nursing facilities or private homes that are located in rural areas as financially unsound clients. This means that I and other small business providers of portable x-ray services cannot afford to provide a service which is not only safer, more comfortable and convenient to the patient but less expensive for Medicare.

It is profoundly ironic that as companies such as mine are forced to deny service to rural patients because of Medicare cost-cutting, the only alternative, transportation by ambulance, significantly drives up Medicare costs.

These service cut-backs to rural areas must be viewed as the early warning signs of a more far-reaching problem. As small business providers are forced to shrink their service area to remain solvent, rural patients and facilities will be forced to spend more to obtain these medically necessary services. This cycle of cost-cutting

leading to higher costs for poor services is potentially lethal to the health care delivery system as a whole.

Perhaps the most dramatic cut mandated by the BBA was the total elimination of the transportation fee for portable EKG services. Clearly if a service provider receives no transportation reimbursement for a service, traveling long distance to rural facilities is simply not economically feasible. In my company's case, I lose an average of $50 for every EKG I perform. This average includes service to local facilities. If I were to calculate our losses based on distance traveled, you would see a steadily rising column of red ink, increasing with every mile we travel to the facility or home.

I am no politician but I do feel that I understand voter sentiments sufficiently to predict the obvious. Americans would be appalled to learn that EKGs will not be available to elderly rural patients simply because they reside outside of the more profitable urban and suburban areas.

I can say, however, that Americans would be proud to learn that you, Mr. Chairman, led the fight last year to reinstate the EKG transportation rate. For that effort, I would like to take this opportunity to thank you on behalf of the providers and patients alike for standing up for this vital cause. I hope that with your strong voice on our side, we may prevail this year and obtain the EKG transportation rate before more patients who are denied this basic care.

Unfortunately, EKG services only represent a small portion of the portable x-ray business. What has happened regarding EKG services is now spreading to the x-rays. My company once offered 24-hour-a-day, seven-day-a-week service to all patients. We have been forced to cut our services to patients located 25 miles distance or more, to between an 8 a.m. and 3:30 p.m. Monday through Friday. Additionally, we are currently turning down all new requests for services outside of a 25–mile radius.

This represent a massive reduction in services, yet we are currently considering dropping these remaining facilities altogether. For our company alone, that decision would deny vital medical services to approximately 15 homes with an average of 80 beds each or a total of 1,200 patients.

1,200 patients denied service from one small company in Missouri. I know that dozens of other small business portable x-rays providers are either considering or have already enacted similar cuts. I have to stress that these service cuts will not save my company or others like it without some form of rate increase. These cuts can only slow our losses somewhat. Without a rate change, portable x-ray services will inevitably vanish, leaving ambulance transportation, with its higher cost and lower patient satisfaction, as the sole alternative.

By the actions of the chairman last year and through many conversations with the Small Business Committee staff, I know that this Committee is truly supportive of the Nation's small business community. I sincerely hope that all members of this Committee will join us in calling for reasonable solutions to this critical problem.

Thank you again for the privilege of sharing my views and experiences with you today.

[Mr. Evans' statement may be found in appendix.]

Chairman TALENT. Thank you very much.

Our next witness is Karen Woods, who is the executive director of the Hospice Association of America. Miss Woods?

STATEMENT OF KAREN WOODS, EXECUTIVE DIRECTOR, HOSPICE ASSOCIATION OF AMERICA

Ms. WOODS. Thank you. Good morning, Mr. Chairman and members. I am very proud personally and professionally to be able to represent hospice agencies, to represent the patients that they care for and their caregivers.

The Hospice Association has been very concerned about the changes that occurred with BBA '97. Our main focus is looking at accessibility and quality of end-of-life care and feeling that all of us deserve quality end-of-life care and we have certainly seen this hampered by changes in BBA because of the way it has affected how hospice operation can work.

This is a national issue and it seems to be doubly impacted upon rural hospices because of all the information that we have heard already, just information on the ability to hire staff, to maintain that staff, to provide that service on an appropriate reimbursement rate.

Currently, only 20 percent of Americans receive terminal care from hospice programs. When you consider that as a national average, again you can certainly say that in a rural area, that is going to be much less than 20 percent. This means that most people are dying with a terminal illness without the care and support that they need and that families are not provided support following the death.

Considering the issue of low population density in rural areas, it makes it inherently difficult to deliver services and specifically with such a targeted area—people with a terminal illness—to get the care where it can be provided, and that care is in the patient's home.

The rural health agenda, some information that we have provided was telling us that rural Americans are faced with issues that create barriers to care because of an inadequate supply of primary care physicians, as well as other health care providers, such as nurses, home care aides, social workers and counselors, and that is a reality. And those particular disciplines are the heart and soul of a hospice home care team.

In conversations with providers that we represent, we have been getting information about the impact and some of the things I am going to list are just in broad terms what they are feeling. Definitely the shortage of nurses, home care aides, therapists and social workers, making it very, very difficult to recruit and then maintain these people. And the Medicare benefit is defined in a way that the hospice programs are required to provide certain core services where they cannot contract with people; they have to be full-time employed, and this is very difficult when the supply is low.

There has also been a decrease in the hospice market basket updates and that obviously has affected every aspect of hospice care and the services provides.

Insufficient reimbursement barely allows them to maintain appropriate wage and benefit packages for their staff.

There is definitely a lack of funding for innovative modalities, such as telehealth care. Now certainly when the Medicare benefit was designed, telehealth, telemedicine did not exist, but in an, I will say, restrictive per diem rate, there is no edge and no give for new technologies.

Hospice programs are faced with restrictive regulations that in some areas prevent them from contracting with specialized nursing services. There may be one particular procedure that normally the day-to-day functions of a hospice nurse does not need to address, but because of regulation, they are restricted from contracting with a specialist to do so.

They are required to have their home care aides supervised only by a registered nurse. It would be nice if a licensed practical nurse could do that. It would certainly allow for a little freedom and less expensive staffing.

There is also restrictive regulatory definitions of service areas. Mileage and driving time are the criteria. The criteria is not the quality outcome. It makes it very difficult and sometimes almost impossible for a hospice program to provide service in a rural area.

We were talking to a program in Nevada and there is an hour drive time. That is the limit. If they cannot make it to the patient in an hour's drive time, they cannot service the area. And in the rural area, that is probably not quite halfway to a routine visit.

We have had a report from some members in the southwest region of Kansas and they were talking about the domino effect of BBA '97. Just this past May, on May 31, the regional hospital center closed its home health agency and the home health agency, in turn, needed to close its hospice program. Their concern is there is a county without any home care services. They said if this was an urban area, competition would certainly move in and they would have patients referred to other agencies as they closed their doors. There is no one to turn the care over to, so these patients are left unattended. To be left unattended in your last dying weeks without the support and care of a hospice program I think is a criminal act.

We have added some information in an appendix to our comments and I would just like to go through those. These are some suggestions, recommendations that we have and actions that we would think would be good to take.

Looking at funding grant programs for training therapists, medical social workers, nurses and home care aides and other hospice personnel with a focus on providing home and community-based practice in areas where shortages exist.

Would like to amend a particular section of the Social Security Act to include a provision allowing specialized high-tech nursing services to be provided by contract under the direction and supervision of a hospice.

Would like to see legislation enacted that would allow LPNs, especially in rural America, to supervise home health aides and certainly under the general supervision of a registered nurse.

Would like to see federal programs that finance hospice services to adjust reimbursement to allow for appropriate wage and benefit levels for all clinical staff.

Would like to see clarity in the definition of hospice multiple site service areas and certainly looking at uniform reasonable and an up-to-date policy that focusses on the ability to provide quality care, rather than imposing arbitrary and ineffective time and distance requirements.

Would like to see legislation clarified around the issue of telehealth and have that as a service provided by a hospice and that Medicare should provide appropriate reimbursement for technology costs for rural hospice providers. And I was pleased to hear that HFCA is looking at that very issue.

And we would like to see the restoration of the reductions in the market basket updates that were enacted by BBA '97 and also the 1999 Omnibus Appropriations Act.

And I thank you and again thank you for your attention to this very important issue.

[Ms. Woods' statement may be found in appendix.]

Chairman TALENT. I thank you and your members for your service to people.

The next witness is Norman Goldhecht, who is the vice president of Diagnostic Health Systems from Lakewood, New Jersey.

STATEMENT OF NORMAN GOLDHECHT, VICE PRESIDENT, DIAGNOSTIC HEALTH SYSTEMS, LAKEWOOD, NEW JERSEY

Mr. GOLDHECHT. Thank you, Mr. Chairman and members of the Committee. I ask that my entire written statement be entered into the record.

I appreciate the opportunity to appear before you today. My name is Norman Goldhecht and I serve on the board of directors of the National Association of Portable X-Ray Providers as the regulatory chairman. I am also an owner of a portable radiology company in New Jersey.

Mr. Chairman, the portable x-ray industry has been seriously threatened by the passage of the Balanced Budget Act of 1997. We are now truly seeing its effects and they are devastating to small business. Our industry is made up of predominantly small businesses, small businesses that cannot withstand the razor sharp cuts in revenue we have experienced over the last several years.

There are three areas that I would like to focus on this morning. I do not wish to sit here and simply complain about the problems my industry is currently enduring. I want to offer some suggestion as to how we might move toward resolving our problems, thus ensuring that we survive the massive changes to the Medicare system currently under way.

The three topics I wish to focus on are as follows. A rural modifier, transportation of EKG, and consolidated billing.

As far as the rural modifier, portable x-ray providers service many skilled nursing facilities, SNFs, and home-bound patients that reside in rural areas of this country. We must travel considerable distances to and from these sites to offer these patients our valuable and cost-effective services.

Our industry has been one of the first cost-saving alternatives for the Medicare system. Based on a 1995 cost report performed by the Center for Health Policy Studies, the average charge to Medicare was appropriate $87 for a typical x-ray performed by a portable x-

ray provider. The average cost to transport that same patient by ambulance was $420. If the patient is admitted to the hospital, the cost rises to thousands. It should also be noted that the transportation portion of our fee is prorated among the number of patients we see per visit. The ambulance fee is per patient.

We are recommending an additional fee when our services are required in a rural area. We understand that this is an established practice in other areas and we feel that the additional travel that is required would warrant such a request. The fee would be reimbursed in the form of a special CPT code only to be used and billed when a provider performs services in a rural area.

Transportation of EKG service. Currently we do not receive any additional reimbursement to travel to a nursing facility when performing an EKG. This reimbursement was taken away from an industry when the Health Care Financing Administration deemed CPT code R0076 a noncovered service. The service had previously been covered.

My current reimbursement for the EKG technical component is $16.49. This is the same reimbursement that a physician's office or a hospital receives if they were to perform the test in their office. Each time an EKG is performed, we must dispatch a technician who must travel anywhere from five to 50 miles or more. Clearly this does not cover the expense of the exam.

We feel the simple solution is to reinstate EKG transportation as a covered service.

Consolidated billing. The pending onset of consolidated billing is a major issue facing our industry. We have been working with several agencies to seek a resolution. The BBA mandated Prospective Payment System, PPS, and consolidated billing for skilled nursing facilities. The basic premise of these acts is that they take away the control of the billing aspects of our members and give them to the nursing facilities.

While consolidated billing has been delayed, PPS has been in effect for over a year and we have seen the effects. Under PPS, residents that are Part A patients of a SNF have to be billed directly to the SNF and the SNF will reimburse the x-ray provider for the service. The problems that we have encountered are that the SNFs sought large discounts and have delayed payment from 90 to 180 days and in some instances, due to the large number of nursing home chains that have declared bankruptcy, we have never received payment.

This has put the small businesses in our industry in financial difficulties, and while PPS only represents a small portion of the work that is performed by our providers, it has given us a look into the future of consolidated billing.

Consolidated billing will require our members to bill the SNF for the services performed to the residents that are currently being billed to Medicare Part B. This will certainly cause the small businesses a hardship. The SNFs will demand discounts from our current fee schedules. The consolidated billing requirement of BBA '97 requires that all ancillary providers performed in the SNF be billed directly to the SNF, rather than the provider billing Medicare directly.

Although consolidated billing has been delayed, the principles behind the system cause serious problems with the small businesses. Medicare currently pays providers within 21 days of receiving a valid claim and pays interest when they do not pay promptly. Additionally, a provider never has to be concerned about receiving reimbursement or having to give a discount in order to provide services.

The onset of consolidated billing would cause providers to wait, on average, 90 days or up to 180 days or even longer for payment. The SNFs would also require the providers to give discounts for the added billing expense that they would incur.

The main objective of consolidated billing was to reduce fraud and abuse. It was to make the SNFs the gatekeepers of services performed in their facilities so that they might monitor the billing that is being done. This is a budget-neutral issue, as the amount of money the government is paying is only being transferred from the providers to the SNFs.

This is why we have suggested the voucher system. This would require the providers to submit a bill at the end of each month to the SNF for all services performed. The SNF then would have to sign off on an approved voucher and the provider then could bill Medicare and receive payment directly. This would accomplish a needed compromise. The facilities verification would cut down on fraud and abuse while allowing the providers to receive payment directly and promptly. It should be noted that if the SNFs receive payment directly from Medicare for services that the provider has delivered, they would have a direct interest in having more services performed. If they require providers to discount their services, they would receive additional funds, meaning the more services performed, the more revenue to the SNF. Since the SNF is a requester of services, they control how many services are to be performed.

The voucher system is a budget-neutral solution which allows us to solve the problems that can arise with consolidated billing while still accomplishing the government's main objective.

Thank you, Mr. Chairman and members of the Committee, for the opportunity to address you today. I would be happy to answer any questions.

[Mr. Goldhecht's testimony may be found in appendix.]

Chairman TALENT. I thank the gentleman.

Our last witness is Mr. William A. Dombi, Esquire, who is the vice president for law of the National Association for Home Care. Thank you, sir.

STATEMENT OF WILLIAM A. DOMBI, ESQ., VICE PRESIDENT FOR LAW, NATIONAL ASSOCIATION FOR HOME CARE

Mr. DOMBI. Thank you, Mr. Chairman and Ms. Velázquez and members of the Committee for the opportunity to testify here today.

The question posed in this hearing is whether Medicare reform has killed small business providers. With home health agencies, the answer is an unqualified yes. Home health care is a dying breed in this country at this point as a direct result of the Balanced Budget Act and the institution of payment reforms with the Medicare home health benefit.

Mr. Talent, in your State of Missouri, Health Care Financing Administration statistics indicate that 79 home health agencies have closed since the Balanced Budget Act, which represents more than a third of the agencies in that state, but the updated numbers are 103. So we have an accelerating pace of closures. In addition, 32 out-of-state home health agencies are no longer servicing residents in the contiguous areas between the state of location and the State of Missouri.

With respect to home health in the Virgin Islands, it has become the virgin island. You do not have home health agencies available to provides services on all of the islands. And each of your states is in a similar position, both in metropolitan but in particularly rural areas.

Rural areas are subject to closures due to the changes in reimbursement, primarily for two reasons. One, Medicare, with its changes in reimbursement, did not respect the differences between rural home health agencies and nonrural home health agencies. The reason is that the system was designed with the concept of averaging and we all know that the only way averaging works is if there is only one participant in the process because with averaging, there are people above and below the line and rural home health agencies are generally below the line. They have costs which for years have been documented to be 12 to 15 percent greater than the cost of nonrural home health agencies. The level of utilization of services has been documented to be over 15 percent greater due to the nature of the patients served in those rural communities.

Home health agencies, by definition are small businesses, 94 percent by HCFA's definition are small businesses. And for rural home health agencies, when we speak rural, we speak of float planes in Alaska. In Montana we talk of snowmobile delivery of services and in the Delta we talk of boats just transporting people from house to house.

When we look at the definition of rural, the nearest McDonald's is 100 miles away, and that is a long way to go to get a hamburger and you are not going to get home care delivered out into those locations.

The policies and practices of the Health Care Financing Administration have added to the problems. In one respect, they tout their successes relative to rural health care providers, but they do not mention home care rural health care providers in that respect. In virtually every case where a home health agencies has a debt with the Medicare program as a result of the reimbursement changes, the Health Care Financing Administration has opposed reorganization of that debt in bankruptcy court. They have institutionally opposed the use of the compromise authority they have on any of the debts.

And, as a result of that, public health agencies and local taxpayers throughout the Midwest and the rest of the country have been forced to subsidize the Medicare program. Small business owners have subsidized them for years and have closed down as a result of that, as well.

The Prospective Payment System for home health begins October 1, 2000 if everything goes on schedule and I know this Congress and the home care industry and the Health Care Financing Admin-

istration hope that PPS is the solution to the problem caused by the IPS of the Balanced Budget Act, and I think the answer to that for rural small home health agencies is: no. It is a perpetuation of the problems caused by the Interim Payment System. It still works on the basis of averages. And despite the authority that Congress specifically gave to the Health Care Financing Administration to recognize geographic differences in home health service delivery, the Health Care Financing Administration has failed to put in place a rural differential and that will lead to further deterioration in the foundation of delivery of home care services.

Why is there a need for a differential? Well, in Washington, D.C. a home health agency will drive probably four to five miles to get to a patient's home. In Northern Virginia the same and in the areas of Baltimore, the same in Maryland. But when you are in Montana, you are driving two and a half, three hours between patients' homes. Productivity levels are significantly lower.

Home care is a local service. Unlike the closure of rural hospitals where patients were then transported by ambulance to the rural hospitals, you are not going to transport the patient to a home care setting. You transport home care to that patient.

In addition, with prospective payment at this point in time, the Health Care Financing Administration still refuses to allow the use of telehealth services within the prospective payment method that is being offered to the home health agencies. No flexibility is being provided to them.

Additional problems—labor and workforce, and part of those are due to Health Care Financing Administration policies. Hospitals are allowed to reclassify their location for purposes of wage index adjustments when the hospital competes with metropolitan-based hospitals for the same labor force. Home health agencies, under the current system and the prospective payment system, are not allowed to do that.

And finally, a HCFA policy that is causing great problems in rural areas is their definition of what is an allowable branch location. A branch location, by definition, cannot be more than one hour away from the parent sites and in order to perform supervision and oversight of the branch, you cannot rely upon electronic transmissions. In other words, telephones, fax machines, email and everything else cannot be considered in determining whether a parent home health agency can adequately supervise a branch site.

Branch sites will allow rural home health agencies to expand their territory, expand their patient base, which is necessary to survive under the prospective payment system. With a rural home health agency, one single patient at $12,000 of cost and $3,000 of reimbursement on the episodic 60–day basis will bankrupt that home health agency, and that is due to the small size and adverse selection by coincidence that will occur for those rural home health agencies.

Within this testimony, I have offered several solutions. We need to change the branch office definition. We need to bring in a rural home health agency differential in terms of reimbursement. We must make the wage index applicable to home health agencies, the same way it is applicable to the hospitals. And we have to create some workforce flexibility to respect the fact that rural areas and

small businesses providing home health services do not have a labor control that you see with larger employers across the country.

I plead with you to try your best to give rural home health agencies the opportunity to serve rural patients. We have a dying breed and by next year, if the system continues as proposed, we will not have a foundation for home health services to provide to the rural communities to restore. Thank you for your time.

[Mr. Dombi's statement may be found in appendix.]

Chairman TALENT. I appreciate that testimony. Go a little bit more into the branch office for me, if you will. HCFA is discouraging home health agencies from establishing branch offices. Is that what is going on?

Mr. DOMBI. The Health Care Financing Administration actually has a variety of policies on this issue, depending upon what regional office that you are dealing with and varying interpretations, as well. But predominantly, the interpretation begins with the question: Is the branch office more than 60 minutes away from the parent site? And if it is, it is presumptively a nonqualified branch office.

They have made occasional exceptions and there have been some recent——

Chairman TALENT. And if you are not qualified it means you cannot provide service out of that branch office?

Mr. DOMBI. You cannot locate a branch there and provide services and receive Medicare reimbursement. And as it comes to the question of oversight and supervision of the branch by the parent office, you have to have staff from the parent actually go to the site of that branch on a regular ongoing basis and the parent's staff must be capable of also seeing the patients served by that branch in order for there to be considered adequate supervision.

Chairman TALENT. Is the concern fraud or something here? Is it the quality of service or what?

Mr. DOMBI. We have asked the question how do you assess the appropriateness of supervision and oversight if the branch is 10 miles away and frankly, we have not yet received an answer to that question because we think the answer should be the same answer that is applied when it is an hour away or two hours away or three hours away.

So we do not know the rationale. We suspect that the rationale is more that branch offices traditionally with HCFA were actually unknown entities. They did not have a formal reporting mechanism for branch offices, so they did not have a formal oversight mechanism for branch offices, either.

Chairman TALENT. Do you want to comment on that?

Ms. BUTO. Yes. Actually, the chairman was right. I think the concern about branch offices did grow out of a concern about a variety of things coming together. One of them was whether the branches really were providing bona fide home health services under the conditions of participation. And then you get into issues is it such as, just an office and you have unsupervised staff; is this really a home health agency? Is it really tied to an entity?

This set of requirements came out of that concern and some of them were looked at by the Inspector General's office and other oversight agencies that pointed out this concern.

So Mr. Dombi is right that this is something where the regional offices have some discretion and that we are, I am told, working with the industry to try to come up with more uniform standards that can be applied. There is an underlying issue of whether the branch itself, in fact, is a real part of the home health agency or whether it is an unsupervised office that really would not meet Medicare conditions of participation for quality and supervision. So that is really where it comes from.

Chairman TALENT. One of the reasons I ask about this is because it seems to me one area of some relief here is to be pretty ruthless in eliminating requirements that raise costs and do not have any relationship to quality.

In other words, in a field where the problems are so severe and the money constraints are so great, every dollar that we waste with some stupid regulation that says a branch office can only be an hour away, it cannot be one hour and five minutes away, is really almost criminal because we do not have the dollars to waste.

I am not saying he is right. One of my complaints about HCFA over the years has been almost a nonchalance regarding how much money may be wasted in filling out a form or some regulation that does not accomplish anything and I wonder if you share that sense of urgency at all.

Ms. BUTO. Oh, absolutely. And I think definitely the point about the right balance and allowing branch offices because they are needed for access purposes is a good point and I think we have to figure out how to do that in a way that everybody is confident that, in fact, this is a home health agency or a branch of a home health agency and I believe that it is possible to do that without having unwarranted requirements that simply waste money.

If I could just comment on one other thing that Mr. Dombi said. I know that the numbers show that a number of home health agencies have closed or consolidated, and we frankly do not know how many of them have consolidated versus really closed.

We and the inspector general's office and the GAO have all looked at and we have also been in touch with our state health insurance counselors, who, like ombudspersons, who take complaints from beneficiaries about access to home care and we are not finding that has been a major problem.

In many of the areas where these agencies have closed and there has really been a relative handful of states, those states tend to be the states where we had a doubling or so of agencies within the last few years and they are the ones where disproportionately we are seeing a reduction. But I just wanted to address the issue of the closures because many of them are consolidations.

Chairman TALENT. Well, let me go into that and get this on the record with you because ever since the Congress passed the act of '97, I have been myself besieged with home health care providers and I am sure everybody in this Committee has had the same experience and these are people who we know in the communities we represent and know to be credible people. I mean they may be mistaken but they are not walking into my office and lying to me about the situation. Anybody can be mistaken.

And over and over again, and I know every member of Congress has had this experience, and I guess what I am trying to say to

you is that is so inconsistent with the response that really there is not a problem, which is kind of what you just said.

Now I appreciate your candor and I do not want to jump down your throat for it. In fact, it is almost a relief to me that—it would be a relief to me to believe that the agency believes there is no problem. I would rather believe that than that you know that there is a problem and you just do not care about it. Do you know what I mean? At least we should be able to establish whether there is a problem or not but I have just been told over—obviously, it is anecdotal; my office does not have the capability of conducting an empirical survey or anything—that, in fact, they are closing down; they are not able to provide the same level of service. People have to be suffering out there.

Is there anybody here who has not had that experience?

Ms. BUTO. I did not want you to think I was saying there was not a problem for home health agency providers. I think the interim payment system has been a problem for many home health agency providers and some of it has been because it is based on a cost experience in the past.

So essentially what it did is it said let's take your cost experience that occurred several years ago and you may have grown in terms of the number of visits you provide and so on. We are going to essentially roll you back to that earlier period and set tight limits based on what your experience was back then, on what your overall cost was that will be recognized. There is no question that I think that has had an impact.

What I was addressing was the beneficiary impact as we know it and has been surveyed by GAO and others, but I do think and we are quite anxious to move to the prospective payment system where we believe by paying on an episode basis, the system will be better for home health agencies, it will provide the greater flexibility for them. They will not be under the same kinds of constraints and there will be more ability to move.

I was interested to hear Mr. Dombi say if we continue on the current path, I guess I am wondering if he is not favoring going to the prospective payment system because I actually thought he was. But I do believe that the October 1 system will be better. It will not be perfect. Some of the things we have done to really scale back on recovery of overpayments are designed to help home health agencies so they do not face drastic reductions. So I did not want to leave you with that impression.

Chairman TALENT. It seems to me logical that there will be a tendency on the part of the facilities to want to overuse services and then make some money back through discounts from the providers, particularly since they are complaining that they are not being compensated enough. Do you think that that is going to be a problem?

Ms. BUTO. The home health agencies, you mean——

Chairman TALENT. As I understand the PPS and somebody correct me if I am wrong, you are going to be billing through the skilled nursing facilities. Is that correct?

Ms. BUTO. Oh, you are talking about the consolidated billing.

Chairman TALENT. Yes.

Mr. DOMBI. That does not apply to home health services.

Chairman TALENT. Okay. It applies to the other ancillary services.

Ms. BUTO. Yes. It would be things like x-rays, as the gentleman was saying, would be billed through the skilled nursing facility and as he said, it has already been billed that way for the prospective payment for skilled nursing facility.

Chairman TALENT. Are you concerned about the phenomenon they are talking about the skilled nursing facilities, in effect, driving—using it as an extra revenue producer for them? In other words, they will overuse services, try to create discounts with the ancillary providers and then they get to keep what is left. So, in effect, we achieve the opposite of what we want. We get services overused and we also have the pressure on the small businesses.

Ms. BUTO. Well, of course, first of all, we have not put this system in place because it is one of the more difficult—it involves both skilled nursing facilities and all these other providers having to—we have to have a way to collect those claims and actually validate them.

We are hearing a lot of this kind of concern. I just want to tell you on the other side, and we do not know exactly what is going to happen, but both we and the oversight agencies have this among the things we will be monitoring the most closely to see what actually is going to happen.

But the concern on the other side, that led to the enactment of the consolidated billing provisions, was that we were getting billed without much oversight by the nursing facility which had the patient by a number of different suppliers—physical therapy, DME, x-ray, et cetera, suppliers providing things like supplies that are used in their nursing home.

In addition to Medicare, there often was a Medicaid payment involved because many of these individuals get both nursing home coverage through Medicaid and Medicare.

What was found in a variety of different surveys by oversight agencies and our auditors was duplicate payment, payment that was very hard to trace to medical necessity, and I think the general recommendation that came out of those studies was we need an accountable entity here that looks at what is being provided to that patient and it ought to be the facility.

So I understand what the gentleman is saying about the potential that the facility will try to get discounts and so on. We understand that. I think we are going to be concerned about access to these critical services if that really seems to be a problem.

On the other hand, HCFA, as you know, is constantly barraged with criticism for setting prices. We do not know what prices are, we cannot predict what the marketplace is going to do, and that is why we are moving to these kinds of systems where we give more of that flexibility to providers to make those trade-offs and try to really strike the best bargain for their patients.

Chairman TALENT. What about Mr. Goldhecht's idea of like a voucher where the facility would still have to approve—that is how I would understand it.

Mr. GOLDHECHT. Correct.

Chairman TALENT. They would approve your billing but they would be paid directly.

Ms. BUTO. And again they would be paid on a fee schedule, as I understand it, that we set.

Again I think we would have to go back to one of the underlying premises of the PPS, which is did we want to give the facilities more of that control or do we want to continue setting the price and sort of guaranteeing a price to every supplier?

HCFA is behind and supports the idea of turning that decision-making over to the facility, but we are obviously going to worry about access issues. That is where we are, and no one has raised the voucher issue before to us and we would certainly be glad to take it under consideration as we think about possible changes in the system, but that is a new idea.

Chairman TALENT. Let me raise two more issues before I recognize the gentlelady from New York and they are related. Parts of the testimony today just seem to me to be again so inherently plausible and I want to get your response to it.

One of them is the concern about ending reimbursement for the cost of transportation or travel really for an EKG service that we have heard about today. So now we are in a situation where—I guess this is Mr. Goldhecht's testimony—the current reimbursement for the EKG technical component is $16.49 and that is what you get regardless of how far you have to travel to give this EKG.

Mr. GOLDHECHT. Right.

Chairman TALENT. So it just seems to me that obviously the cost for small businesses are going to be greater if you have to travel two hours to administer the EKG than if you can do it in five minutes. And if the reimbursement schedule or system does not recognize that, it is flat out obvious that you are going to be underpaying for certain kinds of EKGs.

Why isn't Mr. Dombi right in saying the same thing about the need for a rural differential for home health? If you calculate on an average, you are obviously going to be underpaying people who have greater costs to provide the service.

Now, what is HCFA thinking, that they will just cost-shift or something or that the average is high enough that they can share it? And then the problem with that is if you are a rural provider, you do not have any lower cost services. You are traveling to everybody you are serving.

Ms. BUTO. The issue that you are raising and that——

Chairman TALENT. Ms. McCarthy just wrote two words here: gas prices, which is something that we are all thinking about now and you might want to talk about that, also.

Ms. BUTO. Well, let me directly address that. Medicare does not routinely pay for the cost of transportation and whether we should or not, and I think this Committee would say we should—for instance, if a rural physician as to travel, we do not pay his gas costs. A rural nurse-practitioner, et cetera. We do not do that as a rule.

The issue of whether we should I think is a legitimate question. It would require a change in the law and not just for home health, but for a variety of other areas of the Medicare program. I think you can argue that this would be true for a whole variety of providers and suppliers who must travel distances to get to individuals.

On the issue of the EKG transportation fee, we originally established that to recognize basically the van costs and the need to transport large equipment, as we do for portable x-ray, to remote locations or to other sites.

In the time since we established that fee, EKGs have become a lot more portable. I had a life insurance examination recently and the technician brought over the EKG and the blood work tools and so on in a briefcase.

Recognizing the issue of mileage, which you are raising, the original point of that transportation fee was to recognize the fact that large equipment or delicate equipment needed to be transported by van, and that is how we established the rate.

And the other thing that has happened since then is that because an EKG is more portable, nursing facilities and other providers now have more of this equipment on hand than they did when the rate was originally established.

So that is the rationale. I understand your point about gas and transportation and mileage, but that is really not the way that fee was established.

Chairman TALENT. Mr. Evans wants to say something.

Mr. EVANS. I would like to make a comment on Miss Buto's information she gave you.

While technology has shrunk and made things lighter and more portable, the costs have also gone up. I am sure that before you got these new timers, the old timers were probably big and bulky and a lot different than what you have now.

My concern is that not only has the cost gone up for the technology; you still have to transport that in some way. You still have to transport that piece of equipment some way. It is more cost-effective for us to put all of our equipment into one unit and have it go from site to site in one unit. However, in our case, if we have an EKG 20 miles to the north and an x-ray 30 miles to the east, we actually take that equipment out of that, put it in one of the smaller vehicles and let a technologist go do this other exam.

So I guess my point is we try to be very, very cost-effective and watch the dollars that Medicare is giving us. I used to own a home health agency and went through some of the problems Mr. Dombi was speaking of. It seems to me, and this is my own viewpoint, that the people that are still in business today, they went back, as Miss Buto talked about, going back and looking at the numbers of what happened years ago, not based on whether gas prices rise or your business grows or whatever. It seems to me that the only home health agencies that are still in business are the ones that raised the prices, that had high costs back years ago.

My concern is overall that we stop looking at this through rose-colored glasses and actually look at what is happening in rural America and make the changes based on what is happening in rural America.

Mr. GOLDHECHT. Mr. Chairman, I just want to clarify something Ms. Buto had said. She had mentioned that the equipment got lighter and easier, more compact and that nursing facilities might get it. Well, I can tell you first-hand that I do not know any nursing facilities that own EKG equipment. Most of the larger chains

have gone bankrupt and they are not looking to make any capital purchases.

That being said, the volume, the sheer volume of a typical skilled nursing facility does not warrant them buying a piece of equipment that they might use three times a month. That is why they have a service like us. And whether the equipment has gotten lighter, less expensive to purchase, the cost of transport is the cost of transport. That has always been the case.

I have been in business for 15 years. I can tell you that the difference between what I paid for an EKG machine 15 years ago and what I pay today is negligible. That is not going to keep me in business or put me out of business. The cost that it takes me to send somebody down the road five miles, 50 miles, 75 miles, that is what is killing my business.

Chairman TALENT. Because they are not administering EKGs when they are driving a van or a truck or something.

Mr. GOLDHECHT. Right.

Chairman TALENT. Is there a private pay segment of the market? And if so, what do they pay?

Mr. GOLDHECHT. I am happy you asked that question. What is the problem with our industry is that specifically portable x-rays, we have been designed for the skilled nursing facility. You and I can go to a radiologist's office, a hospital, and get an x-ray. It is much cheaper that way. But the skilled nursing facilities cannot send their patients out. It is much more costly.

So any act that Medicare changes the reimbursement or takes away reimbursement affects 100 percent of our business. We do not, unlike laboratories or ambulance companies that do work for hospitals, do work for private physician's offices, they can offset some of that cost. We do not have that.

Chairman TALENT. So there is no private pay. There is not anybody paying privately for EKGs.

Mr. GOLDHECHT. Right.

Mr. EVANS. Excuse me just a minute. If you do not mind, Norman, I am going to interject here.

In my case, yes, I do have some private payers that we work with for EKGs.

Chairman TALENT. What do they pay for a comparable——

Mr. EVANS. Depending on the client, as we negotiated our contracts, $100 to $175. However, and I want this to be part of the record because I think this is very important, we are 85 to 90 percent dependent on Medicare.

Chairman TALENT. Sure.

Mr. EVANS. I do not have that many private patients.

Chairman TALENT. What I am getting at is Medicare is paying $16 and a private pay is paying $100 to $175.

Mr. EVANS. Correct. And just to be accurate here, the transportation was bundled into that $16 rate.

Chairman TALENT. Isn't that a suggestion that maybe we are undercompensating, Ms. Buto? If the private sector, which—as I understand, you had a problem with fixing prices. I always restrain myself. I tend to get mad at HCFA and then I say, you know, in the first place, a lot of it is Congress, not HCFA. And in the second place, it is very difficult to plan prices and all the rest of it for a

segment of an economy. I mean planned economies tried it for years and it was very difficult, so you have a very difficult job.

I mean to the extent there is a private pay market and they are willing to pay $100 to $175 for what you are paying $16 for, it suggests to me that you are below the competitive rate.

Ms. BUTO. Maybe, but I would like to know where that comes from and how widespread it is and the reason is that we have not really had any complaints, from skilled nursing facilities, who use these portable x-ray providers, that they cannot get them at this rate.

Again, it is a tough thing for us to get into if, in fact, the service is willing to be provided at the rate and I think what I hear people saying is maybe they can provide it at this rate, but they are concerned that deeper discounts will be required if we go to this bundling, consolidated billing approach, that will further erode what they are getting.

I would like to see the information from the private payers. It may be something we need to look at.

Chairman TALENT. I recognize the gentlelady from New York. I appreciate the Committee's patience.

Ms. VELÁZQUEZ. Thank you, Mr. Chairman.

Ms. Buto, I am concerned about the statement that was made by Mr. Dombi. He made reference to the fact that your agency does not respect the differential in terms of rural and urban areas and that you failed to put in place a rural differential in terms of reimbursement. What is your comment regarding that?

Ms. BUTO. This prospective payment system and the interim payment system are very, very driven by the way the statute is written. If there was a rural differential in the statute—and I do not know; maybe during the discussions on the legislation, that was discussed—if there was one in it, it would be there.

There are other areas where, for instance, physician payment, there is a rural bonus that is provided to physicians in rural areas and undeserved areas. There are very specific areas.

The other thing he mentioned, which is being able to reclassify your wage index so that you get higher payment, in hospitals, rural hospitals can reclassify to an urban area, get a higher wage index and get higher payment that way. That is not available—he is right—to home health agencies.

Again, that is something that is driven by the statute and statutory changes could be made along those lines, but they have not been considered before, that I know of. Maybe they were and I just was not aware of it.

And, again, it is the kind of issue, just like the gasoline issue, that I think affects more than just home health, affects more than just portable x-ray. It is an issue that would need to be looked at for rural providers more generally.

Ms. VELÁZQUEZ. Yes?

Mr. DOMBI. If I might respond to that. In fact, the Congress did look at the issue and specifically in the prospective payment statutory language said that the Health Care Financing Administration or the Secretary of HHS, in designing a prospective payment system, has the authority to reflect geographic variations between home health agencies.

The system that has existed up until now for home health agencies has been a per-visit cost reimbursement system with cost limits. Since 1979, the first year of those cost limits, the Health Care Financing Administration has had a difference between a rural cost limit and an MSA, a metropolitan statistical area cost limit, and there is no specific language in the statute that mandated that.

So they have both regulatory power from preexisting practices and statutory authorization to do so and we have, in the discussions and in the formal comments we have given to HCFA relative to the prospective payment system, have said that they should consider a distinction between the rural and the nonrural home health agencies.

I would like to go on the record for one thing just for Ms. Buto's sake. We still do support moving to a prospective payment system away from the interim payment system but the difference is minor. It is a difference of the degrees of temperature in hell because the interim payment system is home care hell for our constituents and the prospective payment system promises to offer a solution for some of the providers of services but I do not believe that the solution is there for the rural small home health agency.

Everywhere I go—in fact, yesterday I was in Idaho and the question that was raised to me when I was explaining the prospective payment proposed system was, "How will it affect we in the rural areas?" And my answer was, "You would have no different system than you have anywhere else."

One last remark in case I do not have any other opportunity. My understanding is Ms. Buto is leaving the Health Care Financing Administration and I would like to take a little bit of leave here and give her my thanks for all the work she has done with the Health Care Financing Administration.

We have had our differences of opinion over the 18 years I think that you have been there but I have always found her to be receptive, professional and certainly rational in her positions. So I would like to thank her for that and wish her successor well.

Ms. BUTO. Thank you.

Ms. VELÁZQUEZ. You wanted to say something more?

Ms. BUTO. No, I was just going to say that I misunderstood what he was saying. And he is right about the interim payment system. And he is right about the issue of the cost limits in the past. I thought he was talking about the interim payment system, where there the structure was a regional per-beneficiary limit. It was very structured and we may have had some flexibility there. I thought we followed the statute pretty closely in order to get it done in just a few months. It had to be done in about four months.

So he is right that in terms of the comments we have gotten on the new system, we are looking at issues like this.

Ms. VELÁZQUEZ. Ms. Buto, why does Medicare reimburse rural areas at a lower rate than urban?

Ms. BUTO. Well, a lot of what Medicare is doing now and even some of the new systems are based on historical costs and on wages. The fact that it is harder to actually go out and attract professionals to an area does not really get factored into that so much.

So what we look at when we do these surveys of wages is wages paid, and wages have been in many respects lower across the

board, although there are definitely exceptions, in health care in rural areas versus urban areas. So that is what you are seeing.

What Medicare, and the Congress has actually done a lot of this over the years, is to try to look at evening that out. In some respects, the Medicare Plus Choice Program, the HMO program that we have in Medicare, looked to raise the payments in rural areas well above what we were paying our regular fee-for-service providers to try to attract HMOs to serve those areas. It has not, unfortunately, succeeded the way I think people had hoped it would.

In the physician payment area, the geographic adjustment factor where you adjust the geographic costs actually is not a total adjuster, and that was done, again, to give more money to rural areas.

So if you look at various ways in which Medicare pays for services, there are many instances where special provisions were attempted to be made for rural areas—the bonus payments for physicians, et cetera.

I think fundamentally what I guess I have concluded over the time I have been there and, as Bill said, I have been there quite a long time, is it is very hard just to get changes in the number of providers who are willing to serve areas based on reimbursement. It helps, but it does not seem to be the whole solution and I know that people are really struggling with how can we get telemedicine services and other things into the system so they will broaden the access?

Ms. VELÁZQUEZ. One area that we care about on this Committee is regulations. Can you explain to us what has your agency done to monitor how regulations from the Balanced Budget Act of 1997 have affected the small rural health care providers?

Ms. BUTO. We have done and we hope to issue soon an analysis of some of our findings. We have done fairly extensive both anecdotal gathering up of information from our regional offices.

We basically said to them, look, we cannot wait for data. That takes too long. We need to hear the stories that you are hearing out there of what is happening to providers. We have gathered that information together.

We have actually looked at things like Bureau of Labor Statistics has information on a monthly basis on hours worked in various industries and we have looked at that and home health and SNF and so on, to see whether it appears there is any change. Whether you can directly attribute it or not, we wanted to know if there were changes in the way services are being delivered.

We have now a capacity to look at cash or payments that are being made on a daily basis to providers through our contractors and we actually set that up during the Y2K exercise so that we could monitor what was actually happening in case there was a breakdown somewhere.

So we are trying in a number of ways to look at current indicators of what the impacts are by area, including rural areas. Rural areas are probably at the top of our list of vulnerable areas, as well as inner city areas. That is one of the areas we are concerned about and one of the reasons why we really supported, in the BBRA, a number of the changes that would allow rural providers to have ei-

ther better reimbursement or a less drastic change in their reimbursement in some cases.

So it is an area, as I said in my testimony, where we want to continue to focus. We have two senior people at HCFA, executives, Tom Hoyer in the central office of HCFA and Linda Ruiz in the Seattle Regional Office, who are contacts, our rural outreach executives, who we tasked with meeting both with rural providers and also gathering the data and analyzing it for us across the board so we can see what is happening.

Thank you. Thank you, Mr. Chairman.

Mr. BARTLETT [presiding]. Thank you.

We will now turn to Ms. Christian-Christensen.

Ms. CHRISTIAN-CHRISTENSEN. Thank you, Mr. Chairman.

I want to thank the witnesses for being here this morning and particularly for the recommendations that you have offered so far as to how to address this issue.

Having been a family physician in the Virgin Islands, I feel like I have been beat up by HCFA almost all my life. I am particularly interested in the testimony and the responses to the questions that have been made so far.

We closed our home health care agency, as you said. I have looked at hospice when I was a practicing physician and because of issues like the kind of staffing that was required—you cannot be temporary—we do not have a hospice. Our skilled nursing facility is struggling, struggling. And I am not even sure where to begin.

Let me ask, I think I heard Mr. Dombi say that all of the flexibility that was available to HCFA was not being utilized. Do you feel that even though the Balanced Budget Act has put a lot of restrictions and caused you to have to implement new policies supposedly to reduce fraud, do you think that HCFA, Ms. Buto, has exercised all of the possible flexibility with regard to rural and small businesses?

Ms. BUTO. We have tried, and I am sure people here will tell you that we have not gone far enough. I think certainly in the home health prospective payment system, we are really trying to make sure that what we are doing here is making sure that beneficiaries can get access to good quality services and we want to be able to pay agencies more for more complex cases and to give them more flexibility to serve those individuals.

We got a lot of comments on the rule, the regulation that we proposed. They were good comments. We have made a number of changes to accommodate concerns that were raised. So we are hoping—that regulation is very much on schedule—that home health agencies will look at it and say you have made some appropriate changes to accommodate our situation. I am hoping that that will be the case and that that will be the case for rural and small home health agencies.

Ms. CHRISTIAN-CHRISTENSEN. The interim payment system is probably the issue that my home health agency talks to me most about and what you are doing is delaying—well, the interest is forgiven for the first year. You are delaying the payments. But I just have the sense that it is still going to be an inordinate burden on the home health care agencies and don't you think we ought to for-

give those—wouldn't that be a better remedy? I realize that for those——

Ms. BUTO. There is no question that it would be a better remedy for those agencies. I cannot give you a definite answer on that because the federal debt collection rules require us to collect those overpayments and I am one of those people who has to sign off and am liable if I do not——

Ms. CHRISTIAN-CHRISTENSEN. When I was a physician I was always told it is not the carrier, it is not HCFA, it is the Congress that is doing this.

Ms. BUTO. These are federal debt collection rules. I am not saying that this is entirely the Congress. These are rules that we have to live with, as federal agencies.

Ms. CHRISTIAN-CHRISTENSEN. Would you like to——

Mr. DOMBI. Yes. Within the Federal Debt Collections Act is authority for the Health Care Financing Administration to compromise any debt that is owed back to the Medicare program and they have institutionally chosen not to apply that authority to the interim payment system debts, which would seem to be the first type of debt that you would, because these are cost- reimbursed providers that delivered care to patients who happen to have needs that exceeded the level of limits that were imposed through the Balanced Budget Act.

So the compromise authority is there and we would gladly take any assistance that we could get from this Committee to convince the Health Care Financing Administration to use the authority it has to compromise rather than to close a home health agency. The option that they are offering right now, is pay back money when you have no money coming to you because you are still cost-reimbursed, or close.

And we have seen the actions in bankruptcy courts, as well, where the Health Care Financing Administration's position is close rather than compromise. We have had bankruptcy courts offer to the Health Care Financing Administration the opportunity to take $1 million on a $1.5 debt and the Health Care Financing Administration said, "No, close them down."

Ms. CHRISTIAN-CHRISTENSEN. So there is an administrative remedy that you can pursue.

We did attempt; I think we will try again and we would be willing to work with others to do that.

I guess this question again is for Ms. Buto. The Balanced Budget Act of 1997 attempted to reduce Medicare reimbursement rates in an effort to save money for Medicare. Has HCFA performed any studies or are any studies planned that will assess the savings or costs to Medicare by the new PPS?

Ms. BUTO. The upcoming PPS or you mean what has already been saved as a result of the changes in the BBA?

Ms. CHRISTIAN-CHRISTENSEN. The one that is in place.

Ms. BUTO. The interim payment system. Oh, yes. I think the most recent public document that is probably worth this Committee taking a look at is the summary from the Trustee's report of the Medicare Trust Fund, which actually looks at what is happening.

You know, the short-term solvency has been extended to 2025 largely due to changes that have arisen as a result of the Balanced

Budget Act, which is, of course, one of the intended consequences, but I think one of the issues that was a surprise to us and is certainly a surprise to providers is that Medicare actually spent less in 1999 than it did in 1998 for the first time in its history. That was unexpected. Again, a lot of that is associated with, if not entirely due to, changes that were made in the statute for Medicare payments.

Home health is one area where the most dramatic change occurred, if you look at it, but our actuaries say that spending in a lot of sectors, including hospitals, was less than expected and we also saw—we did not see changes we have seen over time, like an increase in the case mix or the complexity of cases that are billed to us in hospitals. We did not see any increase. So the actuaries, in consultation with other experts, attribute that to the effort of a lot of the oversight agencies, like the GAO and the OIG, efforts to look at fraud and abuse.

Ms. CHRISTIAN-CHRISTENSEN. Are you looking at also, Miss Buto, at ways to address the staffing issue for hospices? Is HCFA looking at ways to address that? Because in a rural area where you have maybe a physical therapist at a hospital that could provide the service at a hospice and you are not allowed to use it, there is just no way to provide the hospice service. Are you looking at ways to address that, also?

Ms. BUTO. You know, the hospice program is one area where I think we are willing to look at a variety of issues around both the structure of it and I think some issues were raised around the wage index, as well. We are willing to look at that.

The most important thing that I think will be helpful in this evaluation is that Congress required hospices to begin submitting cost reports last year. I know that costs have gone up in a variety of areas, like drugs, for instance, pharmaceuticals, we just do not have the data to show what those costs have been.

We will now have, probably at the end of this year, or the beginning of next year, enough data to begin to look at what the actual costs are, and that will help us in any reevaluation of hospice.

Ms. CHRISTIAN-CHRISTENSEN. I yield back my time, Mr. Chairman.

Mr. BARTLETT. Thank you very much.

Mrs. McCarthy.

Mrs. MCCARTHY. Thank you.

I sit here with fascination because here we are on the Small Business and you have a doctor and a nurse, a nurse that actually has done a lot of home care over her career. But I understand also the issues of the rural areas very, very strongly and the hospice and everything else, I can only relate to when I did private duty nursing and how hard, and I live in a suburban area, how hard—we had a hard time staffing a patient. I mean it was really quite difficult. We had a bunch of friends work together and we went in as a team. So dealing with that issue, just on the rural area, I do not know how you do it.

Obviously we in Congress all had good intentions on the Balanced Budget Amendment, and we did, but it is a mess. When we talk about rural areas, I talk about suburban areas, I talk about

my hospitals, my home health care agencies that I have worked for, somehow this has to be addressed.

And I know what we did, putting rules and regulations down to you, has been really a mess but my concern is even though we are trying to work together and you are certainly implementing and work with the small businesses to try to clarify a number of things, knowing how government works, it takes too long and that is my concern because the bottom line, as we sit here and discuss this, is the patient. That is the bottom line and it is going to be the patients that are suffering.

I think as we try to address this. Hopefully we can do that, especially for small businesses. I find the majority of small businesses that have been in the health care system are good people and they are there to take care of those. But my concern is, especially the traveling that has to be done in the rural areas, we did not take that into account. Unfortunately, Congress does not think of an awful lot of things when we write those, even though we try to reach out to as many people, but I do not think anybody thought it would be the disaster it has become. And I am hoping that we, as a Small Business Committee, will be able to work with those committees to make this the right thing.

Health care is, in my opinion, in an uproar right now, on every level, on every single level. An awful lot of us have been trying to come up with answers but unfortunately, there is not an answer for everybody.

What I am hoping out of this Committee hearing is that we will be able to facilitate the movement a little bit faster so businesses do not go out of business. I sit here and I listen to every single one of your testimonies and I have probably been in the situation where even I was in a nursing home at one time and we had to bring in an outside x-ray.

Now, of course, they did not have to travel that far but I think what people do not understand is how important it is not to transport the patient to a hospital, not to take that elderly patient out of a nursing home setting, to be able to have it there in the surroundings.

And I do not think any of the things that we have done—maybe they did not work with nurses; I do not know. We probably could have given you an earful on every single level. But we have to come up with solutions. We have to save our small businesses. We have to make sure there is no fraud and abuse. We all agree with that. But who suffers in the end? Our business people and our patients.

And with that, I yield back the balance of my time.

Mr. BARTLETT. Thank you very much.

I have a question, I guess for Mr. Dombi first and then anyone else who would like to comment. At some point as we raise the cost of doing business for our small businesses that provide health care, at some point they are going to fail. And if you are talking about home health care, if they cannot get care at home, then they are going to move into a hospital where care is very much more expensive. Is this happening?

Mr. DOMBI. At a recent hearing, I believe of the House Budget Committee, testimony was presented by hospital administrators in-

dicating that they are seeing an increase in the number of patients that normally would have been in home health care and extended lengths of stay.

Now traditionally, the Health Care Financing Administration tries to monitor these things but they are four or five, maybe 10 years behind statistically, so they may not see that. But certainly those are the reports.

The other thing which we find quite fascinating is I believe for the first time in the history of the Medicare program, the expenditures under the skilled nursing facility benefit now exceed the expenditures for the home health benefit.

And I believe we have a public policy in this country to deinstitutionalize people and keep them integrated into the community and when you see a rise in nursing home expenditures, it explains somewhat maybe some lengths of stays in hospitals but it also explains the effect on home care beneficiaries.

This year it is projected that there will be three-quarters of a million less users of Medicare home health services than in 1997 and those patients have to go somewhere because they are the most expensive patients. That is why they are having access problems.

I was pleased to hear Ms. Buto say that they have not found in their studies any major problems in access because I believe just last year the Health Care Financing Administration was saying they have not found any problems at all, so at least we have made it into the problem category to some extent. But I know the Inspector General's office is concerned about access issues. I know that the General Accounting Office is. I know MedPAC is concerned about it. And I know that Ms. Buto and Tom Hoyer and others are also very concerned about access problems because they are growing, rather than shrinking.

Mr. BARTLETT. Ms. Buto, who has the responsibility of monitoring home health care reimbursement and the effect that that has on these providers closing and therefore moving patients into other facilities which are very much more costly—which would therefore defeat the very thing we started out to accomplish, and that was to reduce health care costs?

Ms. BUTO. I do not actually buy the notion that they are moving from home health into skilled nursing facilities. Again we are, and I would be interested to see if Mr. Dombi has information on this but——

Mr. BARTLETT. Are they just dying at home, then? Because if they are not getting the care at home, they are going to go somewhere for care or they will just die at home.

Ms. BUTO. I guess what I was trying to say earlier is that many of them are still getting care at home. One of the changes in the Balanced Budget Act was that venipuncture alone, the need to have a blood draw, is not now, under the law, and probably really should not have been, a reason for getting home health care with all the aide services and so on.

A number of people were affected by that change in the law and there is no question about that. However, we did make sure that they could get lab services provided to them to have blood draws.

But as to the issue of who is responsible, it is our responsibility. We need to know whether there is an impact on beneficiaries, who are the number one reason why we are here, of any reimbursement change, and that is the reason why I was describing earlier that we have the regional offices both looking at anecdotes, where they think there is a problem, or an individual case or they think some agency might be affected adversely, and reporting those to us and in addition, looking at other indicators that could tell us what is happening out there as a result of the reimbursement changes.

We have invited the National Rural Health Association and they have agreed to help us survey rural providers on a systematic basis to get information they have in rural communities about the impacts of the Balanced Budget Act and NRHA has agreed to work with us on that. They are also helping us develop information for beneficiaries in rural areas, so that we can find out from beneficiaries if they are having problems.

So it is our responsibility. There is no question about it. Other agencies, and the industry itself, also pay very close attention and gather information and collect surveys, but it is principally our responsibility to make sure that beneficiaries get access to care.

Mr. BARTLETT. We have had testimony from several witnesses indicating that they are now providing services at less than cost, that they do not have the ability to cost-shift because they do not have enough private pay patients to cost-shift, and they are telling us that they cannot continue this forever, that if they do not get some relief, they are going to have to shut down.

Now if they shut down, then the patients that were getting care at home are going to be moved into a more costly facility. You are saying that that is now not happening.

Ms. BUTO. I am saying I do not know if it is happening.

Mr. BARTLETT. But they are telling us that it is imminent that it is going to happen. Can this problem be solved through the agency or does this require a congressional action to solve this problem?

Ms. BUTO. I guess what I would like to say is that the new home health—and I think you are talking about home health agencies here—I believe will be a major improvement over the situation that they are now operating under. Again it may not be perfect; Congress may want to look at making additional changes.

There also is something looming. I think the additional 15 percent reduction that is in the statute, that was postponed until January, I believe. Obviously we are looking at that and I am sure you are looking at it, too, to see whether that is going to create more difficulty for home health agencies. But we ought to take a look and see what the reaction of your constituents is to the new system, which we think will be an improvement and will make their lives easier.

Again, if it is not enough, we may want to both consider more changes.

Mr. BARTLETT. Mr. Evans.

Mr. EVANS. I just wanted to make one comment that I think is a common thread, whether you are talking about home health, portable x-ray or hospice. With all the changes that are coming down the pike and the changes that you do not know when they are going to be enacted or you think they are going to be enacted

or you plan for them to be enacted, there is no way to plan. There is no way to run your business and to plan.

We have five vehicles that need to be replaced. They have an average of 204,000 miles on them. The highest mileage one has 350,000; the lowest has 95,000 on it. We cannot plan. We cannot plan to change equipment because we do not know what the next—we know what is planned from HCFA, for instance, consolidated billing they are saying now is January 1 of 2001.

Will it happen? We do not know. It was supposed to happen January 1 of 2000. The common thread is you cannot plan.

And one other comment I wanted to make as far as where these patients are going, I think you hit the nail on the head. They are going to the hospitals. And the problem is that when these hospitals get them, because of PPS and how it affects the SNFs, not necessarily the home health agency but the SNFs themselves, these patients are not—the SNFs do not want them. The skilled nursing facilities do not want a high chronic or acute diseased patient. They cannot afford to under this system.

So you hit the nail on the head. It is a problem. It is a big problem.

Mr. BARTLETT. My last comment and question has to do with a systemic problem that has been bothering me. Apparently in health care, we as a country have given up on what is the usual procedure for improving quality and reducing costs, and that is competition. In health care, rather than competition, we appear to be turning to practices that we have applauded the failure of in other countries.

What we are trying to do, as I see it, in health care in containing costs is simply to use a combination of rationing and payment at below cost. I talk to a lot of people who run nursing homes and the Medicaid payments are less than their costs. I talk to people in hospitals. The Medicare payments are less than their cost and the only way that they can stay in business is to cost-shift.

Now when they cost shift, I as a taxpayer am still ultimately paying the bill and it is a false economy to believe that by cost-shifting, we can reduce the cost of health care because providers cannot remain in business being reimbursed at less than the cost of doing business. They tried that for 75 years in the Soviet Union and it did not work.

And I am wondering how we got off track and how we concluded that we could not provide better health care at less cost with competition and why we had to turn to the practices that have failed other countries; that is, the practices of rationing and reimbursement below cost. Where did we go wrong and how do we get back on track?

Mr. EVANS. If I could make one comment, I also own a cardiopulmonary stress test that we go into doctor's offices and perform and just to add onto what you said, Mr. Bartlett, when we go a physician's office and a physician's office is owned by a hospital, that hospital does not want us around. They do not want, even if it is cost-saving, they do not want us there.

It seems to me like everybody, and I do not care whether it is HCFA or a hospital or whoever, everybody is very protective of their own territory.

I echo what you are saying. I agree with what you are saying.

Ms. BUTO. Can I comment on that, as well? Medicare has had a very hard time using competition. We were given authority in the Balanced Budget Act to competitively bid durable medical equipment services and we also were given authority to do—and these are both demonstrations; they were not across the country—limited demonstrations. The other was competitively bid our contribution to an HMO, or HMOs in an area.

The HMO provision was set up in such a way that we had three advisory committees advising us on the design and the method for doing the competition. We took their advice. The advisory committee was chaired by an executive at GM and included people like Mr. Reischaurer, former CBO director, and Chip Kahn, who used to be Ways and Means staff director—a number of people who know a lot about health care. That committee has now essentially had its authority at least frozen for the moment by Congress for a couple of years. We cannot start the demonstration because of concerns coming from that local area.

The other demonstration was more successful. We were sued by the industry and prevailed, ultimately, in the lawsuit. But we had a full and open competition. We were able to meet with beneficiaries. We continue to meet with beneficiaries. They are very satisfied. And we were able to get a lower price but we had to actually go through court to sustain the ability to do a pilot project to do competition.

So, I think there is a legitimate concern on the part of people in the health care community when Medicare does competition. We are the 900-pound gorilla and I understand that. I think we have to do it carefully, openly. It ought to be fully visible to the public. But we have found it extremely hard because of local concerns and concerns about what will happen to whole groups of providers if we engage in competition.

But I agree with you. It is something we feel very strongly we ought to be trying more of in Medicare.

Mr. BARTLETT. I appreciate that there are problems and you identified those problems, but the very fact that we recognize that it is very difficult to provide competition in health care, I think, speaks to a fundamental problem of how did we get here when nowhere else in our society do we have problems providing a better product or a better service with better efficiency and lower cost through competition and we are now admitting that we cannot do that in health care.

I am just wondering, where did we go stray and how do we get back on track because I just have to believe the delivery of health care has to be amenable to the same forces that operate everywhere else in our society, and that is that competition always does two things. It makes the service or product better and it makes it cheaper. And we have not found that true in health care and I just think that rather than nibbling at the margins of the problem, we need to get back and take a broad look at how we got to where we are, which is not where we ought to be. We should not be rationing and we are rationing. And we should not be forcing providers to provide health care at less than cost because that simply results in cost-shifting and there is zero economy in cost-shifting because

we, as the taxpayers, end up paying the costs anyhow because we are not going to have people sitting on the curb dying.

So I just hope that in our desire to fix the system that we now have, which is clearly broken, that we spend some time in looking at how we got here and what do we need to do to get back to where we have true competition, where we will have improved quality and lesser costs because that works everywhere else in our society.

And I just hate to see us trying to do in our country what failed in the Soviet Union for 75 years, and that is a centrally controlled system. It did not work there, it is not working here and it is not going to work for the future.

So we would solicit your help in helping us to understand where we went wrong, because I think that here, as in most cases when we have problems in our society, they began where I am sitting, not where you are sitting—where we went wrong so that we can try to get back to where we ought to be.

Well, I want to thank you all very much for a very good hearing and unless there are additional comments from the panel, we will adjourn the Committee. Thank you very much.

[Whereupon, at 12:15 p.m., the Committee was adjourned.]

STATEMENT OF
REP. JAMES M.TALENT
CHAIRMAN
COMMITTEE ON SMALL BUSINESS
JUNE 14, 2000
HEARING
ON
RURAL HEALTHCARE SERVICES
"IS BBA '97 KILLING SMALL BUSINESS PROVIDERS?"

Good morning, the Committee will come to order.

Today the Committee will be examining the fate of small business health care providers three years after the landmark Medicare reforms incorporated in the Balanced Budget Act of 1997. These reforms promised us an improved ability to reduce waste, fraud and abuse in the Medicare system and to achieve substantial savings. Certainly savings have appeared, and we believe fraud and waste have been curbed but there are some concerns that service for Medicare recipients is suffering as a result.

Over the past two years many of us have read the newspaper articles or seen the reports on television concerning the bankruptcies of major nursing home chains and the financial problems of HMOs that provide significant Medicare services. Most recently, we saw CIGNA Healthcare abandon Medicare services. The common reasons given revolved around the reimbursement and fee schedules established by the Health Care financing Administration after the 1997 BBA changes.

However, as significant and oftentimes disturbing as those events were, a little noticed change was sweeping through the health care industry and devastating the provision of care available, particularly in rural areas. Small businesses involved in the provision of ancillary services to nursing facilities, hospices and home health patients were failing or reducing service in rural areas at a record pace. Theses small businesses offered laboratory services, physical therapy, occupational therapy, wound care, intravenous therapy, portable electrocardiogram, x-ray, and pharmacy services to rural areas.

These providers offer a range of medical services that a rural nursing facility would find impossibly expensive to duplicate. Unfortunately, they are fast disappearing and it appears that the reason may be the Medicare reforms enacted in 1997. Since the enactment of BBA '97 a number of previously covered ancillary services have been eliminated. In addition, many other Medicare services have been effectively eliminated in rural areas by the reduction or elimination of transportation reimbursement rates. Ancillary service providers for Medicare patients at a rural nursing facility now receive no reimbursement for travel to the facility and are forced to either provide services at a loss, or suspend service to rural facilities altogether.

At the same time, other provisions of BBA '97 are taking their toll. The Prospective Payment System was instituted in 1998 to consolidate the billing of Medicare A services through nursing facilities. Facilities are billed directly and then reimburse the ancillary care providers. Unfortunately, this has resulted in some facilities taking advantage of their position as "gatekeepers" to extract discounts from small providers. In addition, many facilities are increasingly slow in providing reimbursement.

This situation creates an additional strain on the system - ancillary providers faced with this situation refrain from providing service. While this is in part good because it prevents unnecessary use, it also creates a scenario for misuse. Services previously provided at bedside are now provided at hospitals, with the added cost of ambulance transportation and the added stress to the patient. We know these services are shifting to hospitals, only last year Congress acted to increase reimbursement to rural hospitals in recognition of that added strain. The question is, have we only treated the symptom?

Today we will discuss these problems and hopefully begin a dialogue to restore the small business sector of the health care industry.

Our witnesses are:

Ms. Kathleen Buto, the Deputy Director of Health Plans and Providers at the Health Care Financing Administration who will discuss HCFA's position;

Mr. Zach Evans - President of Mobile Medical Services in St. Joseph, Missouri, who will provide us with the view from trenches;

Ms. Kathy Woods, Executive Director of the Hospice Association of America, who will discuss how these changes have affected the palliative care services in the hospice industry;

Mr. Norman Goldhecht, Vice President of Diagnostic Health Systems in Queens, NY and Lakewood, NJ another ancillary service provider and finally;

Mr. William Dombi, Vice President for Law at the National Association for Home Care

JAMES M. TALENT, MISSOURI
CHAIRMAN

NYDIA M. VELAZQUEZ, NEW YORK

Congress of the United States

House of Representatives
106th Congress
Committee on Small Business
2361 Rayburn House Office Building
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Opening Statement
Committee On Small Business
"Rural Healthcare Services: Has Medicare Reform Killed Small Business Providers?"
Wednesday, June 14th, 2000

Thank you Chairman Talent.

Today we examine the need for access to healthcare in rural America and the unintended consequences that the Balanced Budget Act of 1997 created.

In study after study, it has been determined that those Americans living in rural areas tend to be poorer, older and less insured.

Indeed, nearly 22 million Americans live in federally designated areas where there is a complete shortage of adequate health care professionals or medical facilities.

And to make a bad situation worse, those who often need health care the most - - - senior citizens - - - represent 1/5 of the total rural population.

This is - - - without a doubt - - - a travesty for this country.

However, while the need is still great - - - the commitment by the federal government is diminishing. **This is due in large part to the Balanced Budget Act of 1997 that has hit small rural health care providers especially hard.**

These small companies were paid through by a simple "cost-reimbursement" system. Simply put - - - they were reimbursed for **REASONABLE** expenses related to providing these services.

In most cases, the costs often involve transportation of critical equipment to these remote sites - - - but these expenses are only reimbursable on a fixed basis - - - regardless on how far they travel to get to the facility they serve.

Unfortunately, these companies are now forced to carry an extra burden without proper compensation for reasonable costs of doing business.

And it is for this reason that we must take all of these issues into consideration - - - **whether we are talking about patient care or protecting small business** - - - to ensure that every American, no matter where they live, will have that continued access to basic health care.

I have looked forward to the start of this hearing. I believe it is important to reveal the unique issues revolving around access to quality rural healthcare, or the lack thereof.

We are all interested in hearing from small businesses that provide healthcare services in rural areas and how we might be better able to continue their growth and success.

It is not in the spirit of equality that America has promised all of us, to be denied the basic necessities shared by all, only because of where you live.

Many of the people in these rural areas who these companies service are farmers. Farmers have committed their lives and their families lives to ensuring that each and every day, all of us have food for our families.

I look forward to working with Chairman Talent and the other Members of the committee, in seeking ways to mitigate the negative impact the Balanced Budget Act of 1997 has on our nation's small businesses.

We are faced with a serious dilemma with this issue - - - and we must find a solution to prevent a serious problem from becoming a potential health care disaster for business - - - and for the people they serve.

Thank you Mr. Chairman and I look forward to hearing from our panelists today.

House Committee on Small Business

"Rural Health Care Services: Has Medicare Reform Killed Small Business Providers?"

June 14, 2000

Opening Statement of Rep. Manzullo
U.S. House of Representatives

Thank you, Mr. Chairman. Today's hearing is a logical next step in our continued focus on small business and rural health care. In previous hearings, this committee has examined the issue of access to health coverage. Twice this term we have looked at Association Health Plans as one option for expanding access to health coverage. Last October, Chairman Talent skillfully guided a significant health care access bill to passage in the full House.

Today, we venture away from the issue of health care access and instead investigate health care availability. What good does it do to provide rural small businesses with greater access to health care if there are no health providers to treat them? Rural health care providers already face many challenges that their urban counterparts do not. In fact, the vast majority of rural health providers are themselves small businesses. We need to be sure that the reforms, rules, and regulations of the federal government do not put small business providers out of business.

I have some real concerns about the Health Care Financing Administration's (HCFA) frequent misinterpretation of Congressional intent and especially the negative impact it has on rural health care. When Congress provided HCFA with more tools to combat waste, fraud and abuse, one of those tools was not a license to harass honest health providers. When Congress addressed the issue of Medicare insolvency through the Balanced Budget Act (BBA), we did not want HCFA's implementation of the BBA to create disparities or cut off necessary health services to rural communities.

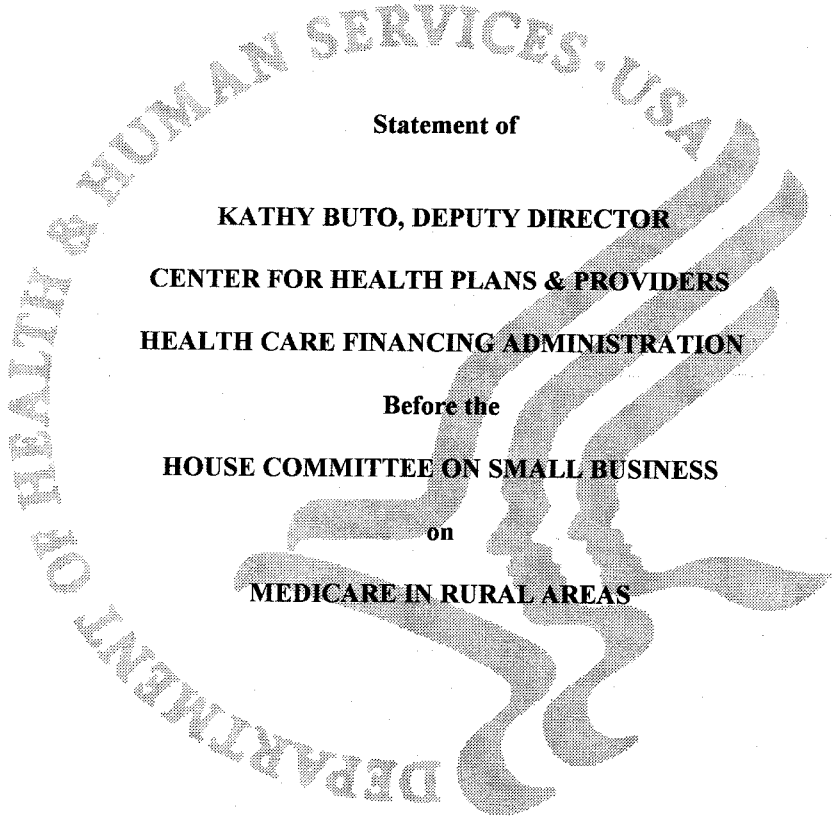
Over the last year, I have witnessed numerous rural home health agencies discontinue service due to BBA payment reductions. I have been contacted by honest health providers unfairly targeted by HCFA fraud inspectors and threatened with overpayment reimbursement demands--sometimes as high as a quarter million dollars. My last example will probably bring a chuckle initially, but I assure you it is real and it concerns me.

A small, struggling, county-owned nursing home was recently blessed with a surprise inspection from local HCFA officials. On the way out, the inspectors left behind a write-up of five or six infractions and a fine of $3,150. To some people, the $3,150 may seem insignificant; however, it is a hefty fine for a nursing home struggling to keep its doors open. So what was so serious that necessitated a penalty from HCFA? Three doors were propped open and there were a few menu disputes. Now

the doors I understand that's a violation of the fire code and that needs to be corrected. However, the menu problems? They must have been egregious to necessitate a fine. The menu plan for one meal said they would be serving baked chicken, but instead, the chicken was fried. Another meal plan called for smothered pork chops, but residents were served pork roast and porkettes. On another occasion, the side dish listed on the menu was California-blend vegetables. What did the residents receive? Cauliflower and carrots! Finally, the nursing home received a separate fine for failing to put a piece of parsley garnish on the plate when the menu said it would be there.

Perhaps part of the problem is that some people at HCFA are more concerned about a senior's access to parsley than they are a senior's access to medically necessary services. There are over 120,000 pages of Medicare regulations and 29 federal agencies promulgating rules for health providers. We don't need HCFA creating additional obstacles for the health providers who take care of some of our most vulnerable citizensour rural seniors.

Mr. Chairman, thank you again for holding this hearing. I know that health care access and availability are issues that this committee will continue to discuss in the months and years to come.



Statement of

KATHY BUTO, DEPUTY DIRECTOR

CENTER FOR HEALTH PLANS & PROVIDERS

HEALTH CARE FINANCING ADMINISTRATION

Before the

HOUSE COMMITTEE ON SMALL BUSINESS

on

MEDICARE IN RURAL AREAS

June 14, 2000

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration

Testimony of
KATHY BUTO,
DEPUTY DIRECTOR, CENTER FOR HEALTH PLANS & PROVIDERS
HEALTH CARE FINANCING ADMINISTRATION
on
MEDICARE IN RURAL AREAS
before the
HOUSE COMMITTEE ON SMALL BUSINESS
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Chairman Talent, Congresswoman Velazquez, thank you for inviting me to be here today to discuss our efforts to support small businesses that provide health care in America's rural areas.

We understand that rural providers face unique challenges in serving the medical needs of their beneficiaries. Assuring and enhancing access to quality care for rural beneficiaries is a priority for us. About one in four Medicare beneficiaries live in rural America, and rural providers serve a critical role in areas where the next nearest provider may be hours away. Yet many of these rural providers have higher costs than their more urban counterparts and face difficulty maintaining enough patients to break even. Medicare has made exceptions and special arrangements to address the needs of rural America and strengthen providers in these areas. And we are committed to continuing to work with you to ensure that these unique needs are met.

We already have implemented a majority of provisions in the Balanced Budget Act of 1997 (BBA) that assist rural providers. We are eager to implement additional provisions targeted to the specific needs of rural providers that were included in the Balanced Budget Refinement Act (BBRA), which became law late last year. And we have taken a number of administrative actions to help providers adjust to changes in the BBA. These steps complement the legislative changes included in the BBRA and will help hospitals and other providers in meeting the needs of the patients they serve.

In addition, we have established a Rural Health Initiative within our agency to increase and coordinate attention to rural issues. This initiative includes senior staff and a specially designated rural point person in each of our 10 regional offices to respond to rural provider inquiries and concerns. And we have enhanced our relationship with our colleagues at the Small

Business Administration (SBA) to ensure we consider the special needs of small health care providers in all of our programs, policies, and guidance.

We will continue to closely monitor how laws and regulations governing our programs affect rural beneficiaries and providers. And we want to work with Congress to make any additional adjustments that may be necessary to ensure that rural providers can continue to provide beneficiaries with access to the high quality care they deserve.

Balanced Budget Refinement Act

Working together, Congress and the Administration last year enacted the BBRA, which includes a number of payment reforms and other changes to address some of the BBA's unintended consequences. A number of these refinements are particularly helpful to providers in America's rural areas and their patients.

The BBRA includes several provisions to assist Critical Access Hospitals, such as:

- applying the 96-hour length of stay limit on an average annual basis;
- permitting for-profit hospitals to qualify for Critical Access Hospital designation;
- removing constraints on length of stay in "swing beds" in hospitals with a total of 50 to 100 beds that serve both acute care and skilled nursing patients;
- allowing hospitals that have closed or downsized in the last 10 years to convert to Critical Access Hospital status;
- permitting Critical Access Hospitals to streamline their billing processes by combining physician and hospital charges; and,
- eliminating beneficiary coinsurance for clinical laboratory tests furnished by a Critical Access Hospital.

The BBRA also gives Sole Community Hospitals an enhanced annual update for FY 2001. For other rural hospitals, the BBRA holds them harmless for 4 years during the transition to the new prospective payment system for hospital outpatient care, and provides separate, budget-neutral payments for high-cost patients and certain drugs, devices, and biologicals for all hospitals,

which will especially help hospitals that would otherwise have had to spread these costs across a small case load.

To help address the need for physicians in rural areas, the BBRA raises the caps by 30 percent on medical residents to strengthen hospital residency training programs in rural areas and encourages urban physician education programs to establish separate training programs in rural areas.

The BBRA extends the Medicare Dependent Hospital program for five years. This program assists small rural hospitals, which serve mostly Medicare patients. In general, Medicare patients make up at least 60 percent of a Dependent Hospital's inpatient days or discharges, have fewer than 100 beds, and do not serve as a Sole Community Hospital.

For skilled nursing facilities, the BBRA provides an immediate increase in payments to skilled nursing facilities that treat high-cost patients. It creates special payments to facilities that treat a high proportion of AIDS patients, and excludes certain expensive items and services from PPS consolidated billing requirements, such as ambulance services for dialysis, prostheses, and chemotherapy. Importantly, the BBRA provides an across-the-board increase of 4 percent for FY 2001 and FY 2002, and gives nursing homes options in how their rates are calculated. It places a two-year moratorium on the physical and occupational therapy caps included in the BBA, which appeared to be presenting particular problems for patients in these facilities.

For home health agencies, the BBRA delays a scheduled 15 percent pay cut until after the first year the new home health prospective payment system is in place. It also provides an immediate adjustment to the per beneficiary limits for certain agencies; gives assistance payments to help agencies cover the costs associated with the OASIS quality survey system; and excludes durable medical equipment from consolidated billing under the prospective payment system. Once the prospective payment system is implemented, payments will be tailored specifically to the condition and needs of the patients. In addition, there will be no per visit or per beneficiary payment limits. A case-mix adjusted payment will be made for each 60-day episode of covered

care, the limit on the number payment episodes will be removed, and agencies will receive extra payments to cover more costly cases.

Administrative Actions

Building on the changes included in the BBRA, we also have taken a number of administrative steps to assist rural providers in meeting the needs of the patients they serve. For example, we are implementing new policies to make it easier for rural hospitals, whose payments are now based on lower, rural area average wages, to be reclassified and receive payments based on higher average wages in nearby urban areas. As a consequence of these policy changes, qualifying rural hospitals will receive higher reimbursement.

Similarly, we are helping rural hospitals adjust to the new outpatient prospective payment system by using the same wage index for determining a facility's outpatient payments rates that is used to calculate inpatient payment rates.

And we are postponing for a period of two years the expansion of the BBA's "transfer policy," which limits hospital payments when patients with certain diagnoses are discharged early from a hospital to a skilled nursing facility or post-acute care setting. As a result, the transfer payment limits will apply only to the current 10 specific conditions included under the BBA, and we are considering whether further postponement is warranted.

We also are taking administrative action to assist home health agencies. We are providing financial relief to agencies by extending the timeframe for agencies to repay overpayments resulting from the interim payment system from one year to three, with the first year interest-free. We are postponing the requirement for home health agencies to obtain surety bonds until October 1, 2000. And we have eliminated a "sequential billing" requirement that had been problematic for some agencies, including some in rural areas.

For skilled nursing facilities, we are using our administrative flexibility to refine, in a budget neutral way, the manner in which we classify medical conditions for purposes of payment in a way that more accurately reflects the full range of costs incurred on behalf of sicker patients.

The refinements will likely increase payments for patients with complex medical conditions.

Rural Workgroup

We also are redoubling our efforts to more clearly understand and actively address the special circumstances of rural providers and beneficiaries. Last year, we launched a new Rural Health Initiative. We are meeting with rural providers, visiting rural facilities, reviewing the impact of our regulations on rural health care providers, and conducting more research on rural health care issues. We are participating in regularly scheduled meetings with the Health Resources and Services Administration's (HRSA) Office of Rural Health Policy to make sure that we stay abreast of emerging rural issues. And we are working directly with the National Rural Health Association to evaluate rural access to care and the impact of recent policy changes.

Our goal is to engage in more dialogue with rural providers and ensure that we are considering all possible ways of making sure rural beneficiaries get the care they need. We are looking at best practices and areas where research and demonstration projects are warranted. We want to hear from those who are providing services to rural beneficiaries about what steps we can take to ensure they get the care they need.

We have put together a team for this rural initiative that includes senior staff in our Central and Regional Offices and dedicated personnel around the country. The work group is co-chaired by Linda Ruiz in our Seattle regional office and Tom Hoyer in our central office headquarters in Baltimore. Each of our ten regional offices now has a rural issues point person that you and your rural provider constituents can call directly to raise and discuss issues, ideas, and concerns. A list of these contacts and their respective States is attached. We are confident that this initiative will ensure that Medicare policies are attuned to the needs or rural health providers and beneficiaries.

Telemedicine

We are proceeding with projects to evaluate Medicare coverage for telemedicine. We recently completed a comprehensive, $2.3 million technology assessment of telemedicine, in conjunction with the Agency for Healthcare Research and Quality, under contract with the Oregon Health Sciences University. This study involved an assessment of the clinical and scientific literature

dealing with the cost-effectiveness of telemedicine, specifically looking into the areas of store and forward, patient self-testing and monitoring, and potential telemedicine applications for non-surgical medical services. We will examine the results of this study to determine if there is a need to expand telemedicine beyond the current payment regulations.

We are also proceeding with demonstration projects to test expanded coverage for telemedicine to include teleconsultations in Medicare. On February 28, 2000, we awarded a $28 million cooperative agreement to Columbia University for the Informatics, Telemedicine, and Education Demonstration Project, as required by the BBA. This randomized, controlled study will explore how teleconsultations between physicians on the upper west side of Manhattan and in rural, upstate New York affect patient care and program costs. It focuses on intensive monitoring and education of Medicare beneficiaries with diabetes through the use of telemedicine devices, case managers, and the Internet. The demonstration is scheduled for completion on September 30, 2001, and an evaluation report is due 6 months after that completion date.

Coordination with the Small Business Administration

Most rural Medicare providers and suppliers are small businesses and we have been actively working to enhance our relationship with the SBA and ensure our policies are responsive to the needs of the small business community, including those located in rural areas.

For example, last year the SBA Office of Advocacy led training session for over 100 agency staff in our Baltimore headquarters to learn about the needs and concerns of small business providers and how best to address them when developing regulations and policies. We also regularly consult with the SBA when developing regulations that may have a particular impact on the small business community. This helps facilitate information sharing and ensures we are aware of any emerging small business issues or concerns.

Additionally, HCFA representatives participate in regional forums conducted by the SBA Ombudsman across the country. These forums allow staff in the field to learn firsthand about small business concerns and also give small health care providers the opportunity to share their needs, concerns, and ideas with us. And we conduct ongoing staff and contractor training,

within our own Agency, to ensure that small business needs are addressed in all aspects of our programs and guidance.

Conclusion

We are all committed to ensuring rural beneficiaries' continued access to quality care, and we are all concerned about the disproportionate impact that policy changes can have on rural health care providers. The Balanced Budget Act, the Balanced Budget Refinement Act, and the administrative actions we have taken address these concerns with specific provisions targeted to assist rural providers. Our Rural Health Initiative and our consultation with the SBA will help us to take any additional steps that may be appropriate.

We are very grateful for this opportunity to discuss our efforts to help rural providers and beneficiaries, and to explore further actions we might take to address their concerns in a prompt and fiscally prudent manner. I thank you again for holding this hearing, and I am happy to answer your questions.

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MEDICARE REGIONAL RURAL REPRESENTATIVES
June 2000

REGION I: **Boston**	Jeanette Clinkenbeard 617-565-1257 Serving: Maine, New Hampshire, Vermont, Massachusetts, Connecticut, and Rhode Island
REGION II: **New York**	Elizabeth Romani 212-264-3958 Serving: New York, New Jersey, Puerto Rico, and the Virgin Islands
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REGION V: **Chicago**	Gregory Chesmore 312-353-1487 Serving: Minnesota, Wisconsin, Michigan, Illinois, Indiana, and Ohio
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REGION X: **Seattle**	Jim Underhill 206-615-2350 Serving: Washington, Oregon, Idaho, and Alaska

TESTIMONY
OF
ZACHARY EVANS

President
Mobile Medical Services, Inc.

"Rural Health Care Services:
Has Medicare Reform Killed Small Business Providers?"

House Committee on Small Business
June 14, 2000
10:00 am

1333 Village Drive • St. Joseph, Missouri 64506 • Telephone 816/232-2727 • Toll Free 1-800-310-2727

Thank you Mr. Chairman and distinguished members of the Committee. It is a pleasure to have the opportunity to testify before you today on an issue of great importance to our industry and small business owners nationwide.

My name is Zach Evans and I am the President of Mobile Medical Services, Inc. and the immediate past president of the National Association of Portable X-Ray Providers (NAPXP). My small business was established in 1992 and is located in St. Joseph, Missouri. I currently employ 5 individuals on a full time basis.

I appear before you today to explain the dramatic impact upon my company, and others like it across the country, of severe cuts in Medicare reimbursement rates. These reductions, mandated by the Balanced Budget Act of 1997 (BBA '97), have hit small businesses the hardest and have, in turn, forced small businesses to cut back on non-profitable services. This impact is particularly alarming because it has ultimately led to a reduction in essential medical services for thousands of Americans, particularly those in rural areas.

In essence, what we are seeing are the early symptoms of a potentially fatal disease that afflicts our nation's health care delivery system. The reduction in Medicare reimbursement rates mandated by BBA '97 has resulted in the complete elimination of profit margins for small business providers of some vital services, particularly in rural areas. As a provider of medical services, which are transported to the patient's bedside, reimbursement rate reductions have forced me to view nursing facilities or private homes that are located in rural areas as financially unsound clients. This means that I, and other small business providers of portable x-ray services, can't afford to provide a service which is not only safer, more comfortable, and convenient to the patient, but less expensive for Medicare. It is profoundly ironic that, as companies such as mine are forced to deny service to rural patients

because of Medicare cost cutting, the only alternative, transportation by ambulance, significantly drives up Medicare costs. These service cutbacks to rural areas must be viewed as the early warning signs of a more far-reaching problem. As small business providers are forced to shrink their service areas to remain solvent, rural patients and facilities will be forced to spend more to obtain these medically necessary services. This cycle of cost cutting leading to higher costs for poorer services is potentially lethal to the health care delivery system as a whole.

Perhaps the most dramatic cut mandated by BBA was the total elimination of the transportation fee for portable EKG services. Clearly, if a service provider receives no transportation reimbursement for a service, traveling long distances to rural facilities is simply not economically feasible. In my companies case, I lose an average of $50.00 for every EKG I perform. This average includes service to local facilities. If I were to calculate our losses based on distance traveled you would see a steadily rising column of red ink, increasing with every mile we travel to the facility or home. I am no politician, but I do feel that I understand voter sentiments sufficiently to predict the obvious. Americans would be appalled to learn that EKGs will not be available to elderly rural patients simply because they reside outside of the more profitable urban and suburban areas. I can say, however that Americans would be proud to learn that you, Mr. Chairman, led the fight last year to reinstate an EKG transportation rate. For that effort, I would like to take this opportunity to thank you on behalf of providers and patients alike for standing up for this vital cause. I hope that, with your strong voice on our side we may prevail this year and obtain the EKG transportation rate before more patients are denied this basic care.

Unfortunately, EKG services only represent a small portion of the portable x-ray business. What has happened regarding EKG services is now spreading to x-rays.

My company once offered twenty-four hour a day, seven day a week service to all patients. We have been forced to cut our services to patients located twenty-five miles distant or more to between eight am and three thirty pm Monday through Friday. Additionally, we are currently turning down all new requests for service outside of a twenty-five mile radius. This represents a massive reduction in services, yet we are currently considering dropping these remaining facilities altogether. For our company alone that decision would deny vital medical services to approximately fifteen homes with an average of eighty beds each, or a total of one thousand two hundred patients. One thousand two hundred patients denied service from one small company in Missouri. I know that dozens of other small business portable x-ray providers are either considering or have already enacted similar cuts. I have to stress that these service cuts will not save my company or others like it without some form of rate increase. These cuts can only slow our losses somewhat. Without a rate change, portable x-ray services will inevitably vanish, leaving ambulance transport, with higher costs and lower patient satisfaction as the sole alternative.

By the actions of the Chairman last year and through our many conversations with Small Business Committee staff, I know that this Committee is truly supportive of the nation's small business community. I sincerely hope that all Members of this Committee will join us in calling for reasonable solutions to this critical problem. Thank you, again, for the privilege of sharing my views and experiences with you today.

Testimony on

RURAL HEALTH CARE SERVICES: HAS MEDICARE REFORM KILLED SMALL BUSINESS PROVIDERS

Before the

COMMITTEE ON SMALL BUSINESS
U.S. HOUSE OF REPRESENTATIVES

HONORABLE JAMES M. TALENT (R-MO), CHAIRMAN

June 14, 2000

By

Karen P. Woods, RN, MSN
Executive Director
Hospice Association of America
228 Seventh Street, S.E.
Washington, D.C. 20003

Thank you for the opportunity to submit testimony on the issues related to the impact of Medicare reform, including the Balanced Budget Act of 1997 (BBA 97) on hospice providers operating in rural areas. The Hospice Association of America (HAA) is a national organization representing the nation's hospices and the thousands of caregivers and volunteers who serve terminally ill patients and their families. HAA encourages, supports, and is actively engaged in improving the availability, accessibility, quality, and continuity of end-of-life care. All people have the right to excellent care at the end of life, but this is often hampered by a fragmented system of institutional-, home-, and community-based care, which is increasingly difficult to access with regulations that can be indifferent to need. This lack of access to appropriate services, especially hospice services, is felt most dramatically in rural areas.

The Hospice Association of America (HAA) deeply appreciates the attention the Chairman and Members of the Committee have shown regarding the problems created by the provisions of BBA 97 and the effects on small businesses such as hospice providers in rural America. HAA respectfully offers the following comments and recommendations on proposed refinements to the Medicare hospice benefit.

Currently less than 20% of terminally ill people in America receive hospice services with an average of significantly less than two months of care at the end of their lives. This means that most of the people who die of a terminal illness each year do not have access to hospice services and for those who do, much suffering has already occurred. Low population density in rural areas makes it inherently difficult to deliver services that target special needs such as hospice care. As reported in the Agency for Health Care Research and Quality, Rural Health Agenda, rural Americans are faced with issues that create barriers to care and the inadequate supply of primary care physicians as well as other health care providers such as nurses, home care aides, social workers and counselors is a reality.

Rural hospice providers have identified the following areas as barriers to the provision of hospice services in their communities:

- shortages of nurses, home care aides, therapists and social workers making the recruitment and retention of Medicare defined "core service" personnel (nurses, social workers, counselors) extremely difficult;

- the impact of BBA97 decrease in hospice market basket updates affects the overall functioning of hospice programs;

- insufficient reimbursement to allow for appropriate wage and benefit packages to recruit and retain qualified staff;
- lack of funding for innovative modalities such as telehealth;
- restrictive regulations that prevent a hospice provider from contracting for services of specialized nurses for infrequent hi-tech nursing procedures;
- requiring that supervision of home care aides be performed only by a registered nurse and not a licensed practical nurse; and
- restrictive regulatory definitions of hospice programs service areas based on mileage and driving time, rather than quality of care outcomes, make it extremely difficult and sometimes, even impossible for a hospice program to provide services in rural areas.

Reports from the southwest region of Kansas note that due to the domino effect of BBA 97 a regional medical center closed both its home health and hospice agencies on May 31 of this year, leaving the rural county with no other providers for these much needed services. The effect on the community might not have been felt so deeply in an urban area where competition would fill in the service gaps and the patients would have their needs met by other providers. In this rural county, people in need cannot access hospice or other health care services.

As noted in the appendix of this document, we have developed the following recommended legislative actions. The Hospice Association of America, its Advisory Board of Directors and its members recommend that Congress:

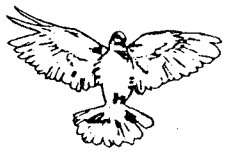
- Fund grant programs for training therapists, medical social workers, nurses, home care aides and other hospice personnel with a focus on providing home and community based practice in areas where shortages exist;
- Amend § 1861(dd)(2)(A)(ii)(I) of the Social security act by including a provision allowing certain specialized high -tech nursing services to be provided by contract, under the direction and supervision of the hospice;
- Enact legislation to allow LPNs to supervise home health aides under the general supervision of an RN when permitted by state nurse practice acts;

- Provide that federal programs that finance hospice services adjust reimbursement to allow for appropriate wage and benefit levels for all clinical staff;

- Clarify the definition of hospice multiple sites service area, establishing a uniform, reasonable, and up-to-date policy that focuses on the ability to provide quality care and positive outcomes rather than imposing arbitrary and ineffective time and distance requirements;

- Clarify legislatively that telehealth constitutes a service provided by a hospice and Medicare should provide appropriate reimbursement for technology costs for rural hospice providers; and

- Restore the reductions in the market basket updates enacted in BBA97 and the 1999 omnibus appropriations measure to the Medicare Hospice Benefit.



APPENDIX

ENSURE ADEQUATE HOME CARE AND HOSPICE PERSONNEL, PARTICULARLY IN RURAL AND OTHER UNDERSERVED AREAS

ISSUE: There is an increasing need for home care and hospice services as a result of the aging of the population, clarification of Medicare coverage policies, continued earlier hospital discharges, and patient preferences for home care and hospice. In recent years, home care visits and hospice services under the Medicare program increased substantially. While this trend has leveled off, home care and hospice providers continue to report shortages of nurses, home care aides, therapists and social workers, especially in rural areas. The cuts in home health reimbursements resulting from the interim payment system have made it increasingly difficult for home health agencies to offer competitive wages and benefits. Increased regulatory burdens on home visiting staff have also discouraged workers from continuing in home care.

Recruitment and retention of home care and hospice personnel, including nurses and home health aides, is especially difficult in rural and other underserved areas. Providing health care in these areas requires special knowledge, training and commitment on behalf of health care providers. Continuing education and training are often not readily available. Health care services can be particularly interdependent in rural communities: when a rural hospital closes, many affiliated health care personnel and services leave the area as well.

In late 1999, the Office of Employment, Bureau of Labor Statistics within the U.S. Department of Labor released new employment projections for the American workforce from 1998-2008. Health services sectors are projected to grow substantially during this ten-year period. In fact, 14 of the 30 fastest growing occupations are related to health care. The projected job growth in the health care occupational sector includes increases in the following occupations: registered nurses, an increase of 21.7%; licensed practical and licensed vocational nurses, an increase of 19.7%; physical therapists, an increase of 34.0%; occupational therapists, an increase of 34.2%; speech-language pathologists and audiologists, an increase of 38.5%; and social workers an increase of 36.1%. Personal care and home health aides is the seventh most rapidly growing occupation, with 58.1% home health job growth projected over the 1998-2008 period.

It is critically important to both increase the supply of qualified health care staff to maintain patient care access and to assure that these staff have the skills needed to provide high quality treatment and rehabilitation services in the home setting. Federal and state regulations should promote the use of nurse practitioners, physician assistants and other qualified home health personnel.

RECOMMENDATION: Congress should fund grant programs for training therapists, medical social workers, nurses, home care aides, and other home care and hospice personnel with a focus on home- and community-based practice in areas where shortages exist. The number of schools providing therapy programs must be increased and the number of slots available in these schools should be expanded. Special incentives such as loan-forgiveness programs to fund schooling and training should be developed to recruit students for practice in geographic areas with staff shortages, such as rural and inner city areas. Grants to educational facilities should be made available for innovative approaches to recruitment and education of home health care personnel, including consideration of job "ladders" and "classrooms without walls." Reductions in the work force in inpatient settings have greatly reduced the opportunities for nursing and physical and occupational therapy graduates to obtain on-the-job experience. Home health agencies generally require one year of experience because they cannot afford to provide the supervision new nurses and therapists need in the home setting.

Congress should fund home care internship demonstration projects for nurses and physical and occupational therapists to provide a year of on-the-job training for new graduates.

Congress should request General Accounting Office and MedPAC studies on the shortage of personnel in home care and hospice settings, with special attention to rural and inner-city areas, and with recommendations on what can be done to overcome this problem.

RATIONALE: The demand for home care and hospice services will continue to increase as the elderly and disabled population grows. More qualified personnel are necessary to meet the increased needs. These personnel should have skills that enable them to apply their services to home- and community-based care situations. Further, these qualified home care and hospice personnel should be encouraged to practice in rural and underserved areas.

When professionals are scarce, costs for providing care increase. Putting funds into training and other incentive programs will ultimately lower costs to consumers.

AMEND HOSPICE CORE SERVICE REQUIREMENTS TO PERMIT THE DELIVERY OF SPECIALIZED NURSING TREATMENTS UNDER CONTRACT

ISSUE: Under §1861 (dd)(2)(A)(ii)(I) of the Social Security Act, a hospice program is required to routinely provide directly substantially all of the nursing care provided by or under the supervision of a registered professional nurse. This requirement restricts the ability of a hospice program to provide through contract certain non-routine, specialized high-tech nursing procedures that are crucial in the overall pain and symptom management of a select group of hospice patients. Since the enactment of this legislation, there have been tremendous advances in the delivery of palliative care including specialized high-tech treatments. A hospice program does not need the services of nurses with certain specialized technical skills on a daily basis. The need is determined on a case-by-case situation. It is a waste of Medicare funds for a hospice program to employ this level of professional when it would be more cost effective to access this level of expertise by contracting for the service on an as-needed basis.

RECOMMENDATION: Congress should amend §1861(dd)(2)(A)(ii)(I) of the Social Security Act by including a provision allowing certain specialized high-tech nursing services to be provided by contract, under the direction and supervision of the hospice as necessary to meet the needs of the hospice patient.

RATIONALE: Requiring that all skilled nursing services for a hospice patient be provided as core services and not through a contractual relationship places a heavy financial burden on the hospice program and, more importantly, may deny the delivery of appropriate palliative treatment to the hospice patient. This situation either forces the hospice provider to maintain and compensate a certain level of nursing staff not required in its day-to-day operation or to limit the choices of effective treatment options it can safely provide to terminally ill patients. Use of appropriate treatments will support care of the patient in the home and help avoid transfer to an inpatient setting.

ALLOW LPNs TO SUPERVISE HOME CARE AIDES

ISSUE: Medicare permits licensed practical nurses (LPNs), who are under the general supervision of registered nurses (RN), to perform nursing services in the home, including such complex care as changing dressings on wounds and inserting foley catheters. However, the Medicare Conditions of Participation do not authorize LPNs to supervise home care aides. Many home health agencies and hospices have found that it is not cost effective to hire LPNs to carry out only direct patient-care activities. In a survey conducted by NAHC, a strong majority (82%) of home care agencies believe LPNs should be allowed to supervise home health aides.

RECOMMENDATION: Congress should enact legislation to allow LPNs to supervise home health aides under the general supervision of an RN where permitted by state nurse practice acts. RNs would continue to be responsible for the overall development and management of the patient care plan. Agencies should retain the option of determining whether RN or LPN supervision is most appropriate.

RATIONALE: LPNs are qualified to supervise home health aides. As part of their formal LPN training, LPNs learn the basic nursing and personal care skills which home health aides perform. LPNs are required to conform to established practice standards.

Allowing LPNs to supervise home care aides would allow RNs more time to perform more of the complex and highly skilled nursing services.

PROVIDE SUFFICIENT HOME CARE AND HOSPICE PAYMENTS SO THAT AGENCIES CAN PROVIDE APPROPRIATE WAGES AND BENEFITS TO CLINICAL STAFF

ISSUE: The annual salary at the current minimum wage is less than $10,800 based on 40 hours per week of work at 52 weeks per year – below the poverty line for a family of three. It is estimated that the value of the minimum wage has declined over the past three decades by 30%. For the minimum wage to have the purchasing power it had in 1968, it would have to be $7.38 an hour.

As part of deliberations on an omnibus bankruptcy bill in late 1999, the Senate approved an amendment that would increase the minimum wage by $1 over three years. Additional efforts to increase the minimum wage are expected during 2000.

The severe limitations on reimbursement under Medicare make it extremely difficult for agencies to comply with any requirements to increase wages, much less provide wages and benefits that reflect the worth of the care provided by nurses and paraprofessionals. In fact, current economic restrictions have resulted in many agencies cutting staff or seeking ways to save on patient care costs by limiting workers' hours or reducing wages or benefits. Payment under the new prospective payment system for home health and payment rates for hospice care services must be adequate to allow for increased wages and benefits for nurses and home care aides.

RECOMMENDATION: Congress should provide that federal programs (Medicare/Medicaid) that finance home care and hospice services adjust reimbursement to allow for appropriate wage and benefit levels for all clinical staff.

RATIONALE: Studies indicate that low wages affect an agency's ability to recruit and retain clinical staff. Generally, aides in nursing homes and hospitals receive higher wages than home care aides. Agencies throughout the nation have begun to experience severe hardships in recruiting and retaining clinical staff.

Because of low wages and benefits, home care aides are often cited in Congressional testimony as an example of a work force which would benefit from an increase in the minimum wage. And, increasingly, efforts are being made to document the relationship between wages and quality of care. In 1996, the Older Women's League's report, "Faces of Care: An Analysis of Paid Caregivers and Their Impact on Quality Long Term Care," linked paraprofessional wage and benefit issues directly to quality of care issues.

Without sufficient reimbursement, financially strapped home care and hospice agencies are finding it extremely difficult to provide quality care and pay increased wages.

CLARIFY THE DEFINITION OF HOSPICE MULTIPLE SITES

ISSUE: Neither the statute nor the hospice regulations provide for establishing hospice "branch" offices or restricts the distance a hospice may travel to serve patients. Several regional offices (ROs) have determined a travel time limitation to patient location. The revised requirements have raised new questions and do not adequately address the current environment with its complex organizational structures. Furthermore, this information was not disseminated to hospice agencies via manual updates.

The site designation program memorandum issued by HCFA central, as well as advisories issued by some of the HCFA ROs to state survey agencies refer to quality of care concerns about alternate sites. However, the criteria (based on mileage and driving time) differ from one region to another, are prescriptive and burdensome, and give little consideration to ensuring quality. Many agencies that have operated alternate sites and delivered quality services effectively and efficiently since the inception of the Medicare hospice benefit do not meet the RO limits.

RECOMMENDATION: Congress should clarify the definition of hospice multiple site service area, establishing a uniform, reasonable, and up-to-date policy that focuses on the ability to provide quality care and positive outcomes rather than imposing arbitrary and ineffective time and/or distance requirements. This definition should recognize that technological advances (communications tools that allow almost instantaneous information exchange by fax, telephone, beeper, cell phone, etc.) provide efficient and effective ways to "distance-manage" offices.

RATIONALE: The current policy on multiple locations is being applied in varying and restrictive ways by state agencies and region offices. As a federal program, criteria for participation in Medicare should be consistent throughout the country. Statutory clarification would provide clear-cut guidance to agencies and regional offices and eliminate the use of conflicting criteria.

Congress and the Executive Branch are seeking ways to more carefully manage the Medicare program's resources. Every effort should be made to apply consistent and reasoned administrative requirements so that previous program resources can be appropriately targeted for providing patient care.

RECOGNIZE TELEHOMECARE AS A BONA FIDE MEDICARE SERVICE

ISSUE: Over the past decade, great strides have been made in telehealth technology and its use in the home. In 1995, there were only three telehomecare nursing projects. This number increased to about 10 in 1997, with even greater growth in 1998. The reason for this growth is the evolution of technology to allow for effective nurse-patient interactions over regular phone lines using equipment that costs less than a personal computer. National standards have already been established by the American Telemedicine Association for the delivery of telehomecare services.

Telehealth technology provides a two-way interactive audio-video connection over telephone lines. During an on-line visit, the nurse at her base station and patients in their own homes see and talk with each other. The following activities can be carried out: health status assessment; monitoring vital signs; medication supervision; monitoring heart and lung sounds; and patient education. Additional devices can be added as needed to perform more in-depth patient tests, such as blood coagulation checks, electrocardiograms, scales, and pulse oximetry. These interactive connections can also be used for remote supervision of home care personnel.

Unfortunately, the Health Care Financing Administration (HCFA) does not recognize telehome care technology and visit costs as reimbursable by the Medicare program. HCFA maintains that telehealth visits do not meet the Social Security Act definition of home health services "provided on a visiting basis in a place of residence." HCFA regulations at 42 CFR 484.48 © define a home health "visit" as "an episode of personal contact with the beneficiary by staff of the HHA."

During 1999, as part of its legislation to address some of the unintended consequences of the Balanced Budget Act of 1997, the 106th Congress provided specific language, within the conference report, directing the Secretary of Health and Human Services to consider new technologies within home health services to improve health outcomes (House Report 106-479). Specifically, the conference agreement of H. R. 3194 urges the Secretary to "consider what changes would be necessary to provide home health care agencies with the flexibility to adopt new market innovations and new technologies that can improve health outcomes while maintaining the goals of quality of care and cost containment." Telehomecare services is one innovative technology that can assist home health agencies in improving health outcomes while at the same time maintaining quality patient care and containing costs.

RECOMMENDATION: Congress should clarify legislatively that telehomecare "constitutes a service(s) ... provided on a visiting basis in a place of residence used as an individual's home" as defined in §1861m of the Social Security Act. Medicare should also provide appropriate reimbursement for technology costs to home care agencies.

RATIONALE: Use of technology that results in more efficient and effective delivery of health care services should be encouraged and recognized as covered Medicare expenditures. Studies indicate that over half of all activities done by a home health nurse could be done remotely through telehomecare. Evidence from these studies has shown that the total cost of providing service electronically is less than half the cost of on-site nursing visits. Furthermore, quality of care and patient satisfaction have been maintained. Given the financial constraints on agencies anticipated under the forthcoming PPS, providers of care should be granted maximum flexibility to utilize cost-

effective means for providing care, including non-traditional services such as telehomecare that have been proven to result in high-quality outcomes and patient satisfaction. These innovative approaches to care are of benefit to the entire Medicare program, frequently helping to reduce acute care episodes and the need for hospitalizations.

Currently, some health maintenance organizations and some state Medicaid programs reimburse for telehomecare services. The Medicare program must keep pace with these programs.

RESTORE THE FULL MARKET BASKET UPDATE TO HOME HEALTH AND HOSPICE PAYMENTS

ISSUE: Under the fiscal year 1999 omnibus appropriations legislation, the Medicare home health market basket index – used to adjust payments for inflation – was reduced 1.1 percentage points from the projected 3 percent update in each of fiscal years 2000-2003. This provision is expected to yield about $900 million over five years.

The Balanced Budget Act of 1997 (BBA) reduced the Medicare hospice market basket update by 1 percentage point for fiscal years 1999 through 2002. During 1999, the Congress enacted BBA refinement legislation (Public Law 106-113) that would increase hospice payment rates otherwise in effect for fiscal years 2001 and 2002 by 0.5 percent and 0.75 percent, respectively.

RECOMMENDATION: Congress should restore the reductions in the market basket updates for Medicare home health and hospice services enacted under BBA and under the 1999 omnibus appropriations measure.

RATIONALE: As the result of the BBA, anticipated Medicare home health outlays are projected to be reduced by close to $70 billion over fiscal years 1998 through 2002. This amount is far in excess of the $16 billion reduction originally contemplated by the Congress, and has had a profound negative effect upon beneficiary access to care and home health agency viability. Reimbursement levels fail to adequately cover the rising costs of providing care, including increased labor costs for home health agencies and hospices, and rapidly rising hospice pharmaceutical costs. Thousands of home health agencies have closed since implementation of the BBA, with more closures expected during 2000. The ability of hospices to provide adequate levels of care has also been seriously challenged as the result of the BBA reductions. Hospice and home health care are efficient and effective in providing vital services to patients in the comfort of their homes. Use and provision of these services should be encouraged, not discouraged.

HOSPICE facts & STATISTICS

Hospice Association of America

UPDATED OCTOBER 1999

HOSPICE facts & STATISTICS

1. HOSPICE ORIGINS

Hospices provide palliative care, as opposed to curative care. Hospice services include supportive social, emotional, and spiritual services to the terminally ill, as well as support for the patient's family. The care is primarily provided in the patient's home to maintain peace, comfort, and dignity. Hospice care relies on the combined knowledge and skill of an interdisciplinary team of professionals—physicians, nurses, medical social workers, therapists, and counselors, in addition to volunteers—who coordinate an individualized plan of care for each patient and family. Hospice reaffirms the right of every person and family to participate fully in the final stage of life.

While the hospice concept dates to ancient times, the American hospice movement did not begin until the 1960s. The first hospice in the United States, The Connecticut Hospice, began providing services in March 1974.

2. TYPES OF HOSPICE

The Medicare program identified 2,287 hospices as of September 30, 1998. There are also an estimated 400 volunteer hospices in the United States. As of February 1998, 44 states licensed hospices.[1] In 1998, hospices served nearly 540,000 patients throughout the United States.[2] Less is known about the hospices that do not participate in the Medicare or Medicaid programs, as the rules and regulations for licensure vary by state.

3. HOSPICE PARTICIPATION IN MEDICARE

Congress enacted legislation in 1982 creating a Medicare hospice program (PL 97-248, §122). Hospice services may be provided to terminally ill Medicare beneficiaries with a life expectancy of six months or less. Effective with the enactment of the Balanced Budget Act of 1997 (PL 105-33) the Medicare hospice benefit is divided into the following benefit periods:

- an initial 90-day period;
- a subsequent 90-day period;
- an unlimited number of subsequent 60-day benefit periods as long as the patient continues to meet program eligibility requirements.

The beneficiary must be recertified as terminally ill at the beginning of each benefit period. The following covered hospice services are provided as necessary to give palliative treatment for conditions related to the terminal illness: nursing care; services of a medical social worker, physician, counselor (including dietary, pastoral, and other), and home care aide and homemaker; short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic system management); medical appliances and supplies, including drugs and biologicals; physical and occupational therapies; and speech-language pathology services. Bereavement service for the family is provided for up to 13 months following the patient's death.

Medicare hospice participation has grown at a dramatic rate, largely as a result of a 1989 congressional mandate (PL 101-239, §6005) that increased rates by 20%. From 1984 to October 1998 the total number of hospices participating in Medicare rose from 31 to 2,287—more than a 73-fold increase (see Table 1). Of these hospices, 890 are freestanding, 811 are home health agency-based, 564 are hospital based, and 22 are skilled nursing facility based (see Figure 1). Table 2 shows the calendar year 1997 distribution of Medicare-certified hospices by state, as well as number of persons, total charges, and program payments.

TABLE 1

Number of Medicare-certified Hospices, by Auspice, 1984-1997

Year	HHA	HOSP	SNF	FSTG	TOTAL
1984	n/a	n/a	n/a	n/a	31
1985	n/a	n/a	n/a	n/a	158
1986	113	54	10	68	245
1987	155	101	11	122	389
1988	213	138	11	191	553
1989	286	182	13	220	701
1990	313	221	12	260	806
1991	325	282	10	394	1,011
1992	334	291	10	404	1,039
1993	438	341	10	499	1,288
1994	583	401	12	608	1,604
1995	699	460	19	679	1,857
1996	815	526	22	791	2,154
1997	823	561	22	868	2,274
1998*	811	564	22	890	2,287

Source: Health Care Financing Administration (HCFA), Health Standards and Quality Bureau.
Notes: Home health agency-based (HHA) hospices are owned and operated by freestanding proprietary and nonprofit home care agencies. Hospital-based (HOSP) hospices are operating units or departments of a hospital. Skilled nursing facility-based (SNF) hospices are operating units or departments of a skilled nursing facility or nursing facility. Freestanding (FSTG) hospices are independent, mostly nonprofit organizations.
*Numbers given are as of September 30, 1998.

Figure 1

Medicare-certified Hospices by Auspice, 1998

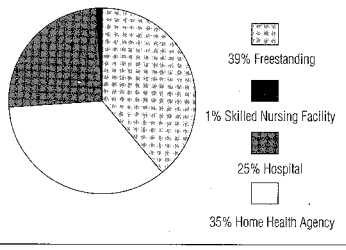


TABLE 2

Number of Medicare-Certified Hospices and Program Payments, by State, 1997

State	No. of Hospices	Persons	Total Charges ($thousands)	Program Payments ($thousands)
AL	63	6,905	39,881	39,527
AK	3	110	809	809
AZ	44	11,287	68,091	66,627
AR	60	4,154	27,784	27,231
CA	192	37,323	211,263	208,618
CO	40	6,140	29,404	29,086
CT	29	3,832	24,621	20,379
DE	5	1,192	5,935	5,930
DC	4	490	2,461	2,431
FL	39	40,008	233,010	231,752
GA	88	9,598	51,443	49,809
HI	8	1,008	4,629	4,623
ID	29	1,487	7,715	7,667
IL	93	17,419	94,074	92,375
IN	63	6,350	32,751	32,044
IA	54	4,842	24,810	24,557
KS	34	3,798	19,375	19,210
KY	29	6,289	37,805	37,778
LA	39	4,018	20,621	20,378
ME	15	877	5,235	4,829
MD	35	5,590	25,989	25,920
MA	46	7,708	36,168	34,729
MI	73	17,049	90,461	89,331
MN	61	6,057	28,511	28,315
MS	33	2,918	20,582	19,610
MO	78	9,112	46,508	45,852
MT	17	1,112	5,665	5,542
NE	27	2,155	10,207	10,124
NV	7	2,245	12,314	12,253
NH	19	1,292	6,682	6,257
NJ	46	10,151	48,483	48,268
NM	31	2,490	12,961	12,768
NY	55	19,582	106,608	105,912
NC	73	9,635	56,052	54,194
ND	13	716	3,775	3,679
OH	99	20,224	105,050	103,596
OK	49	6,379	42,907	42,799
OR	39	6,311	29,344	29,242
PA	118	18,960	94,286	93,055
RI	9	1,674	8,991	8,863
SC	35	4,350	23,631	23,008
SD	12	621	3,007	2,962
TN	65	4,715	25,014	24,377
TX	150	25,451	156,605	154,796
UT	16	1,428	6,249	6,053
VT	8	648	2,759	2,718
VA	46	6,353	34,139	33,643
WA	30	7,313	36,474	36,382
WV	22	2,710	15,948	15,842
WI	53	6,501	32,286	31,589
WY	11	325	1,718	1,676

Source: HCFA, Office of Information Services: Data from the Medicare Decision Support System; data development by the Office of Strategic Planning.
Note: Totals for charges and reimbursements are rounded.

4. HOSPICE FACILITY-BASED CARE

To provide services to a broad population, hospices engage in a variety of arrangements and models of care. A hospice may contract with an approved hospital or skilled nursing facility to provide inpatient hospice care. Hospices provide routine home care services to residents of nursing and assisted living facilities. Some hospices own inpatient facilities; others lease beds from hospitals or skilled nursing facilities and provide staffing or care plan supervision.

To better understand the various types of inpatient models of hospice care, a 1996 study of inpatient hospice units conducted for the National Hospice Organization by Daleview Associates identified 97 inpatient facilities that were owned or leased by a hospice, staffed by a hospice, and whose major policies and procedures were set by a hospice. Of these facilities, 50 were freestanding and the other 44 were physically located within other facilities (3 did not complete the questionnaire). These units, averaging fewer than 13 beds are small by health facility standards; however, they represent a growing sector of the hospice market.[3]

5. REVENUE

The nation's expenditure for health care was projected at $1,147 billion in 1998.[4] Although little information is available specifically on the total national expenditure for hospice, detailed data are available on Medicare hospice expenditures and utilization. Some data also are available on hospice spending under the Medicaid program. In addition to Medicare and Medicaid, some hospice revenues come from private insurance companies. Community donations and grants also contribute to the revenue base, often to fund unreimbursed care and hospice services for patients with little or no insurance. Table 3 shows the breakdown of 1994 hospice expenditures by sources of payment.

A. Medicare Spending and Utilization

The hospice Medicare benefit represents a small proportion of the total Medicare spending. In 1998, one percent of total benefit payments were estimated to be spent on hospice care (see Table 4). The 1999 projections indicate that hospice care will continue to be a small proportion of the total Medicare spending. More than 47% of the estimated $210 billion Medicare spending in fiscal year 1998 and nearly 40% of the projected $222 billion spending in fiscal year 1999 goes to

TABLE 3

Distribution of Hospice Primary Payment Source, 1995

Source of Payment	Percent
Medicare	65.3
Medicaid/MediCal	7.8
Private Insurance	12.0
Indigent Care	4.2
Other	10.7

Source: The National Hospice Organization online, Hospice Fact Sheet.

HOSPICE *facts* & STATISTICS

TABLE 4

Medicare Benefit Payments, FY98 and FY99

Amount	1998 (Estimated) Percent of ($millions)	1998 (Estimated) Amount Total	1999 (Projected) Percent of ($millions)	1999 (Projected) Total
Total Medicare Benefit Payments*	210,136	100.0	222,668	100.0
Part A				
Hospital care	86,563	41.2	87,664	39.4
Skilled nursing facility	13,381	6.4	13,812	6.2
Home health	14,490	6.9	18,032	8.1
Hospice	2,080	1.0	2,181	1.0
Managed care	17,807	8.5	19,535	8.8
TOTAL	134,321	63.9	141,224	63.4
Part B				
Physician	31,594	15.0	32,930	14.8
Durable medical equipment	4,246	2.0	4,246	1.9
Carrier lab	4,779	2.3	4,791	2.2
Other carrier	4,254	2.0	4,371	2.0
Hospital	10,625	5.1	11,175	5.0
Home health	273	0.1	345	0.2
Intermediary lab	1,683	0.8	1,844	0.8
Other intermediary	4,228	2.0	4,625	2.1
Managed care	14,132	6.7	17,117	7.7
TOTAL	75,815	36.1	81,444	36.6

Source: HCFA, Office of the Actuary, 1999 Trustees Report (April 9, 1999).
*Part A total does not include peer review organization payments. Figures may not add to totals due to rounding.

hospitals and about 15% of Medicare spending is for physician services for both years.

With the growth in Medicare-certified hospices, there are concomitant increases in Medicare's total reimbursement to hospices. Table 5 shows the FY97 distribution of hospice utilization by type of hospice. Freestanding hospices served a majority of the hospice recipients. In contrast, skilled nursing facility-based hospices served the fewest number of hospice clients. In 1998, over 39 million aged and disabled persons were enrolled in the Medicare program. For the federal fiscal year ended September 30, 1997, 374,723 enrollees received hospice services, which is more than four times the number of hospice recipients in 1990 (see Table 6).

TABLE 5

Medicare Hospice Outlays, Clients, and Days per Client, by Type of Agency, FY97

Auspice	Percent of Outlays	Number of Clients	Average Days per Client
Freestanding	55.5	193,765	53.4
Hospital-based	17.1	68,688	47.9
Skilled nursing facility-based	0.6	2,547	39.9
Home health agency-based	26.8	109,723	45.9
TOTAL	100.0	374,723	50.1

Source: HCFA, Bureau of Policy Development (April 1999).
Note: The total for average days per client is weighted by the number of beneficiaries in each hospice type.

Medicare hospice expenditures climbed from $118.4 million in 1988 to $2 billion in FY97 (see Table 6). Although the number of hospice users increased to 374,723 in FY97, the average stay declined slightly from 54.5 days in FY96 to 50.1 days in FY97.

The need for Medicare-certified hospices will continue to rise due to an aging population, the increasing interest and concern about end-of-life care, and rising health care costs. More importantly, both medical professionals and the general public are choosing hospice care over

TABLE 6

Medicare Hospice Outlays, Clients, and Days per Client, FY88-FY97

Fiscal Year	Outlays ($millions)	Number of Clients	Average Days per Client
1988	118.4	40,356	37.2
1989	205.4	60,802	44.8
1990	308.8	76,491	48.4
1991	445.4	108,413	44.5
1992	653.6	156,583	56.1
1993	1,151.9	202,768	57.2
1994	1,316.7	221,849	58.9
1995	1,830.5	302,608	58.8
1996	1,944.0	338,273	54.5
1997	2,024.5	374,723	50.1

Source: HCFA, Office of the Actuary, Center for Health Plans and Providers (April 1999).

other forms of health care delivery because of its holistic, patient-family, in-home-centered philosophy.

The Medicare fiscal intermediary calculates each hospice's cap amount by multiplying the adjusted cap amount by the number of Medicare beneficiaries who elected to receive hospice care from that hospice during the cap period, a 12-month period ending September 30 of each year. Each hospice must refund Medicare payments in excess of this cap amount.

Medicare payments for hospice services are made on a prospective basis under four levels of care and adjusted by an area wage index. This local adjustment is necessary to permit payment of higher rates in areas with high wage levels, and proportionately lower rates in areas with wage levels below the national average. Industry representatives, including the Hospice Association of America, participated in a negotiated process for rulemaking with the Health Care Financing Administration to derive a new wage index. This new wage index, which for a period consisted of a blend of the old and the new area wage index, is now based on hospital wage data.

The Medicare hospice rates also vary according to the level of care furnished to the beneficiary. The FY2000 published payment rates, which are adjusted by the hospital market basket index reduced by 1%, are as follows:

- Routine Home Care Day--$98.96. This category is for individuals receiving hospice care at home. The rate does not vary by volume or intensity of services.
- Continuous Home Care Day--$577.59 for 24 hours or $24.07 per hour. Individuals in this category must need skilled services for a period of at least eight hours within a 24-hour period beginning at midnight, but only for brief periods of crisis and only as necessary to maintain the terminally ill individual at home.
- Inpatient Respite Care Day--$102.37. Care may be provided for no more than five days at a time in an inpatient facility.
- General Inpatient Care Day--$440.22. Care may be provided in a hospital, skilled nursing facility, or inpatient unit of a freestanding hospice.

Table 7 shows the distribution of Medicare hospice expenditures and utilization by the type of care. Table 8 provides the average Medicare reimbursement per unit of care for the four categories of hospice care and hospice-related physician services.

Medicare payments to hospices are subject to an overall aggregate "cap amount." The cap amount is adjusted annually for inflation or deflation. For the fiscal year ending October 31, 1999, the cap amount is $15,313.

B. Medicaid Spending for Hospice

As is true for Medicare, hospice services represent a relatively small part of total Medicaid payments. Table 9 shows that of the $123 billion in Medicaid vendor payments, nearly half went for hospital and skilled nursing facility services. Hospice is an optional Medicaid service, currently available in 43 states and the District of Columbia (see Table 10). In FY97 hospice services comprised only 0.3% of total Medicaid payments.

Medicaid hospice expenditures totaled $327.3 million in FY97, an increase of 2.7% over the $318.7 million spent in FY96 (see Table 11).

TABLE 7

Medicare Hospice Utilization, Type of Care, FY96 and FY97

Type of Care	Units of Care FY96	Units of Care FY97	Percent Change
Routine days	17,862,843	18,189,764	1.8
Continuous hours	1,193,623	1,190,982	-0.2
Inpatient respite days	47,218	47,790	1.2
General inpatient days	451,395	470,593	4.3
Physician procedures	185,970	200,376	7.7

Source: HCFA, BPD (April 1999).

TABLE 8

Average Medicare Reimbursements for Hospice Care, FY96 and FY97

	FY96	FY97
Routine home care (per day)	$ 95.25	$ 97.28
Continuous home care (per hour)	24.46	23.93
Inpatient respite (per day)	99.54	100.44
General inpatient care (per day)	437.75	445.19
Physician services (per procedure)	59.15	60.39

Source: HCFA, BPD (April 1999).
Note: Average reimbursements based on total outlays and total units of care.

TABLE 9

Medicaid Payments, by Type of Service, FY97

	Amount ($millions)	Percent of Total
Inpatient hospital	23,142.6	18.7
Nursing home	30,503.8	24.7
Physician	7,041.0	5.7
Outpatient hospital	6,169.0	5.0
Home health	12,236.6	9.9
Hospice (b)	327.3	0.3
Prescription drugs	11,972.3	9.7
ICF (MR) services (c)	9,798.3	7.9
Other	22,360.1	18.1
Total payments (a)	123,551.0	100.0

Source: HCFA, Division of Medical Statistics. Data are from Form HCFA-2082, with the exception of hospice data, which are from Form HCFA-64, (HCFA Online, April 1999).
Notes: (a) Total outlays include hospice outlays from the Form HCFA-64 plus payments for all service types included in Form HCFA-2082, not just the eight service types listed. FY97 totals exclude data from Hawaii. (b) Hospice outlays come from Form HCFA-64. All other expenditures come from the Form HCFA-2082. The federal share of Medicaid's hospice spending is $186 million, or 56.8% of the total FY97 Medicaid hospice payments. (c) ICF is intermediate care facilities.

TABLE 10

Number of States Offering Hospice Under Medicaid, 1987-1998

Year	Total Number	States Added	States Dropped
1987	6	FL, KY, MI, MN, ND, VT	
1988	15	DE, HI, IL, MA, NE, NY, NC, RI, TX, WI	MN
1989	24	AZ, CA, GA, ID, KS, MO, MT, PA, TN, UT	NE
1990	32	AL, AK, IA, MD, MN, NM, OH, VA, WA	TN
1991	34	CO, MS, TN	AK
1992	35	NJ	
1993	36	DC, WV	AZ
1994	38	OR, WY	
1995	40	AK, SC	
1996	41	AR	
1997	42	IN	
1998	44	AZ, NV	

Source: State hospice and home care organizations and HCFA, Bureau of Data Management and Strategy.

C. Managed Care and Hospice

Increasingly, health care services in the United States are financed through managed care organizations. A managed care contract generally specifies a negotiated fee, often called a capitated payment, for the care of patients. A fully capitated plan specifies a lump sum payment per enrollee to cover all care provided through the plan. Choice of provider and access to specialty care vary under managed care arrangements, but there tend to be incentives for consumers to use certain providers who are part of the managed care organization's network. In contrast, traditional health insurance, commonly known as fee-for-service, pays providers of care based on the number of services delivered, with few limitations on which providers could be paid. Managed care is most prevalent in the employer-based health insurance market. In 1995, three out of four insured workers received health benefits through a managed care plan.[5] Managed care enrollment has increased among Medicaid beneficiaries particularly in states that have federal waivers to convert their Medicaid program to a managed care program. As of January 1999, more than 54% of Medicaid beneficiaries were part of managed care arrangements.[6] Medicare managed care enrollment has increased at a slower pace. As of January 1999, about 15% of Medicare beneficiaries were part of Medicare managed care plans.[7]

When a Medicare-eligible patient who is an enrollee of a Medicare participating managed care organization (MCO) elects hospice care, the hospice services must be provided through a Medicare-approved hospice, and the individual must meet the eligibility requirements specified by Medicare. The patient does not need a referral from the MCO and is not required to disenroll from the MCO. Medicare pays the hospice for hospice services and the MCO for attending physician services and services not related to the patient's terminal illness. In addition, MCOs are required to inform enrollees about the availability of hospice care if: a) a Medicare-certified hospice is located in the MCO's service area; or b) it is common practice to refer patients to hospice programs outside such service area.

The increasingly competitive health care market has created incentives for hospices to enter managed care provider networks. Although hospices have considerable experience managing payments under the Medicare prospective reimbursement system's per-patient cap, little is known about the extent to which hospices have entered into managed care arrangements or what impact these arrangements have on hospice clients.

6. HOSPICE RECIPIENTS

As shown in Table 12, most patients receiving hospice care are elderly—about 68% are age 65 or older. Hospice patients are nearly as likely to be male as female. Most hospice patients are married.

TABLE 11

Medicaid Hospice Outlays, FY87 - FY97

Fiscal Year	Outlays ($millions)	Annual Percent Change
1987	1.5	n/a
1988	3.9	165.4
1989	18.9	385.4
1990	20.2	7.0
1991	44.1	117.9
1992	84.2	90.9
1993	128.9	53.1
1994	197.6	53.3
1995	283.5	43.5
1996	318.7	12.4
1997	327.3	2.7

Source: HCFA, Medicaid Bureau (Form HCFA-64) (HCFA Online, July 1999).
Note: FY96 totals exclude data for Florida and Hawaii. FY97 totals exclude data for Hawaii.

TABLE 12

National Hospice Usage, by Client Age, Gender, Race, and Marital Status, 1996

Characteristic	Percent Distribution	Characteristic	Percent Distribution
Age		Race	
<45 years	8.1	White	78.9
45-54 years	7.9	Black	11.2
55-64 years	14.8	Other or unknown	9.9
≥65 years	67.5		
65-69 years	8.7	Marital Status	
70-74 years	15.6	Married	48.4
75-79 years	14.5	Widowed	29.4
80-84 years	12.3	Divorced or separated	6.5
≥85 years	16.4	Never married	9.3
		Unknown	6.4
Gender			
Male	50.3		
Female	49.7		

Source: B. Haupt, "An Overview of Home Health and Hospice Care Patients: 1996 National Home and Hospice Care Survey," in Advance Data from Vital and Health Statistics, Centers for Disease Control and Prevention, National Center for Health Statistics, No. 297, April 16, 1998.
Note: Percentages based on sample representing 393,200 hospice discharges in 1996.

7. CLIENT DIAGNOSES

A recent survey, conducted by the National Center for Health Statistics, found 71% of persons discharged from hospice care in 1996 had conditions related to neoplasms as their first-listed diagnosis (see Table 13). Cancer of the lungs, breast, and prostate accounted for most of the malignant neoplasms.[8] Comorbidity is common among hospice patients; two-thirds of hospice care patients had two or more diagnoses at admission. Other frequent admission diagnoses for hospice patients were infectious and parasitic diseases, which includes human immunodeficiency virus (HIV); diseases of the nervous system and sense organs, including Alzheimer's, Parkinson's, meningitis, etc.; diseases of the circulatory system; and diseases of the respiratory system.

8. VALUE AND COST-EFFECTIVENESS OF HOSPICE

In comparison to hospital and skilled nursing facilities' costs, hospice is a cost-effective service. Table 14 provides a comparison of the average cost for a Medicare patient to stay one day in a hospital, a skilled nursing facility, and a hospice. Hospice charges per day are substantially lower than the hospital and skilled nursing facility charges per day.

Various studies on the cost-effectiveness of hospice, both federally and privately sponsored, also provide strong evidence that hospice is a less costly approach to care for the terminally ill than the traditional approach. A 1988 study conducted by Abt Associates for HCFA concluded that in the first three years of the hospice benefit, Medicare saved $1.26 for every $1.00 spent on hospice care.[9] The study found that much of the savings from hospice care relative to conventional care accrue in the-last month of life, which is due, in large part, to the substitution of home care days for inpatient days during this period. These savings, however, are sensitive to the length-of-enrollment in a hospice; as the beneficiaries' average length-of-enrollment increases, the savings associated with hospice decreases.

The National Hospice Organization (NHO) published an update to the Abt study in 1995.[10] The findings of this study, conducted by the consulting firm Lewin-VHI, Inc., affirm the 1988 HCFA study. Adjusting for sample differences in demographic, medical, and program-related characteristics, the NHO/Lewin-VHI study found that the hospice beneficiaries who enrolled in the last month of life cost Medicare $2,884 less than the nonusers.

Table 15 displays ratios that compare the dollars saved by Medicare in Part A expenditures for every dollar spent on hospice benefit and other Part A expenditures for hospice patients. Medicare saved $1.65 for every dollar spent in the last month of life on hospice beneficiaries who enrolled one month or less before death. The ratios in Table 16 reflect the dollars saved by Medicare, in both Part A and B expenditures, for every dollar spent on a hospice patient. For hospice users enrolled less than one month before death, the ratio of total Medicare dollars saved to dollars spent was 1.68–a net savings of $0.68 for every dollar spent.

Both Tables 15 and 16 show that the Medicare saving ratios decline for earlier months before death. For example, in Table 16, for hospice users who enrolled between 60 and 89 days before death the savings ratio was $0.84—in the first month of enrollment—a net cost of $0.16 for every dollar spent on hospice; however, the overall net savings associated with this length of enrollment was 49 cents on the dollar. While hospice users with the shortest length-of-enrollment experienced the greatest savings (a net savings of $0.68 per dollar spent), even those with lengths-of-enrollment between 180 and 209 days were associated with a net savings of three cents for every Medicare dollar spent.

Additional research on hospice supports the premise that cost savings associated with hospice care are frequently unrealized because terminally ill Medicare patients often delay entering hospice care until they are within just a few weeks or days of dying, suggesting more savings and more appropriate treatment could be achieved through earlier enrollment. Using 1990 Medicare claims data, Christakis and colleagues found the median length of stay for hospice patients was only 36 days.[11] Moreover, only 15% of the dying utilize hospice care.[12] The difficulty of predicting death may account for part of the delay along with the reticence of caregivers, patients, and family to accept a terminal prognosis. Education about hospice and its benefits may help broaden its use and improve end-of-life care.

Cost-effectiveness is not the sole rationale for hospice care. More compelling is the fact that hospice is a humane and compassionate way to deliver health care and supportive services. Based largely on interviews with family members, a study of the end-of-life experience of 3,357 older decedents and seriously ill patients who died reported that 40% were in severe pain prior to their death and 25% experienced moderate to great anxiety or depression before they died.[13] The researchers reported very few of the patients received hospice care prior to death and suggested that encouraging hospice might alleviate some of the distress that patients

typically face at the end of life. Hospice care allows terminally ill patients and their families to remain together in the comfort and dignity of home—preserving one of our country's most important social values, keeping families together. In addition, hospice care allows family members to take an active role in providing or supplementing the care given by formal caregiver(s).

The public heavily favors hospice care as an alternative to institutional care. A 1996 NHO poll conducted by the Gallup Organization reported that close to nine out of ten American adults said that if diagnosed with a terminal illness, they would prefer to be cared for in the familiarity and comfort of their own home or a family member's home rather than a hospital, nursing home, or similar facility.[14]

9. HOSPICE STAFF

Hospices employ physicians, nurses, home care aides, social workers, chaplains, therapists, and counselors who work together as an interdisciplinary team to coordinate an individualized plan of care for each patient and family. Little information is available on the total number of "formal" hospice caregivers. Neither the Bureau of Labor Statistics nor the major organizations that collect information on health care providers gather detailed information on the entire hospice industry. However, HCFA collects information on Medicare-certified hospice staff (see Table 17).

Hospice organizations also rely heavily on volunteers. Table 17 shows that on average Medicare-certified hospices nationally have about the same number of volunteers as employees. A closer look at each caregiver type shows that there are generally more employees than volunteers, except for the homemaker and "other" categories.

It is also important to note that many terminally ill patients receive informal care. Informal caregivers represent family members, friends, or other unpaid helpers who are not trained as hospice volunteers. All Medicare hospice volunteers must participate in intensive volunteer training programs.

Table 13

Percent of Hospice Discharges by First-listed and All-listed Diagnoses at Admission, 1995-96

Admission Diagnosis	ICD-9-CM code[1]	Primary Diagnosis	All-listed Diagnoses
Infectious and parasitic diseases	001-139	*3.9	*2.7
Human immunodeficiency virus (HIV) disease	042	*2.9	*1.6
Neoplasms	140-239	70.6	50.0
Malignant neoplasms	140-208,230-234	69.7	49.6
Malignant neoplasm of trachea, bronchus, and lung	162,197.0,197.3	21.9	12.0
Malignant neoplasm of breast	174-175, 198.81	4.4	2.2
Malignant neoplasm of prostate	185	3.3	1.7
Endocrine, nutritional, and metabolic diseases and immunity disorders	240-279	*	3.2
Diabetes mellitus	250	*	1.7
Diseases of the blood and blood-forming organs	280-289	*	*0.7
Mental disorders	290-319	*	2.5
Diseases of the nervous system and sense organs	320-389	*3.2	4.0
Diseases of the circulatory system	390-459	9.6	17.1
Essential hypertension	401	*	3.0
Heart disease	391-392.0,393-398, 402,404,410-416,420-429	6.8	8.6
Diseases of the respiratory system	460-519	5.2	6.2
Diseases of the digestive system	520-579	*	1.8
Diseases of the genitourinary system	580-629	*2.4	2.1
Diseases of the skin and subcutaneous tissue	680-709	*	*
Diseases of the musculoskeletal system and connective tissue	710-739	*	*1.9
Symptoms, signs, and ill-defined conditions	780-799	*	4.5
Injury and poisoning	800-999	*	*
Supplementary classification	V01-V82	*	1.5
All other diagnoses	630-676,740-759,760-779	*	*
Unknown or no diagnosis		*	...

Source: National Center for Health Statistics, 1996 National Home and Hospice Care Survey.
Note: Percentages based on sample representing 393,200 hospice patients discharged from October 1995 to September 1996.
*Figure does not meet standard of reliability or precision.
...Category not applicable
[1]Based on the *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM) (12).

Table 14

Comparison of Hospital, SNF, and Hospice Medicare Charges, 1995-1998

	1995	1996	1997	1998
Hospital inpatient charges per day	$1,909	$2,068	$2,238	$2,177
Skilled nursing facility charges per day	402	443	487	482
Hospice charges per covered day of care	103	106	109	113

Sources: The 1995, 1996 and 1997 hospital and SNF Medicare charge data are from the *Annual Statistical Supplement, 1998, to the Social Security Bulletin*, Social Security Administration (November 1998). The 1995 and 1996 hospice charge data are from the *Health Care Financing Review, Statistical Supplement*, Health Care Financing Administration; 1997 and 1998, respectively.
Note: Additional years are projected using consumer price index forecasts from the Bureau of Labor Statistics web site.

A. Hospice Staff Productivity

The National Association for Home Care (NAHC) surveyed its member agencies in 1996 to estimate the average number of visits provided in an 8- hour day by salaried and hourly workers.[15] Average productivity for employees providing hospice care is shown in Table 18. Hospice staff ranged from 2.5 visits per day on average for masters' prepared social workers to 4.5 visits per day on average for home health aides. Registered nurses provided 3.7 visits per day on average; licensed practical nurses provided 4.2 visits per day. Social work visits are generally more time intensive, which may account for differences by discipline. The productivity measure was based on a definition from the Uniform Data Set on Home Care and Hospice in which the average number of visits per day is estimated for each discipline based on the number of paid hours for salaried and hourly workers excluding holiday, vacation and sick leave. However,

TABLE 15

Adjusted Medicare Part A Reimbursement Saved per Dollar of Hospice Outlays, by Length of Enrollment and Month, 1992

	Length of Enrollment						
	Less Than 1 Month	30-59 Days	60-89 Days	90-119 Days	120-149 Days	150-179 Days	180-209 Days
Last month of life	1.65	2.13	2.08	1.96	1.96	1.89	0.86
Month 2		0.91	1.07	1.00	0.91	0.90	0.95
Month 3			0.98	0.76	0.69	0.68	0.68
Month 4				0.62	0.62	0.55	0.52
Month 5					0.57	0.51	0.47
Month 6						0.48	0.46
Month 7						0.45	
Total for all months after hospice entry	1.65	1.48	1.29	1.09	0.96	0.86	0.82

Source: Lewin-VHI, Inc. for the National Hospice Organization, "An Analysis of the Cost Savings of the Medicare Hospice Benefit," May 2, 1995. Lewin-VHI analysis of 1991-1992 Medicare Part A claims from the National Claims History File.
Note: To obtain the net difference between hospice and nonhospice decedent Part A outlays, subtract 1.0 from the number in the table cell.

TABLE 16

Adjusted Medicare Part A and Part B Reimbursement Saved Per Dollar of Hospice Outlays, by Length of Enrollment and Month, 1992

	Length of Enrollment						
	Less than 1 Month	30-59 Days	60-89 Days	90-119 Days	120-149 Days	150-179 Days	180-209 Days
Last month of life	1.68	2.46	2.39	2.25	2.34	2.17	1.06
Month 2		1.01	1.35	1.22	1.17	1.16	1.22
Month 3			0.84	0.99	0.91	0.91	0.91
Month 4				0.72	0.83	0.75	0.72
Month 5					0.67	0.70	0.67
Month 6						0.57	0.65
Month 7							0.56
Total for all months after hospice entry	1.68	1.64	1.49	1.29	1.19	1.05	1.03

Source: Lewin-VHI, Inc. for the National Hospice Organization, "An Analysis of the Cost Savings of the Medicare Hospice Benefit," May 2, 1995.
Note: To obtain the net difference between hospice and nonhospice decedent Part A and B outlays, subtract 1.0 from the number in the table cell.

the sample of agencies was nonrandom and relatively small; therefore, the results may not be representative of all hospices. In addition, staff paid by the visit were excluded from the analysis due to variation in agency practice and data collection limitations.

B. Hospice Employee Compensation

A 1998 survey conducted by the Hospital & Healthcare Compensation Service in cooperation with the Hospice Association of America (HAA) collected information from more than 300 hospices on the salary and benefits provided to employees in 69 job categories, including both administration and nonsupervisory positions. Summary results for administrators are provided in Table 19. Table 20 provides summary data on the hourly and per visit compensation rates for hospice caregivers.[16]

TABLE 17

Number of Full-time Employees and Volunteers Working in Medicare-certified Hospices, 1998

Caregiver Type	Employees	Volunteers
Counselors	2,220	2,042
RNs	14,067	8,756
LPNs/LVNs	2,038	194
Physicians	1,662	1,064
MSWs	3,640	169
Homemakers	1,680	2,488
HHAs	8,672	474
Other	8,579	30,911
TOTAL	42,558	46,099

Source: HCFA, Health Standards and Quality Bureau. Online Survey Certification and Reporting data through September 30, 1998.

TABLE 18

Staff Productivity in Hospice

	Number of Visits per 8-hour Day Salaried and Hourly Hospice Staff				Number of Hospices
	Mean	Median	25th Percentile	75th Percentile	
Home Health Aide III*	4.5	4.4	3.4	5.2	57
Practical Nurse (LPN)	4.2	3.4	2.6	6.0	15
Registered Nurse (RN)	3.7	3.1	2.3	4.2	72
Social Worker (MSW)	2.5	2.1	1.5	3.0	55

Source: NAHC Home Care and Hospice Staff Productivity Report, 1997.
Notes: Productivity per 8-hour day is: (Number of visits per discipline) divided by (Paid hours per discipline minus Paid hours for vacation, sick, and holiday leave) x 8. Excludes employees paid by the visit.
* The Home Health Aide III is trained to provide medically directed services.

TABLE 19

Average Compensation of Hospice Executives, October 1998

	Salary by Percentile		
	25th	Median	75th
Director of hospice	$47,070	$56,035	$66,516
Top-level financial executive	44,234	55,598	69,007
Director of nurses/clinical services	43,000	49,062	59,266
Director of social work and counseling	35,414	40,456	46,931
Utilization review/quality assurance manager	40,014	45,250	50,743

Source: Hospice Salary & Benefits Report 1998-99, Hospital & Healthcare Compensation Service in cooperation with Hospice Association of America, 1998.
Notes: **Director of Hospice** is the top level position for the hospice, and can be the owner. **Top Level Financial Executive** is responsible for direction and coordination of activities concerned with financial administration. **Director of Nurses/Clinical Services** plans and implements clinical nursing services. **Director of Social Work and Counseling** is responsible for planning and administering social work and counseling programs and may include supervision of Bereavement Coordinator and Chaplain. **Utilization Review/Quality Assurance Manager** is responsible for ensuring that appropriate care is provided to clients and that all employee and clinical records are in compliance with licensure requirements.

TABLE 20

Average Hourly and Per Visit Compensation of Selected Hospice Caregivers, October 1998

	Per-Hour Rate Range			Per-Visit Rate Range		
	Average Minimum ($)	Average ($)	Average Maximum ($)	Average Minimum ($)	Average ($)	Average Maximum ($)
Registered Nurse (RN)	15.10	18.18	21.26	26.78	31.98	37.18
Practical Nurse (LPN)	10.38	12.44	14.49	16.19	18.82	21.46
Physical Therapist	19.66	23.79	27.93	38.96	43.83	48.70
Social Worker (MSW)	14.06	16.98	19.90	35.06	38.96	42.86
Dir. of Volunteer Svcs.	12.49	15.21	17.92	n/a	n/a	n/a

Source: Hospice Salary & Benefits Report 1998-99, Hospital & Healthcare Compensation Service in Cooperation with Hospice Association of America, 1998.
Notes: The average rate is based on the reported weighted average of workers with the same job title in an agency. Similarly, the minimum and maximum averages are weighted by agency. **Physical Therapist** organizes and conducts medically prescribed therapy programs involving exercise and other treatments. **Social Worker** identifies and analyzes the social and emotional factors underlying client illness. Master's of Social Work degree required. **Director of Volunteer Services** organizes and directs a program for recruiting and training volunteer workers. **Practical Nurse** is a licensed Practical Nurse.

[1] National Hospice Organization licensure survey (February 1998).
[2] Estimate of hospice patients cared for in 1996 prepared by the National Hospice Organization.
[3] National Hospice Organization, "The 1996 National Hospice Organization Inpatient Facility Survey." Prepared by Daleview Associates. Copyright 1996.
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[10] National Hospice Organization, "An Analysis of the Cost Savings of the Medicare Hospice Benefit" Prepared by Lewin-VHI, Inc. Copyright 1995.
[11] Christakis, N. and J. Escarce. "Survival of Medicare Patients After Enrollment in Hospice Programs," *New England Journal of Medicine*, vol. 335, no. 3 (July 18,1996) pp. 172-178.
[12] Estimate based on number of hospice users and total deaths in 1995.
[13] Lynn, J., J. Teno, R. Phillips, A. Wu, N. Desbiens, et al. "Perceptions by Family Members of the Dying Experience of Older and Seriously Ill Patients" *Annals of Internal Medicine*, vol. 126, no. 2 (January 15, 1997), pp. 97-106.
[14] "Knowledge and Attitudes Related to Hospice Care," Prepared by the Gallup Organization for the National Hospice Organization. Copyright 1996.
[15] The 1997 Home Care and Hospice Staff Productivity Report is available through NAHC Publications Department, 228 Seventh Street, SE, Washington, DC 20003; 202/547-7424.
[16] To order a copy of the Hospice Salary & Benefits Report, contact HAA's Publications Department, 228 Seventh Street, SE, Washington, DC 20003-4306; 202/546-4759.

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TESTIMONY OF NORMAN GOLDHECHT

Regulatory Chairman
The National Association
of
Portable X-Ray Providers

"Rural Health Care Services: Has Medicare Reform Killed Small Business Providers?"

House Committee on Small Business
June 14, 2000

Thank you Mr. Chairman and members of the committee. I appreciate the opportunity to appear before you today. My name is Norman Goldhecht and I serve on the board of directors of the National Association of Portable X-Ray Providers (NAPXP) as the Regulatory Chairman. I am also owner of a portable radiology service company in New Jersey.

Mr. Chairman, the portable x-ray industry has been seriously threatened by the passage of the Balanced Budget Act of 1997 (BBA 97). We are now truly seeing its effects and they are devastating to small business. Our industry is made up of predominantly small businesses, small businesses that cannot withstand the razor sharp cuts in revenue we have experience over the last several years.

There are three areas I would like to focus on this morning. I do not wish to sit here and simply complain about the problems my industry is currently enduring, I want to offer some suggestions as to how we might move toward resolving our problems. Thus insuring that we survive the massive changes to the Medicare system currently underway.

The three topics I wish to focus on are as follows:

Rural Modifier
Transportation of EKG
Consolidated Billing

Rural Modifier

Portable X-ray providers service many Skilled Nursing Facilities (SNF) and Homebound Patients that reside in rural areas of this country. We must travel considerable distances to and from these sites to offer these patients our valuable and cost effect services. Our industry has been one of the first cost savings alternatives for the Medicare System. Based on a 1995 Cost report performed by Center for Health Policy Studies, the average charge to Medicare was approximately $87.00 for a typical x-ray performed by a portable x-ray provider. The average cost to transport the same patient by Ambulance was $420.00. If that patient is admitted to the hospital the cost rises to the thousands. It should also be noted that the transportation portion of our fee is pro rated among the number of patients seen, the ambulance fee is per patient. We are recommending an additional fee when our services are required in a rural area. We understand that this is an established practice in other areas and we feel that the additional travel that is required would warrant such a request. The fee could be reimbursed in the form of a special CPT code only to be used and billed when a provider performs services in a rural area.

Transportation of EKG Service.

Currently, we do not receive any additional reimbursement to travel to a nursing facility when performing a 12 Lead Electrocardiogram (EKG). This reimbursement was taken away from our industry when the Health Care Financing Administration (HCFA) deemed CPT R0076 a non-covered service. This service had been a covered service.

The current reimbursement for EKG technical component is $16.49. This is the same reimbursement that a physician's office or a hospital would receive if they

were to perform the test in their offices. Each time an EKG is performed we must dispatch a technician who must travel anywhere from 5 miles to 50 miles or more. Clearly our expenses to perform this test are greater yet our costs are not covered.

We feel the simple solution is to reinstate EKG transportation is as a Covered service.

Consolidated Billing

The pending onset of Consolidated Billing is a major issue facing our industry. We have been working with several agencies to seek a resolution. The BBA mandated Prospective Payment System (PPS) and Consolidated Billing for Skilled Nursing Facilities. The basic premise of these acts is that they take away the control of the billing aspects of our members and give them to the Nursing facilities. This can cause a major problem to which constitutes the bulk of our industry. While Consolidated Billing has been delayed, PPS has been in effect for over a year and we have seen the effects. Under PPS, residents that are Part A patients of a SNF have to be billed directly to the SNF and the SNF will reimburse the X-ray provider for the service. The problems that we have encountered are that the SNF's have sought large discounts and have delayed payment from 90 to 180 days. In some instances, due to the large number of nursing home chains that have declared bankruptcy, we have never received payment. This has put the small businesses in our industry in financial difficulties. While PPS only represents a small portion of the work that is performed by our providers it has given us a look into the future of Consolidated Billing.

Consolidated Billing will require our members to bill the SNF for services performed to the residents that are currently being billed to Medicare Part B. This will certainly cause the small businesses a hardship. The SNF's will demand discounts from our

current fee schedules. The Consolidated Billing requirement of the BBA '97 requires that all ancillary services performed in the SNF be billed directly to the SNF rather then each provider billing Medicare directly. Although Consolidated Billing has been delayed, the principals behind the system causes serious problems with small businesses. Medicare currently pays providers within 21 days of receiving a valid claim and pays interest when they do not pay promptly. Additionally, a provider never has to be concerned about receiving reimbursement or having to give a discount in order to provide services. The onset of Consolidated Billing would cause providers to wait on average 90 days and up to 180 days or longer for payment. The SNF's would also require the providers to give "discounts" for the added billing expense that they would incur. The main objective of Consolidated Billing was to reduce fraud and abuse. It was to make the SNF's the gatekeepers of services performed in their facilities, so that they might monitor the billing that is being done. This is a budget neutral issue as the amount of money the government is paying is only being transferred from the provider to the SNF.

This is why we have suggested the Voucher System. This would require the provider to submit a bill at the end of each month to the facility for all services performed. The Facility would have to sign off on an approved Voucher and the provider then could bill Medicare and receive payment directly. This would accomplish a needed compromise. The facility verification would cut down on fraud and abuse, while allowing the providers to receive payment directly and promptly. It should be noted that if the SNF's receive payment directly from Medicare for services that the providers have delivered they would have a direct interest in having more services performed. If they require providers to "discount" their services, they would receive additional funds, meaning that the more services performed, the more revenue to the facility. Since the SNF is the requester of services they control how many services are to be performed.

The Voucher System is a budget neutral solution, which allows us to solve problems that can arise with Consolidated billing while still accomplishing the government's main objective.

Thank you Mr. Chairman and Members of the Committee for the opportunity to address you today. I would be happy to answer any questions you might have.

Testimony on

RURAL HEALTH CARE SERVICES: HAS MEDICARE REFORM

KILLED SMALL BUSINESS PROVIDERS?

Before the

COMMITTEE ON SMALL BUSINESS
U.S. HOUSE OF REPRESENTATIVES

HONORABLE JAMES M. TALENT (R-MO), CHAIRMAN

June 14, 2000

By
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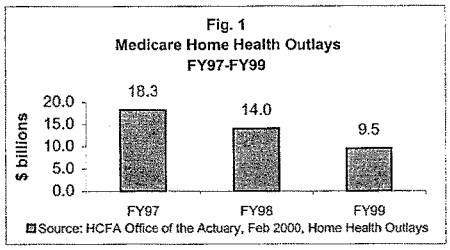
Thank you for the opportunity to testify on issues related to the impact of Medicare reform, including the Balanced Budget Act of 1997 (BBA), on home health providers, and particularly upon small agencies operating in rural areas. The National Association for Home Care (NAHC) is the nation's largest home care organization, representing nearly 6000 Medicare-participating urban and rural home care agencies, including non-profit providers like the visiting nurse associations, for-profit chains, hospital-based providers, and freestanding providers.

NAHC is deeply appreciative of the attention the Chairman and Members of the Committee have shown regarding the problems created by the home health provisions of BBA. NAHC respectfully offers the following comments and recommendations on proposed refinements to the Medicare home care provisions included in the BBA.

Balanced Budget Act Leads to Unprecedented Reductions in Home Health Utilization and Spending

The reductions in Medicare's home health benefit since enactment of the BBA are startling and unprecedented. Since fiscal year 1997 program expenditures decreased 48%, from $18.3 billion in FY97 to $9.5 billion in FY99. (Fig. 1)



While other Medicare programs have seen reductions due to the BBA, no other decrease has been close to what the home health benefit has experienced. (Table 1) In fact, FY99 was the first year in the history of the home health benefit in which Medicare outlays for skilled nursing facility care exceeded those of home health. Less was spent on Medicare home health services in FY99 than was spent in FY94 and 500,000 fewer home health patients were served in 1998 than were served in 1997. Indications are that this trend has continued in 1999 and 2000.

Table 1. Medicare Program Benefits, Fiscal Years 1997, 1998, 1999

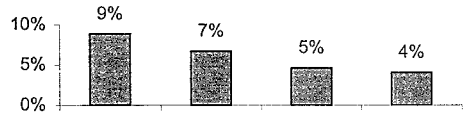
Benefit Type	FY97	FY98	FY99
	Amount ($billions)		
Managed care	25.0	31.9	37.4
Inpatient hospitals	88.3	87.0	85.3
Skilled nursing facilities	12.6	13.6	12.4
Home health	**18.3**	**14.0**	**9.5**
Hospice	2.1	2.1	2.5
Physicians	32.0	32.3	33.5
Outpatient hospitals	10.7	10.5	9.7
Durable medical equipment	4.1	4.1	4.2
Other	14.0	14.6	13.8
TOTAL MEDICARE	207.1	210.1	208.3

Percentage Change by Benefit Type	FY97-98	FY98-99	FY97-99
Managed care	+27.6%	+17.2%	+49.6%
Inpatient hospitals	-1.5	-2.0	-3.4
Skilled nursing facilities	+7.9	-8.8	-1.6
Home health	**-23.9**	**-32.1**	**-48.1**
Hospice	0.0	+19.0	+19.0
Physicians	+1.1	+3.7	+4.8
Outpatient hospitals	-1.9	-7.6	-9.3
Durable medical equipment	0.0	+2.4	+2.4
Other	+4.0	-5.5	-1.7
TOTAL MEDICARE	+1.4	-0.9	+0.6

Source: HCFA, Office of the Actuary unpublished estimates for the President's fiscal year 2001 budget.

Home health spending as a percent of Medicare has dropped precipitously from 9% of total Medicare outlays in FY97 to just 5% of total Medicare benefits in FY99. (Fig.2) HCFA's current projections for FY2000 indicate that home health will drop further, to 4% of total Medicare outlays.

Fig. 2
Home Health Decreases As Percent of Total Medicare Program, FY97-FY00



Every state has seen reductions in Medicare home health utilization and expenditures since 1997. In one year, 1997 to 1998, visits decreased 40%, the average payment per patient decreased 29%, and the average number of visits per patient declined 30%.

The Congressional Budget Office (CBO) originally anticipated a $16.1 billion reduction in home health spending over five years following enactment of the BBA. The most current CBO estimates and projections for home health show that spending was reduced by a total of $19.7 billion in just two years (FY98 and FY99). (Table 2) Based on the latest CBO projections, home care spending will be reduced by a total of $69 billion over five years (FY98-FY2002)—or, four times the intended reduction.

Table 2. Home Health Reductions Exceed $60 Billion Through FY2002

CBO Home Health Baselines ($billions)	FY97	FY98	FY99	FY00	FY01	FY02	FY98-02
January 1997 Outlays	19.0	21.1	23.2	25.3	27.5	29.9	127.0
BBA Target Outlays	19.0	20.0	21.2	21.2	23.3	25.2	110.9
March 2000 Outlays	17.5	14.9	9.7	9.8	11.1	12.5	58.0
Expected Reduction	n.a.	-1.1	-2.0	-4.1	-4.2	-4.7	-16.1
Actual Reduction	n.a.	-6.2	-13.6	-15.5	-16.4	-17.4	-69.0

Network of Agencies Severely Diminished

Not surprisingly, given the level of reductions, home health agencies have been closing at a rate of more than 90 per month since October 1997, leading to a recorded loss of over 2,500 agencies nationwide as of January 2000. (Fig. 3) HCFA data, from which these figures are drawn, generally lags behind actual closures. These losses are particularly problematic in states with large portions of their elderly population living in rural areas (Appendix A). There are now fewer agencies serving Medicare patients than there were in 1994.

Agencies Less Able to Provide Needed Care

Staffing levels of home health agencies have also decreased. From 1996 to 1999, over 133,000 full-time positions in Medicare-certified agencies were lost. This reduction in full-time equivalent (FTE) staffing includes 51,395 fewer nurses, and 54,426 fewer home health aides available to care for patients in 1999 than were employed by agencies in 1996.

The employment reductions in Medicare are in sharp contrast to forecasts of continued growth in demand for home care personnel resulting from strong underlying demographic trends which include an aging population, increased availability of in-home medical technology, and consumer preference for avoiding institutionalization or delaying entrance to nursing homes. The Bureau of Labor Statistics forecasts an 82% increase in the demand for key home health personnel for the period 1998 to 2008. Due to the severity of the payment reductions under the BBA, agencies increasingly are unable to offer competitive wages and benefits to attract qualified staff and labor shortages are developing across the country as a result.

Agencies Must Subsidize Medicare to Provide Services

Concern about the financial viability of home health agencies is growing as cost reports are settled and overpayment notices sent. One fiscal intermediary reported that 91% of home health agencies they oversee had overpayments in 1998, for a total of over one billion dollars. These figures give an indication of the extreme degree to which home health agencies are subsidizing the Medicare home health program.

Further, agencies throughout the nation have reported using funds other than Medicare to help pay for the care they provide to Medicare patients. An informal survey conducted during 1999 by NAHC revealed that 93% of responding agencies must find other funding sources in order to maintain home health access for Medicare beneficiaries. The median subsidy was $165,000. Agencies are tapping funding sources such as state and local government monies, local community charitable funding, profits from other businesses or programs, personal lines of credit, bank loans, bequests, hospital systems, and financial reserves in order to continue

providing care to needy and eligible Medicare beneficiaries. This continuing subsidization of the Medicare program means that agencies are less able to provide indigent care and other services that had been previously funded from some of these same sources, and is threatening the financial viability of many agencies.

Diminished Capacity to Serve Medicare Home Health Beneficiaries Leads to Access Problems

Reductions in utilization of the home health benefit have been dramatic. There were 500,000 fewer beneficiaries served by Medicare home health agencies in 1998 than were served in 1997.

Studies that have examined access to the home health benefit since 1997 agree on one central point: for certain groups of beneficiaries, access to the home health benefit has decreased. For example, a study of the effects of the BBA on home health agencies conducted by The George Washington University (GWU) reported that agencies were finding it increasingly difficult to meet the needs of high-cost patients, particularly complex diabetics. Among hospital discharge planners surveyed as part of the GWU study, 68% reported it was increasingly difficult to obtain home health services for Medicare beneficiaries.

Despite strong evidence that certain groups of eligible patients are in some cases unable to find home health care, The Medicare Payment Advisory Commission (MedPAC) in its March 2000 report to Congress equivocates on the issue of access. The following excerpt from the report is particularly suggestive:

> MedPAC sponsored a survey of home health agencies to examine whether access has been compromised by the IPS (MedPAC 1999). This research reveals that the broad impact of the IPS [interim payment system] did not fulfill 'the worst predictions,' but has likely negatively affected beneficiaries (Abt Associates 1999). ***Results indicate that the new payment system has led agencies to exercise cost-cutting measures, including refusing services to Medicare patients who have chronic, long-term conditions, especially diabetics. More than half of agencies surveyed expected to exceed their per-beneficiary limits and said that, as a result of the IPS, they would be more likely to decrease their Medicare caseloads, deny admission to certain types of patients, discharge certain types of patients, or reduce clinical staff or hours.*** *[emphasis added]*

In its summary of previous research about access, MedPAC's report states,

> The General Accounting Office (GAO) found that access generally has not been impaired, despite the closure of approximately 14 percent of home health agencies since 1997 (GAO 1999). ***But interviews with key stakeholders in areas with higher frequencies of closures suggest that home health agencies are asking more detailed information about potential patients, and that patients who require costlier services are facing difficulty in finding an agency willing to provide visits.****[*emphasis added]

The controversy over the impact on access to home health is focused on how much access has been compromised, not whether it has decreased. Several research institutes, including the Robert Wood Johnson Foundation, have funded studies to look at the impact of the BBA on home health beneficiaries.

Media reports have also identified access problems due to the BBA. In West Virginia, the death of a patient has been linked to the loss of home health services.

Problems are Exacerbated in Rural Areas

While the dramatic impact of BBA policies has affected every community in the nation, rural areas have been even more severely impacted. The Walsh Center for Rural Health Analysis at Project HOPE conducted

several recent studies related to home health, and the impact of certain policies on access to care in rural areas.

"Rural and Urban Patterns of Home Health Use: Implications for Access under the Interim Payment System," by Janet P. Sutton, Ph.D., found that, "Home health agencies serving rural populations may experience even more difficulty than urban agencies in adapting to the IPS [interim payment system] because visit costs tend to be higher and episode lengths are longer. In general, rural populations are older and more chronically ill than urban populations. These factors could indicate that rural home health users are more resource intensive, and make them less desirable to treat.." The study also found that while rural and urban beneficiaries received comparable numbers of skilled nursing visits, rural beneficiaries tended to need more home health aide services, and were more likely to be long term users of home health services. Both of these characteristics create disincentives for agencies to accept patients into care or, alternatively, result in higher costs for treating beneficiaries in rural areas.

In an additional report by the Walsh Center, Project HOPE examined characteristics of the interim payment system (IPS) and analyzed its impact on rural home health agencies and beneficiaries. The study, entitled "Rural Home Health Agencies: The Impact of the Balanced Budget Act," concludes that the reductions in reimbursement associated with IPS resulted in many home health agencies being forced to close and access to home health services in rural areas compromised. While not making specific recommendations, the report concludes that policymakers should focus on various issues such as an agency's case-mix and the impact of a PPS on rural areas that are served by urban home health agencies. Finally, the report notes that the impact of PPS on small, hospital-based non-profit agencies will determine how rural agencies – most of which are smaller, hospital-based, and non-profit – and rural beneficiaries will fare under this new reimbursement environment.

Specifically, the report found that, under IPS, home health expenditures declined to 1994 levels and a "significant number of home health agencies have ceased operating." In fact, the report cites the Congressional Budget Office (CBO) with crediting much of the decline in overall Medicare spending in 1999 to the reduction in home health, whose expenditures declined by 15% in 1998. The report points out that 32 rural counties lost their sole Medicare home health provider and an additional 97 rural counties lost at least half of the number of home health agencies that used to serve their area.

To minimize any unintended consequences of the new, lower reimbursement rates, the Project HOPE report calls on policymakers to examine the possibility of excluding rural providers from home health PPS. The Project HOPE study points to three areas where rural beneficiaries could be put at a disadvantage if subjected to a home health PPS. Under PPS, the case-mix adjustment is partially based on the use of therapy services. These services are less available in rural areas and, therefore, rural beneficiaries may be denied such services. Moreover, under PPS, payment will be based on the beneficiary, not agency location. According to the report, approximately one-quarter of rural Medicare home health beneficiaries rely on urban providers for care. If, under PPS, these agencies reduce their services to rural beneficiaries, access to home care may be reduced in rural areas. Finally, the report calls for close oversight on the impact of PPS on smaller, hospital-based, nonprofit agencies. Since most rural agencies share these characteristics, the impact of PPS on these types of providers could very well mirror the impact of PPS on rural providers.

The cuts in home health reimbursements resulting from the BBA have also made it increasingly difficult for home health agencies to offer competitive wages and benefits. Increased regulatory burdens on home visiting staff have also discouraged workers from continuing in home care. Recruitment and retention of home care personnel, including nurses and home health aides, is especially difficult in rural and other underserved areas. Providing health care in these areas requires special knowledge, training, and commitment on behalf of health care providers. Continuing education and training are often not readily available. Health care services can be particularly interdependent in rural communities: when a rural hospital closes, many affiliated health care personnel and services leave the area as well.

There are a number of regulatory requirements or restrictions, which are particularly burdensome to small, rural home health agencies. Of particular note are the following:

Branch Office Policies. Home health agencies, particularly in rural areas, may establish branch offices that share administration, supervision, and services with the parent home health agency, and from which services can be provided to a specific geographic area served by the "parent" agency. These branch offices: 1) provide a home base for personnel that is close to the patients that the agency serves; 2) make supervision available; 3) make patient records and supplies accessible; and 4) allow personnel to meet to coordinate care with others who are serving the patient. This is a very efficient, cost-effective means of providing high quality service while avoiding duplication of administrative positions and functions. HCFA's regional offices have adopted varying policies that restrict agencies' use of branch offices, frequently by imposing artificial time or distance limits for establishment of a branch, causing many agencies to either close their branch offices, thereby further limiting access to care, or establish them as separate parent agencies, incurring significant additional costs to meet separate survey and certification requirements.

OASIS Data Collection Requirements. In 1999, home health providers were required to begin collecting data on all home health patients receiving skilled services at the time of admission, at recertification, and at various times during the course of their treatment in order to track outcomes of care. Because OASIS data must be collected at specific time points, it cannot always be collected at the time of a regularly scheduled home health visit, resulting in additional visits for which the agency is not paid. . This is particularly burdensome for rural agencies, where the travel time and distance between patients is longer.

Telemedicine. In recent years great strides have been made in telehealth technology and its uses in the home. Currently, HCFA does not recognize telehomecare technology and visit costs as reimbursable by the Medicare program. NAHC believes that Congress should authorize home health agencies to utilize PPS payments in a flexible manner to achieve quality of care and efficiencies without adverse consequences relative to payment, coverage, and compliance with the conditions of participation. Optimal health outcomes should be the main goal of the Medicare program and its reimbursement system. Home health agencies both rural and urban should not be prohibited from taking advantage of new technologies and services, if equal or better patient outcomes can be achieved with greater economies. HCFA has not clarified definitively whether they deem it appropriate to utilize PPS funds for the deployment and use of telehomecare equipment. We believe that HCFA should fully authorize the use of telehomecare and other technology services under PPS. This action will allow rural and urban agencies to evolve in response to changes in practice patterns and technology that affect the level of resources required to furnish home health services to different types of patients.

Requirement for Home Health Aide Supervision. Home health aide supervisory requirements are focused on observation of the patient rather than with the home health aide. In rural areas, this may result in increased numbers of visits by registered nurses that are not reimbursed unless the nurse is already scheduled to make a skilled visit. The home health requirements could be altered to allow agencies the flexibility to establish their own policies for frequency of aide supervision based on the aide's skills, experience, and past performance.

The Move to Prospective Payment for Home Health: The Future of Home Care Hangs in the Balance

In the midst of the chaos that the BBA created, home health faces a major change in the Medicare payment system that is scheduled to take effect October 1, 2000. The IPS that began in October 1997 will be replaced by a PPS. The concept behind the new system is to encourage efficient provision of home health services by paying an amount based on the average national cost of treating a home health client for 60 days. Final payments to agencies are based on the average base payment, and adjusted to take into account patient characteristics (case-mix) and labor market differences (wage index). An outlier payment is provided for cases that exceed the expected costs.

The goal of the PPS for home health is to encourage efficient provision of services without compromising quality. Under a cost-based reimbursement system, there is no financial incentive to reduce utilization because providers are paid for each unit of service. The IPS introduced a per beneficiary limit, which discouraged agencies from providing care that costs more than their average cost of providing care in federal fiscal year 1994. There is no adjustment for patient need under IPS; therefore, agencies have a financial incentive to avoid high-cost patients who may cause the agency to exceed their aggregate per beneficiary limit. The PPS mitigates this financial incentive to avoid high-cost patients by paying greater amounts for higher need patients and by allowing agencies to be paid for multiple episodes as long as the patient continues to meet the Medicare home health coverage criteria. How successful the payment system is depends on how well the system calibrates to patient needs and whether payment rates are based on a sound financial foundation.

Results of the PPS per-episode demonstration indicate that prospective payment can reduce costs, but the demonstration differed in significant ways from the proposed system. For example, the demonstration included a loss sharing provision that prevented agencies from excess losses. No such provision is included in the proposed system.

Agencies are guardedly optimistic about the payment system change. However, the following changes must occur in order to provide a transition to PPS that will not further compromise access to the home health benefit.

1) **Eliminate the 15% cut scheduled to take effect October 1, 2001, and restore full market basket update.** Although federal budget projections show growth in home health following implementation of the PPS in October 2000, these projections are overly optimistic in accounting for the 15% reduction in payment rates scheduled for October 2001. Agencies that have eliminated staff, reduced utilization and cut costs to the bone to cope with the IPS, and whose PPS payments are based on the IPS budget, will not likely respond to a payment system that pays them 15% below their previous year's amounts by increasing services. It is much more likely that a 15% cut in payments and below-inflation update factor will translate into additional agency closures, layoffs and even greater access problems.

2) **Eliminate the budget neutrality adjustment.** Congress set the Medicare home health PPS payment rate equal to what Medicare would have spent if the IPS continued, which is commonly referred to as the budget neutrality adjustment. Because IPS has so severely cut expenditures, the budget neutrality adjustment effectively reduces payment by 22% below the average cost of a PPS episode. HCFA has indicated during meetings with industry representatives that the budget neutrality adjustment is likely to remain 78%. While such an adjustment might have been necessary during a period of unprecedented growth, home health is in a phase of dramatic decline. Given the unexpectedly dramatic decreases in home health spending that have occurred since the BBA was enacted, no budget neutrality adjustment provision is necessary to control spending. As long as the budget neutrality adjustment is tied to IPS, the difficulties created under that flawed system are inherited by PPS.

3) **Revise the spending target to provide adequate financing for classes of patients with specific needs not accounted for in the payment rate.** The case-mix adjusted PPS rate consistently underpays for certain patients who require very expensive supplies or frequent visits. Such cases should be identified and paid for separately to avoid introducing quality and access problems for these patients. Examples are wound care and complex diabetic patients whose needs far exceed expected reimbursement under the proposed PPS.

4) **Recognize costs of new administrative requirements in PPS base rate.** The PPS per episode payment is based on 1996 cost report information with a modest adjustment for inflation. Neither the base rate, computed using 1996 costs, nor the inflation adjustment, which is projected from 1993 data, recognize the additional costs of regulations that have taken effect since 1996. For example, these new regulations included multiple changes in billing requirements, such as mandatory electronic cost reporting and 15-minute interval billing, as well as implementing Y2K precautions and advanced beneficiary notices, among others. To meet these new requirements, agencies had to revise billing practices, purchase or upgrade computer systems and train staff to comply with the new unfunded mandates. None of these newer costs

borne by agencies are recognized in the PPS base rate. (See Appendix B for a detailed description of the additional administrative responsibilities instituted since 1996.) Recognition of these costs in the payment system is essential to ensure that the PPS is established on firm financial footing.

Mr. Chairman and members of the Committee, these legislative changes, combined with the regulatory changes outlined in the previous section, would go a long way toward strengthening the home health infrastructure in our country, and ensuring access to important home health care services for needy beneficiaries, regardless of where they reside. We thank you for your sincere interest, and look forward to working with you and other members of the House of Representatives in this important area. I would be happy to answer any questions that you might have.

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June 13, 2000

Written testimony to the House Small Business Committee

Mr. Chairman and Members:

Hospice of Acadiana, Inc. (HOA) is a not for profit, tax exempt free standing community based hospice program chartered in the State of Louisiana in March of 1983. With an annual budget of only two million dollars Hospice of Acadiana is a small business. In 1999 HOA had an average daily census of 66 patients from throughout its six parish (county) service area. Sixty percent of the patients severed in 1999 lived in Lafayette parish. Lafayette parish as a census population per square mile of land area of about 610. The other forty percent of the patients severed lived in the other five parishes which have an average census population per square mile of land area of 78. These parishes are made up of a few small towns and the rest of the population is spread out in the rural areas. Since HOA cares for patients in both urban and rural areas it is in a unique position to be able to compare the delivery of services in both areas.

The majority of our services are paid for by Medicare, with private insurance paying for about 10%. Medicare pays a per diem rate that is all inclusive, in other words it includes the services provided by our staff as well as medications, medical equipment, supplies, etc. that we must provide to our patients. This rate is determined by a formula that is the sum of a set rate and an adjustable wage index rate. There is a wage index rate for each Metropolitan Statistical Area (MSA). Those areas not in a MSA are lumped together in a rural rate for each state. For the year 2000 HOA's routine home care for the Lafayette MSA is $90.80 while the rate for the rural areas is $85.35, a difference of $5.45 per patient day. Most hospice services are provided in the home of the patient therefore the patients place of residence is a variable that affects the cost of providing services to this population.

It is more expensive to provide hospice services to patents living outside of an urban area for the following reasons:

- Cost associated with getting staff to a patient's home to provide services are higher in a rural area than in a MSA. The distance between patient homes is greater in rural areas, therefore we see an increase in miles traveled as well as in the time it takes the staff to get from one home to the next. Because of increased travel time, staff caseloads have to be lower in rural areas than in urban areas. Looking at internal data from HOA it looks like the miles between patient residences in rural areas is twice that of patients in urban areas. Increased mileage reimbursement, increased time behind the wheel resulting in decreased caseloads equal increase cost to provide services.

- This same concept of the distance that must be traveled to deliver medical equipment, portable diagnostic testing, such as x-rays and EKG's, supplies, and medications affects the price that we must pay for these contracted services. The suppliers we contract with must pass on to us their increased cost of getting their goods and services to the rural patients. Many are no longer providing these services to rural patients because their reimbursement is less than their cost. When these ancillary services are no long available to us, we must transport the patient to a facility that has them. Many times this is more expense and is very difficult on a bed bound, weak patient.

- Another factor that affects availability of goods and services is volume. This especially comes into play when the goods expire after a certain time period. A good example is the pharmaceutical industry. Many of the medications we use in pain and symptom management for our hospice patients are not purchased in sufficient volume for the rural pharmacy to stock them. We cannot guarantee them enough volume to keep their supply current. Many patients purchase these medications at larger urban pharmacies while accessing medical care in the urban area. Unfortunately many of the elderly and the poor do not have the transportation to get them to the urban area to take

advantage of these services. Getting medications to patients becomes more expensive in rural areas when they have to be purchased from a pharmacy that is often many miles from the patient's home. Some patients cannot be left alone, therefore when there is only one care giver either the pharmacy or the hospice has to deliver the medication. Again increasing the cost of the medication.

- Ambulance and other patient transportation cost, which are also included in our per diem, is more expensive in rural areas because it also includes a mileage cost factor.

- As the hospice population becomes more spread out it becomes necessary to add more staff to the on-call schedule to assure adequate response time. Again an additional cost.

- Staffing is also a problem in the rural areas. We are not always able to find qualified staff in a particular area when the need arises. Some hospice providers in our area are having problems finding mastered prepared social workers, as required by our state licensing regulations. Therefore we are forced to hire staff who do not live near our patients and again are faced with the added cost of paying higher mileage cost and travel time.

- Many support and ancillary services such as meals on wheels, support groups, etc., available in urban areas are not available in rural areas. This indirectly adds to the cost of care because we see more caregiver stress and "burn out" where there is a lack of such support services.

In summary the Health Care Finance Administration's (HCFA) formula for paying for hospice services pays less for services provided in rural areas than those in urban areas. This creates a disincentive to provide services to the rural population. A small hospice trying to care for this population is at a great disadvantage in that it does not have a high enough volume of higher reimbursed, lower cost urban patients to help cover the increased cost associated with caring for the lower reimbursed, higher cost rural patients.

Many studies have shown that hospice and home care services are far less expensive than hospitalization. Many hospice programs are taking a second look at their abilities to service the rural population and reconsidering just how far out they can afford to go. Access to these less expensive services becomes harder to get as the number of providers decrease or their service areas decrease.

In conclusion I ask that the government take a second look at its formula for reimbursing rural providers of health care services. I am afraid that if a formula is not devised that adequately reimburses for the cost associated with the provision of services to our rural population there will be no one to serve the rural population in the future. This strategy can only lead to increase utilization of inpatient facilities that are less desirable because they cost more and negatively impact a patient's quality of life. Ultimately some one will have to pay for either the transportation cost of the patient to get to the health care provider or for the health care provider to get to the patient. Obviously I feel that the later is preferable from both an economic and humane perspective.

Sincerely

Nelson A. Waguespack, Jr.

Nelson A. Waguespack, Jr.
Executive Director