ADDITIONAL MEDICARE REFINEMENTS TO THE BALANCED BUDGET ACT OF 1997

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

SECOND SESSION

JULY 25, 2000

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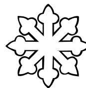

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ADDITIONAL MEDICARE REFINEMENTS TO THE BALANCED BUDGET ACT OF 1997

TUESDAY, JULY 25, 2000

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

The Subcommittee met, pursuant to notice, at 1:09 p.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE Contact: (202) 225–3943
July 18, 2000
No. HL–15

Thomas Announces Hearing on Additional Medicare Refinements to the Balanced Budget Act of 1997

Congressman Bill Thomas (R–CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on further refinements to the Medicare provisions in the Balanced Budget Act of 1997 (BBA) (P.L. 105–33). **The hearing will take place on Tuesday, July 25, 2000, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 1:00 p.m.**

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

BACKGROUND:

In 1997, Congress passed the BBA, which made the most extensive changes to the Medicare program since its inception in 1965. Among the 300 Medicare provisions in the BBA were efforts to reduce waste, fraud and abuse, expand coverage of preventive benefits, establish new payment methodologies for different Medicare providers, and create the Medicare+Choice managed care risk program. When the bill was passed, the Congressional Budget Office (CBO) estimated Medicare savings of $112 billion over five years.

As with any major legislation involving such sweeping fundamental change, there have been unanticipated and unintended consequences for health care providers and implementation delays and problems within the Health Care Financing Administration (HCFA) that have affected the delivery of services to seniors. Understanding the need for fine-tuning, last year, Congress passed the Medicare, Medicaid, SCHIP Balanced Budget Refinement Act of 1999 (BBRA), as incorporated in the Consolidated Appropriations bill for fiscal year 2000 (P.L. 106–113) . The BBRA contained a number of provisions aimed at strengthening Medicare, including assistance for hospitals, particularly in rural areas, nursing homes, home health, and the Medicare+Choice program. Additionally, the BBRA provided and clarified beneficiary protection from high out-of-pocket copayments for certain health services. The CBO estimated that the BBRA provisions would increase Medicare spending by $16 billion over five years.

Even with these Medicare program improvements, the Subcommittee continues to monitor the impact of the BBA on all types of providers and oversee the implementation of the BBA, including the prospective payment systems it established. The Subcommittee periodically assesses whether further refinement of the BBA is warranted and what types of changes may be appropriate.

In announcing the hearing, Chairman Thomas stated: “Both Congress and the Administration must remain vigilant. Problems continue to arise in the implementa-

tion of this landmark legislation. Last year, Congress responded to concerns in a bipartisan fashion, making meritorious refinements where necessary without threatening the achievements associated with the 1997 legislation. I have always said that where inequities still persist, we will examine the possibility of further refinements. I hope that Congress and the Administration will work together again to ensure seniors get the health care services they need.”

FOCUS OF THE HEARING:

The hearing will provide the opportunity to hear from Administration officials and health care providers about the impact and implementation of the BBA and the BBRA.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit six (6) single-spaced copies of their statement, along with an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, with their name, address, and hearing date noted on a label, by the close of business, Tuesday, August 8, 2000 , to A.L. Singleton, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, by close of business the day before the hearing.

FORMATTING REQUIREMENTS:

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

1. All statements and any accompanying exhibits for printing must be submitted on an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, typed in single space and may not exceed a total of 10 pages including attachments. Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.

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

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

4. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers where the witness or the designated representative may be reached. This supplemental sheet will not be included in the printed record.

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

Note: All Committee advisories and news releases are available on the World Wide Web at “http://waysandmeans.house.gov”.

Committee Seeks to Assist Persons with Disabilities at the Committee’s facilities.” The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including avail-

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

Chairman THOMAS. Please find your seats.

Almost 3 years ago, Congress passed the Balanced Budget Act of 1997, which made Medicare payment and benefit reforms really unseen since the inception of the program. This landmark legislation has strengthened Medicare substantially. It expanded coverage of preventive benefits for seniors, including PAP smear tests, colorectal cancer screenings, osteoporosis and other much-needed preventive benefits.

It injected much-needed new flexibility for seniors' different health care preferences by creating the Medicare Plus Choice program. It provided new tools to combat health care waste, fraud and abuse that has resulted in savings to the program, and it has helped improve its efficiency.

Finally, the Balanced Budget Act adjusted payments to providers, and it introduced reforms in fee-for-service programs, such as the Prospective Payment Systems, that have resulted in more accurate payments and have contributed to the extended solvency of the part A trust fund.

When we formulated and enacted the so-called BBA, Congress relied on the data and estimates available at the time, as we always do. The Health Care Financing Administration has implemented most of the more than 300 changes to Medicare that the law required. In some cases, HCFA has missed deadlines for implementation or has developed policies that, upon more recent data, require further refinement.

Last year, Congress recognized that such sweeping changes in payment policy often require some degree of fine-tuning. In response to HCFA's delays, and implementation problems and financial data on the BBA's impact on providers, Congress, in cooperation with the administration, passed the Balanced Budget Refinement Act, which restored more than $16 billion to hospitals, nursing homes, home health care, Medicare Plus Choice and rural health programs.

Perhaps most important, though, the Balanced Budget Refinement Act contained provisions that directly addressed the needs of seniors, limiting the outpatient hospital copayment, increasing payments for PAP smears, and extending benefits for immunosuppressive drugs.

It is worth noting at the beginning of this hearing that the Balanced Budget Refinement Act's relief for providers, $10 billion of the $16 billion is not scheduled to be paid to providers until fiscal year 2001 and fiscal year 2002. Those asking for additional relief should keep in mind this important fact. The request is for legislation to be laid on top of legislation. We have the Refinement Act, and we are talking about a further Refinement Act. One was a 5-year period. This one will be a 5-year period, running concurrently in certain fiscal years.

As Congress evaluates the need for further refinements this fall, we will be factoring in the Balanced Budget Refinement Act payment schedule of funds that providers have yet to receive.

That said, early this year I made the point that the Subcommittee would monitor the continued impact of the BBA on all types of providers. We are willing to consider limited changes to the BBA to address the remaining unanticipated or unintended consequences stemming from this historic legislation. Our goal is not to undo the legislation, it is to refine the legislation. And if refinements are necessary, I am hopeful that a bipartisan consensus can be achieved and that a cooperative working environment between the Congress and the administration will prevail. The time will be relatively short for us to respond, but as in the past, we have on these matters.

I am pleased that HCFA here is to provide a progress report on BBA implementation and technical assistance on Medicare payment areas that need further improvement or of difficulties in implementing provisions that they have been entrusted to implement. And additionally, of course, we are going to hear from people who will tell us about the state of their delivery of health services in all parts of the country.

I look forward to a productive dialog on what specific additional refinements are needed to improve the payment structures in the Medicare Program. And with that, I turn to my colleague from California for any opening remark he may have.

Mr. STARK. Thank you, Mr. Chairman for this hearing.

I would just like to remind our witnesses, and I am sure the members don't need this, but Medicare was a program set up in 1965 to help the Nation's seniors and disabled. It is not a provider welfare program, and it is not meant to be designed for the providers first and beneficiaries as a secondary afterthought.

A second reminder, that the savings that we achieved under your leadership in 1997 were, and are, incredibly important in stopping outrageous and unnecessary inflation in the program. The savings extended the life of the program and saved beneficiaries and taxpayers hundreds of billions of dollars in the years to come.

Many providers make the case that we "saved more than CBO expected to," so we should give it back. A large part of the reduced Medicare spending was, in fact, due to lower general inflation rates and a renewed commitment by HCFA to antifraud efforts. And surely none of our witnesses today are going to advocate higher inflation or more fraud and abuse.

It is important that we not casually throw away the gains made in the 1997 reforms. We should only restore spending where there is evidence that we need to do so to protect beneficiaries. Remember, that every dollar we give back in part A reduces the life of the trust fund. Every dollar we give back in part B increases beneficiaries' monthly premiums. Over the next 30 years, the number of people—and I don't have to remind the Committee—on Medicare will double, from 40 to 80 million, and the numbers of taxpayers we expect to decline.

We face a long-run problem and we should ask whether a provider give back helps us with that long-run problem. If we give back money, we should use it to help beneficiaries deal with the shortfalls on their side of the program. We need a good prescription drug benefit. We should greatly improve the preventive care benefits and actually eliminate the need for co-pays and deductibles in

the use of preventive benefits. We should accelerate the work started by you, Mr. Chairman, in lowering the hospital outpatient department co-pays. It is going to take 40 years to fix that problem. We should speed up the day that co-pays are all at 20 percent. We should presumptively now, I believe, enroll low-income seniors in QMB and SLMB programs to help the poorest seniors.

I hope the witnesses will talk about some of these changes on behalf of the people the Medicare Program was meant to serve, and I hope today's witnesses will give us some hard empirical proof that they deserve help.

A year ago we asked the General Accounting Office to study whether Medicare was paying hospitals more or less than managed care plans were paying hospitals for a similar case. The data is just coming in, and many hospitals fought this project and refused to cooperate. GAO went over to 100 hospitals for data, and they only got data from a sample of 51. Basically, the GAO's draft report finds that Medicare payments were 9 percent above Medicare costs. Managed care plans were 7 percent higher than costs. Since Medicare is paying more than cost-conscious managed care plans, the question comes up of why we should increase the annual update to Medicare hospitals.

The GAO found that 41 percent of these hospitals had managed care plan payments less than costs; whereas, only 24 percent of these hospitals had Medicare payments less than costs. That raises the key question: If we pay hospitals more with taxpayer dollars from Medicare, will they just keep signing low-ball contracts with the managed care plans? If the GAO's data is accurate, we might as well write our checks to Aetna and Pacific Care directly.

Mr. Chairman, I look forward to the testimony.

Chairman THOMAS. Thank the gentleman.

Any other comments members may have can be submitted for the record.

Statement of Hon. Jim Ramstad, a Representative in Congress from the State of Minnesota

Mr. Chairman, thank you for calling this hearing today to assess additional Medicare refinement requests to the Balanced Budget Act of 1997.

Like all of my colleagues on this panel, I have been hearing a great deal from providers about the concerns they have about current payment policies. I take their pleas for changes, especially from those providers in Minnesota, under serious advisement.

At the same time, however, I take the input from the General Accounting Office and MedPAC equally seriously. After all, they were established to provide us this independent, unbiased information to help us make our policy decisions. Input from these two groups has been pivotal to Congress long before I was elected.

How is it that some providers claim need for assistance, while GAO and MedPAC have stated that, for some certain industries, there is little or no evidence that spending reductions have hurt beneficiary access to care?

How can the numbers literally be black and red at the same time?

That's why this hearing today is so crucial for helping us evaluate the implementation of the BBA and the BBRA. Why are we saving so much more than expected under the BBA? Why are some providers still not feeling the positive effects of the $16 billion we put back into the system last year? Are there any health care services that seniors need to fear losing access to because of reimbursement levels? Are there rules, regulations and bureaucratic hurdles that are limiting access to care and/or increasing provider costs unnecessarily?

Mr. Chairman, thanks again for holding this hearing. I look forward to learning more from today's witnesses about what changes may need to be made to the Medicare system.

And I wanted, on the gentleman from California's comments about the Congressional Accounting Office, we purposefully did not have the GAO at this hearing because they were in attendance at the Health Subcommittee of the Commerce Committee, just as the Health Care Financing Administration was not at the Commerce Committee. It is not by accident, it is by intention that these two hearings, last week and this week, be complementary, giving us a broader coverage on this question.

And with that, I would turn to Dr. Berenson, the director of the Center for Health Plans and Providers, indicating that your written testimony will be made a part of the record, and you may address us any way you see fit in the time that you have.

Dr. Berenson, thanks for being with us.

STATEMENT OF ROBERT A. BERENSON, M.D., DIRECTOR, CENTER FOR HEALTH PLANS & PROVIDERS, HEALTH CARE FINANCING ADMINISTRATION

Dr. BERENSON. Distinguished Subcommittee members, thank you for inviting us to discuss further adjustments to the Balanced Budget Act. Congress and the administration worked together to enact this historic law. Many BBA payment changes were justified and have contributed to improved efficiency and the unprecedented fiscal health of the Medicare Trust Fund.

The Prospective Payment Systems mandated by the BBA are particularly important because they create incentives to provide care more efficiently. However, these new payment systems mark a substantial departure from cost—and charge-based reimbursement, and the transition can be challenging for providers.

We have all heard reports from health care providers of financial difficulties, in part, related to BBA changes, and we are concerned about the potential for reduced access to quality care. To address this, the President worked with Congress to increase home health care payments in 1998. We worked together again last year on the Balanced Budget Refinement Act to make adjustments for several types of providers. And we have taken several administrative actions to smooth the transition to new policies and help health care providers adjust.

It appears, however, that some problems persist. We believe further prudent adjustments are warranted to protect access to quality care, and we want to work with the Committee, as we have done in the past, on legislation to make needed adjustments.

The President's mid-session budget proposal includes numerous adjustments to increase payments by $21 billion over 5 years to hospitals, rural providers, teaching facilities, nursing homes, home health agencies, managed care plans and other providers. This includes $9 billion over 5 years to delay further BBA payment reductions, and it includes $11 billion over 5 years in unspecified funds for use in developing additional adjustments.

The improved status of the trust fund and the growing budget surplus make it possible to pay for these adjustments while still achieving our goal of extending trust fund solvency through 2030

and making an affordable voluntary prescription drug benefit available to all beneficiaries.

I want to spend a couple of moments on two particular programs that deserve special attention today. The first are nursing home payments. We are continuing to work to refine the payment classification system in a budget-neutral way to ensure adequate payment for medically complex patients in skilled nursing facilities, and particularly to account more specifically for the costs of drugs and other nontherapy ancillary services. To immediately address industry concerns, the BBRA provided for a 20-percent increase in the SNF prospective payments for 15 categories of patients to address perceived shortfalls in payments for such patients until we were able to determine the best way to make these changes. And those increased payments are now being received.

Using the best data available in 1998, we developed two payment classification models we believed would ensure adequate payment for complex patients. We issued a proposed rule in April of this year which included refinements based on these models and solicited public comments. In addition, we contracted with outside experts to validate the models using more recent data.

When we tested the models with nationwide data from 1999 over the past few months, we found that the models were no longer statistically significant in identifying high-cost beneficiaries with complex needs and the ancillary services they use. Proceeding with implementation of these proposed refinements based on these models could have changed payment levels without any assurance that we were distributing funds more equitably, creating incentives for efficient care and minimizing the risk of negative financial consequences.

Accordingly, today we put on display the final rule deferring the implementation of these refinements. We will shortly begin consulting with outside researchers and experts to begin further analysis using 1999 national data aimed at determining the feasibility of developing case-mix refinements that reflect current practice. Our goal is to include a proposal for such refinements, as soon as possible. However, until a feasibility study is completed, we will be unable to accurately forecast the potential and timing of such refinements. In the meantime, the 20-percent increase in payments included in the BBRA will remain in place until refinements of the system can be implemented, which will be in fiscal 2002 at the earliest. In addition to the 20-percent increase, the BBRA also provided a 4-percent increase in payments for all SNF beneficiaries, effective October 1 of 2000.

The other comment relates to the Medicare Plus Choice program, and we released the numbers just yesterday about the numbers of withdrawals. It exceeded 900,000 beneficiaries affected by withdrawals. In addition to the specific fee-for-service provider payment adjustments listed above then, the President's plan would provide an estimated $25 billion over 5 years to Medicare Plus Choice plans specifically for drug coverage. This is important because Medicare Plus Choice plans are finding it difficult to adjust to the BBA changes, while maintaining the extra services not available in the Medicare fee-for-service program and especially prescription drug coverage.

Even with the BBA changes, payments to M Plus C plans continue to exceed what taxpayers would spend for enrollees if they had remained in the fee-for-service program, but lack of payment to support drug coverage has led plans to significantly reduce the scope of their prescription drug coverage. And it is the primary reason that some plans are leaving the program.

The best way to ensure that the Medicare Plus Choice program is a strong part of Medicare is to ensure that all beneficiaries have access to affordable drug coverage and to pay plans directly for providing it. The President's proposal to create a voluntary, affordable prescription drug benefit for all beneficiaries would do just that. Plans would be paid directly $2 billion beginning in January of next year and $25 billion over the next 5 years to provide the prescription drug coverage. This amount substantially exceeds the $15 billion over 5 years that representatives of the American Association of Health Plans have said they need to continue participating in M Plus C.

Beneficiaries in fee-for-service Medicare would also be able to choose this benefit, regardless of whether they live in areas with managed care plans. And beneficiaries in plans all across the country would be assured of drug coverage rather than just those in areas where nontargeted assistance for plans would raise payment enough to support a drug benefit.

While it is essential that we maintain the fiscal discipline embodied in the BBA, it is equally essential that we make adjustments where necessary to ensure continued access to quality care and provide access for all beneficiaries to an affordable and voluntary drug benefit.

I thank you for holding this hearing, and I am happy to answer your questions. Thank you.

[The prepared statement follows:]

Statement of Robert A. Berenson, M.D., Director, Center for Health Plans & Providers, Health Care Financing Administration

Chairman Thomas, Congressman Stark, distinguished Subcommittee members, thank you for inviting us to discuss the need to make further adjustments to the Balanced Budget Act of 1997 (BBA). Congress and the Administration worked together to make difficult decisions in enacting this historic law. The BBA helped to eliminate the deficit, created the State Children's Health Insurance Program, and reduced and restructured Medicare and Medicaid payments to health care providers. Many of the provider payment changes were justified and have contributed to improved efficiency and the unprecedented fiscal health of the Medicare Trust Fund.

However, information gathered over the last three years suggests that some of the policies may have the potential to affect the quality of and access to health care services. To address this, the President worked with Congress to increase home health care payments in 1998. We worked together again last year in the Balanced Budget Refinement Act (BBRA) to make several necessary adjustments for several types of providers. And we have taken several administrative actions to smooth the transition to new policies and help health care providers adjust.

It appears, however, that problems persist. We have all heard reports from health care providers of financial difficulties—in part related to BBA changes. We are concerned about the potential for reduced beneficiary access to quality care. We believe it is warranted to make further prudent adjustments to ensure that beneficiaries continue to have access to quality care. And we want to work with this Committee, as we have done in the past, on legislation to make needed adjustments.

The President's Mid-session Review proposal includes numerous adjustments that would increase payments by $21 billion over 5 years ($40 billion over 10 years) to hospitals, rural providers, teaching facilities, nursing homes, home health agencies, managed care plans, and other providers.

The President's proposal includes $9 billion over five years ($19 billion over 10 years) to delay further BBA payment reductions, many of which are scheduled to occur on October 1, and includes $11 billion over five years ($21 billion over 10 years) in unspecified funds for use in developing additional adjustments.

PRESIDENT'S MIDSESSION BUDGET PROPOSAL

Dollars in Billions

	5 Years	10 Years
HOSPITALS		
• Full inpatient hospital market basket for '01	$4	$8.
• Indirect Medical Education at 6.5 percent for '01:	$0.2	$0.2.
• Repeal Medicare DSH reduction for '01:	$0.2	$0.2.
• Freeze in Medicaid DSH allotments for '01:	$0.3	$0.3.
• Rural initiative:	$0.5	$1.0.
• Adjusting Puerto Rico hospital payments to 75/25 blend:	$0.05	$0.1.
Total:	$5	$10.
HOME HEALTH		
• Delay 15 percent cut in '02:	$1	$1.
• Full market basket update for '01:	$1	$2.
Total:	$2	$3.
NURSING HOMES		
• Full market basket update for '01:	$0.6	$1.
• Delay therapy cap changes for an additional year:	$1	$1.
Total:	$1.6	$2.
MEDICARE+CHOICE		
• Indirect effect of specified policies:	$1	$3.
OTHER		
ESRD composite rate update of 2.4% for '01:	$0.2	$0.5.
TOTAL SPECIFIED POLICY COSTS:	$9	$19.
UNSPECIFIED PROVIDER RESTORATION POOL:	$11	$21.
TOTAL FUNDING:	$21	40.

AANOTE: Numbers may not add due to rounding. Ricky Ray and diabetes increases would be funded out of the unspecified pool.

The BBA's fiscal discipline and our success in fighting fraud, waste, and abuse have greatly improved the status of the Medicare Trust Fund, which is now projected to remain solvent until 2025, 26 years beyond where it was just 8 years ago. The prospective payment systems mandated by the BBA are particularly important because they create incentives to provide care efficiently.

However, these new payment systems mark a substantial departure from cost-and charge-based reimbursement, and the transition can be challenging for providers.

The improved status of the Medicare Trust Fund and the growing budget surplus make it possible to pay for new BBA adjustments to help providers adjust to these changes while still achieving the President's goal of extending the Trust Fund to at least 2030 and adding an affordable, voluntary prescription drug benefit that is available to all beneficiaries. In addition to the specific fee-for-service provider payment adjustments listed above, the President's plan would provide an estimated $25 billion over five years to Medicare+Choice plans specifically for drug coverage.

MEDICARE+CHOICE

Medicare+Choice (M+C) plans are finding it difficult to adjust to the BBA changes while maintaining the extra services they have provided to beneficiaries in the past. This is especially true for prescription drug coverage that is not available in the Medicare fee-for-service program and which many M+C plans offer, but for which they do not receive specific payment from Medicare. Many M+C plans were able to offer drug coverage and other extras because of excessive payments that were made to them before the BBA.

However, since the BBA was enacted, costs of the extra benefits provided under many M+C plans—particularly prescription drugs that are not offered in the Medicare fee-for-service program—have increased much faster than spending for services in the Medicare fee-for-service program. Our success in holding down fee-for-service costs is due in part to BBA provisions and our fraud, waste, and abuse efforts, as well as other factors. Because payments to M+C plans do not account for the costs of services which are not covered in the Medicare fee-for-service program, plans have significantly reduced the scope of their prescription drug coverage. For example, in the last two years, the proportion of plans that limit drug coverage to $500 or less has increased by 50 percent. In 2000, about 75 percent of plans limit drug coverage to $1,000 or less.

Lack of payment to support drug coverage that is not available in fee-for-service Medicare is a primary reason that some M+C plans are again announcing that they will leave or reduce participation in the program, particularly those with smaller market shares and strong competition. Difficulty in maintaining provider networks is also a factor, as demonstrated by a recent Deloitte & Touche report showing that half of the nation's largest hospitals canceled an HMO contract in the past year. Because some M+C plans believe that they cannot be competitive if they charge a higher premium or reduce benefits, they have simply decided to withdraw from the program. We have no control over their actions. We do believe, however, that even with premiums, M+C plans still represent a valuable option for beneficiaries—particularly as an alternative to Medigap.

For 2001, about 85 percent of current M+C enrollees will be able to continue with their current HMO. However, 65 M+C organizations have announced they will leave the program and 53 will reduce their service areas, affecting a total of 934,000 Medicare enrollees. More than 775,000 should have the opportunity to enroll in another M+C plan, but about 159,000 will be left with no other managed care option and few, if any, options for affordable drug coverage.

Nonetheless, payments to M+C plans continue to exceed what taxpayers would spend for enrollees if they had remained in the fee-for-service program. The General Accounting Office (GAO), in testimony before Congress last week, affirmed that this is still the case despite BBA payment changes and that "Medicare managed care, although originally expected to achieve program savings, continues instead to add to program cost."

The best way to ensure that the M+C program is a strong part of Medicare and an important option for beneficiaries is to ensure that all beneficiaries have access to affordable drug coverage and to pay plans directly for providing it. The President's proposal to create a voluntary, affordable Medicare prescription drug benefit for all beneficiaries would do just that. Under the President's proposal, M+C plans would be paid through a competitive, market-based process in relation to their own costs, rather than through Congressionally mandated administrative prices that have resulted in wide variation in rates and beneficiary access to plans across the country.

Also, plans would be paid $2 billion directly beginning in January and $25 billion over the next five years to provide the prescription drug coverage that most beneficiaries want from managed care. This amount substantially exceeds the $15 billion over five years that representatives of the American Association of Health Plans have said, in testimony before Congress, they need to continue participating in the M+C program. Beginning in 2002, beneficiaries in fee-for-service Medicare would also be able to choose this benefit, regardless of whether they live in areas where managed care plans have chosen to operate. And beneficiaries in M+C plans all across the country would be assured of drug coverage, rather than just those in areas where non-targeted assistance for M+C plans would raise payment enough to support a drug benefit.

In addition, under the President's Mid-Session Review proposal, M+C plans would receive an additional $1 billion over five years through increases to the payment rates which are based on the fee-for-service Medicare system. We also announced on June 19 that we will work with the Medicare Payment Advisory Commission (MedPAC), plans, beneficiary groups and others to develop a slower phase-in of the

current schedule for risk adjustment, administratively addressing the concerns about the current schedule, while maintaining our commitment to using comprehensive outpatient data beginning in 2004.

Meanwhile, to make sure that Medicare is a fair business partner, we have been streamlining the requirements for M+C plans while making sure that beneficiaries who choose managed care receive the benefits, protections, and information they need and deserve. We have modified many requirements in our contracts and operations to be more consistent with private and other public purchasers, and we are implementing additional initiatives to further streamline administrative procedures and lead to more efficient and consistent oversight. Specifically, we are:

- Increasing flexibility in establishing a provider network, which will allow health plans greater opportunity to serve rural areas;
- Improving freedom of choice by allowing plans to offer beneficiaries a point of service option that broadens access to health care services from both in-network and out-of-network providers; and
- Easing compliance plan reporting by eliminating the self-reporting requirement.

Medicare beneficiaries should know that, regardless of the decisions made by private HMOs, they are still covered by a strong Medicare program. Their HMO is required to cover them until December 31, 2000. We are continuing to take strong steps to ensure that, no matter what decisions plans make about their participation in the program, Medicare beneficiaries affected by these changes have options. We are ensuring that beneficiaries who are being forced to change their health care coverage are guaranteed access to certain Medigap plans, regardless of any preexisting conditions, as the law requires. And, in order to make the transition easier for these beneficiaries and to help them make the right decisions about their health care coverage, we are providing them with clear information on their new options and requiring plans leaving the program to do the same.

HOSPITALS

Most experts agree that hospitals' financial status has worsened recently, as a result of several factors. In large part, this results from private payment reductions. MedPAC has found that about three-quarters of the decline in total hospital margins between 1997 and 1998 is due to lower private payments. While Medicare hospital inpatient margins remain relatively healthy, more hospitals had negative margins in 1998 than 1996.

Rural hospital inpatient margins dropped by nearly twice as much as urban hospital margins did between 1997 and 1998. Rural hospitals face special challenges—they tend to be smaller and often cannot attract or keep health care professionals. They also are more dependent on Medicare patients and therefore disproportionately affected by Medicare payment reductions. The BBRA invested about $1 billion over 5 years to address many of these problems. However, additional increases appear to be warranted to help the long term viability of rural hospitals.

Hospitals that serve large numbers of uninsured people also are strained by the increasing number of uninsured. Some uninsured use hospital emergency rooms for primary care while others delay care until problems become more severe and costly. While the number of uninsured has been rising, Federal payments to disproportionate share hospitals (DSH) were reduced by the BBA. This coincided with reductions in payments from private payers which traditionally had helped fund uncompensated care. And academic health centers, which play critical roles in making medical advances, caring for some of the most complex cases, and providing service to underserved populations, also have experienced a significant decline in total hospital margins.

To mitigate these funding problems, allow for more time to assess the full impact of the BBA and BBRA, and to preserve beneficiaries' continued access to quality care, the President's plan would:

- Replace the BBA inpatient hospital update for inflation, the "market basket" (MB) minus 1.1 percentage points with a full MB update for FY 2001;
- Eliminate the BBRA indirect medical education payment reduction for FY 2001, maintaining the additional payments for IME at 6.5 percent;
- Eliminate BBRA DSH reduction of 3 percent for FY 2001;
- Replace the BBA's Medicaid DSH reductions for 2001 with a one-year freeze, so that the Federal share DSH limits for FY 2000 would also apply in 2001.
- Reserve about $1 billion over 10 years for rural provider policies. This will include policies to improve the sustainability of rural hospitals, similar to those in the bipartisan "Health Care Access and Rural Equality Act of 2000," introduced by Sens. Conrad, Daschle and Reps. Foley, Berry, McIntrye, Pomeroy, Stenholm, Tanner and others. We also will consider improving equity for rural hospitals in the Medicare DSH formula.

• Provide fairer payments for inpatient services in Puerto Rico by basing the payments more on the rates that apply everywhere else in the nation.

The Mid-Session Review plan also modifies the President's budget savings policies by dropping the fiscal 2003 through 2007 policies to reduce hospital market basket update and capital payment reductions and to further reduce hospital bad debt reimbursement. These hospital policies would have saved more than $25 billion over 10 years (before interactions).

Meanwhile, we have taken steps to help hospitals adjust to BBA and BBRA changes. Most recently, we delayed implementation of the outpatient prospective payment system to give both us and hospitals more time to prepare. We are distressed about postponing the benefits of this new system for beneficiaries, but the delay is necessary to be fully prepared for this substantial change. We also are requesting that hospitals not collect deductibles or coinsurance from Medicare beneficiaries beginning August 1 until we notify them of the correct amount. And we will provide all hospitals with a "plain language" flyer to help explain the change to beneficiaries.

To assure as smooth an implementation as possible, we have undertaken an unprecedented provider education campaign which has included:

• Allowing hospital representatives to attend our initial training session for intermediaries;

• Training sessions, town hall meetings and satellite broadcasts for providers to explain the new system and to answer questions;

• Use of the HCFA website to post the outpatient prospective payment system regulation, instructions, training materials and answers to questions received to date; and

• Weekly conference calls since April with provider associations to keep them apprised of the progress of implementation.

In addition, we are committed to implementing changes included in the BBRA to accommodate new technology in the outpatient prospective payment system. We are expanding the number of medical devices for which "pass-through" payments will be made and continuing to work with the industry to determine additional devices for which these payments can be made. We also have committed to making unprecedented quarterly updates to the pass-through list to ensure that the outpatient prospective payment system does not inhibit development and use of new technologies.

In other steps to help hospitals, we have postponed expansion of the BBA's "transfer policy" for all hospitals for a period of two years, through 2002. As a result, the transfer payment policy will apply only to the current 10 Diagnosis Related Group (DRG) categories, as prescribed by the BBA. We are carefully considering whether further postponement of this policy is warranted.

We have taken a number of specific administrative steps to assist rural hospitals. For example:

• We have made 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.

• 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 rates that is used to calculate inpatient rates.

• We also are working with colleagues at the GAO and MedPAC to review the impact and appropriateness of the wage index that is used to factor local health care wages into Medicare payment rates and generally results in lower payments to rural hospitals than their urban counterparts.

We also are implementing BBRA provisions, including:

• Easing BBA DSH and IME reductions;
• Extending the Medicare Dependent Hospital program through 2005;
• Easing requirements for hospitals to qualify as Critical Access Hospitals;
• Allowing urban hospitals to reclassify to rural areas; and

Allowing Sole Community Hospitals to have payments based on more recent hospital-specific costs.

HOME HEALTH

There has been a significant decline in home health spending since the BBA. This is due in large part to elimination of overpayments, waste, and fraud, but we are concerned about the potential for access problems in some situations. GAO, MedPAC and the HHS Inspector General agree that there does not appear to be system-wide access problems. However, some studies have suggested that patients who have long-term conditions may have had increased difficulty in accessing home health services. The President's plan would:

• Replace the current law home health update of market basket minus 1.1 percentage points with a full market basket update for FY 2001; and

• Delay the BBA's 15 percent reduction for an additional year until FY 2003.

Home health agencies will be greatly aided by the new home health prospective payment system that will take effect October 1. There has been a very positive response to our regulation detailing how this system will work, and the GAO has stated that it will "generally provide agencies a comfortable cushion to deliver necessary services." We also have taken steps to help home health agencies adjust to BBA changes, such as extending the time to repay overpayments and postponing the requirement for them to obtain surety bonds.

SKILLED NURSING FACILITIES

The BBA created a new prospective payment system for skilled nursing facilities (SNFs) that went into effect in 1998. This new system contributed to changes in the SNF market. Recent GAO and HHS Inspector General studies have found that SNFs were more cautious about admitting high-cost cases. An IG study found that 58 percent of hospital discharge planners reported that Medicare patients requiring extensive services such as intravenous medications have become more difficult to place in nursing homes. Additionally, several large private SNF chains have experienced financial problems that are primarily due to business practices unrelated to Medicare, but compounded by Medicare payment changes.

The President's plan would:

• Replace the BBA's SNF update of market basket minus 1 percentage point with a full market basket update for FY 2001.

• Delay for an additional year (until FY 2002) the application of the therapy caps providing additional time for development of policies.

• Drop the nursing home bad debt reduction budget proposal.

The BBA limited yearly payments for Part B physical/speech therapy and occupational therapy to $1,500 each per beneficiary. This limit meant that a large number of therapy patients had service use that exceeded the payment limits and thus paid for services out-of-pocket.

The BBRA put a two-year moratorium on the caps while a study is being conducted to determine appropriate payment methodologies that reflect the differing therapy needs of patients. However, the moratorium may not be long enough to complete this complicated work.

We are continuing to work to refine the payment classification system in a budget neutral way to ensure adequate payment for medically complex patients, and particularly to account more specifically for the cost of drugs and other "non-therapy ancillary" services. To immediately address some industry concerns, the BBRA provided for a 20 percent increase in the SNF prospective payments for 15 categories of patients to address perceived shortfalls in payments for such patients until we are able to determine the best way to make these changes. We implemented this BBRA provision in early June, and nursing homes should be receiving the increased payments for services delivered on or after July 1.

Using the best data available in 1998, we developed two payment classification models we believed would ensure adequate payment for complex patients. We issued a proposed rule in April 2000 which included refinements based on these models and solicited public comments. In addition, we contracted with outside experts to validate the models using more recent data. When we tested the models with nationwide data from 1999 over the past few months, we found that the models were no longer statistically significant in identifying high-cost beneficiaries with complex care needs and the ancillary services they use.

Proceeding with implementation of the proposed refinements based on these models could have changed payment levels without any assurance that we were distributing funds more equitably, creating incentives for efficient care, and minimizing the risk of negative financial consequences. We therefore are deferring the implementation of the refinements.

We will shortly begin consulting with outside researchers and experts to begin further analysis using the 1999 national data aimed at determining the feasibility of developing case-mix refinements that reflect current practice. Our goal is to include a proposal for such refinements as soon as possible. However, until a feasibility study is completed, we will be unable to accurately forecast the potential and timing of such refinements.

In the meantime, the 20 percent increase in payments included in the BBRA will remain in place until refinements of the system can be implemented, which will be in fiscal 2002 at the earliest. In addition to the 20 percent increase, the BBRA also provided for a 4 percent increase in payments for all SNF beneficiaries, effective October 1, 2000.

END-STAGE RENAL DISEASE

Medicare covers about 300,000 people with end-stage renal disease (ESRD) -people who have diabetes, hypertension or other diseases that result in severe impairment of kidney function. Medicare's composite rate (payment rate for outpatient dialysis services) has not kept pace with the increasing acuity of patients and cost of services. For the past several years, MedPAC has recommended updating the payment rate to reflect these factors.

The BBRA went part of the way to the MedPAC recommendation by updating it by 1.2 percent in 2000 and plans for another 1.2 percent increase in 2001—the first increases since 1991. The President's plan would meet the full MedPAC recommendation and increase rates by 1.2 percent for CY 2001 in addition to the BBRA increase of 1.2 percent.

OTHER ADJUSTMENTS

The President's plan also drops proposed payment reductions for laboratories, ambulances, durable medical equipment, parenteral and enteral nutrients, and prosthetic and orthotics for fiscal years 2003 through 2007, as well as bad debt reductions for non-hospital providers, repeal of the BBRA managed care risk adjustment policy, and the proposal for a preferred provider option.

We also are continuing with development of additional prospective payment systems mandated by the BBA for inpatient rehabilitation facilities, and mandated by the BBRA for psychiatric hospitals, and long-term care hospitals.

As mentioned earlier, the President's Mid-Session Review proposal includes $21 billion for unspecified policies. We look forward to working with Congress to develop additional policies to help providers adjust to the many BBA changes.

CONCLUSION

While it is essential that we maintain the fiscal discipline embodied in the BBA, it is equally important that we make adjustments where necessary to ensure beneficiaries' continued access to quality care. The improved status of the Medicare Trust Fund, combined with current budget surplus projections, provides the flexibility to make the prudent adjustments we are proposing, as well as to make a voluntary, affordable Medicare prescription drug benefit available to all beneficiaries. Enactment of such a benefit is urgently needed to meet beneficiary needs. It also is the best way to ensure that M+C plans can provide drug coverage and give beneficiaries the options Congress intended in the BBA. I thank you for holding this hearing, and I am happy to answer your questions.

Chairman THOMAS. Thank you very much, Dr. Berenson.

Rather than begin the questioning and then come back, we have a series of votes, and let us say that if at all possible, the Subcommittee will reconvene at 1:45 or as soon thereafter as possible.

The Subcommittee stands in recess.

[Recess.]

Chairman THOMAS. Thank you very much.

Dr. Berenson, in your testimony, which I note was modified from the other testimony with new information, we certainly appreciate the new information, although it is received with mixed feelings in that it means that another structure and another deadline has been missed. There may be some crocodile tears out in the audience based upon the Balanced Budget Refinement Act safety net, which has just been woven a little tighter for a little longer for some of these folk, and that isn't the case for a number of the time lines that need to be met.

For example, I believe you stated in your testimony the administration will consider improving the equity for rural hospitals on the Medicare disproportionate share formula. I know that hospitals in different settings have different problems. But one of the concerns we faced for some time is that those hospitals in rural settings not-

withstanding, the idea that you are supposed to be compensated for who is in the bed based upon their socioeconomic and age profile, that many of them, because of the formula, many of the rural hospitals, because of the formulas, are not getting the money.

And you might recall that in the 1997 legislation, Congress directed the Secretary to submit a report to Congress by August 5, 1998, on a new payment formula for DSH. Do you know if that report has been submitted and when, if it has not, it might be?

Dr. BERENSON. It has not been submitted. It is in final clearance at this point. It does deal with the issues of different thresholds for urban and rural hospitals, but it should be out very soon.

Chairman THOMAS. Okay. I am obviously anxious for that because that might be something—would it be in time for us to incorporate it if we were going to make some adjustments continuing to try to ease the pain in the rural area, that this formula might be something we could plug into this legislation?

Dr. BERENSON. Yes. I believe it should be in time for the fall's deliberations.

Chairman THOMAS. Yes, anything that you could put out in August we should be able to use for what is now——

Dr. BERENSON. I will take that back. I know it is in final clearance, and I will try to get that out.

Chairman THOMAS. Probably in September. That would be very helpful. I would hate to see it come out October 1, when we moved legislation in September.

Dr. BERENSON. Yes. And it addresses the issue that has come up about rural—different thresholds for rural and urban hospitals, so it would be germane.

Chairman THOMAS. And in the Balanced Budget Refinement Act, we directed the Secretary to collect data on compensated care starting October 1, 2001. Where are we in that process? Do we have any kind of a structure for collecting that data? Do we have a date on when that might be out? Again, this is the data collection on uncompensated care that was directed in the BBRA.

[The following was subsequently received:]

Per the BBRA, hospital data on uncompensated care will begin to be collected on hospital cost reports for cost reporting periods beginning on or after October 1, 2001. We currently are working to revise the claim form to accommodate this requirement. Hospitals will submit a revised report for data on the costs incurred by the hospital for providing inpatient and outpatient hospital services for which the hospital is not compensated, including non-Medicare bad debt, charity care, and charges for Medicaid and indigent care.

In addition to revising the cost report, we are working to develop definitions of each type of uncompensated care for which the BBRA requires data be collected, since the current definitions can and do vary from state to state.

By September 30, 2002, hospitals will have completed a cost report that includes these data. Within about six months of that date, we should have received the majority of these cost reports. By September 30, 2003 most of them will be settled. As such, the earliest the data we are collecting will be available will be October 1, 2003.

Dr. BERENSON. Yes, I do not. I would have to get back to you on that.

Chairman THOMAS. No problem. You just need to get back on that. Because, again, that is something that we need to, if at all possible, look at in making adjustments in an area that rural hospitals do feel some pressure.

On Page 8 of your testimony, you refer to the steps the Health Care Financing Administration has taken to ease the transition of the hospital outpatient PPS, and it appears that we are on the verge of getting that hospital outpatient. And interestingly enough, just on the verge of actually getting it done, we are getting some hospital groups indicating that maybe we need to delay the implementation of the Prospective Payment System on outpatient because they claim the operational and information systems needed to implement it aren't ready.

So let me ask you a series of questions. If you have the responses verbally, I would appreciate them. But if not, we would like them in writing because this is going to be an area that we need to take a look at. So the question would go like this: Has HCFA tested the new system with fiscal intermediaries in actual hospitals?

Dr. BERENSON. Yes, but not a broad—I mean, most of the testing is happening with fiscal intermediaries. There was extensive testing this past weekend which went pretty well. There have been——

Chairman THOMAS. When did you start this testing?

Dr. BERENSON. Well, there have been a series of steps that occur first.

Chairman THOMAS. Okay.

Dr. BERENSON. The CELIP and then the OCE. There are a number of them. The full implementing system has been in testing in the recent past, and on a broad scale, on the last weekend.

I would want to point out that we reluctantly postponed the effective date of the outpatient system from July 1 to August 1. That is the effective date for date of service for the beneficiary, and we are pretty confident about that date. The actual implementation for the release to the fiscal intermediaries is actually scheduled for 2 weeks later because of the natural delay in claims submission, the 14-day floor on payment. So we actually have a few weeks to do that testing. But we have initiated that testing, and so far it has gone pretty well.

Chairman THOMAS. So you are in the field testing, and you will test right up to the implementation date or beyond the implementation date. My assumption is if something falls through the floor unexpectedly or things just don't work, would that affect the implementation date or would you anticipate going forward?

Dr. BERENSON. Absolutely. I mean, clearly, we don't want to postpone it again. For every month that goes by, beneficiary cost sharing increases about $100 million. We think we will make these dates. But if it is not working, if we cannot pay claims, we would postpone it. We also have contingency planning. If it looks like it is a short window of a few weeks that we would need, we have a mechanism for providing accelerated payments to hospitals, and that would be done on an automatic basis if it is our systems that are not functioning. So we have a couple of alternatives. I really don't think we will need to postpone the actual implementation date.

Chairman THOMAS. Okay, Doctor. One of the concerns I have is that as recent as 1 month before the postponement was announced, we had the administrator here saying that, yes, they were going to meet the deadline. And the answer, "We hope we are going to meet the deadline," is okay for the first time around. This is not the first

time around. So if it doesn't destroy any secret time table that you are working on, this Subcommittee would very much like to see what a go/no go looks like to you for the August 1 implementation.

And just a little bit of gaming, and I am not interested in running this in the newspapers or releasing it, but I would like to have a comfort level that if, in fact, you decide not to go August 1, what is it that would determine that you don't go August 1? And if you do go August 1, what is it that gives you the confidence level that you can go forward? Because postponing it again is better than starting and stopping or forcing us to attach the legislation some time line or criteria that probably won't work. We will be pushing the string again.

So to create a working environment and a comfort level a little higher than "we hope it works this time, and we are shooting for an August 1 date," I would like to see some structure of a go/no go in the decisionmaking matrix that you folks are working on.

Dr. BERENSON. We can provide that for you, as well as some of the detail about our contingency planning, about what would trigger that. And we can provide that for you.

Chairman THOMAS. Part of the problem is this Subcommittee and the Congress has to get a confidence level, so that when people come to us and say, "It isn't going to work," we have some substantive ability to say, "In our opinion, it will, and if it doesn't, there are reasonable and appropriate fall-backs." Because as you know, this season, for some reason, there is less oil between the moving parts, and the friction tends to generate a lot more heat than it should otherwise. And we will appreciate that kind of information.

[The following was subsequently received:]

The Outpatient Prospective Payment System was implemented by our revised August 1 deadline, and the majority of claims are being paid on time.

Thank you.

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

Mr. STARK. Thank you for your testimony, Doctor.

It is my understanding, just for the record, that you have more than just academic experience with managed care health plans, and indeed, started one, ran it efficiently and sold it at a huge profit. Is that a fair assumption or is that a fair characterization of your other career?

Dr. BERENSON. "Huge" is exaggerated.

Mr. STARK. Large.

Dr. BERENSON. At a reasonable, yes.

Mr. STARK. A reasonable profit. All right.

Dr. BERENSON. It was a——

Mr. STARK. I very seldom hear "reasonable" from the Health Plan Association.

Dr. BERENSON. Preferred Provider Organization. It was not an HMO. It was a local PPO, which was pretty successful.

Mr. STARK. So you understand the business side of——

Chairman THOMAS. Would the gentleman yield, briefly?

Mr. STARK. Sure.

Chairman THOMAS. Is this line of questioning a positive or a negative, that someone was out in the real world and made money,

and is now in government service? There have been others that it didn't tend to be a positive comment about. I am just curious.

Thank the gentleman for yielding.

Dr. BERENSON. It was certainly less than Lynn Abramson or some of the others, in terms of what they were able to do.

Mr. STARK. I basically have a couple of questions. I will just try and lay them out and let you deal with them as you choose.

There have been a lot of Medicare Plus Choice withdrawals, reductions, reduction in benefits, complete withdrawal, so forth. Does this argue or does it not argue, one, for a drug benefit to everyone on Medicare?

Two, the plans say they are underpaid. They are going to spend $60 million telling the public they are underpaid. Maybe if they just saved the $60 million they would be all right. The GAO, the Office of the Inspector General, the Medicare trustees all say that we are overpaying plans for the people they actually enroll. Perhaps you can enlighten us on those two issues.

The third is that the American Association of Health Plans is lobbying relentlessly for relief from the so-called onerous burden of collecting physician encounter data, another report that is due Congress one of these days or may be past due.

Chairman THOMAS. Oh, it is past due.

Mr. STARK. Is it past due? Okay.

My question is how will we ever get a risk adjustment system if we don't get the data? And does it make any sense to just make risk adjustment revenue neutral? So those are a series of questions, but can you just comment on that in general in our time, and then perhaps enlighten us.

Dr. BERENSON. I think I would sort of echo the comments of Bill Scanlon of GAO at the hearing last week, that we pay health plans more than adequately to provide the statutory benefits, but perhaps not as much as they are accustomed to providing a generous level of additional benefits that most beneficiaries have become accustomed to. We actually have our own data suggesting that about 24 percent of the payment to plans is for additional benefits. And what is often not appreciated is a large part of that, about 15 percent that makes up the 24 percent is the buy-down cost sharing, and then the next piece of it goes to actual benefits like prescription drugs.

So the plans, in aggregate, it is not true in all parts of the country, we think are being paid for the Medicare benefit, but need more to attract beneficiaries and are reluctant to ask beneficiaries to pay out of pocket. Some choose to and some really feel they can't market that kind of a product and don't do that.

On the issue of risk adjustment, we actually spent a lot of time seeing if there was an alternative model of risk adjustment that did not depend on collecting encounter data from individual visits and really found flaws with the other approaches, like sampling or surveys. And really, the models that are out there really assume encounter data. We are right now doing a study that was mandated by the BBRA to assess the difficulties, and there are operational difficulties for plans, but there is also some lead time.

We have asked plans to start providing encounter data for outpatient and physician visits this October and January. But they

have about 9 months to actually work out the kinks on how that happens. It doesn't become the basis for formally establishing the model or determining their payment until the middle of next year. So we think we have got adequate lead time in the current system, but we are actively now assessing and talking to the plans about the encounter data burden.

And again, finally, on the issue of doing it in a budget neutral fashion, we believe that plans are overpaid for having healthier beneficiaries, and it is in the interests of taxpayers and others to pay appropriately. That will also provide better incentives for the plans to try to attract sicker patients.

Mr. STARK. Thank you very much.

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

Mr. MCCRERY. Yes. Thank you, Mr. Chairman.

Dr. Berenson, as you know, the hospital outpatient regulations are supposed to be implemented on August 1st of this year. And as you probably also know, a number of hospitals have expressed concern, asking for another delay, because of the lack of appropriate software, and their ability to train personnel, and basically their ability to handle these new regulations.

Do you have any plans right now to further delay the implementation of those rules?

Dr. BERENSON. We don't. As the chairman asked, he wants us to identify what our go/no-go criteria area, and we have those, which we will provide. At this point, we feel pretty confident that the effective date of August 1st can be met, and the implementation date, where actual transactions have to occur and be paid later in the month in August, can be met. We were late on some of the preliminary elements that make the system work, but the hospitals have now had many months to prepare for this. There has been extensive education. It is a major overhaul. It is probably the most complicated overhaul of a payment system that we have done.

It, also, I think in retrospect, supports the decision last year to postpone this with Y2K looming, that this would have been too complicated to take on last year, as far as the original implementation date. But at this moment, and I cannot make an absolute guarantee, and we will provide information to the Committee about what could change, we are quite confident that we can make that date. We are in communication with the various associations who have raised these issues and are trying to understand their concerns and respond to them.

Mr. MCCRERY. And in April of this year, HCFA adopted new regulations which deny a Medicare provider a provider number for satellite facilities not within the immediate vicinity of the main campus, so to speak, of a long-term care, acute-care hospital. And there are two different, and somewhat confusing, tests to determine whether the immediate vicinity standard is met.

I have received a complaint from more than one hospital that has a long-term acute care hospital, and they express a lot of concern that this is going to really make it difficult for them to continue operating some of their facilities in underserved areas.

Are you familiar with this problem? Are you working on it? We have sent a letter and haven't really gotten anything back yet. What is the status of that?

Dr. BERENSON. Yes, we are aware. This is referred to as the provider-based criteria in the outpatient rule. And, there is a reason for it because it is too easy, for example, to have physicians' offices that are bought by hospitals who really are not part of the hospital to get higher reimbursement by just being labeled as part of the hospital.

There is a need to have criteria. One of those criteria was that the facility in question had to be in close proximity and serve the same population. Other criteria included that there is ownership, and joint control, and appropriate supervision and that they are clinically integrated. Those seem to be working very well. We have now heard of a number of situations where the first criterion on the close proximity and the serving the same population becomes a barrier to what are deserving satellites or extensions of the hospital. And we have had a number of conversations with individual hospitals, as well as trade associations and are relooking at that aspect.

Whether we can, within the current construct of the regulation, provide some additional guidance or whether we actually have to do a revision at this moment, I don't know. But we are actively working on that issue. It is supposed to go into effect on October 10, and we also recognize that that is of concern to hospitals. So we are very actively looking at that particular aspect of the provider-based regulations.

Mr. MCCRERY. Okay. Well, I am going to yield to Mr. Johnson. But just let me say that the part of the rule with the 75 percent of people in the same Zip Code or, you know, that is not only confusing, but it won't work in some areas.

Dr. BERENSON. Yes. Well, there was a model for that. It is what we used for a sole community hospital designation. We thought it could extend here, but we are now hearing that there are problems, and we are revisiting that very issue right now.

Mr. MCCRERY. I would be glad to yield.

Mr. JOHNSON of Texas. Thank you.

He just brought it up—75 percent of the patients in the two locations must reside in the same Zip Code area. Are you telling me that to get medical care now people have to figure out what their Zip Code is so they can go to the right hospital? I think that is crazy.

And can you tell me how these tests got into the final rule without first appearing in the proposed rule?

Dr. BERENSON. There were similar, but not identical, criteria. What we are trying to do here is——

Mr. JOHNSON of Texas. Well, similar, but not identical; what do you mean?

Dr. BERENSON. Well, there were tests to determine what proximity was. We really do need to determine that a clinic, as an example, which is getting the benefit of being a part of a hospital, meaning the higher payments, as one specific example, actually, is part of that hospital. One of those tests had to do with proximity,

so that not anybody could just set up a clinic and say, "Give me a hospital designation."

Mr. JOHNSON of Texas. Well, but how did you pick Zip Codes for crying out loud? They are crazy all over the country. And in Dallas, we have a great number of Zip Codes, and the hospitals concerned, Baylor, for example, is downtown Dallas. You have got another branch of theirs which sits on the county line in a different county, but it is on the county line, in a different Zip Code, and you prohibited them from going to those two hospitals because obviously the people don't live in that Zip Code. Now, that is an isolated case.

There are also 50 counties in Texas that don't have HMOs, and how do you account for people wanting to come from one county to another to get to a branch? And are your statistics good? Because I am told they are 1992 statistics. Is that true or false?

Dr. BERENSON. 1992 what?

Mr. JOHNSON of Texas. Statistics.

Dr. BERENSON. 1992.

Mr. JOHNSON of Texas. 1992 statistics is what you are using.

Dr. BERENSON. I honestly don't know.

Mr. JOHNSON of Texas. You don't know?

Dr. BERENSON. I do not.

Mr. JOHNSON of Texas. What date are your statistics?

Dr. BERENSON. I don't know the date of these statistics. I am sorry, sir. But I have said——

Mr. JOHNSON of Texas. You don't know the statistics you are basing your decisions on?

Dr. BERENSON. I don't personally know the answer to that. I am sure I can provide that answer for you.

But I have commented that we are—it may well be that the criterion relating to proximity—I mean, it makes some sense that to be part of a hospital one would be geographically associated with the hospital. We are now finding examples where that creates a problem, and we are actively looking at that.

Mr. JOHNSON of Texas. Well, I appreciate it. When are you going to make a decision? Because you know if you get rural hospitals, which have been deprived of HMO service, and they need to go somewhere else to get it, they are obviously going to be out of that Zip Code. And you know you need better——

Dr. BERENSON. We are looking at that. At the same time, we need to know that the clinic that is distant from the hospital actually is integrated with that hospital to get the benefits of the additional payment that occurs. There have been abuses in this area before. I mean, they are a provider, whether they should benefit from the level of compensation is really what is——

Chairman THOMAS. The gentleman from Texas is on a role. Does he want to take his own time now or is this still out of the gentleman from Louisiana's?

Mr. JOHNSON of Texas. I will return my time to him. I think I have made the point. Thank you.

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

Mr. CRANE. Please. Thank you, Mr. Chairman.

Dr. Berenson, Mr. George Renaudin, at the bottom of Page 6 in his testimony for the AAHP states that, "The actual payment from

the government is $415 in Terrebone Parish, Louisiana, and is $574 in Orleans Parish." A check of HCFA published by Medicare Plus Choice rates for 2000, however, shows that the rate for Terrebone Parish is $570, rather than the $415 figure, and is $651 in Orleans Parish, in contrast to the $574 figure.

Can you explain this discrepancy in rates?

Dr. BERENSON. Excuse me. What we publish in the rate book is based on a beneficiary who has average demography. We adjust the payment rates that go to the plan based on the age, sex and institutional status of the beneficiary, so that somebody 70 years old would have a different payment than a beneficiary 85 years old. So our number is based on sort of the county average. We are now going to factor in risk adjustment, but we don't have to go there for this discussion.

I can only presume that the actual payment that this particular Medicare Plus Choice organization is receiving is because they have probably a younger population than the average in that county, and therefore their actual payment is lower. But the people who are younger presumably do have lower medical care costs, and so that is how I would reconcile those two numbers. I haven't had a chance to actually meet with the plan to see if that is the explanation. But that is what we believe is the likely explanation.

Mr. CRANE. That kind of spread can be 30 percent, 40 percent. That is not unnatural.

Dr. BERENSON. We have just seen this testimony and actually have had a chance to briefly talk to our actuaries to see if they could understand what the difference would be. The one for Orleans is plausible to have that kind of spread. The one from Terrebone County seems awfully large, and I don't think it is easily explained. But we would be happy to sit down with the plan and see if we can't come up with an explanation. That is a very large spread to explain simply on gender and age differences.

Mr. CRANE. Very good. Thank you.

I yield back the balance of my time.

Chairman THOMAS. Does the gentlewoman from Florida wish to inquire?

Mrs. THURMAN. Thank you, Mr. Chairman.

Just an inquiry to the chair. Are we going to have more than one round or is this kind of our best shot?

Chairman THOMAS. I believe the gentlewoman should figure it her best shot.

[Laughter.]

Mrs. THURMAN. Okay.

Chairman THOMAS. If you are going to give me a choice, you know the one I am going to take.

Mrs. THURMAN. Well, you know, I just wanted to know if I needed to bring my yellow flag out or not. But nonetheless, in saying that, because, as you can imagine with this hearing, we have——

Chairman THOMAS. Let me say this is on the chair's time, so don't keep her clock going right now.

Mrs. THURMAN. Thank you. I think the yellow flag worked.

Chairman THOMAS. Does that help a little bit? Keep going.

Mrs. THURMAN. I thank you, Mr. Chairman.

Because, as you can imagine, this is such a big issue for so many of our constituencies that we serve and also with the providers. And as I am sure that has happened in all of our offices, there are several questions that we would like to be able to put on the record that we are not going to have time if this is the only thing. So I would hope that we would be able to submit questions.

Chairman THOMAS. No question. I would tell the gentlewoman from Florida this is the beginning of this process, not the end of the process, and that I know Dr. Berenson——

Mrs. THURMAN. And you will be with me until the bitter end of the process.

Chairman THOMAS. I will be here till the bitter end, as will Dr. Berenson. And he would be pleased to respond, but he may very well need to have written responses anyway. And there is no problem whatsoever in submitting additional questions because, frankly, we are going to be carrying this dialog along through August during the break. It does not need to occur right now. There is no window of supplying information that would be closed if you don't get it in right now.

The primary focus would be, in my opinion, on getting the provider group up here, so they can spread on the record. They don't get nearly the opportunity to provide for the record their own particular concerns. They have avenues available to them, but not on the record. We will have an open dialog with the administration on where and how we need to make adjustments.

Mrs. THURMAN. I thank the chairman because, as you know, I have been very concerned about immunosuppressants. I have huge issues with hospitals in my district.

Chairman THOMAS. The gentlewoman's clock will begin.

Mrs. THURMAN. Okay.—with issues dealing with my hospitals, teaching hospitals, GME issues. Mr. Ramstad and I have a piece of legislation on technology that we are very concerned about, and streamlining a process. I mean, there are several things that are very concerned about and would like to have a dialog with you. And I do have lots of those questions.

But like many of my colleagues up here, the July 1st deadline has come and gone, and we are now facing very angry people in our communities, and in some cases to the extent where our HMO Medicare Choice programs have now pulled out, and leaving no coverage. And some of us have already seen some meetings on this. I think we need some help here in how we go back to these folks that are losing their coverage, and if you saw the faces and the articles of people that ar 80-years-old, that all of a sudden—I mean, here is a great picture. You know, this woman is 80-years-old, and she is at the hearing of the discussion of the Medicare HMO pullout. They are trying to ask us questions, and have chosen to use a couple of ideas.

One that I might ask you about is—and I know we changed the law on this, but maybe you can give me some better reasons to tell them why we did not force HMOs to stay in an area for a period of time—once they go in, if they stayed in for 3 years or whatever—why they think the differential cost. And I have to tell you, the cost issue is not—or the reimbursement issue is not as big as the issue as why one area gets more benefits, less premium, and one area

gets no benefits except for maybe prescription drug and pays a premium. They do not understand that, and quite frankly, I agree with them. I thought Medicare was Medicare and everybody was supposed to have the same benefit and that should be the premises on which we should work from first. Why is it that you can have HMOs in one area of the state, they pull out in another state? Why aren't they covering a whole state, cutting their risk or covering their risk across county lines? Because in this case and like in Hernando County, they could go—I mean one said they actually were going to go set up sets in Pasco County because Pasco County is not losing their Choice program, but the one next door is, and the differentiation in their ability for reimbursement is only maybe $20. To the south of them, they get less money.

So there are all these questions that people are asking. And just as importantly, and the biggest concern I have in talking to some of the HMO providers, they have told me, "It does not matter what Congress does at this point. We probably would never go back into those counties anyway."

But I think we need to tell the whole story around this. I mean, I think part of our problem is—and I think part of it is the BBA problem, particularly in Florida. We have now got a situation where BBA has cut into some of these hospitals. They can no longer shift their costs, so their contracts with their HMOs are not as good as they used to be, and they do not have an ability to cost shift. I mean, help me, because on the 4th of August, either I am going or you are going—I do not which—about these 500 people that are going to be asking some very tough questions, and what I could take back to them in offering them some solutions.

Dr. BERENSON. Well, you have certainly—I think virtually everything you have said, I do not disagree with. I mean, the cost shifting clearly has happened. In fact, there was a recent report by Deloitte & Touche that documented that over—about 50 percent of large hospitals had terminated an HMO contract, and we are certainly hearing that they are requesting higher payment rates, partly as a result from decreased Medicare margins, but the Medicare margins are still pretty healthy. So there had been, in essence, some cross-subsidization going on.

This is a tough dilemma. I mean, the idea of keeping plans in for two or 3 years sounds attractive, but I have actually been dealing with some plans, who in the middle of a year, actually wanted to terminate a contract because they were beginning to hemorrhage financially. We would only do that in extreme circumstances because we feel that the contract year is a commitment, and that the plan should not be getting out within that year.

I actually think—and this is not the time for the full discussion—we really need a fundamental restructuring of how these plans get paid. The President has one approach which would pay the plans more in relationship to their own costs. The plans would submit a bid for providing the services, rather than through this administrative formula, which for a number of reasons has problems. So I think that is one approach, certainly providing some additional support in the form of a subsidized prescription drug benefit is another approach. There is actually a provision in the BBA that permits Governors of states to either have a statewide service area or

define a metropolitan service area and a non-metropolitan service area as a way to try prevent some of the segmenting of service areas that occurs, but plans have difficulty serving that whole area, given the differences in payment.

So I do not have a simple solution within the current construct of how these payments occur, and I do think we need to be looking at perhaps some fundamental change in how the plans are paid, but I do not know that that helps for this August.

The other thing I would say, that if the Congress is able to pass legislation this September with a prescription drug benefit and plans would wish to come back in, or existing plans would want to change their benefit packages, we are now doing contingency planning at HCFA to be able to handle the requests that would be coming to us to make that available. So we will be there if Congress does act this fall.

Chairman THOMAS. Subcommittee members, we have a non-Subcommittee member with us, and he has a question that he would like to ask, and obviously, the rules are that the Subcommittee goes first. If it is okay for the other Members of the Subcommittee, we could call on the Chairman of the Social Security Subcommittee, because I know he has a question. Is that all right with the Members of the Subcommittee? And our friend, the gentleman from Maryland, who used to be on this Subcommittee—because of the rules, he is not, but you are a regular, so we are going to fold you in with the other members.

Does the gentleman from Florida wish to inquire?

Mr. SHAW. Yes, very briefly, and there is two areas that I would like to bring to the attention of the Committee and to the attention of the witness. And I very much appreciate your recognizing me and allowing me to sit with you these few minutes.

I would like to have the Committee and the administration to consider my bills, which is H.R. 4571, which is a Pap Test to Save Women's Lives, a bill that I have introduced with Mrs. Thurman of this Subcommittee; and another bill that provides for digital testing for breast cancer.

As you recall, Mr. Chairman, I offered and withdrew my bill, The Pap Test to Save Lives Act, as an amendment to the Medicare Prescription 2000 Act. I introduced it with Mrs. Thurman. At that time, Mr.Chairman, you suggested it would be more appropriate to be discussed in the context of the Balanced Budget Refinement Act.

This act would provide for annual Pap tests for women under the Medicare. Under current law, the women are only allowed to have this done every 3 years as a payable expense unless they are determined to be high risk. I think that most of your doctors will recommend that women over a certain age have this done every year. The cost, I feel, is very minimal next to the dangers that are presented by not having it, and I would also point out that I believe that the prostate exams for men are permissible every year, so I find that there is a certain inequity there that I think that we ought to be addressing.

I would hope also that we would make similar progress in detecting and curing breast cancer. The new bill that I am announcing today would be a positive step toward this goal. While mammographies are invaluable for screening for signs of breast

cancer, the x-ray based technology that we are using today is 20 years or older. So when I had an opportunity to see a demonstration of new digital mammography equipment, which has been 11 years in the making, I immediately set out to work to make this technology available to women elsewhere. This bill would make sure that Medicare beneficiaries get these digital tests by making the necessary adjustment to the Medicare reimbursement policies.

I will be sharing this information with you, Mr. Chairman, and with Members of the Subcommittee over the coming days in an effort to gain support for this. I have a keen personal interest in this. My wife lost both her sister and her mother to cancer, and both of them were victims of breast cancer. It seems today that we should, through our Medicare beneficiaries, make the very latest in technology available to them, so that we are doing everything we can to screen for cancer, and hopefully at an early date, that we will have some of the—we will be bragging about some of the results that we have from this new digital detection equipment that the Pap test has certainly shown in saving lives of women.

And, doctor, if you would like to comment on that, or if you prefer to do it at a later date, put this out to you.

Dr. BERENSON. We will certainly look at that. I know the President's proposal for modernizing Medicare identifies a number of prevention screening tests that should now be done without any out-of-pocket expenses. I don't believe that proposal recommended changing the schedule of every 3 years, and we certainly want to look at that. I would also want to raise the issue of the thin prep that I know that has some interest here, that we are actively looking about being able to achieve administratively a proper reimbursement for that test within the current way we do gap filling, and then establish a national rate. And I have met with the company to try to make that particular Pap smear technology available at an appropriate cost.

So we certainly share your interest, and look forward to seeing the details of your legislation.

Mr. SHAW. Thank you, doctor. And thank you, Mr. Chairman.

Chairman THOMAS. Thank you, gentlemen. And with the passage of the bipartisan Thomas-Stark Coverage and Appeals Bill, any of these preventive measures can move rapidly to a national status.

Does the gentleman from Texas wish to continue his zip code inquiry?

Mr. JOHNSON of Texas. Well, thank you, Mr. Chairman. I think we have about exhausted zip codes. We figure people cannot define those.

But let me switch to home health care, if I might, and ask you. In your testimony you indicated that there are some problems with access to home health service. You are forcing the closure of branch offices more than 70 miles from a parent agency, and in Texas, we have got 47 counties which have no home health care, and the branch offices were a key component of getting those services to Texans in those counties. But HCFA has come out with a rule that stipulates it cannot be more than 70 miles from the parent facility.

I might tell you, Texas has got—it is more than 1,000 across from one end to the other, and a lot of those little counties our in West Texas do not have hospital facilities or home health care fa-

cilities. So could you tell me, first of all, does HCFA recognize branch facilities as an efficient and effective way of getting seniors the care they need?

Dr. BERENSON. Again, it is similar to the other situation. If in fact the branch office is truly part of the parent and the appropriate supervision and controls, and so forth, are there, then it would be appropriate. I believe in this area there were a number of examples where the branch office, the so-called branch office was able to achieve a higher reimbursement rate, but really was not functioning as part of the base office, and it was really not appropriate, and so that was the basis for setting up a criterion of 70 miles.

Mr. JOHNSON of Texas. Well, how does HCFA determine whether it is an appropriate branch or not? Have you been out to West Texas and visited any of the docs out there and talk to them personally?

Dr. BERENSON. Actually it was in East Texas, but not West Texas. I visited hospitals in East Texas last year, but I have not been out to West Texas.

Mr. JOHNSON of Texas. How do you determine whether a branch is appropriate or not from HCFA, sitting there in your office?

Dr. BERENSON. Well, that is why we come up with criteria that may sound arbitrary, but that is why we have them, so that is why 70 miles was selected, because we do not have the ability to be——

Mr. JOHNSON of Texas. Well, who came up with 70 miles?

Dr. BERENSON [continuing]. In the field and then make that judgment on a case-by-case basis.

Mr. JOHNSON of Texas. Where did you get 70 miles from if you do not have data, you do not know where the data comes from?

Dr. BERENSON. Again, on that particular issue, I cannot tell you the precise basis for why 70 miles and not 50 miles or 90 miles, but I can certainly provide that information back to you, and look into that issue.

[The following was subsequently received:]

The State Survey Agencies and the HCFA Regional Offices review the Home Health Agency's (HHA) request for a branch office, consider all the national guidelines and communicate their final decision in writing to the HHA. Specifically, our Regional Offices examine how the branch office shares HHA administration, supervision, and services with the patent HHA; how the patent HHA supervises the branch staff and ability to provide quality care for patients; past compliance history of the parent and its current ability to meet the conditions of participation; any relevant State issues and recommendations; and mileage and travel times from the branch to the parent.

In the following HCFA policy and guidelines on approving HHA branches, our Regional Offices do have the flexibility now to approve a branch that is capable of providing quality care, particularly when access to home health care may be an issue, especially in rural areas. And, while we consider all of the factors indicated above, each alone would not be a single issue in determining the appropriateness of a branch office, and each factor might vary from one area to the next. Further, we do believe that we allow for modern technological communication advances to be used between the parent and the branch, yet technology is not a substitute for the physical presence of a supervisor, overseeing the provision of quality care to all beneficiaries being served by a branch.

We have continued to meet and work with industry groups to ensure that flexibility exists in our Regional Offices' determination of home health branches. When a remote site cannot qualify as a branch, the parent HHA must set-up a submit rather than a branch office. A submit is an entity that must have its own administrative and supervisory capacity, meeting the conditions of participation on its own,

ensuring quality of care. HCFA's policy on branch offices is consistent with regulatory and statutory requirements and serves to promote quality patient care.

Mr. JOHNSON of Texas. I wish you would. Let me ask you another question concerning ambulance services. What is HCFA's best estimate on the date which a proposed rule on Medicare ambulance fee schedule will be issued?

Dr. BERENSON. As you know, I am sure, the ambulance proposal was the result of negotiated rulemaking with the various parties. We are basically now taking the results of that rulemaking process, and it is in final clearance. We expect to have the proposed rule out within days, because it needs to be implemented on January 1st, and so the timing accomplishes that. And so——

Mr. JOHNSON of Texas. So there is supposed to be a 60-day period for comment, and you anticipate getting the rule done by January the 1st anyway?

Dr. BERENSON. We do, because to a large extent we have benefited from the fact that this was negotiated rulemaking, most of the parties who have a stake in the result have already participated and have agreed to the rule. There have been some issues raised, rural again has come up. There have been a couple of states which have come in because of particular forms of ambulance services that they have, but we actually think because most of the stakeholders were already part of the process, the 60-day comment period, our review of comments, will permit us to make that January 1 timetable.

Mr. JOHNSON of Texas. Okay. Your new date was put at August the 31st. It was supposed to be out in May or June. So you anticipate making that August 31st date

Dr. BERENSON. It will be out in August.

Mr. JOHNSON of Texas. Okay. Yield back the balance.

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

Mr. RAMSTAD. Thank you, Mr. Chairman.

Dr. Berenson, as you know, the BBRA included provisions to establish a hospital outpatient pass-through payment system for new medical devices, new medical technologies that will help gather important data on these devices to insure adequate payment levels for them.

While the initial list, I think everyone concurs, fell short of what was designed, HCFA has done a pretty good job of refining and expanding that list, and I thank you, Administrator Min DeParle and many others who worked on the list. I also appreciate your willingness to work with industry, to work with my staff and me on this critical issue, as well as with others on the House Medical Technology Caucus. I have been told that an additional list of items of inclusion in the pass-through was to be released today, in fact, this morning. I was wondering if that list was in fact released, and I would appreciate an update on the status of the list and its contents.

Dr. BERENSON. My understanding is it will be released today. I do not know if it has yet. It will be today. I do not think it has happened. And this would be the list that would be included for payment effective August 1st. It essentially includes approximately 596 items, if I am reading correctly. We are also reviewing others

that missed that deadline and are being reviewed right now for—I take it back—it was 443 that will be in the initial list, and we are reviewing a lot more for inclusion in October 1st. I can provide you the specific information about it, but essentially we are putting up today the list that will be effective for August 1st. We will, in the very near future, essentially over a period of the next few days into a week or so, be reviewing the next list. We approved most but not all. In some cases the devices are not eligible because they are pre-1997. In some cases they do not have the appropriate FDA or other approvals, but for the most part, we have found acceptable the requests. And I guess the final point to make is—we are committed to doing this on a quarterly basis. We are in the process of setting up a routine process, so all the manufacturers understand it, know what the timetables and deadlines are so that we can do our work.

Mr. RAMSTAD. So this will be available after the hearing today?

Dr. BERENSON. Yes, I can provide that for you.

[The information was subsequently received and is being retained in the Committee files.]

Mr. RAMSTAD. Okay. I appreciate that. I know there are a lot of other people in this room and elsewhere awaiting anxiously this list. And I do appreciate the collaborative effort. I think that is so important, to work with industry instead of in an adversarial way. And I applaud you and your staff and the administrator for that.

Also, I would like to say, Dr. Berenson, as co-chair of the House Medical Technology Caucus, that I appreciate HCFA's efforts to create what is really a more transparent and reasonable coverage decisionmaking process for Medicare. Certainly there is room for improvement, as everybody recognizes, but progress has been made. I must say that on June 29th I sent Administrator Min DeParle, after meeting with her in my office, a letter about a pending coverage decision that is expected to be made soon, and I regret having to address this issue again, because I thought significant reforms had been made, but I am told that there are major problems in the process, especially regarding the initial operations of the new MCAC, the Medicare Coverage Advisory Committee, which recently reviewed two existing urinary incontinence treatments, biofeedback and pelvic floor electrical stimulation. And I know there are concerns that have been voiced about the appropriate use of the advisory panels and the consistency of evidentiary standards throughout the coverage process. It has also come to my attention from a number of sources that during the panel deliberations, both panel members and HCFA staff made troubling comments about the process itself, and I was wondering if you would care to comment?

Dr. BERENSON. I actually would probably not. Jeff Kang is the head of the Office of Clinical Standards and Quality and has direct jurisdiction over that, and I really do not, and so I think that it would be inappropriate for me to comment at this point, but——

Mr. JOHNSON of Texas. Would you pass on, please, my concerns to Dr. Kang, and if he would call or respond, I would appreciate that.

Dr. BERENSON. Absolutely.

Mr. JOHNSON of Texas. And I see that my time is up. Thank you again, Mr. Chairman.

Dr. BERENSON. And I would be happy to arrange a meeting so that—with Dr. Kang and appropriate staff with you.

Mr. JOHNSON of Texas. That would be very appropriate and much appreciated. Well, let's do that, Dr. Berenson. Thank you again. Mr. Chairman.

Chairman THOMAS. Thank you. Does the gentlewoman from Connecticut with to inquire?

Mrs. JOHNSON of Connecticut. Thank you, Mr. Chairman. Welcome, Dr. Berenson. I am going to state my question, then I want to give some background, but I thought if I just say the question first, it will be easier. I am going to ask you why is the administration choosing a full market basket increase rather than MedPAC's recommendation, which is market basket plus. Also, what do you think should happen in the out years? This is an extremely important question to me. All the hospitals in my district have negative margins. All but two hospitals in Connecticut have negative margins. They are eroding their endowments, and we are on the verge of creating big access problems. If a group of these slide into bankruptcy and close or limit their services in a state like Connecticut, which in the icy winters access is a real issue, we will materially alter the access of senior citizens to Medicare benefits.

In your testimony you attribute the increasing difficulties faced by hospitals to reductions in private payments, and the date you are using is 1998. I would agree in '98 that one of the reason hospitals were having trouble was the sharp reduction of payments by managed care payers and the private market in general. But this is the year 2000, and it is not just the private sector. It is a catastrophic failure of Medicaid to keep abreast. It is an increase in the number of uninsured and uncompensated payments, and it is the fact that Medicare payments themselves, where they are adequate, are barely so, and in some cases they are inadequate. And in your testimony you mentioned that rural hospitals are having a problem because they are more Medicare-dependent, which indicates that Medicare is part of the problem, even according to the 1998 data. What I am telling you is that the year 2000 data is far worse, and because we do not have it clearly under our old system, we really cannot avoid it. In other words, if you look at Connecticut, if you look at rural hospitals, if you look at teaching hospitals, if you look at hospitals with uncompensated tier, I believe many of our hospitals, enough of our hospitals, are in the same state that nursing homes were in 2 years ago, that you are going to see the same level of bankruptcies out there that we have seen in the nursing home industry in the last year, if we are not more aggressive in addressing their problems. So when MedPAC says market basket plus 0.6 to 1.1, I think that is important.

Let me add one other fact here. My own local hospital used to see drug costs increase at about 3 percent—this was the first half of the 'nineties. Then I have forgotten which year it was, about 4 years ago, drug prices went up 7 percent. Last year the drug costs for that hospital went up 40 percent. You know, we are not taking into account a lot of the costs that these institutions are facing, and I think we have to be far more aggressive this year. So I want to

know why you do not support MedPAC's recommendation for next year, and whether you think that we should continue to give full market basket the whole 5 years?

Dr. BERENSON. I guess my——

Mrs. JOHNSON of Connecticut. And I have two other questions, so I do want to move through——

Dr. BERENSON. I guess very quickly, in addition to recommending market basket, the administration has also recommended freezing the indirect medical education for the year, repealing the DSH reduction, freezing the DSH allotments in Medicaid, and it adds up to $5 billion over 5 years, and there is an additional amount that we want to work with the Congress and with this Committee to identify. At this point we have looked at least at the aggregate numbers from '98 that show that inpatient margins are still at 14 percent and that total margins are still at 6–1/2.

Mrs. JOHNSON of Connecticut. And what year data is that based on, that 14 percent?

Dr. BERENSON. That is data that MedPAC published recently, that we have been a part of providing some support for, but it was basically a MedPAC report.

Mrs. JOHNSON of Connecticut. I want to hear from you later after this hearing so we can take that apart.

I know of no hospital that has a 14 percent margin on even Medicare, although Medicare fee-for-service is still the best payor. But you know, in Connecticut, where you had really big managed care participation recently, that is a problem.

Dr. BERENSON. Yes. Well, and again, that same report I was referring to earlier is suggesting that hospitals are renegotiating or changing their contracts with managed care. I am not sure we necessarily want to assume what the condition is going to be out 5 years. We are certainly committed for this year. Part of the data does show there are more hospitals than have been in a negative position, so there seems to be some distribution occurring, and it may well be that Connecticut is particularly hard hit, but I will be happy to share that information with you, and again, we want to work with you on that additional amount that has not been specifically allocated at this time.

Mrs. JOHNSON of Connecticut. Okay. And I would just like to mention that we need to look also at the Medicaid DSH payment because that is not enough. If Connecticut is any indication, they are paying 20 cents on the dollar into Medicaid because their money is going into nursing home care. So I think we have to look at the hospital component of Medicaid and how adequate that is in the states. We may even need to change the law so they have to be more realistic.

Chairman THOMAS. What we are going to try to do though, is stay within our jurisdictional boundaries. The Health Subcommittee of Commerce has had its hearing, and I was very pleased with their staying within their boundaries, and I want to return the courtesy. Now it is time to—we have to look at it as a whole, we do have split jurisdiction in the House, which just means we have to double our efforts to coordinate. Thank the gentle lady.

Does the gentleman from Michigan wish to inquire?

Mr. CAMP. Thank you, Mr. Chairman.

Dr. Berenson, less than 6 months ago the administration proposed $70 billion in cuts over 10 years to the Medicare Program. That was 18.2 billion in fiscal year 2001 alone. Yet just a few days before our vote in the House on our Medicare Modernization and Prescription Drug Legislation, the administration did 180-degree reversal, suggesting that increasing Medicare payments by about $21 billion over 5 years would be appropriate. Do you think Congress made the right decision in rejecting the administration's initial suggestion to reduce Medicare? And what caused such a sudden change in your thinking?

Dr. BERENSON. I think the recommendation was done in the context of the mid-session budget review. I think it was, to some extent, the recognition of a general budget surplus, the increasing information, such as what Congresswoman Johnson has just reported, that the data that we had been basing our judgments on was perhaps not as timely as it might be, and even though we have been trying to understand specific situations or trying to understand whether beneficiaries are having difficulty getting access to quality care, I guess the judgment was made that in the absence of contemporary data, that the stories and arguments that we have been hearing from many providers were becoming compelling, and we wanted to take in a sense preventive action at this time. We do not think, actually, at this point beneficiaries do not have access to the important services they need, but we were beginning to hear from, for example, hospital discharge planners, that they were beginning to have difficulty placing patients in nursing home or in home health agencies. They were able to do it, but they were beginning to experience difficulty doing it. So I think it was a combination of factors that resulted in the proposal to head off what could be problems in the future.

Mr. CAMP. Doctor, you also state in your testimony that the administration will consider improving equity for rural hospitals in the Medicare disproportionate share formula. As I recall in 1997, BBA, the Secretary was directed to submit a report to Congress by August 5th, 1998 on the new payment formula for the disproportionate share. Do you know if that report has been submitted yet?

Dr. BERENSON. We have discussed that. I has not been. It is in, I believe, its final clearance at this point. It has been up a couple of times and back, and I believe you will see that report in time for your next deliberations.

Mr. CAMP. Will the report address the inequities in the formula?

Dr. BERENSON. The report will address the different thresholds that urban and rural hospitals have to meet to qualify. What we do not have at this point is an ability to identify those who really do not have any source of insurance at all, which is really what MedPAC has recommended as a basis for an overhaul of the DSH formula. In that area I promised the Chairman that we would get back to him with our current ability to get a data collection system going, but it will certainly address the issue of the current distribution amongst urban, rural and types of hospitals.

Mr. CAMP. All right, thank you. Thank you, Mr. Chairman.

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

Mr. ENGLISH. Thank you, Mr. Chairman, I would.

Dr. Berenson, in January HCFA published an interim final rule expanding its definition of days countable and the DSH formula effective on January 20th, but permitting only a narrow group of states to qualify. Hospitals in our bordering state, New York, and seven other states would be eligible to claim waiver days, and HCFA had—and that HCFA had previously said we are not allowable, as I understand it. Pennsylvania's general assistance recipients are part of its Medicaid state plan, and therefore, are not statutorily permissible—are statutorily permissible under any interpretation. However, Pennsylvania was not included as a qualifying state. I understand you may not be familiar with this issue, but I sent a letter to Administrator DeParle on May 25th, asking for clarification of HCFA's rule. Can you give me any indication when I might receive a response to that letter?

Dr. BERENSON. We will make sure you have it in the next couple of days. It really——

Mr. ENGLISH. Prior to the recess?

Dr. BERENSON. I think we can do that. We will certainly do that prior to the recess. And I really do think the interpretation does go to general assistance days being state days, and waiver days having a Federal Medicaid component, but we will try to clarify that and provide the basis for that judgment in that letter, and I will make sure you get it this week.

[The information follows:]

While we initially determined that states under a Medicaid expansion waiver could not include expansion waiver days as part of the Medicare disproportionate share adjustment calculation, we have since consulted extensively with Medicaid staff and have determined that section 1115 expansion waiver says are used by patients whose care is considered to be an approved expenditure under Medicaid (Title XIX). Therefore, patient days under a Section 115 waiver are considered to be Title XIX days by Medicaid. It contrast, In contrast, general assistance days continue to be considered days for patients covered under a state-only or county-only general assistance program, whether or not any payment is available for health care services under the program. These patients are not Medicaid-eligible under the state plan. Therefore, Pennsylvania, and other states that have erroneously included these days in the Medicare disproportionate share adjustment calculation in the past, will be precluded from including such days in the future.

Mr. ENGLISH. I am not sure I understand, but I certainly will await your response. Doctor, recent studies by George Washington University Project Hope, MedPAC and the GAO, all have found that sicker, more costly Medicare beneficiaries are having trouble gaining access to the home health benefit. Do you have any data that contradicts the findings in those studies?

Dr. BERENSON. Well, the Inspector General, in particular, has done a couple of surveys of discharge planners from hospitals in terms of their ability to locate appropriate sources of care for beneficiaries, and is beginning to find some difficulty placing the high acuity of the sicker home health patients, and so I guess what we are beginning to find is information that is consistent with what you have described, and it is one reason that we are recommending that we would not ask for that 15-percent reduction that is supposed to take place for home health agencies this year.

We believe, very strongly, that the new prospective payment system that will go into effect on October 1st, very much will improve the situation, replacing the interim payment system, reward the home health agencies more appropriately, and it does have a case

mix adjustment component. It does have an outliner component in that proposal. So we think the PPS, as well as not taking that 15-percent reduction for the year, should, we are hopeful, address the problem that you have raised.

Mr. ENGLISH. Do you see any public policy, or for that matter, clinical argument for an additional 15 percent across the board cut in the home health benefit?

Dr. BERENSON. For this year we are recommending that we would not take that cut, and I think we need to see—we need to hold judgment about the future. It depends a lot upon the success of the prospective payment system and whether it is able to adequately compensate agencies for taking care of higher acuity patients who they are treating at home.

Mr. ENGLISH. Can I be clear then, are you advocating simply delaying the 15 percent cut, or are you recommending that we act to eliminate it at this point?

Dr. BERENSON. We are recommending a 1-year deferral, so we would not eliminate it at this time.

Mr. ENGLISH. So you would retain it as part of the budget calculation and as part of our future policy at this stage?

Dr. BERENSON. At this stage we would.

Mr. ENGLISH. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you. Does my friend from Maryland wish to inquire?

Mr. CARDIN. Thank you, Mr. Chairman. I appreciate the courtesy of being permitted to ask some questions.

Dr. Berenson, thank you very much for your testimony. It is interesting. We try to balance cost issues with quality issues, and I am going to ask you to get back to me on a matter that was brought to my attention on breast cancer, that deals with different procedures that are available, one that would permit the stereotactic breast biopsy versus the surgical biopsy, and that the methodology used to determine the reimbursement for the less intrusive treatment, stereotactic breast biopsy, appears to be inadequate to allow those procedures to go forward, which would be counter-intuitive to saving costs and being more convenient for the patient. And I am going to ask if you would take a look at that and get back to us by September, so that it could be useful in our Committee's deliberation.

Dr. BERENSON. That one clearly does fall under my jurisdiction. I do not know that issue right now, but I will, and will get back to you.

Mr. CARDIN. I appreciate that. And let me just also join many of my colleagues who have expressed concern about the health of the different communities, medical communities. Since the passage of the BBA Act in 1997, we have seen in the nursing industry, the collapse of stockholder values in nursing homes, and many of the nursing homes going into bankruptcy, and our hospitals, as my colleagues have pointed out, the margins are not acceptable for any long-term viability of our hospital community. When you take a look at the home health cares, so many of them that have closed in our community and around the nation, take a look at our academic centers, and the list goes on and on and on.

And I appreciate the Chairman's comment that we have passed the Refinement Act, and we haven't fully seen the full implementation of that Refinement Act. But I must tell you, looking at is as a snapshot today, there is reason for all of us to concerned, and I appreciate the fact that the administration has put forward a proposal to try to deal with this, and I hope that we are able to come forward with legislation this year.

Let me, in the time that I have, talk a little bit about the HMO issue, because I think it is—there are a couple philosophical issues here. And you have mentioned the geographical disparities with the formula that we have adopted, and perhaps we are going to have to change that philosophy or formula for reimbursing Medicare Plus Choice plans, but let me talk for a moment about what I think has been a philosophy since the beginning of Medicare Plus Choice, and that is that we reimburse HMOs of what we think the cost is for basic health care under Medicare under covered service, and we expect that they are going to perform—or reimburse more than just the covered services, and that they can do that by reigning in costs and saving money, which is no longer the case. And it seems to me that as we are looking at some type of refinement to that payment structure, the point that Mrs. Thurman pointed out, without putting something into the underlying wall that protects the system and the beneficiaries for the services that we expect HMOs to provide, we might very well be paying them a bonus, and find out that they are just going to continue to erode the extra services such as prescription medicines or the deductibles or copays or the other preventive health care and some of the other issues that are included in HMO coverage. They might just eliminate that, and what we thought we were doing in passing a bonus in fact has not become reality. So I do think if we are going to be looking at additional bonuses, we should be looking at additional responsibilities of Medicare Plus Choice plans, to either cover these services or to stay in the market for a longer period of time. And I would appreciate your comments on that.

Dr. BERENSON. Yes. I actually think it is worth saying, one point about the fact that—we tend to talk about the program as sort of a monolithic program, what the plans are doing. In fact, the experience of this year demonstrates that different companies have very different attitudes, and business sort of decisions in relationship to the Medicare Program. Of the 900,000 plus beneficiaries who lost plans, nearly half of them were withdrawals from two companies, Aetna and Cigna, both of whom withdrew from—each of them, about 69 percent of their beneficiaries were affected, and in one case there was a court order that kept them in another area. Contrast that with Pacificare, which is the largest Medicare Plus Choice contractor, which serves nearly a million beneficiaries. About 2 percent of their beneficiaries were affected by non-renewals. And Kaiser Permanente, which serves almost 800,000 beneficiaries, 0.2 percent of their beneficiaries were affected by non-renewals.

So what we have are very different business decisions. We have this tendency, again, to talk about what the HMOs are doing or what the payment rates are. There is a lot of different behavior. And clearly, one of the unfortunate realities is that HMOs, as op-

posed to hospitals or nursing homes, do not have bricks and mortar; they are not in the community. They can easily withdraw, and if they are losing money, some of them do so. Others seem to have much more of a commitment and seem to have been able to figure out how to make a decent business out of the Medicare business, and so we need to understand a little more why these companies have these different philosophies.

Mr. CARDIN. But if I understand you correctly, that if Congress passes a further refinement, you are prepared administratively to act on reinstatements so that effective January the 1st it is possible, if the legislation is framed correctly and there is HMO interest, that we could have some of these HMOs back in the market. At least you are prepared administratively to accommodate——

Dr. BERENSON. Clearly, we are talking about how to get the information to the beneficiaries. The handbooks will be outdated. We will figure out how to get them the appropriate information. We will short-circuit and do what we need to to review the ACRs. We are doing that kind of planning. We would want plans—if there was substantial action, plans that had withdrawn, we would have a window to let them back in, as well as plans that were already in should have the same opportunity. We would actually hope that the legislation itself would sort of provide the parameters of that, but we are working administratively to be able to do that if there is action this fall.

Mr. CARDIN. Thank you, Mr. Chairman.

Chairman THOMAS. The Chair just wants to caution that dialog a little bit. We did include provisions in the Balanced Budget Refinement Act for those plans that pulled out in terms of the times, the penalties and the rest. I would just tell you the Chair is going to be a little reluctant to create a "come on back" when plans left for business reasons if there were multiple plans in the area. Clearly, where beneficiaries do not have choice, where they did have choice, we may need to devise a set of rules which at least creates a hierarchy of who gets attracted back and under what circumstances. Ny goal is not to roll back the calendar and pretend that January 1 did not happen for some plans who make decisions based upon their refusal to change their plan to meet the needs of the beneficiaries. I just want that on the record.

Dr. BERENSON. I think that is a very good point. Clearly, that is what I wanted to emphasize, is the plans who stayed should not be in any way disadvantaged because some plans left and are afforded an opportunity to come back, and the point about maybe it should not be across the board is a good one, so I appreciate that.

Mr. CARDIN. And I basically asked the question, Mr. Chairman, for that same reason. I am concerned about those areas where there is no options and no competition today.

Chairman THOMAS. However, where clearly it may be a problem with the administration of the hokey AAPC with numbers that are not realistic or the failure of HCFA to meet a time line which is appropriate, we will deal with those issues as well since we have in the past repeatedly.

Mrs. THURMAN. Mr. Chairman?

Chairman THOMAS. The gentlewoman from——

Mrs. THURMAN. Just to follow up on that, let me ask this question then. With that 5 percent buy-back into areas that were under served, have we had any takers on that?

Dr. BERENSON. I do not believe—no, not so far.

Mrs. THURMAN. Thank you.

Chairman THOMAS. The gentlewoman from Connecticut, I think wants to be——

Mrs. JOHNSON of Connecticut. On the preceding discussion, I would just be concerned that one of the reasons one could stay in the market was because the other two did leave, so that they gave them the option and could increase their premium base more rapidly.

I just wanted to, before you left, make a statement, since there really is not any questioning further. But we did pass a requirement that the GAO conduct a study that looks at the practice expenses involved in the delivery of cancer treatment in the community-based centers, and I know you are well up on this problem, but 90 percent of cancer care takes place in outpatient settings, and I would hope that you would not make any change in the price of drugs to oncologists and that reimbursement structure until this report is concluded, because from it we think we will be able to do a more adequate and precise job, actually, on the reimbursement issues that lie with changing the reimbursement for the price, as opposed to the administration of the cancer drug.

Dr. BERENSON. I appreciate that. I have personally met with the Society of Clinical Oncology and have understood how we are reimbursing fairly generously for the prescription drugs, but probably we need to improve the way we are reimbursing for administration. And we have started looking at that, and we will work with the GAO for sure to see what they come up with.

Mrs. JOHNSON of Connecticut. Thanks. I do have a couple of wonderful sites you could visit and would invite you back up to Connecticut to visit them.

[Laughter.]

Dr. BERENSON. Okay.

Mrs. JOHNSON of Connecticut. Thank you.

Dr. BERENSON. I would be happy to.

Chairman THOMAS. The gentlewoman from Florida has one additional question.

Mrs. THURMAN. Dr. Berenson, have you at HCFA looked at all, since we are talking about prescription drugs, of doing reimbursement for Hospice in some of the prescription drug areas, as well? They are really complaining about the cost of drugs now and their ability to be effective?

Dr. BERENSON. I will have to take that back and get back to you.

[The information follows:]

We currently are looking at Medicare reimbursement levels for for hospice-provided drugs, which are covered as a portion of the per diem rate paid to hospice providers. The Balanced Budget Act of 1997 stipulated that hospices submit cost data to us so we can evaluate the adequacy of current levels of Medicare hospice reimbursement. We are now collecting and reviewing this cost data, and will have a better sense of whether payments to hospice are adequate later this year.

Chairman THOMAS. Thank you very much. Just let me say that your comments to the gentleman from Pennsylvania, I would rather buy than rent. For the home health care 15 percent, we invested

$2.5 billion to buy 12 months, and the administration is now advocating—excuse me, $1.5 billion for 12 months—and the administration is indicating they want to buy another 12 months for a billion dollars, and that is $2.5 billion over 2 years, to postpone a decision.

I understand no-fault in the area of insurance. But it seems to me that partly, if you are so high on your October 1 Prospective Payment System, that we might examine this 15 percent. Because it seems to me the administration's position is hedging so that they have the ability to use that as a fall-back or a no-fault arrangement. And I would be very concerned if we continued to invest money to delay a decision because there was not a high enough confidence level in the product that we were putting out. If there were other reasons, I would be interested, but right now I think that is the primary reason. You don't need to respond.

In the BBRA, we thought we were creating a relatively clean short-term adjustment, which was a straight percentage adjustment on the RUGs, to modify the acuity within categories that we thought did not provide appropriate compensation. Those what we thought were straight arithmetical computer-adjusting decisions were supposed to go into effect April 1. They did not. You indicated in your opening statement that money is being received now. Do we know that for a fact? Because I am getting some comments still from plans that although you may have it in the pipeline, it hasn't started coming out the other end yet. Do we have any confirmation that people have actually received this money?

Dr. BERENSON. I can't tell you right now. Clearly, we didn't make April. June 5th is when—again, because of the backup from Y2K, we could not do it in April, and my understanding was that the payments were to begin on July 1st, and I have not heard that we have had problems.

Chairman THOMAS. My only concern is, as we plan here talking about making additional responses, especially with perhaps a bit more forward funding than in the previous piece of legislation, I have some concern that something as an arithmetical adjustment on an increased percentage, where the Health Care Finance Administration couldn't make the date, and that notwithstanding the argument that it has already been done, I am still not hearing from the field that it is there.

If, in fact, we arrive at statutory dates for the implementation of programs, the model I would hope that we think about emulating are these envious presidential announcements of administrative initiatives from the Rose Garden. Because never once have I heard HCFA say they can't afford it, we need more money for the administration; number two, have I ever heard HCFA say to the President, we can't make that date.

Somehow, every time there is an administrative request, HCFA is able to respond, and I look forward to the day that the same response and timeframe would be available for the statutorily agreed-upon changes.

Dr. BERENSON. Could I just add one thing, which is, again, I am not aware that we are not making the claims. But the plan is to provide the add-on for services back to April 1, even though we did miss the April 1 date. So——

Chairman THOMAS. So when they get it, they will get it.

Dr. BERENSON. Yes.

Chairman THOMAS. I appreciate that.

I thank you very much. And, again, thank you for the administration's willingness, in an area where clearly it is the beneficiaries that are ill-served if we don't move solutions in a timely frame.

Thank you very much.

Dr. BERENSON. Thank you. Thank you very much.

[Questions submitted by Mrs. Thurman, and Dr. Berenson's responses, follow:]

Q1. Please update me on the status of the rule regarding Medicare reimbursement for psychologists under GME and when we can expect it to be published.

A1. We are actively proceeding with a proposed rule that addresses Medicare payment for training clinical psychology students. The document is currently going through the clearance process. As you know, the complete clearance process for any regulation requires time. However, we recognize that the development of this regulation took longer than anticipated, and we understand your concern over the delay. We are working very closely with our colleagues in the Department so that we can expedite this process as quickly as possible.

Q2. In the BBA, Congress directed HCFA to bring ambulance services under the fee schedule. The rulemaking process has been completed. Do you believe the implementation of this rule will be in effect on 1/1/01 as Congress directed?

A2. We expect to publish a proposed regulation based on the negotiated rulemaking committee's consensus agreement on September 12. Then there will be a 60-day comment period, followed by publication of a final rule. Our goal is to complete this process in time for the fee schedule to be effective on January 1, 2001 (with a four-year phase-in as developed by the negotiated rulemaking committee).

Q3. A study was done by Project Hope for the Ambulance Association. Have you had a chance to review this study? If so, did you have any comments on the study and the impact on the cost to ambulance services?

A3. We have not had an opportunity to review this study. Project Hope generated a smaller study that we examined as part of our negotiated rulemaking process; however, we understand the new study is expanded significantly. We would be happy to discuss this further with you or your staff.

Q4. Last year, this Committee provided more than $1 billion for the managed care industry to lure them into areas that were not served by a Medicare HMO. Have any HMOs taken this offer? If not, where is this money? Do you think it would be a wise investment to increase payments, once again, to HMOs? Do you think more money would solve their problem? Or, do you think it would be a better investment to give that money to our providers who are providing the care that the HMOs do not want to pay for? Do you think this money would have been of a greater benefit to our seniors if it went towards a prescription drug benefit?

A4. No Medicare+Choice plans (M+C) have taken advantage of this offer to come back into areas not served by a M+C plan, or enter the program for the first time in areas not served. However, some plans whose applications were pending at the time the Balanced Budget Refinement Act was passed, including our recently approved private fee-for-service plan, will see the benefit of this bonus program. It is unclear how much money will be spent on this bonus, which is tied to the number of beneficiaries enrolled in the eligible plans, because these plans only just recently began enrolling beneficiaries.

We believe the best way to ensure that the M+C program remains a strong part of Medicare is to ensure that all beneficiaries have access to affordable drug coverage and to pay plans directly for providing it. The President's reform proposal to create a voluntary, affordable Medicare prescription drug benefit for all beneficiaries would do just that. Under the President's proposal, M+C plans would be paid through a competitive, market-based process in relation to their own costs, rather than through a statutory formula that has resulted in wide variation in rates and beneficiary access to plans across the country. Plans would be paid $2 billion directly beginning in January and $25 billion over the next five years to provide the prescription drug coverage that most beneficiaries want from managed care. This amount substantially exceeds the $15 billion over five years that representatives of the American Association of Health Plans, in testimony before Congress, have said they need to continue participating in the M+C program.

Q5. Transplant recipients must take immunosuppressive medications every day for the life of their transplant. In most cases, Medicare limits coverage for these

medications to 36 months (the BBRA extended coverage for recipients who had a transplant after Dec. 31, 1996 or who are eligible for Medicare based on age or disability). For transplant recipients who do not have private health insurance benefits that include coverage of immunosuppressive drugs, paying for medications can be nearly impossible—at a cost of more than $11,000 per year. For a kidney transplant, the first year expenses with a transplant average more than $93,000, including follow-up care. Medicare spending for dialysis patients averages $52,000 a year. The IOM issued a report that supports Medicare coverage of immunosuppressive drugs. It just doesn't make sense that Medicare pays for the transplant but doesn't pay for the medications to prevent rejection. I have introduced legislation, HR 1115, with my colleague from Florida, Mr. Canady, which would eliminate the time limit on Medicare coverage of immunosuppressive drugs. This bill now has 272 cosponsors. Could you discuss how important this coverage is, and how it could save Medicare dollars in the long-run, by reducing the number of re-transplantations, and reducing the dollars spent on dialysis because of organ rejection?

A5. We, too, believe that the immunosuppressive drug benefit is a vital component of the overall Medicare benefit that covers organ transplants, I appreciate your leadership on this important issue. Unfortunately, we are unable to provide costs or savings projections on an indefinite extension of the immunosuppressive benefit.

As you probably know, the President's 2001 budget proposal would permanently extend the immunosuppressive benefit by one year, bringing the total number of months of coverage up to 48. Also, the President has proposed a Medicare prescription drug benefit, which would provide the security of a prescription drug benefit for all Medicare beneficiaries.

Under the President's proposal, Medicare would pay 50% of a beneficiary's prescription drug costs after benefits under Parts A and B expire. Additionally, catastrophic coverage would cover 100% of the beneficiary's costs after an out-of-pocket limit has been reached. In the first year of the benefit (2001/2002) the out-of-pocket limit is $4,000. Thus, under the President's plan, beneficiaries would continue to receive Part B benefits until they expire. They would then be eligible for 50% cost-sharing on their immunosuppressive drugs until they reach the catastrophic limit. Beyond the catastrophic limit, Medicare would pay 100% for their drugs.

Q6. Cardiovascular disease is the leading cause of death of American women—killing more than half a million women each year. However, Medicare does not cover regular cholesterol screenings. Hospital charges for cardiovascular disease cost Medicare more than $26 billion in 1996. Yet, we know there are steps that can be taken to identify this disease earlier in order to treat the modifiable risk factors. I am a cosponsor of HR 3887, the Medicare Wellness Act, which would add several preventive benefits to the Medicare program, including cholesterol screening. What should Congress do to give beneficiaries the tools they need to fight against the nation's leading cause of death, cardiovascular disease? And, would you support legislation, such as HR 3887, to add preventive benefits to Medicare?

A6. Although the Administration has not taken an official position on H.R. 3887, we strongly support increased attention to and coverage of preventive benefits. We have implemented the expanded preventive benefits authorized by BBA 97. Additionally, in his fiscal year 2001 budget, the President proposed further improvements to preventive benefits, including eliminating all beneficiary cost sharing for preventive benefits. We look forward to working with you ensure Medicare beneficiaries receive the most effective care possible.

Q7. I have long been concerned that Medicare beneficiaries are not getting access to the best and most appropriate technologies and procedures. I understand that there are several processes that new technologies and procedures must go through in order to be made available to beneficiaries. The first process involves making specific coverage determinations about which medical procedures and products to make available to Medicare beneficiaries. However, I understand that simply covering a product or procedure doesn't mean that beneficiaries will actually have access to it, but that two other processes exist to establish a "procedure code" and then the appropriate payment category or level for the product. And even after coverage, coding and payment issues have been resolved, there still remain the basic mechanics of notifying fiscal intermediaries and carriers to go ahead and make payment.

Q7: *Please explain how coverage, payment, coding, and intermediary/carrier operations are currently organized in HCFA. Please explain how HCFA ensures that patients get timely access to appropriate technologies, and how management coordinates the various offices at HCFA, as well as the central and the local carriers who are also involved in many of these processes.*

A7: There are three levels of coverage and payment determination, each serving important functions in assuring that beneficiaries have access to appropriate tech-

nology. The vast majority of determinations are made on a case-by-case basis by our local contractors. Because most new technology involves only minor modifications to existing technology, these determinations are usually straight forward and rolled into existing coding and payment mechanisms. For new technology that is significantly different, our coding system includes generic A99" codes in each benefit category which providers can use to file claims. Claims with these codes are manually reviewed and priced. For new diagnostic and surgical procedures provided by hospitals and other facilities paid through prospective payment systems (PPS), no coverage determination is generally necessary as new technology is automatically folded into the appropriate diagnostic related group (DRG) payment category. (There is one exception; the new hospital outpatient PPS system includes a pass through for new technology.) Under the hospital inpatient PPS system, the actual impact of innovations on costs are reflected through charges that the facility includes on its Medicare claims that drive future classification recalibrations. These charges often show that new innovations lower overall charges by, for example, decreasing the number of days patients must remain in the hospital, even if the new technology itself costs more than what it replaced.

A second, formal level of coverage and payment determination is also carried out by local contractors when they develop Alocal medical review policy.@ These policies, developed by contractor medical directors, outline how contractors will review claims to ensure that they meet Medicare coverage requirements. We require that local policies be consistent with national guidance (although they can be more detailed or specific), developed with input from medical professionals (through advisory committees), and consistent with scientific evidence and clinical practice. The use of local medical review policy helps avoid situations in which claims are paid or denied without a full understanding of why. This resource-intensive process is typically reserved for high volume/high dollar items or services, and is generally conducted quarterly to facilitate orderly changes in systems. We expect to soon release guidance to the contractors designed to make development of local medical review policy parallel our new national coverage determination process, providing more notice and opportunity for providers and the public to have input and request policies on specific matters. Copies of every contractor's local medical review policy can be found at *www.lmrp.net.*

We substantially improved the National Coverage Determinations (NCD) process last year to be much more open, accountable, and explicit in every respect, including the right of beneficiaries and other members of the public to request reconsideration of decisions. The new process establishes clear procedures for how national coverage policy decisions are made, allows any individual to submit a formal request for a national coverage decision or reconsideration, institutes timeliness standards and mechanisms for keeping the public informed about the status of national coverage issues, and guarantees beneficiary input through the open meetings of a new Medicare Coverage Advisory Committee. When an NCD is made, the decision is immediately posted on our web site and local contractors generally can immediately begin payment through mechanisms described above. In rare instances, when an NCD reverses an earlier national noncoverage policy and requires changes to claims processing computer systems, additional time may be necessary before payment can begin. We establish an effective date by which contractors must provide coverage. Time between an NCD and an effective date is used to establish new codes and national payment rates, make changes to claims processing computer systems, and provide explicit, written instructions on how the new policy is to be implemented. We have up to 180 days (tied to the next closest quarterly systems update) to complete systems changes from the time that instructions are generated, which can take up to an additional 60 days. However, we have completed this in less than 180 days for all NCDs under the new process, and we are continually working to further streamline this process. This 180 day time frame compares favorably to other businesses making orderly and efficient changes in electronic systems like our claims processing systems.

Within HCFA, NCDs are under the purview of the Office of Clinical Standards and Quality. Payment and coding operations are the responsibility of the Center for Health Plans and Providers. Development of local medical review policy is under the direction of the Program Integrity Group in the Office of Financial Management. Intermediary and Carrier operations are overseen by the Center for Beneficiary Services. These offices work together through the Medicare Contractor Oversight Board to coordinate coverage and payment for new technologies and to ensure clear communication of policies to the contractors.

Q8. I understand it can take up to 2 years for HCFA to change payment amounts or categories to a more appropriate reimbursement for a new technology. The first year is to evaluate a full year's worth of HCFA's internal data set—the Medicare

Provider Analysis and Review (MedPAR) file and the second year to implement the change. Could you please explain why HCFA does not extrapolate from partial year MedPAR data or accept statistically valid, verifiable external data from willing companies?

A8. Partial year MedPAR data or external data (used in setting inpatient hospital payments) do not take into account the impact of total costs on a treatment episode, which is how care is paid for under Medicare's prospective payment systems. New technologies that in and of themselves may be more expensive than what they replace often lower total costs once fully implemented into patient care. For example, laparoscopic surgical equipment for gall bladder surgery is more expensive than the traditional surgical equipment it replaced, but it substantially reduced the number of days patients were required to remain in the hospital, and thus lowered total costs for gall bladder surgery. An accurate assessment of the total impact would not have been feasible with only limited data on costs of the equipment itself.

Q9. As you may know the FDA has specific statutory timeframes within which they are required to review and approve medical technology applications for safety and effectiveness. FDA is currently operating within its statutory review timeframes for 510(k)s and has made great strides with respect to PMAs, In fact, in its annual budget submissions, the agency submits information on how well it has performed and the resources needed to meets it review and approval performance goals. I understand that it can sometimes take years—four years or more—for a product to get covered, coded, and reimbursed appropriately. Does HCFA keep track of the timeframes involved in making coverage, coding, and reimbursement decisions on each of the technologies and procedure applications it receives? Can you please tell me how long it takes HCFA to make a coverage determination, coding decisions, and payment decisions?

A9. The process for a national coverage determination (NCD) could take less than 90 days when evidence is clear and compelling. More complex determinations referred to Medicare Carrier Advisory Committee or outside technology assessment bodies can take longer, depending on the amount of research and deliberation these outside experts feel is appropriate to accurately assess whether the new product or procedure in fact meets the statutory requirement of being reasonable and necessary. Our limited experience to date suggests that the independent experts who, with industry and consumer representatives, make MCAC assessments, can take up to several months to make these determinations.

However, it is important to stress that local claims processing contractors can generally make payment for newly approved products or procedures immediately after an NCD is announced, either through an existing code that may apply or through a miscellaneous code that can be used when no existing code is appropriate. Payment amounts for claims filed under the miscellaneous code are determined by these contractors until a new code and any necessary systems changes are implemented and a national payment rate is established. In rare instances, when an NCD reverses an earlier national noncoverage policy and requires changes to claims processing computer systems, additional time may be necessary before payment can begin. We establish an effective date by which contractors must provide coverage. Time between an NCD and an effective date is used to establish new codes and national payment rates, make changes to claims processing computer systems, and provide explicit, written instructions on how the new policy is to be implemented. We have up to 180 days (tied to the next closest quarterly systems update) to complete systems changes from the time that instructions are generated, which can take up to an additional 60 days. However, we have completed this in less than 180 days for all NCDs under the new process, and we are continually working to further streamline this process. This 180 day time frame compares favorably to other businesses making orderly and efficient changes in electronic systems like our claims processing systems.

Also, with regard to coding issues it is important to understand that many stakeholders are involved in the assignment of national codes and computing national payments.

- Providers, particularly hospitals and physician offices, seek stability in coding and payment. Frequent changes and updates disrupt claims processing systems, raise issues of compliance, and create uncertainty in payments;
- The medical community has an interest in assuring that coding systems are clinically coherent, and;
- Private and other public insurers often use the same coding and payment systems as HCFA.

We cannot unilaterally assign codes without consulting all of these stakeholders, and that is why these processes take time. Moreover important changes stemming from the Health Insurance Portability and Accountability Act will require greater

standardization and consultation across the industry. Yet we understand that the timeframes for assigning new national codes for breakthrough technologies can be longer than the manufacturing industry would like. As we have done in the past, we welcome the opportunity to meet with you and other stakeholders to examine potential ways to speed up this process.

It also is important to note that the vast majority of determinations are made by our local contractors. There have only been approximately three hundred NCDs over the life of the Medicare program; 15 in the past 12 months. And we have substantially improved the NCD process to be more open, accountable, and explicit in every respect.

Q10. In April 1999, HCFA published a notice announcing a new national coverage process including procedures for seeking reviews by the new Medicare Coverage Advisory Committee. In that notice, HCFA stated that after a coverage determination was made, HCFA expected "to make a payment change effective within 180 calendar days of the first day of the next full calendar quarter that follows the date we issue the national coverage decision." Can you please help me understand that statement? Am I correct in interpreting this to mean that it will take HCFA 180 days to issue a code, even after the Agency has already affirmatively decided to cover a new technology or procedure? If so, do you believe that it might be of better service to our beneficiaries to reduce the number of days that it takes to issue a code?

A10. Local contractors can generally begin payment immediately after a national coverage determination (NCD) is made, either through existing coding and payment mechanisms, or through generic A99" codes in each benefit category which providers can use to file claims that are then manually reviewed and priced. In rare instances, when an NCD reverses an earlier national noncoverage policy and requires changes to claims processing computer systems, additional time may be necessary before payment can begin. We establish an effective date by which contractors must provide coverage. Time between an NCD and an effective date is used to establish new codes and national payment rates, make changes to claims processing computer systems, and provide explicit, written instructions on how the new policy is to be implemented. We have up to 180 days (tied to the next closest quarterly systems update) to complete systems changes from the time that instructions are generated, which can take up to an additional 60 days. However, we have completed this in less than 180 days for all NCDs under the new process, and we are continually working to further streamline this process. This 180 day time frame compares favorably to other businesses making orderly and efficient changes in electronic systems like our claims processing systems.

Chairman THOMAS. And could we call the next panel in, please.

We thank the second panel for their patience. Don Richey, who is the administrator of the Guadalupe Valley Hospital in, is it Seguin, Texas? Seguin; Dr. Richard Corlin, who is the president-elect of the American Medical Association; Michael R. Walker, chairman and chief executive officer of the Genesis Health Ventures, Kennett Square, Pennsylvania, here on behalf of the American Health Care Association; Judith G. Sutherland, president and chief executive officer, Visiting Nurse Corp. of Colorado, from Denver, Colorado, on behalf of the Visiting Nurse Associations of America; George Renaudin, II, senior vice president of administration at the Ochsner Health Plan of Louisiana in Metairie, Louisiana, on behalf of the American Association of Health Plans; and Howard Bedlin, who is the vice president for Policy and Advocacy of the National Council on Aging.

Now that you are all seated, thank you very much. Any written testimony that you have will be made a part of the record, and you may, in the time that you have, address us in any way that you see fit. And why don't we just start over here with the gentleman from Texas, Mr. Richey, and then just move across the panel.

Let me say, one, you need to turn on your mikes and, two, the mikes are very uni-directional, so you need to speak directly in them.

Thank you.

STATEMENT OF DON RICHEY, ADMINISTRATOR, GUADALUPE VALLEY HOSPITAL, SEGUIN, TEXAS, ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. RICHEY. Thank you very much, Mr. Chairman. My name is Don Richey. I am the administrator of Guadalupe Valley Hospital in Seguin, Texas. It is a pleasure for a country boy to be here in this august attendance today and appear before you on behalf of the American Hospital Association.

As you know, the BBA resulted in some major cuts in hospital reimbursement, plus many unintended consequences, especially for rural hospitals. In fact, some of the changes were quite confusing and problematic. For instance, in Texas, we think hold harmless means hold harmless. It appeared that congressional intent was to make reimbursement to rural hospitals whole rather than a reduced amount. That would create some real problems in our cash flow.

In our particular situation at Guadalupe Valley Hospital, a couple of years ago we had 18 home health agencies in our community. BBA cuts and changes in the programs eventually eliminated all but one. That was the hospital-based home health agency. It is, at this point, losing about $150,000 a year, but we consider it a necessary service for our patients, and therefore have continued to operate it.

We also had a skilled nursing facility. It was a hospital-based skilled nursing facility that was built from scratch and deemed by the Medicare Program as a model program and one of the best in the whole State of Texas. Seventy percent of the patients went home after their skilled nursing stay, and yet the BBA cuts eliminated that program, too, by cutting our reimbursement from $700 a day to about $250 a day. We had to shut the unit. Now, 250 patients instead end up going usually to a rehabilitation hospital at $1,500 a day for a 20-day stay and then off and on to a nursing home. So it is costing the government a lot more money, and the results aren't nearly as good as they would have been with our skilled nursing facility. That is just one hospital's story.

I have got in front of me a red book that I would like to submit for your review. It is a story of 27 institutions in and around San Antonio who basically have bared their souls and talked about staff cuts, eliminating programs and services, and about losing, on average, a half-a-million dollars per month, per institution.

We also have some new problems coming up. We've got employee shortages, particularly in the area of registered nurses and pharmacists. Prescription drug utilization is going up, and the new drugs are costing more. We have got new blood products coming out. They are better, but they are also more expensive, and we have got new technology which also costs more.

I am asking you today to consider a 2-year full market-basket update, H.R. 3580. Inflation from 1998, 1999, and 2000 was up

about 8.2 percent. Payments were only up about 1.6 percent. We can't continue to operate in that kind of methodology.

We are also encouraging you to adopt a rural relief agenda. Rural hospital closures are devastating to rural hospitals. And contrary to popular opinion, the closing of a rural hospital not only is hard for that community, but it is also hard on the urban hospitals who end up picking up that adverse case mix. So it doesn't help anybody. H.R. 4677, the Rural Hospital Closure Agenda, would help us very much.

We would also ask you to cut further reductions in Medicare and Medicaid disproportionate share payments—H.R. 3698, and then, finally, to delay outpatient PPS until it is fully workable. We, at Guadalupe, anticipate benefiting under APCs. We think it is going to work for us. It is going to cost the patients more in Texas, and that has not been explained to them. But we think it is going to work to our benefit. But it only works where we get one payment from the government, not a partial payment, then a next payment and have to do all kind of billing gyrations with the rest of the secondary payers and the patients themselves.

We support prevention in the form of screening mammograms, and stereotactic biopsies and PSA testing. Those are good programs. We agree that home health agencies should be spared the 15-percent cut, not just deferred, but completely have that cut eliminated. We support prescription programs for Medicare patients. We know that, and even in Medicaid in Texas, patients get their prescriptions. We want to see rural hospitals survive, and we want to have reasonable reimbursement for Medicare and Medicaid patients all across the Nation. We know that Medicare is Social Security.

Mr. Chairman, we have a booming economy and a $2.2 trillion surplus. Soon we are going to have baby boomers joining the Medicare rolls. This is not the time to make cuts. This is the time to preserve the Medicare system. Let us keep Medicare secure.

Thank you very much.

[The prepared statement follows:]

Statement of Don Richey, Administrator, Guadalupe Valley Hospital, Seguin, Texas, on behalf of the American Hospital Association

Mr. Chairman, I am Don Richey, administrator of Guadalupe Valley Hospital in Seguin, Texas. I appear today on behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems, networks, and other providers of care. We appreciate this opportunity to tell you first hand the dramatic impact of the Balanced Budget Act of 1997 (BBA) on America's hospitals and health systems.

In 1997, Congress and the White House faced a large and seemingly intractable federal budget deficit and projections that the Medicare Hospital Insurance Trust Fund would be bankrupt by 2002 unless Washington acted.

Congress responded with the 1997 Balanced Budget Act. The Congressional Budget Office (CBO) estimated that the BBA would cut $116 billion from 1998 to 2002 in projected Medicare spending. More than $50 billion of these cuts were estimated to come from reduced payments to hospitals. An additional $10 billion was to be cut from Medicaid hospital payments.

The intent of Congress and the White House was to save the Medicare program. The result, though, threatens the viability of America's hospitals and health systems.

According to projections, the five-year impact of the BBA for hospitals and other Medicare providers is over $200 billion, partially due to larger than anticipated reductions to providers. This unintended and excessive reduction in Medicare spending is severely affecting hospitals' ability to provide vital patient care services.

BBA Medicare and Medicaid spending cuts have especially victimized rural hospitals. My hospital, Guadalupe Valley is a 105-bed public hospital with a diverse patient population, serving residents of Seguin and Gonzales, Texas, as well as Mexico. While it located in a metropolitan statistical area, in reality, the hospital acts and serves as a rural provider. For instance, the two closest trauma care access points are each an hour away—University Hospital in San Antonio and Brackenridge Hospital in Austin.

Prior to the BBA, the hospital opened a skilled nursing facility (SNF), which was ranked number one in the state by Medicare. However, the payment reductions forced us to close the unit. We operate the only home health agency in town. Before the BBA, there were 18 home health providers in the community. Since the BBA, they have all closed, leaving Guadalupe Valley as the sole furnisher of home health services.

And Guadalupe Valley is just one example of the hardships caused by the BBA's cuts. Across the country, hospitals are struggling. Services are being cut and facilities are being impacted:

- For Wilkes-Barre General Hospital in Wilkes-Barre, Pennsylvania, BBA Medicare and Medicaid spending cuts have forced the hospital to make some tough decisions... like eliminating a diabetes center; health promotion programs; geriatric psychiatric inpatient services; a Women's Health Network; the School of Anesthesia; and the ambulance service.
- In Arizona, BBA cuts have forced the John C. Lincoln Health Network to discontinue its disease management programs for patients with congestive heart failure and chronic pulmonary disease. "Health Source," a free health information service, also was discontinued. And a busy skilled nursing care unit, which averaged 20 patients a day, was closed. Why? Take for example, one patient whose stay was 93 days. The facility's costs per day were $650; Medicare reimbursed only $260, resulting in losses of $36,270. Hospitals simply can't continue to provide services their communities need if doing so guarantees financial hemorrhage.
- BBA cuts are affecting more than just Medicare beneficiaries. In Stuart, Florida, for example, Martin Memorial, a 336-bed facility, will shut down its nurse midwife program in October. The hospital is facing a $30 million decrease in Medicare reimbursements over five years. Martin Memorial had no choice but to close the 17-year program.
- In Massachusetts, the state is expected to lose close to 23,000 health services sector jobs by 2005, according to a Standard & Poor's/DRI report. The BBA's five-year cuts of $1.7 billion for the state's hospitals are a significant cause of the job hemorrhage.

Last year, Congress and the White House recognized some of the BBA's "unintended consequences" on hospitals and the patients they serve, when they enacted the Balanced Budget Refinement Act of 1999 (BBRA), which restored an estimated $16 billion of the BBA's Medicare reductions. While the BBRA marked an important first step to remedying the BBA's unintended consequences, America's hospitals need additional relief. And here's why.

THE CASE FOR BBA RELIEF 2000

When Congress passed the BBA, CBO estimated that hospitals would contribute $53 billion over five years toward deficit reduction. Estimates now put that number well over $75 billion. Congress should return, at a minimum, the excess funds it did not intend to cut to America's hospitals.

The BBA reduces Medicare payments for hospital inpatient services by providing payment updates that are below the market basket index, which is Medicare's measure of inflation. This below-inflation update has seriously hampered hospitals' ability to keep pace and maintain access to services for Medicare beneficiaries. Over fiscal years 1998, 1999 and 2000, hospital inflation rates rose a total of 8.2 percent, while the payment updates have *totaled* 1.6 percent.

Compounding the effects of the BBA is a series of market pressures no one could have predicted in 1997. Labor, drug and technology costs are skyrocketing. The costs of caring for all of our patients, including Medicare beneficiaries are increasing rapidly.

Since 1998, annual wages and benefits paid to registered nurses increased 6 percent, total employee benefits increased nearly 7 percent, and pharmacists' wages increased more than 25 percent. As stated earlier, for the same period, hospitals' annual Medicare updates have totaled only 1.6 percent.

The cost of prescription drugs has increased dramatically. The average price for new drugs is about $71, more than twice the average price for previously existing drugs. New and more expensive drugs are constantly emerging, replacing older drugs and increasing the overall use of drugs in patient care. Yet, only a fraction

of the cost of new drugs is included in the inflation measurement the government uses to calculate hospital payment updates.

The cost of blood also is on the rise. The Food and Drug Administration soon will approve new blood screening techniques to make our blood supply safer. But quality improvements will increase the cost of blood by $40 to $50 a pint, a 50 percent jump. New techniques, such as "viral inactivation," are expected to double or triple the cost of blood. However, the cost of these new techniques is not included in today's measure of hospital inflation.

In addition, providers will be required to make a major investment to comply with new federal administrative simplification standards and with new patient record privacy and security requirements. The White House estimates that new privacy requirements will increase the costs for providers and health plans by $1.2 billion for the first year alone, and $3.8 billion over five years. Other estimates, however, have put the cost as high as $43 billion. Current Medicare payment policies do not reimburse for these costs.

The economic outlook is so grim, that financial experts are losing confidence in what has historically been a fairly stable industry. Moody's Investor Service reports that downgrades in bond ratings for hospitals were the most ever in 1999, outpacing upgrades 5–1. And this month, Moody's reported that the 2000 financial picture is not improving. In fact, the rating agency warned that the amount of debt affected by downgrades in 2000 may be on course to actually exceed the total amount of debt downgraded for 1999. A poor financial prognosis means it costs hospitals more to borrow and invest in the people, technology and infrastructure necessary to keep pace.

At the same time, America's hospitals and health systems continue to serve as the nation's health care safety net... caring for those who have nowhere else to go for care. Current estimates put the number of Americans who lack health insurance at about 44 million. That number is projected to continue to increase, soaring to 55 million by 2010. Hospitals are America's safety net for caring for the uninsured, but at increasing costs. Government support makes up only a small portion of costs for treating the uninsured.

BBA cuts... rising costs... a darkening financial horizon ... the problems of the uninsured. Our ability to take care of our patients and communities is being seriously challenged. But it's not just hospitals that are saying America's health care providers are facing a financial crisisa...outside experts confirm that we need a cost of caring adjustment.

WHAT OTHERS ARE SAYING

Recently, the Medicare Payment Advisory Commission (MedPAC), Congress' advisor on Medicare payment issues, agreed that more needs to be done. The commission recommended that Congress increase the inpatient prospective payment system update by between 3.5 percent and 4 percent—more than twice what is in current law. MedPAC's data analysis shows that nearly 35 percent of the nation's hospitals are operating in the red. This is due, in part, to the dramatic Medicare cuts contained in the BBA. MedPAC recognized the need for Medicare to keep pace with the high cost of providing health care today.

In addition, two independent studies, one by the Lewin Group and another by Ernst & Young/HCIA-Sachs confirmed that hospitals are unable to cover their costs when treating Medicare patients. Lewin predicts that without further relief from the BBA, 60 percent of hospitals may lose money treating Medicare patients by the end of 2004. And the Ernest & Young study reinforces the Lewin results, by showing that total Medicare margins, which measures the operating margin on all hospital services to Medicare patients, continue to decline to dangerously negative levels.

No organization, including the nation's hospitals and health systems, can continue to serve if it gets paid less than the cost of providing services.

Mr. Chairman, it's time for lawmakers to heed both the recommendations and the warnings of financial experts. Hospitals and health systems need a cost of caring adjustment.

Last week, CBO announced new on-budget surplus estimates of $2.2 trillion over 10 years—estimates that have more than doubled in four months. This is further proof of what we've known for a long time: Congress and the Administration have the resources to reverse the unintended consequences of the BBA. It's time for Washington to act.

BBA RELIEF 2000

The BBA has hit hospitals hard in ways no one could have foreseen when the law was written. With today's booming economy, now is the time to remedy the flaws

of the BBA. And the best way is to provide relief to all hospitals by repealing the last two year's of the BBA's inpatient market basket reductions.

Indeed, Washington has taken notice and the momentum for BBA relief is growing. The AHA is pleased to cite that 299 representatives have cosponsored the Hospital Preservation and Equity Act (H.R. 3580), which would restore the last two year's of the BBA's inpatient market basket reductions. Similar legislation in the Senate is also gaining support with 55 senators cosponsoring Medicare inpatient relief (S.2018).

The AHA is also asking Congress for targeted relief, including:

- For outpatient services, provision of the full market basket update;
- For teaching hospitals, continuation of the current adjustment for indirect medical education of 6.5 percent;
- For rural hospitals, a package of relief that would include: equalizing the qualification threshold for payments to rural hospitals under the Medicare disproportionate share (DSH) program; improving flexibility for Medicare critical access hospital program; updating current rural payment classification systems; providing a payment adjustment for rural ambulance providers; and several technical changes for rural hospital services;
- And for America's safety net hospitals, repeal of the current state caps on Medicaid DSH payments.

Mr. Chairman, we enjoy a booming national economy, which is fueling a federal budget surplus of billions of dollars. We can avert a health care crisis in our communities. We urge you and your colleagues to support our efforts to secure additional BBA relief now and help ensure that high-quality health care will be there when our communities need it.

Thank you for providing me with the opportunity to address you today.

Chairman THOMAS. Thank you, Mr. Richey.
Dr. Corlin?

STATEMENT OF RICHARD F. CORLIN, M.D., PRESIDENT-ELECT, AMERICAN MEDICAL ASSOCIATION

Dr. CORLIN. Thank you, Mr. Thomas. Good afternoon. I am Richard Corlin. I am a gastroenterologist in private practice in Santa Monica, California, and I am president-elect of the AMA. We appreciate the opportunity to appear before this Subcommittee to present our views about refining the Balanced Budget Act of 1997, the BBA. Today, I want to discuss four recommendations for providing needed relief under the BBA.

First, savings from the BBA have far exceeded CBO forecasts. HCFA and the CBO have attributed this to their success in combatting so-called waste, fraud and abuse, yet this has come with a hefty price tag. HCFA, in its zeal to reduce waste, fraud and abuse, has imposed mountains of complex regulations that often interfere with the delivery of quality medical care.

For instance, HCFA contractors subject many physicians to post-payment audits that egregiously interfere with physicians' medical practices. Carriers make inappropriate use of a technique called extrapolation to calculate alleged overpayments, and physicians are denied all due process rights to an appeal unless they agree to an extremely invasive and expensive carrier audit. Physicians often cannot get answers from carriers about routine billing questions and procedures, and indeed are not informed of a billing problem until there is a post-payment audit. To make matters worse, HCFA does not adequately educate physicians on coding, documentation and coverage issues.

Physicians do not want to deal with the hassles any more. Some are retiring or leaving the Medicare Program. For example, a cardiologist in my, and the Chairman and the Ranking Member's home State of California has been repeatedly subject to carrier audits. The first few audits turned up a total clean bill of health. Even though there was no change in his billing practice, the carrier recently assessed that physician a $175,000 overpayment based on another audit done just 1 year later. He then had less than 30 days to repay the $175,000.

We urge that the Subcommittee, number one, ensure that HCFA allocate enough resources for education purposes and, two, require HCFA to reform its post-payment audit process.

Second, I would like to discuss regulatory costs imposed on physicians under the BBA. Despite that HCFA is required by law to take certain regulatory costs into account when updating the physician payment schedule, this does not occur. We recommend that HHS, including HCFA, be required to calculate the costs of new regulations and increase Medicare physician payments each year to account for these costs.

Next, I would like to address physician practice expenses. We appreciate the Subcommittee's efforts under the BBA to correct HCFA's initial approach to establishing a new system of payment for physician practice expenses, yet more work is needed. HCFA's current practice expense methodology and data do not accurately reflect physicians' actual practice costs, and we are concerned that this will adversely impact patients, physicians and health care providers.

Thus, we urge the Subcommittee to include in any BBA refinement legislation provisions that would maintain for the year 2000 and subsequent years the 50/50 formula for determining practice expense relative value units, with an exception for certain office visits and consultation services. This proposal is supported by 40 physicians offices, teaching hospitals, medical schools and clinics, and the AMA's House of Delegates recently voted to seek legislation to implement this proposal.

The proposal strikes an appropriate balance by allowing increases in those services, while generally limiting large reductions in payments for other services. Thus, our support is predicated on the inclusion of the exception for office visits and consultations.

And, finally, I would like to address deferment of student loans for residents. The downstream effects of Medicare cuts under the BBA, especially with respect to GME, are difficult for medical residents who are required to repay enormous amounts on their student loans while being paid a stipend that barely covers their ongoing expenses. Accordingly, we urge the Subcommittee to ensure that the BBA refinement package includes a provision making it easier for residents to qualify for a student loan economic hardship deferment during their medical residency.

Thank you very much, and we would be pleased to respond to any questions.

[The prepared statement follows:]

Statement of Richard F. Corlin, M.D., President-Elect, American Medical Association

We appreciate the opportunity to provide our testimony to the Subcommittee concerning the American Medical Association's (AMA) recommendations as the Subcommittee moves forward in its consideration of further refinements to the Balanced Budget Act of 1997 (BBA).

The AMA deeply appreciates the Chairman's and the Subcommittee's support of refinements of the Medicare physician payment system that were included in the Balanced Budget Refinement Act (BBRA) enacted last fall. Further refinements, however, are needed.

The BBA imposed tremendous changes in the Medicare program. Although these provisions required regulatory implementation, the Health Care Financing Administration (HCFA) has imposed massive amounts of burdensome regulatory requirements on the physician, provider and beneficiary communities beyond what Congress intended. Indeed, physicians are subject to over 100,000 pages of Medicare regulations and policies, including preambles to the regulations, which, while attempting to explain the intent of the often convoluted and ambiguous regulations, often raise more questions than they answer. Further, in addition to new and existing regulations, physicians must be familiar with the volumes of ever-changing bulletins and carrier materials sent to their offices.

The BBA and related implementing regulations have adversely impacted or threaten to have such impact on Medicare patients' access to and quality of care. Thus, certain BBA "fixes" are needed to ensure that these results do not continue to plague beneficiaries. Accordingly, the AMA recommends that the Subcommittee approve the following refinements to the BBA:

Health Care Financing Administration (HCFA) Reform

The AMA recommends that the Subcommittee include in any BBA-refinement package provisions to (1) ensure that HCFA and its carriers devote the proper level of resources to educating physicians concerning Medicare coding, billing and documentation requirements and (2) reform HCFA's post-payment audit process by (i) allowing physicians to maintain their due process rights; (ii) requiring ongoing communication between the carrier and physician during the audit; (iii) ensuring that physicians who voluntarily remit overpayments to HCFA will not be targeted for future audits; and (iv) curtailing HCFA's use of extrapolation for physicians' inadvertent bill errors.

Actual savings from the BBA have far exceeded the amount that the Congressional Budget Office (CBO) had forecast when it "scored" the legislation in 1997 as it was being considered prior to its enactment, and payment reductions to physicians and health care providers are steeper than anticipated by those forecasts. These cuts have impacted the entire industry, including patients.

The CBO and HCFA often have alleged that this discrepancy between CBOs original savings forecast and reality is due, in large part, to HCFA's success in combating "waste, fraud, and abuse." Yet, such "success" has come with a hefty price tag. In its zeal to reduce such "waste, fraud, and abuse," HCFA has gone to the extreme by imposing mountains of needlessly complex regulations and violating physicians rights to due process and basic fairness.

HCFA contractors are subjecting many physicians to post-payment audits, which amount to egregious carrier interference in physicians' medical practices. During these audits, HCFA contractors identify possible billing errors from a small batch of claims and use these possible errors to "extrapolate" enormous overpayment amounts from physicians, suppliers and providers. Since the amount is determined through extrapolation, it can easily rise to tens of thousands of dollars. Once carriers arrive at this projected overpayment amount, carriers give physicians three options: (1) repay the extrapolated amount and waive their appeal rights; (2) repay the extrapolated amount and submit additional information while waiving their appeal rights; or (3) open up their practice to a statistically valid random sampling (SVRS) of claims during the same time period. HCFA's carrier manual options prevent physicians from retaining their due process rights unless they agree to open up their practices to a larger SVRS audit. During this process, many HCFA contractors have no direct communication with the physician, supplier, or provider, who frequently have difficulty obtaining answers from the carrier regarding the carrier's interpretation of correct billing procedures. Thus, physicians feel compelled to settle any assessed "overpayment" with the carrier in order to avoid an even more protracted, invasive and expensive carrier audit.

HCFA's overzealous enforcement activities are forcing physicians to spend less time on patient care and too much time completing paperwork in order to avoid car-

rier hassles and the possibility of an unwarranted, costly and lengthy post-payment audit. Further, some physicians are retiring from medical practice or are leaving the Medicare program because they simply can not tolerate the hassle of participating in the program anymore. In addition, many physicians view billing Medicare as a legally treacherous endeavor, as the below examples demonstrate——

- In Idaho Falls, a family practice of three physicians recently left the Medicare program. Although they perceived their billing practices as meeting HCFA's confusing and massive regulatory requirements and never received any notification of billing problems from their carrier, the practice was subjected to a post-payment audit. As a result, the practice was deemed by the carrier to owe the Medicare program tens of thousands of dollars. The physicians agreed to settle with HCFA because they could not risk undergoing a more protracted and expensive audit. After the audit, each of these physicians dropped out of Medicare because they could not be certain they would be able to comply with Medicare's burdensome and confusing billing policies. The prospect of another onerous audit was daunting. Consequently, many patients in the Idaho Falls area were left without their family physician.
- In northern California, a cardiologist underwent a number of audits over the last few years, and during the first few audits the physician had a "clean bill of health.." Nevertheless, in the physician's last audit, the carrier assessed the physician $175,000, even though the physician continued to bill in the same manner as during the first few audits. The physician then had less than 30 days to payback the alleged $175,000 "overpayment."
- In Denver, Colorado, the ratio of Medicare patients to physicians who are willing to participate in the program no longer appears to be a sufficient to adequately treat these patients. Many Denver physicians attribute the situation to HCFA's current "waste, fraud, and abuse" initiatives.

The BBA requirements and HCFA's subsequent regulatory burden threatens patient access to care—especially in rural areas—which, in turn, affects quality care.

Finally, although HCFA expects physicians to understand all of its confusing and often inconsistent regulations, notices, fraud alerts, and program memoranda, the agency does not adequately educate physicians, especially with regard to Medicare billing requirements. Indeed, physicians cannot receive written consistent and clear answers from their carriers regarding coding, documentation and coverage issues.

Accordingly, as discussed above, we urge the Subcommittee to ensure that any BBA-refinement legislation requires HCFA to remedy its over-zealous regulatory approach to implementation of the BBA, especially with respect to the agency's physician and provider education process as well as its post-payment review enforcement activities.

HHS Accountability for Regulatory Costs

Last year, this Subcommittee ensured that provisions were included in the BBRA to clarify and correct certain fundamental flaws in the method by which physicians are paid under the Medicare physician payment schedule, and, specifically, under the sustainable growth rate system. We greatly appreciate the Chairman's and the Member's of this Subcommittee efforts in enacting these important refinements, and urge you to continue your efforts in this refinement process of the Medicare physician payment schedule.

The cost of the numerous BBA and other burdensome regulatory requirements discussed above impose tremendous costs on physicians' medical practices. Yet, much of these compliance costs must be absorbed by physicians' practice. We recommend that the Secretary of the Department of Health and Human Services (HHS) and HCFA be required to calculate the costs of new regulations and increase Medicare physician payment rates each year to account for these costs.

HCFA annually updates Medicare payments to physicians to account for certain factors, including inflation and legislative and regulatory factors affecting physician expenditures. Yet, these updates do not take into account the costs of compliance with the continuing onslaught of costly BBA and other regulations.

For example, HCFA recently proposed two new codes to cover certain services that HCFA requires physicians to provide for home health patients. HCFA has incredulously proposed to *decrease* Medicare payments to physicians overall to cover any additional costs billed under these new codes. HCFA alleges that such a decrease is justified because physicians are already paid under other codes for these home health services, and thus physicians should not be able to double bill for the same services. This is not the case. Physicians have never been paid for these services, yet HCFA is proposing to cut alleged "payments" to physicians for services they are required to provide.

We urge the Subcommittee to pass legislation requiring the Secretary of HHS to determine the cost of *each* regulation on physicians' practices (and not simply those regulations affecting the physician payment schedule) and annually take such costs into account when updating Medicare payments to physicians. Further, for oversight purposes, we recommend that the Secretary be required to report to the Medicare Payment Advisory Commission (MedPAC) and the General Accounting Office (GAO) on the costs imposed by all relevant regulations and to consult with organizations representing physicians concerning the methodology used in determining such impact. Finally, we recommend that the GAO advise Congress on improvements to the Secretary's methodology for calculating these regulatory costs.

Physician Practice Expenses under the Medicare Physician Payment Schedule

We urge the Subcommittee to include in any BBA-refinement package legislative provisions that would maintain for the year 2000 and subsequent years the "50/50" formula for determining practice expense relative value units, with an exception for certain office visit and consultation services.

In 1994, Congress directed HCFA to establish a new system for Medicare payment to physicians for their overhead practice expenses, which was to be based on the relative practice expense resources used in furnishing a service. As a result of concerns with HCFA's initial approach to establishing this new system, Congress, under the BBA, intervened and provided HCFA with specific instructions for developing new practice expense resource-based relative value units. Congress further directed that the new system be implemented under a four-year transition period, with full implementation in 2002.

Although we are already half-way through the transition period, HCFA has failed to comply with most of the practice expense mandates under the BBA and the current methodology and data do not accurately reflect physicians' actual practice costs. Indeed, HCFA's Administrator Nancy Ann DeParle recently stated before the House Appropriations Committee that "we do not believe that it is possible to determine actual physician expenses associated with providing services to Medicare patients." Further, previous budget constraints have made it even more difficult for HCFA to develop a system that fairly reflects physicians' practice costs. Consequently, we are concerned that the current plan will adversely impact physicians and many other health care providers, as well as patient access and quality of care. Thus, an immediate remedy is required.

At the AMA's June meeting, our House of Delegates agreed that we should seek legislation that would maintain for 2000 and subsequent years the 50/50 formula for determining practice expense relative value units for all services except for certain office visit and consultation services which would be based entirely on the relative practice expense resources involved in furnishing the service.

This proposal, which is supported by 40 physician organizations, teaching hospitals, medical schools and clinics, would also allow the 50 percent of the relative value units that are based on resource costs to continue to be subject to review and refinement. We urge the Subcommittee to include this proposal in your BBA-refinement package.

We emphasize that the AMA's support for this proposal is predicated on the inclusion of an exception for office visits and consultations. We believe that by allowing increases in these services while generally limiting large reductions in payments for other services, the proposal strikes an appropriate balance. Payments for primary care services would be increased to help protect Medicare patients' access to these services without the need for huge payment cuts that could jeopardize beneficiaries' access to needed procedures. We could not endorse a plan that does not have both of these key elements.

Loan Deferment for Residents

We further urge the Subcommittee to include in any BBA-refinement package an amendment to improve the formula for determining whether medical residents can qualify for a student loan deferment during residency.

The downstream effects of Medicare cuts under the BBA, especially with respect to GME, are difficult for medical residents who are required to re-pay enormous amounts on their student loans during their residency while being paid a stipend that barely, if at all, covers their expenses.

Currently, under the Higher Education Act, there is a very strict formula based on "economic hardship" for determining whether a student can get a loan deferment. This formula is much too narrow to be effective, and many medical residents who legitimately need a loan deferment for economic reasons fail to qualify. By the time

medical students begin their residency programs, which are generally four or more years in duration, they must begin to repay their medical school loans, yet they typically are not paid enough to make ends meet.

Based on a federal debt burden of $72,000 and national average figures (using full-time pay for first year residents and monthly housing payments), a typical resident would be left with less than $440 a month, after paying federal taxes, housing and loan payments. This amount must cover all other expenses such as food, insurance, utilities, telephone, state/local taxes, transportation, medical books, computer-related expenses, professional memberships, educational conferences, health care expenses and clothing. Yet, under current law, this resident would not qualify for a deferment and thus would have to begin repaying his or her loans.

With a minor adjustment to the formula, residents with over $48,000 in federal debt (rather than $72,000) could qualify for federal loan deferment during their residencies.

Thus, we urge the Subcommittee to approve a BBA-refinement provision that would permit residents, through a more realistic economic hardship formula, to obtain deferments for their full initial residency period if they continue their education through a medical internship or residency program.

We thank the Subcommittee for the opportunity to provide our views concerning the foregoing matters, and appreciate the Subcommittee's efforts to provide relief under the BBA. We look forward to working with the Subcommittee to achieve reasonable remedies for hardships imposed by the BBA and related burdensome regulatory requirements on Medicare patients, physicians and the provider community.

Chairman THOMAS. Thank you, Doctor.

Mr. Walker?

STATEMENT OF MICHAEL R. WALKER, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, GENESIS HEALTH VENTURES, INC., KENNETT SQUARE, PENNSYLVANIA, ON BEHALF OF THE AMERICAN HEALTH CARE ASSOCIATION

Mr. WALKER. Thank you. My name is Michael Walker. I am the chairman and founder and chief executive officer of Genesis Health Ventures, one of the largest elder care providers in the Nation, currently filed Chapter 11.

Today, I speak on behalf of the American Health Care Association. Skilled nursing homes continue to struggle with the implementation of the Balanced Budget Act of 1997. These are very tough times for providers.

Mr. Chairman, I would like to thank you and Members of the Committee. We are most appreciative of the leadership you provided last year in attempting to rectify the problems through the Balanced Budget Refinement Act. The rise of skilled nursing medical utilization during the past decade reflects the legitimate clinical efforts by providers to meet beneficiary needs.

As envisioned by Congress in OBRA 87, skilled nursing facilities have become centers for post-hospital rehabilitation and restorative services. Today, more than half of the admissions, nearly 2 million beneficiaries annually, are Medicare-qualified. At Genesis, nearly 9 out of 10 skilled nursing home admissions are Medicare-qualified, and we are returning 50 percent of these individuals back to their communities.

Earlier this year, the Lewin Group released an analysis of the effect of BBA and BBRA on Medicare payments to skilled nursing facilities. The analysis documents that Congress targeted to reduce

Medicare SNF spending by $1 for every $6 forecasted to be spent 1998 through 2004. As managed by HCFA, aggregate Medicare spending will fall by nearly twice the original estimate—nearly $1 out of every $3 expended. These financial challenges raise the most critical question before this Committee: Who will take care of this most vulnerable population if we continue to lose the infrastructure of our skilled nursing facilities at a time when demographics create an increased demand for care?

The unintended consequences of these changes have been dramatic on the provider sector. Access to capital has been destroyed. You cannot get equity or mortgage loan. Eighty percent of marketed capitalization on Wall Street has been eliminated in the last 24 months. Twenty-five percent of freestanding proprietary Medicare-participating facilities have filed Chapter 11.

In turn, as providers struggle to adjust, beneficiary services have been put at risk. Three out of four skilled nursing patient days are purchased by the government, Medicare or Medicaid. The financial consequences many of us are face with are beyond our control. The cost of care is rising, labor cost is rising, people are living longer with impairments that require professional intervention. Yet patients are going down. With average Medicaid rates of approximately $4 an hour and Medicare paying slightly less than $10 an hour for care, our hands are tied.

Decisions are made by government entities that have profound effect on patient care. There is no doubt that the overall underspending has wreaked unwarranted havoc on skilled nursing providers and patients alike.

AHCA recently submitted to you four specific recommendations to address Medicare underspending crisis. I will summarize them:

First, adjust the SNF PPS base to account for the flawed update factor between 1995 and 1998. Specifically, we have documented the need for a one-time adjustment of 13.5 percent to the SNF PPS base to account for the forecast errors between 1995 and 1998.

We have spent the last several months analyzing this data with Muse and ex-HCFA actuary, King. Translated into per-diem calculation, the Muse analysis documents that skilled nursing facility costs, driven primarily by changes in labor and operating costs, increased by about $25 per day. The SNF market basket, reduced by the BBA formula of market minus one, adjusted average rates by $5.30 or a meager 22 cents per hour.

We urge Congress to correct these forecast errors and compensate for the imprecision of its measurement of cost changes between the base year 1995 and the beginning of the SNF PPS cost report periods, July 1998.

Second, delay the implementation of the proposed RUG Refinement Rules until HCFA can correct deficiencies and reissue the proposals for public comment.

Third, develop a process for revising the SNF market basket. The current skilled nursing facility market basket index is an imprecise measure, and it is seriously flawed. It is not a specific measure of skilled nursing cost changes, nor does it accurately predict cost changes in a dynamically changing health care environment. We support a formal process by the administration to review the SNF market basket.

And, fourth, Medicare reform should include an updating of the SNF benefit. We look forward to the opportunity in the coming Congress to sit down with this Committee to consider policies to ensure skilled nursing benefits provide the most effective and efficient service to the Medicare beneficiary. An $8,000 co-pay for a nursing home stay is woefully inadequate when a $500 co-pay or deductible exists in a hospital stay.

In closing, Mr. Chairman, there are two key points that I emphasize:

First, dollars spent on caring for patients on the front end of admission help to reduce their reliance on institutionalized care. Admissions and discharge statistics for the past decade demonstrate that nursing homes are returning a larger percentage of their patients to the community. Medicare fueled this transformation. That investment in intense skilled nursing care facilities serves as a win-win. Beneficiaries win—they will return to home. government wins—the burden of cost is reduced. Health care systems win—care is given in the most appropriate setting.

The BBA and BBRA, as being implemented by HCFA, are unraveling the win-win and making it a lose-lose. Unless quickly addressed, the burden of care costs will rise, and there will be a backlog of patients, inappropriately placed patients. Medicare and Medicaid costs will explode.

Second, demographic projections indicate that once the baby boom generation returns, retiring en masse in a few years, the burgeoning demand for skilled care and related services will exceed the available supply, and there will be nobody there to provide it.

Thank you.

[The prepared statement follows:]

Statement of Michael R. Walker, Chairman and Chief Executive Officer, Genesis Health Ventures, Inc., Kennett Square, Pennsylvania, on behalf of the American Health Care Association

My name is Michael Walker, and I am the Chairman and CEO of Genesis Health Ventures, one of the largest eldercare providers in the United States. Today I speak on behalf of the American Health Care Association—a federation of affiliated associations representing over 12,000 non-profit and for-profit assisted living, nursing facility and subacute care providers, nationwide.

Before I testify, Mr. Chairman, I'd like to thank you and members of the committee for recognizing the eldercare funding crisis caused by the flawed implementation of the 1997 Balanced Budget Act. We are most appreciative of the leadership you provided last year in attempting to rectify these problems through the Balanced Budget Refinement Act.

The skilled nursing home sector continues to struggle with the implementation of the Balanced Budget Act of 1997. These are very tough times for providers. Companies, such as Genesis Health Ventures, that are attempting to pioneer creative strategies for improving both the efficiencies and effectiveness of delivery are confronting a hostile policy environment and threatening economics.

Importance of Medicare:

The rise of skilled nursing facility Medicare utilization during the past decade reflects legitimate clinical efforts by providers to meet beneficiary needs. As envisioned by the Congress in OBRA 87, skilled nursing facilities have become centers for post-hospital rehabilitation and restorative services. Meeting the needs of higher acuity, post-hospital discharge admissions have transformed facility roles and functions and cost structures. As facilities stepped up to these challenges, the number of patients qualifying for Medicare coverage grew. Today, more than half of skilled nursing admissions—nearly 2 million beneficiaries annually—are Medicare qualified. In our case at Genesis, nearly nine out of ten skilled nursing admissions are Medicare qualified.

Medicare Skilled Nursing Facility (SNF) Spending Spiraling Down:

Earlier this year, the Lewin Group, a leading national policy research organization, released an analysis of the effect of the Balanced Budget Act of 1997 (BBA) and the Balanced Budget Refinement Act of 1999 (BBRA) on Medicare payments to skilled nursing facilities.[1] The analysis documents that Medicare spending projections for SNF patients, inclusive of the changes enacted last fall by Congress, will be $15.8 billion less than Congress intended during the seven year budget period (1998–2004).

Put in perspective, Congress targeted to reduce Medicare SNF spending by $1 for every $6 forecast to be spent (1998–2004). As managed by the Health Care Financing Administration, aggregate Medicare SNF spending will fall by nearly twice the original estimate—nearly $1 out of every $3 expended.

Although Congress passed the BBRA to restore vital Medicare spending, Medicare SNF outlays continue to spiral down. The BBRA budgeted an increase of SNF spending in FY2000 to $13.3 billion, but the Congressional Budget Office reports SNF care spending will actually come in $2 billion below estimates ($11 billion in this fiscal year).

Impact:

The unintended consequences of these changes have been dramatic on the provider sector—access to capital has been undermined (87% reduction in market capitalization between January 1998 and March 2000); providers have been thrust into bankruptcies—one in four (25%) of freestanding, proprietary, Medicare participating facilities are in financial restructuring. In turn, as providers struggle to adjust, beneficiary services have been put at risk.

Rather than the rate of Medicare growth being slowed—as envisioned by this Committee and by Congress—actual cuts have affected care giving. For Genesis Health Ventures, the final SNF PPS rates translated into a reduction of 25% of our Medicare per diem rates. Medicare revenues account for approximately 25% of our total revenues. More importantly, the rate reduction affected the payments for 90% of our inpatient admissions. Virtually no business could survive with cuts that drastic.

My company made a commitment to admit all patients regardless of reduced Medicare payments for services which averages about $100 a day reduction from our pre-SNF PPS rates. We are the most recent provider to succumb to bankruptcy. Bankruptcy is not just financial restructuring. Bankruptcy directly affects employee morale, recruitment and retention, care services available and investments toward future care and services. In reality it is a major distraction from care giving.

These financial challenges raise the most critical question before this committee—who will take care of this most vulnerable population if we continue to lose the infrastructure of our skilled nursing facilities at a time when demographics create an increased demand for care? The consequences will be devastating. Patients will not be able to receive the care they need—if and when they need it. In no area do we feel this more strongly than in labor. We dedicate a tremendous amount of time and resources into recruiting high quality caregivers—the type of workers that you would trust with a loved one. Yet, in the current marketplace, they leave their nursing home jobs all too often for other employment that is not only much more lucrative but also less demanding.

Three out of four skilled nursing facility patients' care is paid for by Medicare or Medicaid, both government programs. The financial consequences many of us are faced with are beyond our control. Cost of care is rising, costs associated with labor are rising, people are living longer—with impairments that require professional intervention—yet payments are going down. With average Medicaid rates of approximately $4 an hour and Medicare paying slightly more than $10 an hour for care on average, our hands are tied. Decisions made by government entities have a profound effect on patient care.

If SNF PPS were implemented by HCFA to achieve the cost reductions originally targeted by the Congress, we wouldn't be here today. The GAO and others have recently testified that there is no crisis in long term care. This flies in the face of sound research and reality and is an irresponsible and questionable claim to make. The OMB's mid-summer review, the Lewin Group's independent study, 2000 SNF bankruptcies in less than a year, and concerns expressed by hundreds of thousands of caregivers on the front lines simply cannot be disregarded.

While providers manage to continue providing the best possible quality of care to their patients—and while we've done our best to adjust to unexpected budgetary

[1] Lewin Group, "Briefing Chartbook on the Effect of the Balanced Budget Act of 1997 and the Balanced Budget Refinement Act of 1999 on Medicare Payments to Skilled Nursing Facilities," May, 2000.

constrictions—there is no doubt that the overall under-spending has wreaked unwarranted havoc on skilled care providers and patients alike.

Recommendations

The American Health Care Association recently submitted to you four specific recommendations to address the Medicare under-spending crisis, Mr. Chairman, I will summarize them for the full subcommittee:

First: Adjust the SNF PPS base to account for the flawed update factor between 1995 and 1998. Specifically, we have documented the need for a one-time upward adjustment of 13.5% to the SNF PPS base to account for forecast errors between 1995 and 1998.

We have spent the last several months analyzing this data with Muse and Associates, and Guy King, the former chief actuary at HCFA. The actual rates of cost changes incurred by Medicare participating skilled nursing facilities are substantially higher (affirmed by audited cost report, BLS labor data and independent wage and compensation studies) than those forecast by the current market basket. The resulting payment rates are artificially suppressed.

Guy King reviewed real increases in the cost of delivering skilled care between 1995 and 1998. In his review he compared closed and audited HCFA cost reports against the SNF market basket update factor. The HCFA update factor raised Medicare SNF per diem rates by 8.2% between 1995 and 1998. King's review of research of audited SNF cost reports filed with HCFA shows that actual per diem costs incurred by SNFs increased by 27.4%. In other words, 19.2% should be added to HCFA's 8.2% increase. This 19.2% should be reduced to account for expectant increases in case-mix between 1995 −1998. This is how we empirically arrive at a one-time 13.5% upward adjustment.

Translated into per diem calculations, the Muse/King analysis documents that skilled nursing facility costs—driven primarily by changes in labor costs and routine operating expenses—increased by about $25 per day, per annum. The SNF Medicare market basket reduced by the BBA formula of market basket minus 1% adjusted average rates only $5.30 per day, per annum, or a meager $.22 per hour.

We urge Congress to correct these forecast errors and compensate for the imprecision of its measurement of cost changes between base year FY1995 and the beginning of SNF PPS for cost report periods on or after July 1,1998.

Second: Delay the implementation of proposed RUG Refinement Rules until HCFA can correct deficiencies and reissue the proposals for public comment.

The proposed rules should be withdrawn and reissued for comment only after HCFA has completed its analysis of the current national PPS data base and completed the recalculation of the observed weights and distributions based upon current beneficiary population. It would be an absolute disaster for participating providers if HCFA proceeds with this rule making on the basis of interim final rules while it tinkers with its calculations.

These proposed rules are illustrative of how our hardships are being exacerbated by the actions of the Health Care Financing Administration. Congress mandated HCFA to fix the inadequate payment for non-therapy ancillaries. HCFA responded with these incomplete and flawed proposals.

An independent analysis just completed by the Lewin Group, "Evaluation of the Proposed Refinements to RUG–III Classification System: Comments on the Abt Study and HCFA Proposed Regulation," documents HCFA has not learned from its past mistakes. The report concludes: "...2However well-executed, the Abt study and resulting refinement models are not sufficiently comprehensive for the design and/or calibration of a final payment system." [2]

The litany of methodological flaws parallel those observed in the initial rule-making process.

Third: Develop a process for revising the SNF market basket.

The current skilled nursing facility market basket index is an imprecise measure; it is seriously flawed. It is not a specific measure of skilled nursing cost changes, nor is it an accurate predictor of cost changes in a dynamically changing care environment. The market basket model used by HCFA offers a limited snapshot of cost changes, year-to-year, based upon historic patterns of spending across a broad array of long-term care setting. Over time, the inaccuracies of the market basket are amplified (compound effect), and the rate structures erode. The actual rates of cost changes incurred by Medicare participating skilled nursing facilities are substantially higher than those forecast by the current market basket.

[2] Lewin Group, "Evaluation of the Proposed Refinements to RUG–III Classification System: Comments on the Abt Study and HCFA Proposed Regulations, June 7, 2000, p. 4.

We strongly support a formal process by the Administration to review the SNF market basket to ensure it keeps pace with and fully accounts for the actual increases in costs incurred and reflects changes that will affect costs in the delivery of skilled nursing care.

Fourth: Medicare reforms should include an updating of the SNF benefit.

We look forward to the opportunity in the coming Congress to sit down with this committee to consider policies to ensure the skilled nursing benefit provides the most effective and efficient service to the Medicare beneficiary. We believe Congress must act to protect beneficiaries from excessive co-payments, must act to eliminate outdated controls on access to the benefit and must act to remove barriers to care management. Today, only 2% of beneficiaries who enter a skilled nursing facility actually receive the 100 days of coverage promised by Medicare. To get the 100 days of SNF coverage a beneficiary must pay nearly $8,000 out-of-pocket (approximately a day after the 20th day).

Summary

In closing, Mr. Chairman, there are two key points that I emphasize.

First, dollars spent on caring for patients on the front-end help to reduce their reliance on institutional care. Admissions and discharge statistics for the past decade demonstrate that nursing homes are returning a larger percentage of their patients to the community. Medicare fueled this transformation. That investment in intense skilled nursing facility services is a win-win. Beneficiaries win—they are returned to their home setting; government wins—the burden of care costs are reduced, and the health system wins—care is given in the most appropriate settings. The BBA and BBRA as being implemented by HCFA, are unraveling that win-win, making it a lose-lose. Unless quickly addressed, the burden of care costs will rise, there will be a backlog of patients inappropriately placed, and Medicaid and Medicare costs will explode.

Second, demographic projections indicate that once the baby-boom generation begins retiring en masse—in just a few years—the burgeoning demand for skilled nursing care and related health services will exceed the available supply. Unless we as a nation are willing to assume the full burden of caring for our grandparents, parents, and siblings, we need to fix the eldercare funding crisis immediately. If we don't, quality long-term care will not be there when you and your loved ones need it—no matter who pays for it. The federal government should provide a favorable environment encouraging providers to invest now to meet future needs—not wait until the level of problems threatens to overtake our ability to solve them.

Thank you very much, Mr. Chairman, for this opportunity to express our deep concerns and frustrations with the current PPS system and its flawed implementation by the Health Care Financing Administration.

Chairman THOMAS. Thank you very much, Mr. Walker.

Ms. Sutherland?

STATEMENT OF JUDITH G. SUTHERLAND, PRESIDENT AND CHIEF EXECUTIVE OFFICER, VISITING NURSE CORPORATION OF COLORADO, DENVER, COLORADO, AND, CHAIR, BOARD OF DIRECTORS, VISITING NURSE ASSOCIATIONS OF AMERICA

Ms. SUTHERLAND. Mr. Chairman and Members of the Subcommittee, as chair of the Visiting Nurse Associations of America board of directors, I would very much like to thank you for allowing us to present our views. I am also the chief executive officer of the Visiting Nurse Corp. of Colorado, which is the largest home care agency in the State.

In 2 months, home health care will be reimbursed by a Prospective Pay System. We believe in this system. We believe that it will solve the current crisis in home health care. But we also believe that two actions must be taken. The first is to waive the BBA's budget neutrality restriction on PPS expenditures, so that the base-

per-episode payment can be increased. And, second, we believe that the 15-percent cut must be repealed.

We believe in these actions because PPS, while excellent, cannot succeed without sufficiently reimbursing providers for the cost of care and also removing the threat of the 15-percent cut.

Mr. Chairman, under your leadership, this Subcommittee has taken the lead during the past 2 years by developing policies that reward cost efficiency. Under your guidance and watchful eye, Congress passed such legislation in 1998 and in 1999. VNAA has been grateful for your efforts. As the chief executive officer of an agency, I, too, have. We urge you to continue to go down this path.

We realize that there is hesitancy on the part of the Health Subcommittee to place significant trust in the home health industry because of the overutilization that occurred in some parts of the country prior to BBA. It has been said, and we have heard it today, that some favor delaying the cut, so that it can be implemented in the future if the utilization of the benefit rapidly increases after PPS.

VNAA opposes a delay in this. And primarily that is because it is another "punish everyone for the bad behavior of some" approach that VNAs and other cost-efficient agencies were subject to under the IPS. We believe that there are sufficient safety measures under PPS that will identify who is playing by the rules and who is not. Medical review will target areas for potential abuse and provide appropriate responses.

On behalf of home health providers who want to provide cost-efficient and compassionate care to Medicare beneficiaries, VNAA asks you to please repeal the 15-percent cut. It, in fact, is no longer needed to achieve the BBA savings, which was its only purpose. The CBO's March 2000 projection of home health savings is more than four times its original projection. Savings will now equal $69 billion, rather than the original projection of $16.1 billion. No other sector of health care has been as negatively impacted by the BBA as home health care. We represent 5-percent of Medicare spending, but we account for 60 percent of combined savings from home health, hospitals and skilled nursing facilities.

Since fiscal year 1997, program expenditures decreased 48 percent. From calendar year 1997 to 1999, the number of home health beneficiaries served by home care dropped by nearly 1 million or 26 percent. According to several reports, patients are currently spending more time in hospitals and nursing homes than they need to because access to home health care has, indeed, become a nationwide problem.

In Colorado, one-third of the agencies have closed, and their staffs, in large part, have transferred to other professions because home health salaries and benefits are no longer competitive. This is directly due to the budget cuts we have had to make under the IPS. We no longer have the staff to accept all hospital and physician referrals. Repeal of the 15-percent would not add a dime to Medicare Home Health expenditures, but would help CBO's error.

The 48-percent drop in Medicare Home Health expenditures during the last 2 years also forced HCFA to develop a PPS system under serious budget constraints. As a result, reimbursement is insufficient for many case-mix categories. VNAA's analysis of the

PPS proposed rule, using a sample of VNA's recent data, reveals that reimbursement for 9 of 10 of our most prevalent case-mix categories will be less than the cost of care.

To ensure sufficient reimbursement rates under PPS, we recommend a simple and direct method for appropriately linking reimbursement to the cost of care. We recommend waiving the BBA budget neutrality factor, which would allow the base 60-day-per-episode rate to be raised by a certain percentage.

Another way to more accurately link reimbursement to cost of care would be to improve the PPS outlier system. An example on HCFA's website for constructing an outlier payment demonstrates the disparity between cost of care and reimbursement, even with the outlier payment. To improve the outlier system, we recommend that you authorize $500 million in each of the next 5 years for outlier payments.

Another change to BBA that VNAA believes is essential for PPS to succeed is to remove medical supplies from the per-episode payments and create a budget-neutral fee schedule for only the supplies that are actually used by patients. The BBA's requirement to bundle the average cost of Medical supplies will underpay or overpay agencies, depending on the needs of their patients.

Thank you for allowing us the opportunity to testify.

[The prepared statement follows:]

Statement of Judith G. Sutherland, President, and Chief Executive Officer, Visiting Nurse Corporation of Colorado, Denver, Colorado, and, Chair, Board of Directors, Visiting Nurse Associations of America

I. Introduction

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to testify on additional Medicare refinements to the Balanced Budget Act of 1997 (BBA97). My name is Judy Sutherland, and I am President and CEO of the Visiting Nurse Corporation of Colorado, which is the largest home care agency in the state of Colorado with 870 employees making 400,000 home care visits annually. I am also Chair of the Board of Directors of the Visiting Nurse Associations of America (VNAA), on whose behalf that I present these remarks today. VNAA is the national membership association for Visiting Nurse Agencies (VNAs), which are non-profit, charitable and community-based home health agencies. Having created home health care over 100 years ago, VNAs have a long history of delivering cost-effective and compassionate care to people in their communities.

VNAA appreciates the opportunity to present our viewpoints during the first year of this new millennium, which we believe represents a turning point for the Medicare home health benefit. In two months, home health agencies will be reimbursed by a prospective payment system (PPS) under Medicare, which creates a reimbursement framework that is based on significant research and tested experience from two HCFA PPS Demonstration Projects and HCFA's Case-Mix Research Project. HCFA has constructed a well thought-out PPS design that uses the best data available to ensure that Medicare home health beneficiaries receive appropriate, medically-necessary care in the most cost-effective manner.

The challenges presented by PPS in the year 2000 are parallel to the challenges that faced VNAs during the beginning of the 20th century. In 1900, VNAs were quietly revolutionizing health care in this country by providing medical and preventive services to those people who did not have access to such care. Visiting nurses brought health care to people's homes and community clinics to prevent unnecessary hospitalization, which was considered the health care of last resort because of hospitals' high costs. It is no different today. Compared to the average hospital inpatient operating cost per day of $1038*, a patient could receive health care at home at an average cost of $66.50 per-visit** or $133 per day for patients requiring two visits per day. Two visits per day is typically the maximum number of visits for newly discharged patients, which would equal 13% of the daily hospital inpatient operating cost. Following the first few days of home health admission, the number of visits per day and per week decrease as families learn patient care skills.

Mr. Chairman and Subcommittee Members, Congress has the opportunity now to make the Medicare home health benefit the cornerstone of a more cost-efficient, more compassionate Medicare program. The Medicare population is estimated to double by the year 2015, which emphasizes the need to begin re-prioritizing Medicare expenditures today to support innovative models of health care in the most cost-effective setting. There will be a stronger need to rely on family and community support. We believe that the public health model adopted by VNAs over 100 years ago will be the most cost-effective model for the future Medicare program. A February 17, 1999, publication of the Journal of the American Medical Association (JAMA) reported the findings of a study that showed that *home health care for newly discharged, high-risk seniors saved Medicare an average $3,000 per patient on avoided hospital re-admissions.*

- Source: American Hospital Association's FY 1997 data
- Source: VNAA's FY 1997 data

II. Current State of Home Health Care

The Health Subcommittee's interest in providing additional refinements to the BBA97 will begin to lay the foundation for a stronger Medicare program. Home health PPS must begin on solid footing to achieve Congress' goals of cost-efficiency and appropriate patient care. Unfortunately, PPS is beginning when the home health industry is in a period of turbulence.

HCFA's recent data reveals a disturbing picture of the current state of the Medicare home health program (please see Table 1, which is attached).

- Since fiscal year 1997, program expenditures decreased 48%, from $18.3 billion in FY 1997 to $9.5 billion in FY 1999.
- From calendar year 1997 to 1999, *the number of home health beneficiaries served dropped by nearly one million, from 3.5 million to 2.6 million, or by 26%.*

(Source: Preliminary 1999 HCFA/HCIS data.)

VNAA urges you to turn around the Medicare home health benefit by 180 degrees to prevent it from continuing its rapid downward spiral. *If Medicare expenditures for home health care continue to decrease at the rate of the last two years, there will be no home health benefit in 2015.*

The drop in expenditures has directly affected beneficiary access to care. According to several reports, patients are currently spending more time in hospitals and nursing homes than they need to because access to home health care has become a nationwide problem.

- Researchers at George Washington University surveyed hospital discharge planners regarding their ability to find home health care for patients. According to the GWU, 68 percent of the discharge planners reported that it is becoming increasingly difficult to obtain home health services for Medicare beneficiaries.

In Colorado, one-third of the home health agencies have closed. This has had a tremendous effect on access to home health care in Colorado because my agency and the other existing agencies do not have the available clinical staff to accept the increased number of hospital referrals. This is due to a nationwide shortage of home health care personnel. The BBA Interim Payment System (IPS) has forced VNAs to cut their budgets by an average 25%. As a result, we are unable to offer competitive wages and benefits to attract qualified staff. However, demand is increasing for home care. The Bureau of Labor Statistics forecasts an 82 percent increase in the demand for key home health personnel for the period 1998 to 2002.

We do not understand why the United States General Accounting Office (GAO) maintains that access to home health care is generally not a problem. Their findings are in direct contrast to HCFA's data showing a 25% reduction in beneficiary use of the home health benefit over two years and our day-to-day experience in the field. We've offered to the GAO to discuss their research with them to find out why there is such a discrepancy.

We realize there is hesitancy on the part of the Health Subcommittee to place significant trust in the home health industry because of the over-utilization and other abusive practices that occurred in some parts of the country prior to BBA97. It has been said that some favor delaying the 15% cut so that it can be implemented in the future if utilization of the benefit rapidly increases following the implementation of PPS. *VNAA opposes a delay for such purposes because it is another "punish everyone for the bad behavior of some" approach that VNAs and other cost-efficient agencies were subject to under the Interim Payment System (IPS).* There's no other way to say it: It's not fair. There has to be a better way to achieve the same purpose. The BBA97 has more than corrected the fraud and abuse that had previously occurred. The GAO confirmed that the areas in the country that had the highest pre-BBA97 utilization are the areas with the highest number of home health agency closures.

III. Recommendations

Mr. Chairman, under your leadership, this subcommittee has taken the lead during the past two years by developing policies that reward cost-efficiency and promote ethical behavior. Under your guidance and watchful eye, Congress passed such legislation in 1998 and 1999. *VNAA has been grateful for your efforts.* We urge you to continue to go down this path. PPS provides an excellent start. HCFA's medical review of home health care will be focused on potential areas of abuse with appropriate responses. Medical review using OASIS and normative standards data will identify who is playing by the system and who is not. VNAA would like to work with you to address any future problem areas through new legislation. On behalf of home health providers who want to provide cost-efficient and compassionate care to Medicare beneficiaries, *VNAA asks you to please REPEAL THE 15% CUT.*

In addition, and of equal importance, we urge you to *authorize immediate new expenditures to ensure the successful transition to prospective payment.* HCFA has developed an outstanding system. VNAA believes that only a few systemic changes are necessary, which we will discuss later in our testimony. The only real obstacle for PPS is the constraint of the BBA that ties PPS expenditures to IPS expenditures (if IPS were to remain in effect). Because expenditures for home health care under IPS dropped 48% from FY 1997 to 1999, HCFA was forced to develop a PPS under serious budget constraints. Our analysis using a sample of VNAs' 1999–2000 data found that the cost of care for nine out of 10 of our most prevalent case-mix categories exceed reimbursement under the PPS proposed rule. The same data is currently being analyzed using the final rule reimbursement rates, which we would be pleased to share with the subcommittee. We are concerned that if Congress does not authorize additional expenditures for PPS, access to care will deteriorate.

VNAA was amazed at GAO Director William Scanlon's following comment during last week's hearing of the Health and Environment Subcommittee: "In our [GAO] view, the new home health PPS rates overall are likely to provide agencies a comfortable cushion to deliver necessary services." Again, the GAO's findings are in direct contrast to our data and HCFA's estimates for outlier payments (see "Improve the PPS Outlier System" below).

The five national home health associations—VNAA, the American Association for Homecare, the American Federation of Home Care Providers, the Home Care Association of America, and the National Association for Home Care—jointly recommend that the subcommittee take the following legislative actions this year.

1. Repeal the 15 percent cut

The 15% cut scheduled for October 1, 2001, is no longer needed to achieve BBA97 Medicare home health savings, which was its only purpose. The Congressional Budget Office's March 2000 projection of such savings is more than four times its original projection (from $16.1 billion to $69 billion).

No other sector of health care has been as negatively impacted by the BBA 97 as Medicare home health services (see the attached Table 1 and Charts 1 and 2). The Congressional Budget Office (CBO) recently reported that the "larger than anticipated reduction in the use of home health services" was the primary reason total Medicare spending fell 1 percent in fiscal year 1999. Likewise, according to the American Hospital Association's Year 2000 Lewin Study, BBA97 has reduced hospital-based home health services by 30.5%—*the largest reduction of any hospital service affected by the* BBA 97.

Repeal of the 15% cut would not add a dime to Medicare home health expenditures, but would help correct CBO's error and partially restore congressional intent. We can assure you that home health care would generate more savings to Medicare than would a 15% cut if VNAs and other home health providers were allowed to provide sufficient services to patients.

2. Improve the PPS outlier system.

A direct method for more appropriately linking reimbursement to cost of care would be improvement of the PPS outlier system. An example on HCFA's website for constructing an outlier payment demonstrates the disparity between HCFA's imputed cost for a 60-day episode of care (for case-mix category weighted 1.9532)—$6534.93—and the total payment for the episode (including the outlier supplement payment)—$4214.65. In this example, reimbursement with the outlier payment is 64% of the total wage-adjusted imputed cost of care of the episode based on HCFA data.

We recommend that the subcommittee authorize $500 million in each of the next five years to be used as outlier payments under the prospective payment system for services to the most medically-complex and costly patients. This funding level for

outlier payments would be equivalent to 10% of the total payments projected or estimated to be made under the PPS each year. This would double the current BBA97 5% allocation requirement for outliers. Under this provision, the added portion of the outlier pool would not be subject to the budget neutrality factor and would not reduce the base episode payments.

3. Create a fee-schedule for non-routine medical supplies.

Our recommendation is to remove medical supplies from the per-episode payments under the prospective payment system and create a budget-neutral fee schedule for only the supplies that are actually used by patients. Unbundling the average cost of the non-routine medical supplies from the base episode payment rate is essential because some agencies' patient populations have greater or lesser than average medical supply needs. The bundling of the average cost of non-routine medical supplies would underpay or overpay agencies depending on the needs of their patients.

In addition, Medicare beneficiaries receiving home health agency (HHA) services for a specific illness or injury may have a preexisting need for medical supplies for a non-related chronic illness. In these cases, the beneficiary would have an established relationship with an HME provider. Under the PPS final rule, HHAs would be responsible for the supplies unrelated to the reason for home health admission. Therefore, an abrupt switch from the HME supplier to the HHA may leave beneficiaries vulnerable if there is a gap in services or confusion about a beneficiary's medical supply needs.

4. **The five national associations representing home health care also recommend that you instruct HCFA to**

Authorize emergency payments during the first six months of PPS, which would have minimal budget impact. We support the provision in S. 2835 (the "Grassley-Feingold" bill) that would provide one-time advance payments to providers during the transition from IPS to PPS to account for cash-flow crises as a result of the elimination of the Periodic Interim Payment (PIP) system. Payments would equal the average total Medicare costs incurred by an eligible agency in the most recent three-month period reported on the agency's most recently-settled cost report. Payments would be available for six months and be repaid within twelve months.

PIP, which is primarily provided to non-profit, community-based home health providers, will be discontinued as of October 1, 2000. If PPS delays a substantial portion of payment until after termination of a patient episode, providers will have significant cash flow problems. Many agencies are unable to secure lines of credit or other loans because of the effect of the IPS on cash reserves.

In addition, VNAA urges you to instruct HCFA to change the split payment ratio to 80/20 from the 60/40 in the final rule. The vast majority of our patient care is provided in the first 30 days following patient admission. Reimbursement of 60% of the episode payment three weeks following the start-of-care will present significant cash flow problems for VNAs. A change in the split-payment ratio would be budget neutral.

Reimburse HHAs for OASIS-related costs

Under the PPS final rule, agencies will be reimbursed $4.32 per episode for ongoing OASIS adjustment costs and a one-time implementation cost for OASIS form changes of $5.50 per first year episodes.

VNAA surveyed our members and asked the following question, "What is your best estimate of the average costs incurred during a 60-day episode of patient care by performing the OASIS survey (i.e. total costs for all assessments during the 60-day episode—start-of-care, discharge, and any other OASIS assessment during that timeframe)? Please estimate only the additional costs of doing OASIS vs. your previous patient assessment."

The results from our survey indicated that VNAs' average per 60-day episode cost for performing the OASIS assessment is $67, primarily due to labor costs that are not accounted for by HCFA. Based on this data, we believe that a significant amount of the OASIS costs will not be reimbursed under PPS. VNAA believes that OASIS data will provide invaluable patient outcomes and normative standards data. However, OASIS is overly burdensome and costly. *We recommend additional per-episode reimbursement for OASIS to account for labor costs or instruction to HCFA to reduce the number of assessment questions to the 20 used for case-mix under PPS. We also recommend that the assessment be limited to Medicare and Medicaid patients only.*

Clarify in the Medicare statute a uniform, reasonable, and up-to-date definition of a Medicare home health agency branch office.

This definition must focus on an agency's ability to provide quality care and positive patient outcomes rather than the current definition that imposes arbitrary and ineffective time and/or distance requirements between the parent office and the branch office. Medicare home health policy regarding branch offices must recognize that technological advances (e.g., communication tools that allow almost instantaneous information exchange) provide efficient and effective ways to "distance manage" branch offices and workstations.

Increase payments for home health services in rural areas by 10 percent

A 10% add-on to the episodic base payment for rural home health agencies would help address the 12–15% higher costs of delivering care in these areas.

IV. Conclusion

Thank you again for the opportunity to present our views. We appreciate the fact that you are working with a finite set of funds and, therefore, have difficult choices to make. VNAA asks you to keep in mind the issues that we have raised in our testimony. Your support at this important time of transition to PPS is essential. Home health care has the potential to save the Medicare program millions (if not billions) of dollars. It should be a primary component of Medicare reform efforts to extend the life of the trust fund. Most importantly, home health care is the preferred choice of individuals with chronic illnesses or disabilities. It enables Americans to live independently and remain a part of their communities. I would be pleased to answer any questions about our testimony. We look forward to working with you this year and years to come.

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

Benefit Type	FY97	FY98 Amount (billions)	FY99
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	11 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.

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

CHART 1 -- ANNUAL GROWTH RATE: MEDICARE

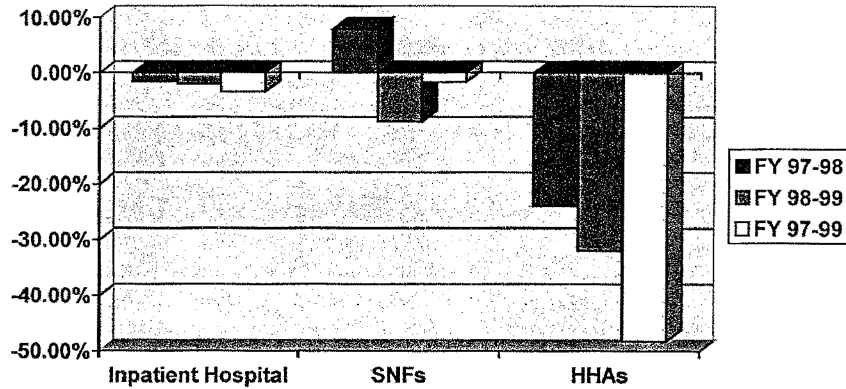
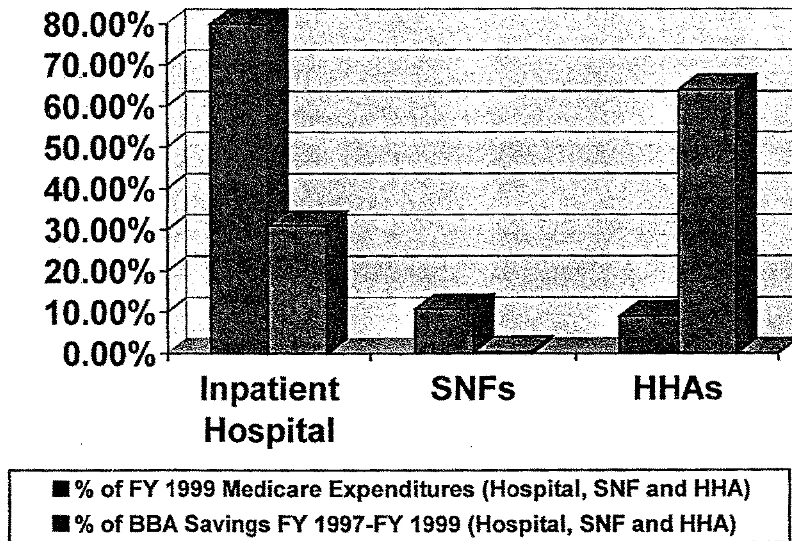


CHART 2: EFFECTS OF THE BBA97 ON SPENDING AND SAVINGS



Source: Congressional Budget Office

Chairman THOMAS. Thank you, Ms. Sutherland.

And before I turn it over to Mr. Renaudin, I want to let the gentleman from Louisiana chair because I know when I am outclassed. I have get to get two Louisianans going after each other, rather than someone from California in the middle of that.

And I have read your testimony. And it seems to me that probably the most appropriate remark I could make—I apologize. I have got to go to a meeting the Speaker just called me to—is that

this needs to be a joint effort. And probably the best way to make it a joint effort is that I would invite all of you to bring the numbers, and we will bring the decimal points.

Ms. SUTHERLAND. Fair enough.

Mr. MCCRERY [presiding]. Please proceed.

STATEMENT OF GEORGE RENAUDIN, SENIOR VICE PRESIDENT OF ADMINISTRATION, OCHSNER HEALTH PLAN, METAIRIE, LOUISIANA, ON BEHALF OF THE AMERICAN ASSOCIATION OF HEALTH PLANS

Mr. RENAUDIN. Thank you. Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to testify. I am George Renaudin, a senior vice president with Ochsner Health Plan. I am testifying today on behalf of the American Association of Health Plans.

The Medicare Plus Choice program offers important advantages to both Medicare beneficiaries and the government. Fifteen years ago the government made a deal with Medicare beneficiaries. Medicare HMOs would achieve cost savings and pass along those savings to beneficiaries in the form of increased benefits and reduced out-of-pocket costs in exchange for the beneficiary's enrollment in an HMO. It is an important point that needs to be considered.

The incredible success of the Medicare HMO program led Congress to establish the Medicare Plus Choice program in 1997 to continue increasing the choices available to Medicare beneficiaries. Unfortunately, the Medicare Plus Choice program has not met this promise and has, in fact, led to fewer choices for many beneficiaries.

There are a few major problems that have led us to this detrimental result:

First and foremost, the Medicare Plus Choice program is significantly underfunded.

Second, the Health Care Finance Administration has imposed, many times, excessive regulatory burdens on health plans participating in the program. Much of the funding problem has been caused by the unintended consequences of the Medicare Plus Choice payment formula. To demonstrate the issue, please consider the following facts:

The total premiums collected by health plans participating in the Federal employee health benefits program for the average enrollee has increased 29.1 from 1997 through the end of 2000. During the same period, the government payments to Medicare Plus Choice plans has increased an average rate of only 8.6 percent.

In January 2001, as you have heard from Mr. Berenson, more than 900,000 beneficiaries will be forced to change health plans and return to the Medicare fee-for-service system. This number is greater than the number who were affected in the previous 2 years combined. Additionally, many other beneficiaries, including those in my plan, have lost important benefits and are paying much higher out-of-pocket costs, even though they are able to keep, in some instances, the Medicare Plus Choice plan.

To understand why beneficiaries are losing choices of benefits, please consider that Ochsner's expected medical costs in 2001 will exceed our expected payment by 11 percent in the areas from

which we are withdrawing. No health plan can survive while paying 11 percent more in health care benefits than it receives in payments. Keep in mind this 11-percent loss is before any administrative costs at all are incurred.

In addition to the difficulties resulting from the program's inadequate funding and excessive regulations, you should also know about an additional problem in some parts of the country and in several parishes back home. Just so that you know, in Louisiana we call counties parishes.

The problem facing some plans is the monopolistic behavior of a few providers who dictate payment rates to health plans that are at times higher than they would otherwise receive from participation in the Medicare fee-for-service program. The withdrawal decision is particularly difficult for a physician in hospital-owned health plans like mine. We did not take this action without much debate and discussion. We know and we regret that the disruption is particularly difficult for low-income Medicare beneficiaries whose health security will be severely compromised if this program is not saved quickly.

We realize that these disruptions are painful for our members and made every attempt to avoid causing such disruptions; changing benefit plans, trying to recontract with providers, cutting administrative costs, all of those factors were considered. Despite this, and with our regret, you should note that this program has, and does, provide unprecedented value to Medicare beneficiaries, and we are committed to working with you to save this program.

We believe that approximately $15 billion in direct payments to the Medicare Plus Choice program is needed over the next 5 years to stabilize this program on a long-term basis. A commitment of this magnitude is needed to assure that the Medicare Plus Choice program fulfills its promise of preserving and expanding health care choices for all Medicare beneficiaries, as promised when the BBA was enacted.

We also urge you to combine this additional funding with meaningful regulatory reforms so beneficiaries are receiving quality and value in the Medicare Plus Choice plans. As a former regulator, I believe it is critically important to assure that the benefits of regulations outweigh the costs of those same regulations. Recognizing that more than 6 million Medicare beneficiaries are relying on the Medicare Plus Choice program to meet their health care needs, we believe this is one of the most pressing issues facing Congress.

We look very much forward to working with the Subcommittee to address this seriously important issue in the remaining days of the 2000 legislative session.

Thank you very much.

[The prepared statement follows:]

Statement of George Renaudin, Senior Vice President of Administration, Ochsner Health Plan, Metairie, Louisiana, on behalf of the American Association of Health Plans

Mr. Chairman and members of the subcommittee, thank you for the opportunity to testify on the impact the Balanced Budget Act of 1997 (BBA) has had on Medicare+Choice organizations and the beneficiaries they serve. I am George Renaudin, Senior Vice President of Administration for Ochsner Health Plan, which is the largest HMO in Louisiana and the fifth largest provider-owned HMO in the nation. I oversee administrative functions at Ochsner Health Plan, including the

management of our Medicare+Choice plan, Total Health 65, which currently serves 36,572 Medicare beneficiaries. In January 2001, due to the problems I will discuss in my testimony, we will be forced to withdraw from six parishes in Louisiana and terminate coverage for 5,982 beneficiaries.

I am testifying today on behalf of the American Association of Health Plans (AAHP), which represents more than 1,000 health maintenance organizations (HMOs), preferred provider organizations (PPOs), and other similar health plans that provide health care coverage to more than 140 million Americans.

AAHP's membership includes Medicare+Choice organizations that collectively serve more than 75 percent of those beneficiaries who have chosen Medicare managed care over the fee-for-service program. AAHP member plans have strongly supported efforts to modernize Medicare and give beneficiaries the same health care choices that are available to working Americans. AAHP member plans have had a longstanding commitment to Medicare and to the mission of providing high quality, cost effective services to beneficiaries.

To fully understand the impact the BBA has had on Medicare+Choice plans and enrollees, I believe we should begin by briefly reviewing the Medicare HMO program that existed before Congress established the Medicare+Choice program in 1997. Under the original Medicare HMO program, the government paid health plans a set amount per month to cover the health benefits of each beneficiary. This amount was based on 95 percent of the costs the government paid for beneficiaries served by the Medicare fee-for-service system.

This Medicare HMO program offered important advantages to both the government and Medicare beneficiaries. The government paid less for beneficiaries who enrolled in Medicare HMOs; at the same time, beneficiaries were well-served by a system that allowed Medicare HMOs to provide high quality care while providing additional benefits—beyond those covered by the fee-for-service program—often at no additional cost to beneficiaries. By delivering care in a more efficient way, Medicare HMOs achieved cost savings that were passed along to beneficiaries in the form of increased benefits and reduced out-of-pocket costs. As a result, beneficiaries in Medicare HMOs did not have to purchase costly Medigap coverage to protect themselves from health care expenses not covered by the old fee-for-service program.

The success of the Medicare HMO program was evidenced by the fact that beneficiaries signed up for Medicare HMO coverage in large numbers. From December 1993 through December 1997, enrollment in Medicare HMOs increased at an average annual rate of 30 percent. In states such as Louisiana, Pennsylvania, Ohio, and Texas, enrollment in Medicare HMOs increased even more rapidly. In Louisiana, enrollment in Medicare HMOs increased from 2,344 in 1994 to 80,756 in 1997, reflecting a 33-fold increase. In December 1997, shortly after the enactment of the BBA, Medicare HMO enrollment stood at 5.2 million, accounting for 14 percent of the total Medicare population—up from just 1.3 million enrollees and 3 percent of the Medicare population in December 1990.

Beneficiaries valued this important health care choice under the original Medicare HMO program—and still value it today—because Medicare HMOs, when adequately funded, are able to provide a more comprehensive package of benefits and lower out-of-pocket costs than the old Medicare fee-for-service system. This is particularly important to low-income beneficiaries. For many seniors and persons with disabilities who live on fixed incomes, having access to a Medicare HMO means that they can spend their limited resources on groceries and other daily essentials—instead of "going without." Beneficiaries also like Medicare HMOs because they provide coordinated care and place a strong emphasis on preventive services that help them to stay healthy and avoid preventable diseases. According to a survey conducted by HCFA, when Medicare managed care enrollees were asked to rate their plans on a scale of 1 to 10 (with 10 being the highest score), 50 percent assigned a "10" rating to their plan and another 34 percent assigned an "8" or a "9" rating to their plan.

The success of the Medicare HMO program inspired Congress to establish the Medicare+Choice program in 1997. The new program was intended to further expand beneficiaries' health care choices by establishing an even wider range of health plan options and by making such options available in areas where Medicare HMOs were not yet available. Three years later, however, the Medicare+Choice program has not fulfilled its promise of expanding health care choices for Medicare beneficiaries. Instead, a large number of beneficiaries have lost their Medicare+Choice plans or experienced an increase in out-of-pocket costs or a reduction in benefits.

Two major problems are responsible for this outcome: (1) the Medicare+Choice program is significantly underfunded; and (2) the Health Care Financing Administration (HCFA) has imposed excessive regulatory burdens on health plans participating in the program. The funding problem has been caused by the unintended consequences of the Medicare+Choice payment formula that was established by the

BBA, as well as the Administration's decision to implement risk adjustment of Medicare+Choice payments on a non-budget neutral basis. Under this formula, the vast majority of health plans, including Ochsner Health Plan, have been receiving annual payment updates of only 2 percent in recent years—while the cost of caring for Medicare beneficiaries has been increasing at a much higher rate.

To underscore the inadequacy of the government's payments to Medicare+Choice plans, I offer three examples for the subcommittee's consideration:

1. Total premiums collected by health plans (from OPM and from enrollees) participating in the Federal Employees Health Benefits Program (FEHBP) have increased, for the average beneficiary, by a total of **29.1** percent between January 1997 and December 2000. During this same time period, government payments to Medicare+Choice plans have increased, for the average beneficiary, by a total of only **8.6** percent. In 2001, government payments to Medicare+Choice plans will again generally increase by just 2 percent—making this the third time in four years that the annual update was 2 percent. In Louisiana, our medical costs have increased at a rate of 5 to 7 percent per year, while we have received than a two percent increase in payment per year because of the impact of the risk adjuster and because Medicare+Choice plans paid the entire cost of the Medicare Beneficiary Information Campaign for the first three years of the program. We have had to both withdraw from service areas and increase beneficiary out-of-pocket costs in order to sustain participation in the program.

2. In many geographic areas where large numbers of Medicare beneficiaries are enrolled in Medicare+Choice plans, government payments for Medicare fee-for-service beneficiaries will exceed government payments to plans on behalf of Medicare+Choice beneficiaries by **$1,000 or more per beneficiary in 2004.** These areas include—to name just a few—my home town of New Orleans (which currently has 26,532 Medicare+Choice enrollees); Los Angeles (314,000 Medicare+Choice enrollees); New York (174,000 Medicare+Choice enrollees); Miami (134,000 Medicare+Choice enrollees); and Philadelphia (78,000 Medicare+Choice enrollees). This payment differential has challenged the ability of health plans to offer beneficiaries the quality coverage they deserve and, additionally, to maintain provider networks and expand into new geographic areas.

3. By establishing a blend of local and national rates, the BBA intended to reduce the variation in Medicare+Choice payments among counties. As noted above, however, the blend has been funded in only one year and government payments to Medicare+Choice plans continue to vary among geographic areas, including neighboring geographic areas. For example, the monthly actual payment from the government is $451 in Terrebonne parish, Louisiana and $574 in Orleans parish, Louisiana—a difference of $123 even though these areas are just a 40-minute drive apart.

These examples raise serious concerns about the adequacy of Medicare+Choice payments. However, to fully appreciate the crisis in the Medicare+Choice program, it is important for Congress to examine the impact it has had on Medicare beneficiaries.

In January 1999, 407,000 beneficiaries were forced to change health plans or return to the Medicare fee-for-service system because many health plans—faced with inadequate government payments and excessively burdensome regulatory requirements—were forced to curtail their participation in the Medicare+Choice program. In January 2000, 327,000 experienced similar disruptions in their health coverage. Additionally, many other beneficiaries have lost important benefits and are paying higher out-of-pocket costs even though they have been able to keep their Medicare+Choice plans. To understand why beneficiaries are losing choices and benefits, please consider that, in the six parishes from which we are being forced to withdraw in January 2001, the ratio of medical costs to total reimbursements is 111 percent for our Medicare+Choice members. No health plan can survive while paying 11 percent more in health care benefits than it receives in payments.

These disruptions have been particularly painful for low-income Medicare beneficiaries. A recent analysis by AAHP indicates that Medicare+Choice plans play an important role in providing supplemental coverage (i.e., coverage that pays for services not covered by Medicare Part A and Part B) to Medicare beneficiaries who are financially vulnerable. Our analysis indicated that a very large proportion of Medicare+Choice enrollees are "unsubsidized"—meaning that they do not receive any third party assistance from, for example, a former employer or through Medicaid, in purchasing supplemental coverage for prescription drugs and protection against out-of-pocket expenses. For many of these individuals, affordable Medicare+Choice plans may be the only alternative to going without supplemental coverage.

For many vulnerable beneficiaries, returning to the fee-for-service program, with its higher costs and reduced benefits, would result in serious hardships. Changing plans and health care providers—plus losing benefits such as prescription drug coverage and paying large supplemental coverage premiums—can be a highly traumatic and disruptive experience for low-income beneficiaries.

In an effort to address the crisis in the Medicare+Choice program, Congress enacted the Balanced Budget Refinement Act of 1999 (BBRA). While this legislation was a step in the right direction, it provided only a small fraction of the resources that are needed to fully stabilize the program on a long-term basis. As a result, the Medicare+Choice program will experience further disruptions in January 2001. I do not want to downplay the significance of the BBRA, however, because the small increase allowed us to stay in a parish—with 2,000 members—from which we otherwise would have been forced to withdraw.

As the subcommittee knows, July 3 was the deadline by which Medicare+Choice organizations were required to notify HCFA of their intention to participate in or withdraw from the Medicare+Choice program during the 2001 contract year and, additionally, submit any proposed changes affecting premiums or benefits. In the weeks leading up to this deadline, Medicare+Choice organizations were forced to make extremely difficult decisions on these matters. Those health plans that decided to curtail their participation in the program did so only as an option of last resort. In many cases, health plans reluctantly concluded that—because Medicare+Choice payments are inadequate and because the program's regulatory requirements are so burdensome—the Medicare+Choice program is not providing health plans a viable framework for serving Medicare beneficiaries.

The Health Care Financing Administration (HCFA) recently announced that 934,000 Medicare beneficiaries will suffer the loss of their current health coverage in January 2001 because Medicare+Choice organizations are being forced to exit the program. This number is greater than the number who were similarly affected in the previous two years combined. Moreover, among the 934,000 beneficiaries who will lose their health plans in January 2001, approximately 159,000 will be left with no other Medicare+Choice HMO options in their area.

This is unfortunate news for hundreds of thousands of Medicare beneficiaries and it is disappointing to Medicare+Choice plans that have done everything possible to avoid this unfortunate outcome. The reality is that these withdrawals could have been avoided. For two years, AAHP and our member plans have urged Congress and the Administration to take bold action to address the crisis in the Medicare+Choice program. Although Congress took an important first step to improve Medicare+Choice payments last year, the need for more meaningful changes has not been addressed. Beneficiaries are now paying a heavy price for this inaction.

Despite our disappointment, we remain committed to the success of the Medicare+Choice program and we will continue to work with you to advance the changes that are clearly needed to put the program on sound footing. We are encouraged that there is bipartisan movement within Congress to enact such changes. We also appreciate Congressman Bilbray's resolution—approved by the House on June 29 by a strong bipartisan vote of 404 to 8—which acknowledged that "inadequate reimbursement rates" are a problem in the Medicare+Choice program and that action must be taken this year to address this critical issue. I thank Congressmen McCrery and Jefferson and other members of the Louisiana delegation, as well as the 11 members of this subcommittee, who voted for this resolution.

We now urge you to take action this year on specific legislation that follows through on the serious concerns you expressed when you voted for Congressman Bilbray's resolution. We believe Congress must provide $15 billion directly to Medicare+Choice plans over the next five years to stabilize the Medicare+Choice program on a long-term basis. A commitment of this magnitude is needed to assure that the Medicare+Choice program fulfills it promise of preserving and expanding health care choices for all Medicare beneficiaries. As you consider options for devoting more funds to the program, we urge you to assure that resources are allocated in such a way as to assure that the Medicare+Choice program is viable in areas where beneficiaries have already selected health plan options and that the program can expand in areas where such options are not yet widely available.

We also urge you to combine this additional funding with meaningful regulatory reforms so beneficiaries are receiving quality and value in their Medicare+Choice plans. It is critically important to assure that the benefits of regulations outweigh their costs. Currently, Medicare+Choice plans are being forced to devote substantial human and financial resources toward compliance activities, thus leaving fewer resources available for paying for health care services provided to beneficiaries—resulting in higher premiums and reduced benefits for beneficiaries. One example of a set of unnecessarily onerous requirements that merit immediate attention can be

found in the physician encounter data requirements under the Medicare+Choice risk adjustment initiative. Preparations for their implementation are requiring an enormous commitment of resources by Medicare+Choice organizations, and this burden will spill over to require similar efforts by their network providers. However, less costly options are available that would meet HCFA's need for data for risk adjustment purposes. We believe beneficiaries will be better served by a regulatory environment that assures quality of care and, at the same time, assures that the costs associated with regulations do not unnecessarily divert resources away from patient care and benefits.

Recognizing that more than 6 million Medicare beneficiaries are relying on the Medicare+Choice program to meet their health care needs, we believe this is one of the most important issues facing Congress. We look forward to working with the subcommittee to address this critically important issue in the remaining months of the 2000 legislative session.

Mr. MCCRERY. Thank you, Mr. Renaudin.

Mr. Bedlin?

STATEMENT OF HOWARD BEDLIN, VICE PRESIDENT, PUBLIC POLICY AND ADVOCACY, NATIONAL COUNCIL ON THE AGING

Mr. BEDLIN. Thank you, Mr. Chairman.

Mr. Chairman, Representative Stark, Members of the Subcommittee, the National Council on the Aging, the Nation's first organization formed to represent older Americans and those who serve them, appreciates this opportunity to share our views on the need for further refinements to the BBA.

Older Americans across the Nation hope that this will be the year to finally provide access to affordable, meaningful prescription drug coverage. Unfortunately, the prospects for a prescription drug bill becoming law this year are not good. Little time is left on the legislative calendar, and the Finance Committee is struggling with Chairman Roth's complex proposal.

Seniors who have been counting on getting prescription drug coverage soon will be deeply disappointed. The public debate over prescription drugs has raised high expectations that something helping beneficiaries directly will be enacted into law. If all Congress does on Medicare this year is increase provider reimbursement rates, we suspect the beneficiaries' disappointment will turn to anger.

Funding for BBA refinements must not diminish the resources committed to Medicare prescription drug coverage. In evaluating provider requests, we urge you to exercise caution and consider how much will give-backs increase beneficiary premiums, how will give-backs affect trust fund solvency, to what extent are providers' financial difficulties caused by non-Medicare payment sources, and what evidence indicates that beneficiaries are experiencing real access problems for Medicare services?

In addition to considering the concerns of Medicare providers, NCOA strongly urges the Subcommittee to include provisions that would directly help beneficiaries. We appreciated, for example, the outpatient co-insurance, and immunosuppressive drug coverage improvements included last year in BBRA. However, these initiatives comprised only about 2.5 percent of the $16 billion allocated. This year we must strike a more equitable balance between spending on provider and beneficiary concerns.

My primary message today is that providers are not the only ones who can use some assistance this year. Medicare beneficiaries need help, too. For example, we urge the Subcommittee to lift the cap on immunosuppressive drug coverage by passing Representatives Canady's and Thurman's H.R. 1115 and to accelerate the phase-down of outpatient co-insurance to 10 years. Other incremental prescription drug improvements that should be passed include Representative Dunn's H.R. 2892, which would cover certain self-injected drugs, and Representative Cardin's H.R. 634, which would improve access to Medigap drug coverage.

Our written statement describes specific legislative recommendations that address serious beneficiary concerns. The proposals are generally noncontroversial and have or can gain strong bipartisan support.

For example, we urge the Subcommittee to fix the Medicare Home Health homebound problem, which is forcing beneficiaries to be imprisoned within their own homes. The homebound provision in H.R. 2546 is endorsed by 46 national organizations, representing tens of millions of beneficiaries. Specific examples in our written statement vividly illustrate just inhumane and outmoded the current homebound policy is.

We also urge the Subcommittee to pass Representative Stark's H.R. 745, which would give beneficiaries the option to receive Medicare Home Health in an adult day setting, modernizing the benefit by increasing choice, flexibility and competition. The bill is designed to be budget neutral, would enable family care givers to go to work and would increase social interaction in a less-isolated setting.

NCOA also supports a complete repeal of the proposed additional 15-percent cut in Medicare Home Health. In the areas of health promotion and disease prevention, we urge the Subcommittee to continue the shift in Medicare from a sickness to a wellness program that began in BBA by passing Representative Levin's H.R. 3887.

To improve Medicare Plus Choice for beneficiaries, we urge the Subcommittee to pass Representative Kelly's H.R. 4753, which would empower beneficiaries by creating Medicare consumer coalition demonstration projects to decentralize and improve education and information and negotiate for better benefits, lower premiums and multi-year contracts. Consumer coalitions could also help lower the cost of prescription drugs, Medigap and long-term care insurance and help beneficiaries choose among multiple PBMs

Our written testimony also includes specific recommendations to improve Medicare for low-income and chronically ill beneficiaries.

Last, but not least, we appreciate and support Representative Thomas's proposal to improve beneficiary coverage and appeals in Title II, Subtitle C of H.R. 4680.

In conclusion, in crafting this year's Medicare refinement bill, we urge the Subcommittee to remember that beneficiaries need help too. Collectively, the proposals described in our written statement would significantly improve Medicare for beneficiaries at a relatively modest cost. We look forward to working with the Subcommittee to move forward on proposals that can achieve broad bipartisan support.

Thank you.

[The prepared statement follows:]

Statement of Howard Bedlin, Vice President, Public Policy and Advocacy, National Council on the Aging

Chairman Thomas, Representatives Stark and members of the subcommittee, The National Council on the Aging (NCOA)—the nation's first organization formed to represent older Americans and those who serve them—appreciates the opportunity to share our views on the need for further refinements to the Medicare provisions of the Balanced Budget Act of 1997 (BBA).

The National Council on the Aging is a private, nonprofit research, education, and advocacy organization. With over 7,500 member and affiliated community service and consumer organizations, NCOA represents America's diverse aging network. We are proud of our 50-year history of innovation, including the development of: the Meals on Wheels program; the first national guidelines for geriatric care managers; the Foster Grandparents program; and the only accreditation program for adult day service providers. Members of our National Coalition of Consumer Organization on Aging—one of ten NCOA constituent units—represent over 1.5 million older consumers.

Historically, NCOA has had a particular interest in the needs of disadvantaged, frail older persons. Therefore, as we look at the many issues facing Medicare beneficiaries today, we try to focus special attention on low-income chronically ill beneficiaries.

Older Americans across the nation hope and expect that this will be the year to finally provide access to affordable, meaningful prescription drug coverage to all Medicare beneficiaries. NCOA is pleased that there is virtually unanimous bipartisan consensus that significant new resources must be devoted to providing such coverage. The debate is no longer about whether, but how.

Unfortunately, it appears to us that the prospects for a prescription drug bill becoming law this year are not good. Little time is left on the legislative calendar and the Senate Finance Committee appears to be struggling with a proposal offered by Chairman Roth, which is significantly different from the bill passed by the House and adds major new elements to an already complicated debate. For example, NCOA strongly opposes a 20 percent copayment for Medicare Home Health services, as Chairman Roth has suggested.

The issues involved in providing Medicare prescription drugs are extremely complex—both substantively and politically—and we are saddened to conclude that Medicare beneficiaries will most likely have to keep waiting for a bill to become law. We urge members of Congress to continue to explore areas for bipartisan compromise in hopes that a miracle can happen, but we expect that millions of seniors who have been counting on getting prescription drug coverage soon will be deeply disappointed.

We acknowledge and are concerned that providers in many parts of the country are struggling, for reasons that may include, but certainly go beyond, the BBA. At the outset, we strongly urge that any funding for BBA refinements in no way diminish the resources committed to making prescription drug coverage available to all Medicare beneficiaries. In determining the degree to which specific provider requests merit action this year, we urge you to exercise caution and seriously consider how much provider give-backs under Part B would increase beneficiary premiums and the extent to which Part A give-backs would adversely affect trust fund solvency.

We also suggest that attempts be made to analyze the extent to which Medicare payments are causing providers' financial difficulties, relative to payments from other sources, such as employer-based private insurance and Medicaid. More important, we urge you to closely examine what evidence exists that beneficiaries are experiencing real problems in accessing specific Medicare covered services. In conversations with our members in the field and with other national organizations representing Medicare beneficiaries, we have found little evidence to suggest that serious access problems exist, except in the home health area.

Nonetheless, it appears that the most likely Medicare legislation to become law this year will address refinements to the BBA. However, no one should doubt that the very visible public debate over Medicare prescription drug coverage has raised high hopes and expectations that something helping beneficiaries directly will be enacted into law this year. If all Congress accomplishes on Medicare this year is to increase provider reimbursement rates, we strongly suspect that, for many beneficiaries, disappointment will turn to anger.

In addition to considering the concerns of Medicare providers, we strongly urge the Ways and Means Committee to take the opportunity this year to include provisions that would directly help beneficiaries.

We greatly appreciated, for example, the outpatient coinsurance and immunosuppressive drug improvements included in last year's Balanced Budget Refinement Act (BBRA). However, these initiatives comprised only a very small portion of the $16 billion allocated in the BBRA. This year, we should revisit these and other issues and go further, while striking a more equitable balance between new spending on provider and beneficiary concerns.

Our testimony today is intended to make a number of specific recommendations that, we believe, combine good policy with good politics. We believe they can garner broad bipartisan support in Congress as well as strong support from Medicare beneficiaries. Some of our suggestions address clear, serious problem experienced by Medicare beneficiaries. Others would help beneficiaries by strengthening and modernizing the Medicare program. Collectively, the proposals would significantly improve Medicare at a relatively modest cost.

A number of the recommendations we have included are directly related to specific BBA and BBRA provisions, such as:

- improving coverage for preventive care (BBA sections 4101 to 4108);
- fixing the Medicare Home Health "homebound" problem (BBA section 4613(a));
- improving Medicare+Choice (M+C) for beneficiaries (BBA section 4001);
- conducting further analysis on the impact of using lower Medicaid rates to determine provider payments for Qualified Medicare Beneficiaries (BBA section 4714);
- lifting the cap on immunosuppressive drug coverage (BBRA section 227); and
- accelerating the phase-in for hospital outpatient coinsurance (BBRA Title II, Subtitle A).

NCOA recommends that the logical next steps be taken on these issues to better address the problems that were intended to be resolved.

Our recommendations are divided into six sections: (1) Improving Medicare Prescription Drug Coverage for Beneficiaries; (2) Improving Medicare Home Health for Beneficiaries; (3) Improving Medicare Preventive Care Coverage for Beneficiaries, (4) Improving Medicare for Low-Income Beneficiaries; (5) Improving Medicare for Chronically Ill Beneficiaries; and (6) Other Medicare Improvements for Beneficiaries

Many of the bills that we support in our testimony have not yet been scored by the Congressional Budget Office (CBO). If they had been scored, we believe that significantly more members of Congress would have signed on as cosponsors than at present. We request that the subcommittee ask CBO to score the bills described below over the next several weeks so that, come September, they will receive the informed consideration they deserve.

Improving Medicare Prescription Drug Coverage for Beneficiaries

Improving access to prescription drug coverage is the number one concern for older Americans. It is clearly the biggest problem now facing beneficiaries. NCOA has been working closely with other organizations in the Leadership Council of Aging Organizations (LCAO) to move legislation consistent with principles we agreed upon early in the year. A Medicare prescription drug benefit should be accessible, voluntary, affordable, manageable and effective.

As we have stated above, it appears that enactment of a Medicare prescription drug bill is not likely this year. However, that does not mean that Congress should do nothing in this area. We strongly urge that Congress take advantage of the unique opportunity and momentum that currently exists to **do something this year to improve prescription drug coverage for Medicare beneficiaries.**

We believe that there are three incremental proposals that are straightforward and inexpensive, would help a significant number of beneficiaries in need, and could be passed with broad bipartisan support. The proposals would not impede more comprehensive reforms from occurring at a later date. Passage of the three proposals would acknowledge the clear public sentiment that this Congress should not respond to the urgent need for Medicare prescription drug coverage by *doing nothing.* Specifically, we urge the Ways and Means Committee to pass: (1) H.R. 1115, the Immunosuppressive Drug Coverage Extension Act, (2) H.R. 2892, the Access to Innovation for Medicare Patients Act, and (3) H.R. 634, the Medigap Access Protection for Seniors Act. We also urge the subcommittee to consider coverage of oral cancer drugs.

H.R. 1115, the Immunosuppressive Drug Coverage Extension Act, would eliminate the time limitation on benefits for immunosuppressive drugs under Medicare. We are grateful for last year's BBRA improvement to extend coverage from 36 to 44 months for individuals whose transplant occurred after December 31, 1996. Representatives Canady and Thurman have introduced H.R. 1115 to eliminate the time

limitation entirely for transplant recipients who are Medicare-eligible based on age or disability. The bill has 272 bipartisan cosponsors, including 22 members of the Ways and Means Committee and 29 members of the Commerce Committee. President Clinton's budget also proposed to raise the current cap. In a December 1999 Institute of Medicine report (requested by Congress in the BBA), the IOM recommended that the rationale for eliminating the time limitation is strong, noting the positive economic, clinical and social implications of indefinite Medicare coverage.

The current limit is arbitrary and costly. It makes no sense for Medicare to pay for the more expensive consequences of organ rejection, such as dialysis or a second transplant, but refuse to pay for the drugs to prevent the rejection of the initial transplanted organ beyond 44 months. This coverage can mean the difference between life and death for some and, for others, the difference between a transplant recipient having to experience the pain of an organ rejection, a return to dialysis—for kidney recipients—and the return to a long waiting list for another organ. We urge the Ways and Means Committee to pass H.R. 1115.

H.R. 2892, the Access to Innovation for Medicare Patients Act, would expand Medicare coverage of certain self-injected biologicals. Sponsored by Representative Dunn the proposal has 65 bipartisan cosponsors. Currently, Medicare will only cover drugs that are administered "incident to" a physician's service. These include injectables or infusion therapies administered in a physician's office or an outpatient setting. There is no good policy rationale for Medicare to cover intravenous drugs and physician-administered formulations, but to refuse to cover more patient-friendly, convenient alternatives. Refusing to cover biologicals that can be self-administered is particularly harmful to beneficiaries in rural areas and disabled and lower income seniors that have difficulty getting to their physicians' offices. Almost 1.2 million Medicare beneficiaries suffer from the four diseases that the biologicals under the bill could help with—Rheumatoid Arthritis, Multiple Sclerosis, Hepatitis C, and Deep Vein Thrombosis. We urge the Ways and Means Committee to pass H.R. 2892.

H.R. 634, the Medigap Access Protection for Seniors Act, would guarantee that Medicare beneficiaries enrolled in M+C plans offering prescription drug coverage have access to a Medigap policy that offers similar presciption drug coverage in the event the M+C plan terminates service in the area in which the beneficiary resides. The proposal is sponsored by Representative Cardin. By next January, approximately 1.5 million Medicare beneficiaries will have been forced involuntarily to leave their M+C plan. Unfortunately, for those beneficiaries who have no choice but to enroll in the traditional fee-for-service program, only three of the ten Medigap policies are guaranteed issue, with no underwriting. Not one of these three policies covers prescription drugs. Medicare beneficiaries in these situations must have access to a Medigap policy with prescription drug coverage. We urge the Ways and Means Committee to pass H.R. 634.

We also urge the Ways and Means Committee to analyze and consider extending Part B coverage to cancer drugs in oral forms. Currently, injectibles and IV chemotherapeutic agents are covered. Some limited oral chemotherapy drugs are covered only if they have an IV equivalent. Many of the newer chemotherapeutic agents will be in oral tablet form and will be easier for the patient to take. Since Medicare covers all IV and injectible cancer drugs now, serious consideration should be given to coverage of oral forms so that beneficiaries will have access to the most appropriate and effective cancer treatments.

Finally, NCOA would like to suggest an area for further analysis and discussion in hopes of helping to bridge the divide and find some middle ground between Republican and Democratic prescription drug proposals. One of the primary disagreements has been over the respective roles of the public and private sectors in providing such coverage. We suggest that additional work be done to explore the feasibility of developing a competitive system in which both private insurers and the traditional fee-for-service program offer prescription drug coverage on a level playing field. Conceptually, this is consistent with the proposal considered by the National Bipartisan Commission on the Future of Medicare. Clearly, a variety of important issues would need to be worked out, foremost among them—how to craft subsidies to avoid adverse selection and ensure affordability for all beneficiaries. NCOA looks forward to working with members of the subcommittee to develop a compromise Medicare prescription drug proposal that can receive broad bipartisan support.

Improving Medicare Home Health (MHH) for Beneficiaries

The MHH program is particularly important to lower income, frail beneficiaries. The typical home health user is widow over 75 years of age with income below $20,000. If our most vulnerable older Americans are to live independent lives and avoid premature institutionalization, a number of critical improvements must be

made to the program. We are specifically recommending that the Ways and Means Committee pass: (1) Section 5 of H.R. 2546, which would fix the "homebound" problem; (2) H.R. 745, which would give beneficiaries the choice to receive home health in an adult day setting; and (3) H.R. 4219, which would repeal the proposed additional 15 percent MHH cut.

H.R. 2546, the Preserve Access to Care in the Home (PATCH) Act, includes a provision that would fix the MHH homebound problem. The bill is sponsored by Representative Riley and includes several other home health provisions, some of which were addressed last year in BBRA. Section 5 of H.R. 2546 is identical to identical to S. 2298, sponsored by Senator Jeffords, cosponsored by Senators Helms, Snowe, Reed and Leahy, and endorsed by 46 national organizations represented millions of seniors and persons with disabilities. We are currently working with Rep. Markey to introduce a freestanding version of Section 5.

Under current law, in order for Medicare beneficiaries to receive coverage for home health services they must be "confined to home." Current irrational and inconsistent policy interpretations by the Health Care Financing Administration and followed by fiscal intermediaries are causing substantial harm to Medicare beneficiaries by effectively forcing home health users to be imprisoned within their own homes. For example, these restrictions are inappropriately denying access to adult day services, which complement home health benefits, relieve caregiver burdens and delay nursing home placement, at no cost to the Medicare program.

We recently heard of three homebound stories that help to illustrate the problem. First, a beneficiary with Alzheimer's disease in Vermont was denied home health coverage because, on a particular occasion, he wandered out of his home. Second, four beneficiaries in Illinois were not permitted to attend adult day care without losing home health coverage, even though the adult day center was *in the same apartment building* they lived in. Finally, a woman in Vermont never got to see her husband during the last two weeks of his life in a hospice, because she was afraid that a visit would result in her losing home health coverage. Current policy on the homebound requirement is inhumane and unnecessary.

Section 5 of H.R. 2546 would clarify that, while beneficiaries still must have a normal inability to leave home in order to receive MHH coverage, periodic absences from home would be allowed, and attendance at adult day care centers would be permitted without losing home health benefits. We urge your support of the proposal for a number of reasons, including:

- Since Medicare home health only covers part-time or intermittent services, supplemental benefits such as adult day care can be critical to keeping families together in a home or community setting;
- Current law can be detrimental to the health of a beneficiary who, for example, has suffered a broken hip and should walk around the block as part of her therapy plan, but does not for fear of losing home health coverage;
- Current law is unenforceable because there is no way to effectively monitor the frequency and length of absences from the home; and
- It is irrational to deny home health services to a quadriplegic beneficiary who is lifted into a wheelchair and uses specially adapted transportation and is therefore not considered to be homebound.

We strongly urge the Ways and Means Committee to pass section 5 of H.R. 2546.

H.R. 745, the Medicare Substitute Adult Day Care Act, would give beneficiaries the option to receive some or all of their Medicare home health services in an adult day setting. The bill is sponsored by Representative Stark and has 39 bipartisan cosponsors. A companion bill—S. 2826—was recently introduced by Senator Santorum. Fundamentally, the proposal would modernize the MHH benefit by giving beneficiaries more choice, making the benefit more flexible and increasing competition. This would be a substitution, not an expansion, of services. The bill would not make new people eligible for Medicare home health benefits or expand the list of services paid for. In fact, in addition to home health benefits, transportation, meals and planned supervised activities would also be provided at no additional cost to Medicare. The bill is designed to be budget neutral but has not yet been scored by CBO.

The primary difference from current law is **where** services would be provided. Giving beneficiaries and their families the choice to receive Medicare home health services in an adult day location has a number of important advantages, including:

- increasing social interaction in a less isolated setting, which will reduce depression and facilitate healing and rehabilitation;
- individualized therapeutic activities, nutrition, health monitoring and transportation for no additional cost to Medicare;
- improving providers' opportunities to monitor and observe the beneficiary's health status;

• enabling family caregivers to continue working, since the beneficiary would be cared for all day; and enhancing the ability to monitor and assure quality of care, since services would be delivered in one location in a group setting, rather than in numerous settings with only the beneficiary and provider present.

We urge the Ways and Means Committee to pass H.R. 745.

As the front page New York Times story indicated on April 21st of this year, Medicare spending on home health has plunged over the past two years. The dramatic and unprecedented BBA cuts in home health have had a significant negative impact on beneficiaries. Over the past two years, we have heard from many beneficiaries about serious home health access problems. Recent estimates indicate that the cut was approximately 54 percent and that **the number of beneficiaries served under the program has declined from about 3.5 million to 2.6 million.** We were particularly pleased to see the steps taken last year to address the very serious problems in MHH caused by the BBA.

It is shocking to think that current law includes an additional 15 percent cut in MHH, scheduled to take effect in October of next year. *H.R. 4219, the Home Health Payment Fairness Act,* the Home Health Payment Fairness Act, would repeal the scheduled 15 percent MHH cut. Sponsored by Representative Watkins, the bill has 119 bipartisan cosponsors. Senator Collins' companion bill—S. 2365—has 53 cosponsors. Another one-year delay merely postpones what clearly must be done. We urge the Ways and Means Committee to repeal the cut by passing H.R. 4219.

Improving Medicare Preventive Care Coverage for Beneficiaries

We deeply appreciate the critical role subcommittee members played in including provisions in the BBA to improve coverage for preventive services for Medicare beneficiaries. However, the time has come to go further. It is often easier and less expensive to prevent disease than to cure it. Disease prevention must be an essential component of Medicare beneficiaries' continuum of care. Medicare still fails to cover a number of important preventive services, and those that are covered are underutilized. We, therefore, urge the Ways and Means Committee to pass H.R. 3887.

H.R. 3887, the Medicare Wellness Act, would promote health promotion and disease prevention services and expands Medicare coverage of preventive benefits. Introduced by Representatives Levin and Foley, the proposal has 22 bipartisan cosponsors and is endorsed by 23 national organizations representing older Americans. H.R. 3887 would provide Medicare coverage for some of the most prominent, underlying risk factors for illness that face all Medicare beneficiaries, including: hypertension screening, tobacco cessation counseling, glaucoma screening, medical nutrition therapy, hormone replacement therapy counseling, vision and hearing loss screening, osteoporosis screening and counseling, and cholesterol screening. In addition, H.R. 3887 incorporates an aggressive applied and original research effort that will investigate ways to promote early detection and improve the utilization of current and new preventive benefits.

The addition of these new benefits would accelerate the critical shift in Medicare that began in 1997 under the BBA, from a sickness program to a wellness program. The legislation offers a cost-effective approach to disease management and injury prevention that looks back at some of the lessons learned from the BBA and addresses the underutilization of preventive services.

We also urge the Ways and Means Committee to consider the President's proposal to eliminate all coinsurance and deductibles for preventive services. According to recent studies, utilization of these critical services has been surprisingly low. We believe that by encouraging greater utilization of these services, beneficiaries' quality of life would be greatly enhanced and Medicare expenditures would decline over the long run.

We recognize that it might not be feasible this year to cover all of the new preventive benefits included in H.R. 3887. We appreciate, for example, the leadership of Representative Johnson to extend Medicare coverage to nutrition therapy under H.R. 1187, the Medicare Medical Nutrition Therapy Act, which has 283 bipartisan cosponsors. We would encourage members of the subcommittee to evaluate those preventive benefits that would help the greatest number of older people and provide the greatest potential for long-run savings.

Improving Medicare+Choice for Beneficiairies

Under Medicare today, beneficiaries are having an increasingly difficult time navigating their way through an unstable system that is growing more and more complex. Not only are beneficiaries having problems getting timely and accurate information about the new choices they face, but they cannot effectively exercise their clout in the marketplace. As we move toward a more competitive program, it is essential to test models designed to help competition work well for beneficiaries.

NCOA has worked closely with Representative Kelly to craft *H.R. 4753, the Seniors Health Care Empowerment Act,* which would create six demonstrations to set up Medicare Consumer Coalitions (MCCs) to provide education and information and to negotiate for better benefits and lower premiums for Medicare beneficiaries.

NCOA first testified on MCCs before the Senate Finance Committee in 1997 at hearing on FEHBP as a model for Medicare Reform. We also testified on MCCs last year before the National Bipartisan Commission on the Future of Medicare. NCOA completed a study in December on the feasibility of MCCs, funded with a grant from the Retirement Research Foundation. The study was authored by NCOA President and CEO James Firman; David Kendall from the Progressive Policy Institute; Jay Greenberg, who helped create the CALPERs insurance program; and Dwight McNeil, who has served for many years as a consultant to private, employer-based insurers. The study was assisted by a distinguished advisory panel composed of many Medicare researchers who have testified over the years before this subcommittee.

MCCs would be non-profit, community-based organizations designed to empower Medicare beneficiaries to be informed consumers, help them get the most out of their healthcare dollars, and enhance consumer protections. MCCs would boost seniors' purchasing clout by aggregating individual buying behavior into group purchasing power. The coalitions would consist of existing local organizations such as grassroots seniors groups, union and employer retiree groups, senior centers, health insurance counseling programs, area agencies on aging, and faith congregations. A majority of MCC Board Members would be Medicare beneficiaries.

Informed and empowered consumers are the key to any effort to reform and improve Medicare. MCCs would help to achieve this objective. H.R. 4753 would also permit MCCs to enter into multi-year contracts with M+C plans, which would add much-needed stability to the market. The coalitions could help lower the cost of prescription drugs, as well as Medigap and long-term care insurance. MCCs could also assist beneficiaries in negotiating with and choosing among multiple Pharmacy Benefit Managers.

A survey of 2,000 older consumers commissioned by NCOA found that about four out of five (78 percent) would like to receive information and counseling from a Medicare information coalition. Fewer respondents (ranging from 25 to 35 percent) in the same survey said they would like to receive this information from the government, employers, or health plans. Fifty-seven percent of the seniors polled expressed interest in becoming a member of a Medicare purchasing coalition.

Medicare information coalitions are included both in S. 2807, the Medicare Prescription Drug and Modernization Act (introduced by Senators Breaux and Frist) and S. 2758, the Medicare Outpatient Drug Act (introduced by Senator Graham).

MCCs appeal to the legislative need for bipartisanship and achievable progress to reform Medicare this year. Empowering seniors by building on what works in the private sector should attract support from both liberals and conservatives. We are not asking for authority to create MCCs nationwide, but to demonstrate the feasibility and efficacy of this promising innovation. We urge the Ways and Means Committee to pass H.R. 4753.

Improving Medicare for Low-Income Beneficiaries

Our current methods for protecting low-income Medicare beneficiaries against increasing out-of-pocket costs are simply abysmal. Low-income beneficiaries pay far too much out-of-pocket for care. Those eligible for protection do not receive it, reliable data is severely lacking and the problems are only going to get worse (primarily because of a BBA provision that jeopardizes access by permitting states to pay for protections at Medicaid, rather than Medicare, rates). Current Medicare low-income protections are an embarrassment. Changes must be made.

According to the Urban Institute, in 1996, only 63 percent of beneficiaries persons eligible for Qualified Medicare Beneficiary (QMB) protections received it (payment for premiums, coinsurance and deductibles for persons with incomes below 100 percent of poverty) and only **10 percent** of those eligible for Specified Low-Income Medicare Beneficiary (SLMB) protections received it (premium payments for persons with incomes between 100 percent and 120 percent of poverty). Under BBA, premium protections were created under a block grant program for "Qualified Individuals" (QI–1s), persons with incomes between 120 percent and 135 percent of poverty. Some of the more obvious impediments to participation include: lack of outreach; a confusing, expensive application process; and a restrictive, burdensome asset eligibility test (less than $4,000 in non-housing assets for singles, $6,000 for couples).

It makes no sense for Medicare protections to be the responsibility of states under Medicaid. States strongly resent these programs and do a poor job administering

them. Ideally, the QMB program should be federalized, eligibility levels should be increased to 150 percent of poverty and the program's asset test should be eliminated. These three simple changes would solve the problem. The only issue is cost. We believe the changes would be well worth it.

If the costs of these proposals are deemed prohibitive at this time, a far less expensive improvement would be to reform the SLMB and QI–1 programs in the following ways:

- **Incorporate the QI–1 program into the SLMB program and make it federal**—Unlike QMBs, most SLMBs and QI–1s are not Medicaid eligible. It makes no sense for these two programs to be separate.
- **Eliminate the SLMB and QI–1 asset tests**—This would reduce the cost of the application process by reducing the time spent on verification of information. We do not believe that this change would open the program up to a large number of new eligibles since there is a strong correlation between income and assets among older persons.
- **Improve data collection**—Reliable data on SLMBs is severely lacking. Federalization will help a great deal in this regard.

We also suggest that Congress enact *H.R. 854, the Low-Income Medicare Beneficiary Assistance Act,* which would amends Medicaid to provide for a presumptive eligibility period for the QMB and SLMB programs. This would provide significant help to those who are eligible for these benefits but do not receive them. Sponsored by Representative Bentsen, the bill has 25 bipartisan cosponsors. The proposal is similar to *H.R. 1455, the QMB Improvement Act,* sponsored by Representative McDermott.

Finally, BBA Section 4714 permitted states to pay providers serving QMBs the Medicaid rate rather than the typically higher Medicare rate. We understand that at least 33 states have taken advantage of this provision. We have received anecdotal reports that, not surprisingly, the change has resulted in reduced access to providers for QMBs. The problem is we do not have good data on what is happening. We suggest that GAO or MEDPAC be requested to analyze the problem and report on the degree to which QMBs are suffering from greater access problems, relative to other Medicare beneficiaries, as a direct result of this BBA provision.

Improving Medicare for Chronically Ill Beneficiaries

NCOA also urges the Committee to incorporate in it's Medicare package several provisions proposed by members of the Chronic Care Coalition, a group of national organizations, including NCOA, working to find person-centered, systems-oriented solutions to chronic care.

Chronic conditions our leading cause of illness, disability and death. Yet our system continues to function around the needs of acute illness care. Chronic conditions represent the highest cost segment of health care, accounting for 70 percent of all personal health care expenditures and the major of all major spending categories financed by Medicare; e.g. an estimated 96 percent of home care visits and 83 percent of prescription drug use.

The nature of chronic illness is out of sync with the way we administer, finance and deliver care. While chronic conditions require the support of multiple health care providers and disciplines that should be working collaboratively to meet the diverse needs of frail elders with multiple conditions, we have an archaic, fragmented health care system composed of multiple providers working independently. We need to begin devising systems approaches that promote integration of services, financing and care delivery. For example, we should refine Medicare and Medicaid waiver authority to enable unification of administrative and oversight functions and help facilitate integration of benefits and care delivery.

In addition, BBA provisions changing the way fee-for-service and M+C plans are financed discourage plans and providers from serving high-risk populations. While the prospective payment policies and M+C risk adjustment methods devised by HCFA are built around "average costs" of Medicare beneficiaries, the frail chronically ill are anything but average. In fact, their per capita medical expenditures are two to four times the average Medicare beneficiary.

To address these issues, the Chronic Care Coalition has been working on legislation to improve chronic illness care in this country. NCOA urges members of this Committee to incorporate selected provisions from this proposed legislation into your Medicare package, including:

- **Establish a National Commission on Improving Chronic Illness Care** to create awareness of the problems the chronically ill face in receiving appropriate coordinated healthcare and supportive services. The Commission would be charged with examining barriers, developing a coherent national policy and establishing direction in reforming current approaches regarding chronic illness care.

• **Consider the cost effectiveness of chronic illness prevention measures over time.** The CBO should be required to submit to Congress a study describing methodologies for measuring the long-term cost effectiveness of covering certain preventive benefits under Medicare. Currently, CBO scores legislative proposals on the basis of expenditures and cost savings attributable to specific providers and specific programs for a specific budget cycle. Since coverage of preventive interventions can accrue across budget categories for specific providers and programs, and because some interventions do not produce short-term savings, we need to modify the way we evaluate public spending for the chronically ill.

• **Establish a national database on chronic illness.** In order to set national goals and targets regarding the reduction of chronic disease prevalence rates and reduce the growth of public and private expenditures for chronic illness care, we first need to establish a unified database on chronic care costs. Currently data is collected by provider type, by program type and by budget cycle. Chronic care expenditure data are not aggregated to show total system-wide expenditures over the expected lifetime of specific chronic conditions.

• **Develop and implement a common patient assessment instrument across settings.** A common assessment instrument would provide for comparability of information and reduce the need for repeated evaluations and data entry at each new site of service. It would dramatically reduce the amount of duplication of data collection required by current regulations and free up needed dollars for direct services.

• **Develop a National Resource Center on the Internet for disabling chronic illness.** The Agency for Healthcare Research and Quality should be directed to develop in electronic format an authoritative, reliable National Resource Center for disabling chronic illnesses, for use by patients and their families for education and self-management. The Center also would include information for patients and providers on current clinical guidelines that are currently available in the National Guidelines Clearinghouse maintained by the Agency.

There is also great potential for community service organizations to work with Medicare providers to improve preventive health services and chronic illness care. Demonstrations should be designed and funded to test the efficacy of community service organizations to improve health outcomes and reduce costs for specific chronic conditions.

Finally, we urge that the full Ways and Means Committee to pass *H.R. 3872, the Long-Term Care and Retirement Security Act,* which would provide a new $3,000 tax credit for individuals with long-term care needs or their caregivers and give individuals purchasing a qualified long-term care insurance policy an above-the-line tax deduction for the premiums paid. We deeply appreciate Representative Johnson's leadership on this bill, which has 46 bipartisan cosponsors.

Other Medicare Improvements for Beneficiaries

Another very important issue for beneficiaries is the coinsurance paid for outpatient hospital services, which now averages almost 50 percent of costs. Although coinsurance amounts will remain fixed at their current dollar level until they are reduced to 20 percent of Medicare-approved payment amounts, the process will take up to 40 years for some services. By comparison, the most gradual phase-in Medicare has used to date for any payment system change is 10 years. We greatly appreciate last year's BBRA proposal under Title II, Subtitle A to cap the coinsurance amount at the inpatient hospital deductible. However, the current phase-in schedule is simply far too long. MedPAC has twice recommended that the reduction to achieve a 20 percent coinsurance rate be accomplished in a more reasonable time frame. We urge the Ways and Means Committee to accelerate the phase-in period on outpatient coinsurance to 10 years.

NCOA deeply appreciates Chairman Thomas' efforts to improve beneficiary coverage and appeals procedures in Title II, Subtitle C of H.R. 4680, the Medicare Rx 2000 Act. These provisions would respond to serious concerns with current procedures. We urge the Ways and Means Committee to pass Title II, Subtitle C of H.R. 4680.

H.R. 2870, the Medicare Vision Rehabilitation Coverage Act, would provide Medicare coverage for restorative services to promote the independence of beneficiaries diagnosed with a vision impairment. Sponsored by Representative Capuano, the bill has 101 bipartisan cosponsors. These specialized services help older persons with vision impairment to recover the ability to walk around safely, carry out regular daily activities, and learn new methods of reading and writing. They can restore a person's independence, prevent injuries, and improve quality of life. We urge the Ways and Means Committee to pass H.R. 2870.

Finally, as we look at the future of the Medicare program as our population rapidly ages, we urge the Congress to take advantage of the historic opportunity to devote approximately 15 percent of the non-Social Security surplus to extend Medicare solvency. It is important to remember that dedicating these dollars to the trust fund also counts toward debt reduction, thereby creating a double benefit.

Conclusion

The very visible public debate over Medicare prescription drug coverage has raised high hopes and expectations that something to help beneficiaries directly will be enacted into law this year. But if Congress merely increases provider reimbursement rates, we suspect that many beneficiaries will be disappointed and angry.

Funding for BBA refinements must in no way diminish the resources committed to making prescription drug coverage available to all Medicare beneficiaries. In evaluating provider requests, we urge you to exercise caution: seriously consider how much provider give-backs under Part B will increase beneficiary premiums and the extent to which Part A give-backs will adversely affect trust fund solvency. We suggest that attempts be made to analyze the extent to which Medicare payments are causing providers' financial difficulties, relative to payments from other sources, such as employer-based private insurance and Medicaid. We also urge you to closely examine what evidence exists that indicates that beneficiaries are experiencing real problems in accessing specific Medicare covered services.

In addition to considering the concerns of Medicare providers, **NCOA strongly urges the Ways and Means Committee to take the opportunity this year to include provisions that would directly help beneficiaries.** Specifically, we urge the Committee to pass the following proposals this year:

- H.R. 1115, the Immunosuppressive Drug Coverage Extension Act;
- H.R. 2892, the Access to Innovation for Medicare Patients Act;
- H.R. 634, the Medigap Access Protection for Seniors Act;
- Consider extending coverage to oral cancer drugs;
- Section 5 of H.R. 2546, the Preserve Access to Care in the Home Act;
- H.R. 745, the Medicare Substitute Adult Day Care Act;
- H.R. 4219, the Home Health Payment Fairness Act;
- H.R. 3887, the Medicare Wellness Act;
- H.R. 1187, the Medicare Medical Nutrition Therapy Act;
- Eliminate all coinsurance and deductibles for preventive services;
- H.R. 4753, the Seniors Health Care Empowerment Act;
- H.R. 854, the Low-Income Medicare Beneficiary Assistance Act;
- Recommendations from the Chronic Care Coalition, including:
- Establish a National Commission on Improving Chronic Illness Care;
- Consider the cost effectiveness of chronic illness prevention measures over time;
- Establish a national database on chronic illness;
- Develop and implement a common patient assessment instruments across settings; and
- Develop National Resource Centers on the Internet for disabling chronic illness;
- H.R. 3872, the Long-Term Care and Retirement Security Act;
- Speed up the phase-in period on outpatient coinsurance to 10 years;
- Title II, Subtitle C of H.R. 4680, the Medicare Rx 2000 Act; and
- H.R. 2870, the Medicare Vision Rehabilitation Coverage Act.

Mr. MCCRERY. Thank you, Mr. Bedlin, and thank you all for your testimony.

And we will now proceed to questions from our panel. Mrs. Johnson is first.

Mrs. JOHNSON of Connecticut. First of all, let me commend the panel on the specificity of their recommendations. We really appreciate that. At this time in the process, we need to know specifically what you thought was most important, and I think you ought to be thinking about priorities, as well.

Second, let me say that I appreciated Mr. Renaudin laying out so clearly the fundamental problem with Medicare Plus Choice plans. This administration has starved those plans, and it is a tragedy. Because look at how the seniors feel about their choice be-

tween their managed care plan, their Medicare Plus Choice plan, and going back to Medicare. They aren't happy to go back to Medicare, and they wouldn't be having to go back to Medicare if this administration had, frankly, been fairer about reimbursements.

You do, though, get to the regulatory reforms only at the end of your testimony. You mentioned the onerous and unnecessary requirements associated with the physician encounter data requirements. And so I just want to make sure that you line out the regulatory problems for us a little more clearly, as you have the reimbursement policies.

Unfortunately, I only have 5 minutes, so I want to run through a couple of things that I need from people.

Mr. Walker, I appreciate all you say, and again your specific recommendations. But one of the things that absolutely is driving nursing home providers in my district out of their minds and making it very hard for them to retain their very best employees is the administrative complexity associated with the current reimbursement system, and they were stunned to be confronted with additional layers of administrative complexity associated with the new payment system that is going to go into place.

Now, I am not quite sure from today's testimony whether just the sheer increase in payment under the old system carries also that regulatory burden. But we have got to do something about the regulatory burden in the system. It certainly is affected Home Health, too. We are going to drive people out of the care-giving environment because they came there to give care, not to do paperwork.

So any specific recommendations you can give us in this, and I am looking at several sets of eyes here for this bill, is important. Because you can talk about this system, you can tout the system politically, but we are going to destroy, particularly the small providers, but eventually force small providers into big systems if we don't do something about the enormity of the paperwork problem.

And, Mr. Corlin, I did want to ask you a question. Your testimony, because—this is extremely important. I did not agree with you on the collective bargaining bill of my colleague from California, but I do agree with you that the problems in the system are extreme. We have included in our prescription drug bill, a reform of the appeal rights for patients in Medicare, because now they effectively have no appeal rights. But this issue of physicians getting no right to provide better information and being subject entirely to penalties and over payment judgments made by extrapolation, for the small family practitioner out there, this is devastating. They do not have the office staff. They cannot afford the legal staff. They cannot counter.

And so I am very interested in completely altering the way we deal with physicians in this regard, because talk about no rights in a free society, this is a total abrogation of physician rights, far worse, than frankly, what is going on for them in the private sector, and I am an advocate of the right to sue, so I think there are a lot of problems in the private sector.

So I hope you will think about what specifically could be done there,—because I am using up most of my questioning time to tell you what I need to know—because we really—there are adminis-

trative problems in the system that are so severe, that even if the reimbursements are adequate, and the most we are going to hope for in the next round is barely adequate, unfortunately, but we are now pushing people out of the system, and there is no question in my mind, but that seniors in my district are experiencing less access, not just as Medicare Plus Choice goes out, but in general. We are going to see it more in specialties and further on down. If the administration goes through with their proposal to change the reimbursements for cancer drugs, all of those community based cancer centers are going to fold up, and all of that is going to go to the hospital, less convenient and more costly to us. So reimbursement policies can either create access or they can destroy access, and some of the things that you pointed to here today that are not about money are very much about care. So please feel free to follow up with us on administrative issues as well, and this problem with the physicians and the extrapolation and the penalties is simply a very big one. You probably have 30 second, Dr. Corlin. The red light went on. You can come back to it later.

Mr. MCCRERY. Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman. I just wanted to set the record straight a little bit before I inquire of Mr. Bedlin. I just want to suggest to you that the two complaints I am hearing are that HCFA has imposed excessive regulatory burdens, I talked to HCFA, and they suggest that they are getting a lot of vague whining from the managed care plans. Their most serious complaint is that the plans have to demonstrate how they improve the quality of care—and I suspect they cannot demonstrate it, which is why they do not like to fill out those reports—but HCFA also tells me because the managed care plans have been whining so much about it, they have stopped asking for it. And the second, of course, is the issue of physician encounters so that we can get some relative way to pay people for risk adjustment, which I am afraid the managed care people feel will cost them money, so they are not being very cooperative. But at any rate, HCFA has asked—and I will repeat the request—that you send us a letter, describing specific excessive regulatory burdens. I would just like it written out, please, so I can see. Send me the form. Show me what is excessive, and I certainly would be glad to go to bat.

Now, the other problem is that Medicare is significantly underfunded. I would point out that according to MedPAC staff this morning, that the growth for Medicare fee-for-service, in contravention to some of the testimony that was presented, since '97 has been 5–½ percent, whereas the cumulative growth in the average Medicare Plus Choice payment has been 8.6 percent, and since '97, all Medicare Plus Choice plans have received payment increases of at least 6 percent total. So that in fact the Medicare Plus Choice payment has gone up more than the Medicare fee-for-service. We should see that the record is clear on those issues.

Mr. Bedlin, if we give relief to the providers, all those folks to your right there, would you think that it might make some sense to insure that the extra money we give them actually goes to providing services and just does not drop through the operation statement to the bottom line or to higher executive pay? For example, if we give more money to the SNFs, could we ask them to pass it

on in higher or appropriate staffing ratios? If we give home health agencies more money, could we ask them to make available to the public how many visits per episode they actually provide? Would those sorts of things be fair exchange for giving more money to the managed care plans?

Mr. BEDLIN. I am not sure precisely how you would craft that or enforce it, but certainly we do believe that if providers are going to get increases in reimbursement, that that should inure to the benefit of the beneficiary population. So the ideas that you have articulated are certainly ones that I think should be seriously considered, particularly with regard to staffing. It is a huge problem right now, both within nursing homes and home health, and we really need to do something about that, and to the degree that we attempt to address those issues, I do think that we need to be very careful that the dollars go specifically to the people that they are hiring, those new staffers, yes.

Mr. STARK. I agree. Let me toss a couple more at you, because I would like to encourage Chairman Thomas and my colleagues on the Subcommittee to have a little of however much goes back, go back to the beneficiaries. Let me give you a couple of ideas and see which ones sound good to you.

Congresswoman Kelly has a bill to promote. Medicare Consumer Co-ops. I hope to introduce a bill this week requiring Medicare, or at least one of its carrier contractors, to establish a website, basically for the purchase of pharmaceuticals, either overseas or in this country to get some prices out to the seniors over the Internet so they can see what pharmaceuticals actually cost, whether they bring them in from Canada by mail or wherever.

The other issue is the QMB and SLMB plans are under utilized, as we are all aware. Their outreach is bad, and Mr. Bentsen and Dr. McDermott have a presumptive enrollment bill, that just says, “Look, let us presumptively enroll these people through a Social Security data match, and then they are in.” I am not sure that the cost would be much greater, but we would at least then take care of some of the seniors who can least afford either co-pays or they would get help to pay the managed care plan.

My third suggestion, again which might not cost much, is we are trying to introduce a bill to encourage coordination in the care of the chronically ill. You have talked about the problems, but we are wondering if we can carve out some easier parts of this coordination of chronic care. I wonder if you could elaborate on the need for that legislation or any other ideas you might suggest, the less costly the better, to see that some of this give-back finds its way to the beneficiaries.

Mr. BEDLIN. We would strongly support all three of the initiatives that you have described. Medicare consumer coalitions would help to empower beneficiaries in a marketplace where right now they have little or no clout. To lower the cost of prescriptions drugs, Medigap, long-term care insurance, help a great deal in terms of decentralizing the education and information, which is extraordinarily difficult in terms of navigating through a very complex system. QMBs and SLMBs, you are absolutely right. It is unbelievable how low the participation rates are. According to the Urban Institute, for example, in 1996, the SLMB rates—and that is pre-

miums for people between 100 and 120 percent of poverty—only 10 percent who were eligible actually used that benefit. For QMBs, which includes co-payments and deductibles as well for less than 100, it was a little bit less than two-thirds. These are the most vulnerable beneficiaries out there. They clearly need a great deal more help than we are giving them now, and we would strongly support the legislation that you described in terms of presumptive eligibility, and would urge that we, frankly, go further than that.

In terms of chronic illness, that is going to be a major, major crisis in our health care system, particularly with regard to Medicare over the next several decades. The fastest growing segment of our population is over age 85. These are individuals that have multiple chronic illnesses. The Medicare is not well suited to handle these kinds of problems, and they are the ones that these individuals are experiencing. In our testimony we specified some of the things that can be done to improve the care for people with chronic illness. My understanding is that you are going to be introducing a bill shortly that we are very interested in, in working with the National Chronic Care Consortium.

Finally, there are some things in the Medicare home health benefit that we think could help to modernize it, help to address this homebound issue, which is very inhumane and is harming lots of beneficiaries. Those are chronic care issues as well that cry out for Congress to do something about.

Mr. STARK. Thank you very much.

Mr. MCCRERY. Mrs. Thurman.

Mrs. THURMAN. Thank you, Mr. Chairman. I first want to say something to this panel because I think this is very important. Even though we did some buy-backs last year, there were many of us up here—and particularly based on your testimony and the specificity that you put in your testimony, many of these are not issues that we have not heard about before; they were also brought up in last year's testimony and were asked to be acted upon. So just to say it is a blame here or a blame there, I think is not fair. That is not what we should be here, and what we should be here about for. We should be here because we need to fix this problem, and I think that is where you say "Amen." But none of this is new. I mean, I can remember RUGs, I remember bad debt, I remember DSH, I remember GME, I remember payments to HMOs. I mean, we have heard it. So I think we need to get beyond the blame game.

But I have to go back to some issues though that I would like to talk to, in particular with my HMO person out here, Mr.—say your name for me.

Mr. RENAUDIN. It is Renaudin. Just pretend like the "U" is not there.

Mrs. THURMAN. Renaudin, Okay. All right, I will try. Mr. Renaudin—and I appreciate what you have said about the fact that the HMO Medicare choices were out there on the idea that you could save money, so therefore you could provide better benefits. Here is a question or a couple of questions, and you heard a little of the line of this question in the last time, that I think is important. The money issue, for number one. Help me understand this. If I live in a certain part of Florida—you know, everybody talks

about Miami getting $800—but if I also live there, I also get a better prescription drug benefit, I get eyeglasses. I might get hearing aids, I might get these kinds of things. And I pay no premium. If I live in another part of the state, obviously, maybe the reimbursement is 500 and something. I am now getting fewer benefits. Probably mostly what I get is some kind of a prescription drug, and I pay a premium.

Okay. So you can understand why seniors are a little concerned that their same Medicare tax that they paid all of their lives or through their working ages, has now provided them with a Medicare system that it off balance, or they are not getting the same thing as somebody else for the same amount of money that they put in.

But here is the question that I do not understand, that in some parts of the State of Florida, in areas closely related—let me just give you an example. In, say for example, in Citrus County right now we have no HMO. Hernando County just pulled out their last two. In Citrus—or in Hernando County, in 2001, they would receive $553.54, you know, and you know how that goes, it is on a per patient—that is not exactly correct, give or take this or that change in it. But in Hillsborough County, which is a county and a half below them, they receive $531.00 in 2001. They stay there, but they pull out. So money cannot be the only action that is happening out here. So you need to help me understand, or more importantly, you need to help those people that you are trying to sell a program to, why this is happening, and particularly based upon what the Chairman said. He is not just going to put more money out there. He is going to require some issues to be looked at. How do I respond to that? How do I respond to them the Medicare Program works well because we put everybody in a risk pool, we spread the risk through 39 million people, therefore, we keep our cost lower than if—so why would we not do it on a state basis? And also then, why would we not ask—if we are giving you the money from the Medicare Trust Fund, why would we not be asking you to give a commitment to those folks? I mean, those are questions that are being asked by those beneficiaries who, quite frankly, are very concerned about what the next step is for them.

And then the last question that I would you is this: even if we did the $25 billion on prescription drugs, even if we did some new dollars for reimbursement, would you be able to come back in to those counties? Do you think there would be a decision to come back into those counties now that they have left?

Mr. RENAUDIN. Mrs. Thurman, let me try to address the issues one by one. Actually, the last issue you mentioned refers directly back to your beginning issue. I think that, as I said in my testimony, there are more than just payment factors, although payment factors are first and foremost, because if that is taken care of, then some of the other issues I will discuss in following up will also be addressed. But I will try to reach where you are going here.

The fact that the difference that you just mentioned, where there is a plan in one area that is about 530, I think was the number you used, and not a plan where there is also a $530 payment, there are many factors that can influence that. I discussed briefly one of those factors in my oral comments, which is the provider situation

and the provider environment. That comes into play. And some of the things that affect the providers, the physicians and the hospitals, are not simply contracting with the plans. There are many other factors that impact them as well, some of the things you are hearing them discuss about the difference in Medicare payments, the fact that in many states Medicaid also has not kept up with inflation. So depending upon the payers, depending upon the designation of the hospital or physician, there may be external factors that are impacting the type of payment they will demand from us in order to provide the care.

You have other factors besides just the payment that they are getting from Medicare, Medicaid, whether or not they are urban or rural. You have factors impacting them as well. Other factors beyond that may be competition. The parish where—the county, sorry—where you do have a plan at 530 may be one—and I have no idea of the Florida market, so excuse me—but may be one where you have a couple provider systems. The one where you said the same payment rate is out there, but you do not have a plan may be there is no competition among providers. That all filters through to us. We, as a plan, pull together all the different pieces of a health care system. So if there are factors that are impacting any of the people to my right all along the way, it also impacts us in our ability to contract with them, in our ability to provide the benefits and services.

So, for example, one of the areas that I am withdrawing from, unfortunately, in my service area is a county that is fairly close—it is a little bit west—but fairly close to some of the counties where I am staying. The difference in that county is there is a particular provider in that one county that exhibit amazing monopolistic behavior, and this is not just shown to the Medicare Program. If you look at the way our state employee benefits program also, the people insured by state employees are insured, they actually, if they choose my health plan will pay somewhere between 30 and $45 more a month if they live in that particular part of our service area due to that one hospital.

So there are many factors that—without knowing the Florida market in particular, that I cannot address all of those. But I can say in fairness also to my colleagues to my right, that some of their problems become our problems as well because we are just pulling it all together. So I do not know if that addresses the total reason for your situation that you just mentioned, but that may be part of it.

Mrs. THURMAN. If the Chairman will indulge me for just—as a kind of a response.

Mr. MCCRERY. Sure.

Mrs. THURMAN. But I think that is part of the problem that we are having out there is, you know, we look at what we have got to spend on everything. We have been told that we are actually paying now more for a Medicare Choice than we are for fee-for-service. I mean, that is what the numbers are, and you kind of admitted that the numbers under Medicare Choice are going up at a higher percentage than what we are—at 5.5 for Medicare fee-for-service.

But here is the problem. When we go to face these folks, you know, all they think is that you just have to give them money. It is all about just giving more money, when in fact, there is a whole lot of other—and it is a very multi-faceted kind of issue that is going on out there, and I would just beg of your organizations—and I will be glad to help you with some of the issues as it deals with regulation, although I think, quite frankly, we have probably created some of that because my guess is that HCFA does not write laws on its own, or rules. They are kind of supposed to follow what we pass up here, but if there are things that need to be done to get rid of some of that regulation that may seem nonsensical, that just is not working, then we need to know that.

But on the other side of that, I really wish that some would start looking at the whole issue of Medicare Choice and not just pinning it on the one issue that seems the easiest. It is kind of like people have said, "Oh, if you throw money at education, you can fix it", and then you hear other people saying, "Oh, no, we cannot do that. We have got to do some real reform up here to make it work." I mean I think we are still—this is applicable in these areas too, and I think we are just starting some fires out there with all these pull-outs that are not really going to address the problems that are necessary.

Mr. RENAUDIN. If I may also respond to the second part of your question in follow up. The payment differences between the parishes are the major reason for the withdrawals that I had—that was one particular parish out of six that it was a provider issue. So I can tell you from my personal experience that 5 out of 6 counties it was payment was the issue, not the provider side.

You also asked a question about the commitment. We would love—we would absolutely embrace being able to make the same kind of commitments to the Medicare Plus Choice program as far as long-term contracts as we do—in my particular state you can tell where I am going with this by the companies I mention—as we do with Exxon and Chevron and Shell and Texaco, and so forth. We have multi-year contracts with them. But what I get in exchange for those multi-year contracts is a commitment from them that they will not change the rules as we go through, that the payment will not be changed as we go through, that, you know, some of the extra things that would be nice for the beneficiaries in those plans are not going to happen if they result in higher cost.

Let me give you a very specific—low-cost, but specific example of how this happens. I say "low-cost" as some relative terms. We now have to use a mandated schedule of benefits, and it is a great idea, so that when a senior is sitting down at the kitchen table, they unfold all the scheduled benefits among all the plans and they compare them. That sounds like a wonderful idea, and it is one that we support. The problem is, just in the past month, month and a half—I may be off by a couple weeks—there have been four different versions or editions to that schedule of benefits that we have had to deal with as HCFA keeps on revising it. That is something that Exxon or Chevron or Shell would not do. We would come to the table, we would agree on the schedule of benefits. It would not be continuously revised, reviewed and changed as we go forward. So we would, believe me, love to make the same sort of commit-

ments to the Medicare Plus Choice program that we make to others. Provide our own plan, it is part of our mission to do so, but unfortunately, if the rules keep on changing, you cannot then criticize us for making changes in our decisions after you have changed the rules.

Mr. CORLIN. Ms. Thurman, may I add a response to that, please?

Mrs. THURMAN. You have to ask the chair.

Mr. CORLIN. Mr. Chair?

Mr. MCCRERY. Sure, please.

Mr. CORLIN. Thank you. I feel compelled, on behalf of the AMA to comment on the last response that was made, and to say there is a bit of disingenuity there

. Those same concerns about changes that go on, and the fact that they do not like bidding on a contract or making a long-term commitment to a contract where the clauses may be changed, that was stated by the representative of the industry that puts clauses in its contracts with physicians, saying, "If you want this contract, you must agree to take any contract we come up with, regardless of the terms, even those we have not come out with yet." So that does cut both ways.

Mr. RENAUDIN. My plan does not do that, just for your information.

Mr. MCCRERY. Thank you, Mrs. Thurman, and thank all of you. I now have a few questions, and Mr. Renaudin, I am going to give you a chance to rest for just a second, and go to Mr. Walker. As you probably know, the GAO testified last week, I believe, and his testimony, Mr. Scanlon of the GAO, said that the recent bankruptcies experienced in your industry are primarily due to poor business decisions, and not on Medicare and PPS implementation. He claimed that the new Medicare payment system for SNF services adequately covers the cost of services, but no longer supports the extensive capital expansions or the ancillary service business that corporate chains relied on to boost revenues. I assume you would like to respond to that assertion. I will give you the chance.

Mr. WALKER. Yes, I would. First of all, on the issue of poor decisions, it is important to understand how we got here. From 1990 through 1997, we went through demonstration projects with HCFA jointly throughout the United States. All of the details of prospective payment of substance were worked out through those demonstration projects. The industry, including my company, supported prospective payment. The one issue that was not worked out was the cost of the non-therapy ancillaries. Through the last demonstration project ending in 1997, HCFA said, "When the final regs. come out, we will add a component to that payment for non-therapy ancillaries." That was as late as the summer of 1998. On publication that fall, there was no additional funds for non-therapy ancillaries in the proposed payment.

Prior to that implementation, my companies and others made strategic plans on how to phase in business decisions into the prospective payment system. We looked at pharmacy. We looked at rehabilitation. We looked at long-term care. And we selectively built elder-care health care networks on the East Coast to the United States, eliminating excessive cost and reducing the cost of care to the payors.

When those final regs. were published, there was a 25-percent reduction in the payment rate. The expected reduction was less than 20 percent. The changes in utilization that occurred at the same time, because it changes to the hospital payment systems, penalties for early discharge, forcing hospitals to be afraid to discharge early, keeping people longer, caused occupancies to drop throughout the long-term care industry. So not only did you get a reduction in rate, you got a reduction in utilization. I think if you look throughout the country today, you will see occupancy rates down 3 to 5 percentage points. That is because of the lower payment and because of the longer stays in hospitals. And if you go into my primary marketing areas, Southeastern Pennsylvania, Wilmington, Delaware, you will see hospitals have no beds available today.

So I would tell you, we incurred the debt and raised the capital—and by the way, the capital we raised to do those things was 50 percent equity and 50 percent debt. We did not rely totally on debt capital. Our cash flow before PPS was over $400 million a year. It went down to 220. We cut over $100 million in costs out of the system. Nobody expected the devastation created by the lack of full disclosure by HCFA. And you may think I am blaming somebody. I do not intend to. I am just stating the facts. That is what happened.

You go back to Mr. Scanlon's comments about a fair payment. Well, I would like to—from memory, if I can do it, but I may have the piece of paper here—describe to you the payments and the use of the dollars, and I will try to make it as simple as possible. Nursing homes spend 80 percent of the revenue dollar before PPS on salaries, wages and supplies, 5 percent on overhead. That means filling out the cost reports, buying the goods and services, human resources, but administrative task. So we have 15 percent left of the payment rates to pay for everything else. The cost of working capital—in a nursing home you do not get paid for 90 days—$1.5 million on 120 beds. It costs 3 cents to finance the working capital if I can get somebody to lend me the money. The cost of reinvestment in the physical plant—I have to continue to restore the physical plant because it is used up—costs me about $500 a bed. Every 5 years I have to put in a complete facility renovation on the interior. The total cost is about 2 cents. I am not down to 10 cents left. If you built a $50,000 nursing home bed in this nation today, and you financed it 100 percent with debt capital—which is not possible—it would cost you 16 cents. If you add up those numbers, I am minus 6 cents before the implementation of prospective payment. Now, those providers who really serve the Medicare population—and I would include Genesis in that category—we have double and triple the amount of Medicare patients in our system that the industry does overall. 25 percent of our revenues come from Medicare. We receive a reduction of $400 to about $300 as a result of PPS. That is a 25 percent price reduction. A 25 percent price reduction on 25 percent of your revenues results in a 625 basis points reduction in your margin. So now I am losing well over 10 cents.

Mr. Scanlon, I do not truly believe, understands the financial implications of long-term care. Those providers who did not serve the

Medicare population, who did not have distinct parts, who did not have the infrastructure in place, that price increases at one or two or three patients in a building. But those providers who really stepped up and built the infrastructure got whacked right across the side of the head. Over 200,000 Medicare beds are in bankruptcy today. That cannot be because five chief executive officers made bad decisions. Remember, I had a hundred bankers and a hundred credit staffs. Not only did I have bank lenders, but I had investment bankers. When we did those transactions, we were reviewed inside and outside by hundreds of Committees. They are not all dumb people. They all read the same information that I read and made the same decisions. The information was flawed.

Mr. McCRERY. Well, thank you. I thought you might want to have a few words in response.

Mr. WALKER. Thank you. You can ask a few more.

Mr. McCRERY. Mr. Richey, there seems to be a pretty general agreement that our rural hospitals, primarily I guess because they have fewer private pay patients, are most threatened by reductions in Medicare reimbursement. What specific proposals does AHA have to remedy the fragile condition of rural hospitals?

Mr. RICHEY. Well, you are absolutely correct, sir, Mr. Chairman. One of the major problems in the rural sector is you do not have the number of commercial insurance payors that you would in an urban setting, and therefore, the reliance on the Medicare and Medicaid patients are significantly higher. We have a rural relief package that we would urgently suggest that this Subcommittee pass on. We would also ask for protection of Medicare, and particularly for the rural hospitals, Medicaid disproportionate share funds. They rely, in large parts on both Medicare and Medicaid disportionate share payments to make their entire bottom line. Then, likewise, the same issues that the urbans are seeing with home care are a major problem for them, and the SNFs. With fewer nursing homes available, the rural hospital tends to have to be the provider for the vast majority of services.

Mr. McCRERY. Unfortunately, Medicaid is not in the jurisdiction of this Committee, but we will pass your suggestion on. You did say you had a packet though of materials that I am sure you will share with us on specific recommendations for rural hospitals, and we appreciate that.

Dr. Corlin, much of your testimony focused on HCFA's antifraud efforts, and while I sympathize with the thrust of your testimony along those lines, I am sure you sympathize with our concern about fraud in the Medicare system and ferreting out that fraud.

Dr. CORLIN. Absolutely.

Mr. McCRERY. So how can we best balance the public's interest in insuring the Medicare dollars are being spent wisely with a physician's right to privacy, and more important, to due process?

Dr. CORLIN. Thank you, sir. First of all, I agree very strongly that we have got to be as vigilant as we can in dealing with issues of fraud. In going through that whole process there are several points that I think can be improved. First of all, we are told as physicians and as medical associations that what physicians should do, is if there is a question about billing, to find out what is the right code for this? Forget for a moment the E&M guidelines that

were disastrous that were put out—we will get to that in a moment—if there is a question about billing, the physician or the physician's billing clerk should call the local intermediary for Medicare, the carrier, and ask for advice, and preferably try to get it in writing, and that if you get the advice at all, it will be helpful in guiding you. If you get it in writing from the carrier and you are then subsequently audited, you can use that written response from the carrier, if you are complying with it, as the standard to which you will be held. But, you cannot get written responses from the carriers. They will not provide them. Many times if you call them, they will not even tell you—the clerk you are speaking to will not even tell you their name in order to verify on July 23d I called and I spoke to Mary Smith, and she told me. You cannot get the clerk's name you are speaking to.

So the issue of informing the physician to answer questions cannot be done. There is virtually no funding available and no programs available for physician education in proper billing and coding. The AMA would love to be involved in a HCFA-funded project for physician education in coding. There are a lot of private coding consultants out there whose total goal is to give a course, "How can you maximize coding", whether or not it is the right way of doing it. We would like to see education done properly. That is one issue.

Second, a post payment audit, as I indicated in my testimony, is often the first indication that there is any problem at all, and the example I gave of the cardiologist in California is one. How can one doctor, one doctor, who gets a clean bill of health on an audit, 1 year later be told that he owes $175,000 when nothing is done differently at all? Once that statement for recapture of money comes out, if you want to deal with it and pay it to get rid of it administratively, the only way you can do it is to waive all your right to appeal. If you wish to appeal, you have to got to go through an extremely onerous process, and I would point to the results of that process as evidence of the fact that what HCFA is doing is wrong. Of those claims that go to the administrative law judge for hearing, 70 percent are found in favor of the physician that the intermediary has done the audit wrong.

The entire process is flawed. We are not opposed to anything to detect fraud. We are not opposed to anything to detect abuse. We want to have more education in the system. But the specifics of the mechanics as to how we got there, as to how we get there in that system, are just plain wrong,and we want to have that corrected. The reason you have so much opposition from physicians is that we are frustrated. We are used to working off of a database in how we deal with our patients. It is a changing database to be sure, but it is a database. In dealing with HCFA about questions as to how do I bill, what is the right code, we cannot get the right answers to know how to do it up front.

And one final point, sir, and this has to do with the E&M coding mess that HCFA is currently revisiting. You heard a lot of physicians and a lot of groups complaining about the amount of time that was necessary and the excess documentation that was necessary and how burdensome it was. That is one aspect of it. There is another aspect of it that concerns me more. I am a gastroenterologist. We have a high-intensity practice. We see a lot of

acutely ill patients, many of whom are in intensive care units, treated by four or five different people, cardiologists, pulmonologists, infectious disease specialists and so on. The requirements for documentation are such that the standard shorthand that physicians always used is no longer considered acceptable. When I go into an intensive care unit and look at a patient's chart, the last 2 days' progress notes may be 12 pages of notes, whereas they used to be 2–1/2 or 3 pages of notes. There is no more information in it; there is just the same information repeated redundantly by everyone over and over and over because it is a HCFA requirement. That impedes the delivery of good quality medical care, because if I get called in there and the patient started to hemorrhage and I need to assess things in a hurry, I cannot go through 12 and 15 and 20 pages of notes. I need to be able to go through a couple of pages of notes and find out what is going on, particularly if those notes just repeat things.

And I was at a meeting with Dr. Berenson last week. We discussed that. He acknowledged that HCFA is aware of it. We will wait to see if anything happens. Yes, documentation for the level of service billed for, that it was delivered, absolutely, but when that documentation gets to the point that the chart becomes virtually illegible based on its volume, the patients are being hurt, not helped.

Mr. MCCRERY. Thank you. Mr. Renaudin, I appreciated your comments about the reimbursement rates and the way they vary from parish to parish or county to county, and I am not going to dwell on that, but suffice to say that I think the formula that is used is not the best we could come up with, and it does result in, I think, inequities. Certainly in my state we have seen those inequities very clearly, demonstrated by the fact that now in North Louisiana we do not have any Medicare HMOs. Ochsner was the only one, and it is gone. And you cannot convince me that in Shreveport, Louisiana it costs $100 or more less per patient to treat somebody than it does in Baton Rouge, Louisiana or even New Orleans, Louisiana. And yet, the methodology that we use to determine what a managed care plan gets reimbursed results in just that, and that is nuts. So, I appreciated your comments on that.

Mr. Crane asked me to follow up with you, Mr. Renaudin, on a question that he asked Dr. Berenson earlier, and that is concerning the discrepancy between the published rate of reimbursement and the actual reimbursement. Would you have any idea as to why that discrepancy exists and expound upon it if you do?

Mr. RENAUDIN. I can, and if I get too detailed, please let me know.

There are large sets of charts that come out with that published rates, and those large sets of charts have to do with all the different factors that you then take away or sometimes add to that published rate. They vary from age, sex, institutional status, ESRD status, whether or not they are an institution, whether or not they are Medicaid dual eligible. There are—then there is a whole other set of facts for ESRD rates. So there are a large set of factors that come into play, and then you add on top of that some additional things that have happened since BBA. For example, the Community Education Assessment Fee, which the BBRA wanted to try to

make some change to and has done so, but it is still there to some extent. So you have that fee that is added on to it. You have the automatic—you have some other adjustments that are added to it as we go forward. Also, those numbers that we give you, the actual payment rate that we receive, now, those payments change every month based on all sorts of dynamic things that go on.

To give you an example of a huge change that can happen, and this happens sometimes going back years, up to 3 years, in August of last year, we had suddenly, almost—I believe it was 2 million; don't hold me to the number, somewhere around there—taken away from what we normally expect to get that month. And the reason is, they took back that amount of money because of what they called a working aged adjustment. It appears to—in somewhere in one of the HCFA files that was out there, that we were getting paid more than we should have because we had a large number of people who were actually working age, and for your information, those are folks who still have insurance provided through an employer. So the theory behind it is since they have some insurance provided by employer, pay us less because they are getting some supplementary coverage elsewhere. And that is correct. The problem is, I believe there are three, maybe four different databases that HCFA uses to determine whether or not we have a working aged member. And what happened, a phenomenon that happened across the country, HCFA suddenly updated from some other database—we still do not know which one—that working aged adjustment. So they went back and took back money for 3 years, for 3 years, from members that we did not think were working age, but they thought were. Now, what we found out since, and we spent a lot of money and consulting fees and other database fees to find out, that the vast majority of the take-back was not true.

So there are all sorts of factors that come into play, but the major ones are the ones that Mr. Berenson did mention. The demographic adjustments and the risk adjustors are the big factors. But the idea that that is simply a fact of getting a healthier population may not necessarily be true. If the average age of a beneficiary in a particular parish is 75, and we are getting them at 72, by age alone you would say they are healthier, but that may not be true, because one of the things impacts—for instance, Ochsner is a large transplant facility. One of the things that impacts us to some extent is how many transplants we give, and the older you are generally—I am not a physician, so excuse me—you are not eligible for a transplant. So some of those younger members, who by age may look healthier, are actually possibly receiving much higher-intensity care services, and because of Ochsner and our reputation as a coronary care facility, we do get a larger share of transplants than I believe most of my competing plans do, and in fact, I do have evidence, because the maid of honor in my wedding is a social worker in the transplant area at Ochsner, and they all automatically, if someone gets on the transplant list, try to get them eligible for Medicare to get them on my plan so they do not have to pay high deductibles and co-insurance. So the adverse selection does happen to us in some instances. Maybe we are a rare bird because of a transplant facility, but it does happen, and that is not taking into

consideration when you hear the comments about, "Oh, well, they are getting healthier populations."

Mr. MCCRERY. Thank you very much. Ms. Thurman?

Mrs. THURMAN. Okay. Actually, I just wanted to bring to your attention—because when you had talked to Mr. Richey about the hospitals and he said there was a package, I actually have submitted the Florida Hospital Association, and if you turn to page—let me see if I can find it—on page 4 they have actually put down "action needed." And we also wanted to present this, particularly from a perspective of a high—and we heard some of this earlier from the panel—the high amount of Medicare beneficiaries that we have in the State of Florida, which is disproportionate to exactly what you had mentioned in coverage of spreading that risk out over private paid and other folks within a system, so I think you will find that very interesting, so I just wanted to let you know that we had submitted that or would like to submit that for the record along with the testimony from the other folks here today. And I just need to make——

Mr. MCCRERY. Without objection.

[The information was not received at the time of printing.]

Mrs. THURMAN. If I can say just one thing on this other—I want to tell you that my mother is under home health care right now through Medicare, and I have to tell you, it took me a while to get some kinks worked out, but in saying that, I think you do have some very caring people in your system, and I would hate to lose the ability for people to stay in their home, but I would like to talk to you about coordination of Medicare home health care, as well as with paid private, because I think there are some things that we could be doing for families out there if we could coordinate times for when they could come in, and juggling, and would save some money for families who are trying to provide that care, because there is some big overlap there, that I think if we could figure out a way to do it, that I would certainly like to sit down with somebody and work on that, because I have found that to be just so awkward, and my schedule is not easy. And I am trying to provide her 24-hour care, and it is very costly, and I do believe there are some things we could be doing that would offset a little bit of that.

And, Mr. Bedlin, I actually turned to my staff when you talked about the homebound. I think that is absolutely crazy. Because if I take my mother out—and I can assure you, I cannot cut hair, nor would you want me to—but just to even take her to go to a place to have her hair cut could potentially put her Medicare benefit at home in jeopardy. And I have to tell you, for somebody who has gone through what she had gone through, and be told that she has to have her daughter cut her hair, and she just wants to look nice, you know, for her cousins that are coming to visit, and that could jeopardize her, I think we have done an awful, awful situation to our seniors who are put into that situation, so I tend to agree with you on your issue on homebound, and I will look forward to working, and maybe this year we will have a debate on these issues and not be told that if you talk about it, it will not get in the bill. Thank you.

Mr. MCCRERY. Thank you all very much for your patience today and your excellent testimony and response to questions, and we

look forward to working with you to further nurture this Medicare, this lovely government Medicare system that we have. Thank you. The hearing is adjourned.

[Whereupon, at 5 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of American Association for Homecare, Alexandria, VA

The following statement is submitted to the House Ways and Means Subcommittee on Health on behalf of the American Association for Homecare. The American Association for Homecare (AAHomecare) is a new national association resulting from the merger of three national home health associations—the Home Care Section of the Health Industry Distributors Association, the Home Health Services and Staffing Association and the National Association for Medical Equipment Services. AAHomecare is the only association representing home care providers of all types: home health agencies and home medical equipment providers, be they not-for-profit, proprietary, facility-based, freestanding or governmentally owned. AAHomecare is pleased that the Subcommittee is addressing the dramatic impact of the Balanced Budget Act of 1997 (BBA'97) on home health.

HOME CARE IS THE ANSWER

Homecare is pleased to report that home health care has benefited from an explosion of new and emerging technologies. These breakthroughs are allowing Americans to receive a vast array of complex therapies in the setting that they most prefer—their own homes. From the use of space-age materials to make wheelchairs and mobility aids lighter, to the application of micro-chip computer technology in implantable devices used to dispense critical medication, technology makes it possible for the care received in the home to equal or exceed that received in a hospital, at a fraction of the cost. Today, it is common for a Medicare beneficiary to undergo chemotherapy in the comfort of his or her own home, a feat that was inconceivable just a few years ago. In the future, advances in tele-medicine and similar technologies will make it possible to further reduce health care costs and improve the quality of care for people who receive care in the home. None of these advances could have been envisioned at Medicare's inception in 1965.

Not only is homecare patient-preferred, numerous studies [1] have shown that home care providers are a cost-efficient component of the healthcare delivery system. One study conducted by the Hudson Institute, an independent research organization, particularly demonstrates these savings. This study, *The Cost Effectiveness of Home Health Care,* examines the highly successful In-Home/CHOICE program instituted by the State of Indiana in 1985. Indiana provides 100% of the funding for this program, which covers the costs of home health care for qualified residents in need of long-term care in order to prevent unnecessary institutionalizations.

- Styring, William & Duesterberg, Thomas, *The Cost Effectiveness of Home Health Care: A Case Study on Indiana's In-Home/CHOICE Program,* (Vol. 1, No. 11), November 1997, (Hudson Institute, Indianapolis, IN).
- Mann, Williams C. et al, "Effectiveness of Assistive Technology and Environmental Interventions in Maintaining Independence and Reducing Home Care Costs for the Frail Elderly," *Archives of Family Medicine,* May/June 1999 (Vol. 8, pp. 210–217).

The authors of the study note that the coming crisis in health care funding for America's rapidly growing elderly population could be alleviated by home health care programs such as Indiana's. By avoiding institutionalized care, Indiana was able to reduce inpatient caseload costs by 50% or more, while allowing patients to receive care in the comfort of their own homes. The cost saving associated with this increased reliance on home care was considerable. The study states that home care for the elderly in Indiana can be provided for one half the cost of skilled nursing facility care. In addition, the quality control and screening procedures used in the Indiana program have successfully avoided problems with fraud and abuse. The Hudson Institute Study concludes that "Properly crafted and administered, home health care can play a critical role in helping society meet the looming health care needs of the 'Baby Boom' generation."

ACCESS TO HOME HEALTH HAS BEEN SEVERELY COMPROMISED

Unfortunately, as the possibilities for home care are advancing, access to the Medicare home health benefit has been severely compromised. No other health care provider group has been as negatively impacted by the BBA'97 as home health pro-

[1] For recent studies, please see:

viders have. The Congressional Budget Office (CBO) originally estimated that the BBA'97 would reduce spending for the home health benefit by approximately $16.1 billion over five years. However, the actual impact of the BBA'97 was much more dramatic. CBO recently revised their estimate to a reduction of $70 billion over five years, more than four times the original estimate. In March 2000, the Congressional Budget Office (CBO) announced that home health services had a rate of growth of −35%, less than any other health care sector.

The CBO recently stated that the "larger-than-anticipated reduction in the use of home health services" was the primary reason total Medicare spending fell 1% in fiscal year 1999. Likewise, according to the American Hospital Association's Year 2000 Lewin Study, the BBA '97 has reduced hospital-based home health services by 30.5%—the largest reduction of any hospital service.

Unfortunately, these dramatic reductions in reimbursements have an inevitable impact on the availability of the home health benefit. The George Washington University's Center for Health Services Research & Policy has released two studies reviewing the impact of BBA'97 on home health patients and providers. The studies show that the number of Medicare home health patients has declined by 50% from 1994 levels. Patients who were most likely to lose access to covered services included those suffering from chronic and complex conditions (e.g., diabetes, congestive heart failure, multiple sclerosis, and wound care patients). Sixty-eight percent of hospital discharge planners reported increased difficulty in obtaining home health services for Medicare beneficiaries. Fifty-six percent of the discharge planners reported increases in the number of beneficiaries requiring substitute placements, primarily in skilled nursing facilities, in lieu of home health services.

STOP FURTHER CUTS TO THE HOME HEALTH BENEFIT

AAHomecare urges the Subcommittee to stop the decimation of the Medicare home health benefit by eliminating the additional 15% payment cut scheduled to be implemented on October 1, 2001. This cut has no basis in public policy and was included in the BBA'97 as a scoring mechanism. Clearly, home health has contributed its fair share of Medicare cuts and the need for the 15% reduction no longer exists. However, the threat of the additional 15% reduction continues to exacerbate the access problems described above.

The continued expectation of the 15% cut does not allow home care providers to begin to recover from the devastating impacts of the BBA'97. In fact, a mere delay will only prolong the existing access problems. Home health providers can not take the financial risk of accepting sicker, costlier patients or making home health services available in rural areas when they are planning for an additional cut in funding that is already inadequate. Additionally, home health agencies will not be able to expend the resources needed to sufficiently prepare for PPS while an additional dramatic reduction lurks in the future. Many agencies are finding that they can not secure loans needed for the transition to PPS because lending institutions are leery of the financial viability of home care providers. For these reasons, AAHomecare urges this Subcommittee to support the full repeal of the scheduled 15% cut and further funding for rural agencies and an increase in the outlier payment for high-acuity patients. All five national home health associations support these priorities.

HOME MEDICAL EQUIPMENT

Home medical equipment (HME) providers supply medically necessary equipment and allied services that enable beneficiaries meet their therapeutic goals. Pursuant to the physician's prescription, HME providers deliver medical equipment and supplies to a consumer's home, set it up, maintain it, educate and train the consumer and caregiver in its use, provide access to trained therapists, monitor patient compliance with a treatment regimen, and assemble and submit the considerable paperwork needed for third party reimbursement. Specialized home infusion providers manage complex intravenous services such as chemotherapy in the home. HME providers also coordinate with physicians and other home care providers (e.g., home health agencies and family caregivers) as an integral piece of the home care delivery team.

The BBA'97 instituted a freeze on the annual inflation adjustment for Medicare's durable medical equipment (DME) fee schedules. In addition, the BBA'97 cut reimbursement for home oxygen therapy by 30%. These cuts have had a dramatic impact on a market dominated by small, mom-and-pop providers. AAHomecare members report that there has been a dramatic increase in bad debt and an unprecedented number of bankruptcies since 1997.

The larger, national HME provider chains have also been reeling from the impacts of the BBA'97. *PriceWaterhouseCoopers* (PWC) recently updated a 1999 survey

of nine publicly held HME companies. PWC observes that all nine companies were earning a positive net income in 1996, and by 1999 two-thirds of these companies were losing money, bankrupt or out of business. This dramatic reversal occurred during a period where the average US corporate profit margin rose by 18%. One national company laid off 1,471 out of 6,000 employees in the past 24 months and closed 30 branches that served Medicare beneficiaries. During this period, the equity value of this company's stock fell by nearly $1 billion. Another national HME provider laid off 350 employees and closed 65 branch locations and its shareholder value fell $237 million. This company's stock fell so much the company was delisted from the NASDAQ stock exchange.

At the same time that HME providers have been adjusting to the loss of the annual inflation adjustment, costs have been skyrocketing. Certainly, when the freeze in payments to HME providers was enacted, no one could have foreseen the recent dramatic rise in fuel prices. These increased costs disproportionately impact the HME industry whose main function is the delivery and in-home maintenance/refill of medical equipment. In addition, recent increases in labor prices have also impacted this staff-intensive health care sector.

In order to recover from the destabilization caused by rapidly increasing costs and declining reimbursements, AAHomecare asks you to restore the full cost of living (COLA) adjustment for HME providers in fiscal years 2001 and 2002. By restoring the COLA, you will enable HME providers to begin to rebuild and continue to provide high quality in-home medical services.

INHERENTLY REASONABLE?

AAHomecare remains concerned that the Health Care Financing Administration's (HCFA's) implementation of the expanded inherent reasonableness (IR) authority granted in the BBA has been based on shoddy research, superceded Congressional intent, and will ultimately threaten beneficiary access to quality medical equipment services. AAHomecare urges this Subcommittee to require a few budget-neutral changes to the expedited IR authority to make it viable.

In 1985, HCFA was granted the authority to alter Medicare reimbursements for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) through the IR authority. This authority allowed HCFA to adjust reimbursements for individual items and services if the payments are found to be grossly deficient or excessive. A BBA'97 provision (Section 4316) granted HCFA a greatly expanded IR authority to adjust DMEPOS reimbursements by as much as 15% each year without industry consultation, publication in the Federal Register, or public comment. HCFA and the Durable Medical Equipment Regional Carriers (DMERCs) quickly announced planned IR reductions for a number of DMEPOS items. AAHomecare remains concerned about the arbitrary nature of these reductions, the lack of sound evidence for the reductions, and the apparent violation of the 15% threshold established in the BBA'97.

The Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106–113) contained a provision (Section 223) that required HCFA to: "(1) reevaluate the appropriateness of the criteria included in the interim regulationa... and (2) take appropriate steps to ensure the use of valid and reliable data when exercising the authority." In addition, the report language states that the IR authority should "be administered judiciously and applied only after public concerns and suggestions about proposed administrative criteria have been openly addressed."

A recent General Accounting Office GAO report (GAO/HEHS–00–79) has described the data collections techniques used by the DMERCs to support their proposed reductions as "deficient," "inconsistent" and "inappropriate." In fact, the GAO confirms the industry contention that the DMERCs failed to determine what type of enteral formula is covered by the Medicare Program prior to announcing planned cuts based on faulty data. Not only did the carriers collect data on the wrong items, they failed to use a standard survey technique. The GAO dubbed the data collection efforts "judgmental" and "less rigorous," and listed a number of deficiencies in the survey process. For instance, the GAO states that the DMERCs:

- "did not choose their sample in a consistent way, nor did they set sufficient criteria so that we [the GAO] could be assured that the locations sampled represented retail prices nationally." (p.21)
- "did not follow a consistent methodology, leading to differences in how they collected an analyzed retail prices..." (p.21)
- "did not establish criteria to define populous state, less populous state, urban area, and rural area, and consequently each DMERC used different criteria in selecting locations." (p.22)
- "did not develop a consistent set of survey questions to use when they requested prices from retail stores." (p.23)

• did not "fully consider the geographic distribution of Medicare beneficiaries." (p.22)
• "The DMERCs did not consider relative prices in the localities from which they sampled." (p.22)

Despite these inadequacies, HCFA officials have indicated that they plan to move forward with IR reductions for a number of items of DMEPOS, regardless of the above mentioned problems with their data. AAHomecare urges Congress to insist that the Medicare Program go back to the drawing board. We hope that your Committee will again insist that reimbursement adjustments be based on consistent, reliable data.

In addition, AAHomecare urges Congress to restrain HCFA from superceding the 15% authority granted in the BBA'97. As you are aware, the BBA outlined specific notice and comment guidelines for Medicare to follow when enacting payment adjustments over 15%. AAHomecare suggests that by including the legislative language addressing the process for implementing adjustments greater than 15%, Congress was expressing its intent for HCFA to follow this process. We are disappointed that HCFA has decided not to meet this requirement and ask this Subcommittee to reiterate its original intent.

MEDICAL SUPPLIES IN PPS

AAHomecare is also concerned about the bundling of nearly 200 supply codes into the home health agency (HHA) prospective payment system (PPS) base rate. AAHomecare maintains that the bundling of non-routine medical supplies into the HHA PPS rate and consolidated billing for medical supplies ignore the inherent complexities of the home health market and threaten the continuity of needed medical care. AAHomecare urges Congress to remove non-routine medical supplies from the home health PPS rates and to eliminate consolidated billing for these supplies. Importantly, this adjustment to the PPS would be completely budget neutral.

To illustrate the problem with the supply issue, consider the case of a Medicare beneficiary with an ostomy for a urinary bypass who is receiving HHA services for a broken hip. The HHA would provide therapy and aide services for the hip while the beneficiary is self-sufficient in his/her ostomy management. The HHA plan of care may not address the beneficiary's need for supplies such as drainage bags, nighttime drainage bottles, tubing, adhesives and cleaners. In addition, the HHA professionals meeting the acute care needs of the beneficiary may not provide any services related to ostomy care. In this case, the chronic condition would be incidental to the HHA services required. However, bundling and consolidated billing would require the company providing the ostomy supplies to cease serving the beneficiary and make the HHA responsible for the supply function. This change in medical supply providers may be unnecessarily burdensome for the beneficiary—especially if the supplies offered by the HHA are substantially different or incompatible with the equipment and supplies provided by the existing supplier.

In addition, the bundling of supplies into the PPS rate threatens to cause a great deal of confusion and a dramatic rise in billing errors. Currently, there is no way for a HME supplier to be notified when a beneficiary with chronic supply needs enters the plan of care of a HHA. However, if consolidated billing and bundling go into effect, any HME provider who submits a claim for supplies with a date of service coinciding with a HHA plan of care would violate the False Claims Act (FCA). An HME provider who runs afoul of the FCA is liable for treble damages and up to $10,000 in fines per improperly billed claim. Understandably, the inherent risks associated with bundling and consolidated billing may cause HME providers to become reluctant to serve beneficiaries with chronic supply needs.

CONCLUSION

Home health care continues to evolve to meet the increasingly complex needs of today's Medicare beneficiaries. By capitalizing on technological advances, home care providers have the potential to conduct increasingly complex medical and therapeutic regimens in the comfort of beneficiaries' own homes. Not only will these advances serve the needs and preferences of the Medicare population; they will reduce Medicare expenditures by avoiding costly institutionalizations. We urge this Subcommittee to recognize the many benefits of home care by strengthening Medicare's commitment to home health.

AAHomecare asks that you acknowledge the contribution that home health agencies have made to Medicare cost containment by permanently eliminating the pending 15% cut in reimbursement. Further, you should restore the annual cost of living adjustment for home medical equipment providers. In addition, we urge you to continue the needed oversight of the implementation of the IR authority granted in the

BBA'97. You should insist that HCFA and its carriers implement a sound costing methodology that uses statistically reliable data. Finally, in order to ensure a continuity of patient care, avoid unnecessary billing confusion, and ease the transition to a PPS system, we urge this Committee to remove the requirement that non-routine medical supplies be included in the PPS rate and eliminate consolidated billing for these supplies.

Again, thank you for the opportunity to provide this statement. Please feel free to contact Erin H. McKeon with any questions or comments regarding these issues.

Statement of American Association of Blood Banks, America's Blood Centers, and the American Red Cross

Technological Advances Make Today's Blood Supply Safer than Ever

Recognized by Congress, the American Public, the Federal government and the blood banking community, patient access to the safest possible blood supply is a national public health priority. The blood banking and transfusion medicine communities work diligently to assure that safety improvements are implemented in a timely manner. Two recent initiatives have been introduced to increase the safety of the blood supply. However, these measures significantly increase the cost of blood products and services for both the hospital and the blood bank. They are:

- *New infectious disease testing:* **Nucleic acid (gene) amplification testing (NAT)** allows for early detection of infectious diseases (such as HIV and hepatitis C (HCV)) in blood by detecting the genetic material of viruses. More than 90 percent of all blood components in the United States are currently tested by NAT under an FDA-approved investigational new drug protocol (IND). In the first 15 months of implementation, NAT testing has detected and intercepted four HIV-positive donations and more than 57 HCV-positive donations. This means that roughly 150 potential HIV and HCV infections were prevented as a result of NAT.
- *Leukoreduction technologies:* Several studies have shown that removing the leukocytes or white cells from blood components can reduce the frequency and severity of complications from blood therapy. One process, known as **leukoreduction,** has the potential to shorten the duration of a hospital stay for patients who receive blood. FDA has indicated that it will require universal leukoreduction of all blood components in the near future.

These important safety improvements are costly. **Universal leukoreduction and NAT are estimated to add over 40 percent to the cost of blood.** In the future, additional life-saving technologies, such as viral inactivation, are likely to add to the cost of transfusion therapies.

Not-for-profit Blood Centers and Transfusion Services Cannot Absorb Added Costs

Not-for-profit blood collection centers operate in the same managed care environment as our hospital customers. As a result, blood centers must charge hospitals for the blood products and services we provide to recover the costs associated with collecting, testing, processing, storing and distributing blood for patients in need. Hospitals, in turn, must get timely reimbursement for these life-saving and life-enhancing products and services. Currently, there is a lag of up to three years between the time that an FDA-recommended procedure is implemented and the time the hospital is adequately reimbursed.

Legislation to Provide Fair Reimbursement Needed to Ensure Patient Access to Highest Quality Blood Therapies

Fair and adequate Medicare reimbursement is necessary to ensure patient access to the safest possible blood. Unfortunately, the current system by which the Health Care Financing Administration (HCFA) determines inpatient reimbursement rates does not account for these safety improvements in a timely manner.

In 1999, Congress and the Administration acknowledged the importance of supporting blood safety advancements through fair Medicare reimbursement in the *outpatient* setting. However, the vast majority of blood is supplied in the *inpatient* setting. Thus, it is critical that inpatient reimbursement policies also be adjusted to reflect increases in the cost of these products and services.

LEGISLATIVE PROPOSAL: Recognizing the importance of patient access to a safe and adequate blood supply, Congress should enact legislation that assures fair Medicare payments for inpatient blood products and services. The American Association of Blood Banks, America's Blood Centers and the American Red Cross strongly urge Congress to adopt legislation that:

• Increases the Medicare hospital inpatient "market basket" by 0.45 percent to cover the added costs associated with recent blood safety enhancements that are FDA recommended and/or adopted as the standard of care. This increase should be provided on an annual basis until a longer-term remedy is implemented (see below); and

• Directs HCFA to develop a specific mechanism in the hospital market basket to account for changes in costs for blood and transfusion therapy-related products and services from year-to-year. HCFA should be directed to develop this mechanism within one year of the legislation's enactment.

The American Association of Blood Banks, America's Blood Centers, the American Red Cross and the American Hospital Association support this legislative proposal, in addition to separate legislation (S. 2018 and H.R. 3580) to restore excessive Medicare inpatient payment reductions, as a means of ensuring hospitals have adequate resources to cover blood safety enhancements. Together, the market basket increases called for in these two legislative proposals are notably less than the market basket adjustments recently recommended by the Medicare Payment Advisory Commission (MedPAC). These increases are necessary to restore adequate payment to hospitals, which, in turn, will ensure patient access to state-of-the-art blood products and services and the safest possible blood supply.

Statement of the American Association of Orthopaedic Surgeons (AAOS)

The American Association of Orthopaedic Surgeons (AAOS), representing 16,000 Board certified orthopaedic surgeons, appreciates the Subcommittee on Health of the Committee on Ways and Means for holding hearings to address further refinements of the Medicare program. We would like to offer our perspective on select issues related to implementation of the many changes under the Balanced Budget Act of 1997 (BBA) and make specific recommendations for consideration as amendments.

Practice Expense Adjustments

The Health Care Finance Administration's (HCFA) failure to comply with BBA mandates pertaining to the "practice expense" component of the Medicare Physician Fee Schedule has seriously impacted patient care. The current methodology and data does not accurately reflect physicians' actual practice costs. As a result, reimbursement rates are seriously distorted and fundamentally unfair.

In 1994 Congress directed HCFA to change the way Medicare pays for physicians' practice expenses. Concerns with initial proposals presented by HCFA on how to proceed prompted Congress to intervene and include detailed instructions for developing practice expense relative value units (PE RVUs) in the BBA. Now at the halfway point, the new system is to be fully implemented in 2002.

Practice Expense Recommendations

HCFA has acknowledged the difficulty in determining actual physician expenses associated with providing services to Medicare patients. Budgetary constraints have only compounded this problem. The AAOS believes that the budget surplus presents an opportunity to ensure mandatory obligations to increase reimbursement for primary care office services while ensuring appropriate payments for specialists. **We support the Practice Expense Coalition's request to:**

• Halt the transition at the current blend of 50% 1998 PE RVU and 50% projected 2002 PE RVUs practice expense values; and

• Allow scheduled increases for certain office and consultation services to proceed immediately to their projected 2002 amounts.

Fraud and Abuse

Also among the extensive changes to the Medicare program in the BBA were efforts to reduce waste, fraud, and abuse. The AAOS shares the Federal government's concern about intentional acts to defraud the Medicare program. There is no question that every reasonable effort needs to be made to eliminate true waste, fraud and abuse from the Medicare program. However, fraud and abuse regulations should not be so complex and so difficult to follow that the vast majority of honest physicians wind-up making unintentional errors.

More importantly, these regulations are threatening access to quality health care services for Medicare beneficiaries because physicians have less time to spend with patients. Time once spent treating patients is now being spent completing mandatory documentation and billing requirements, as well as other regulatory obliga-

tions. Not only are physicians spending more time away from treating patients, but also HCFA's burdensome and complex requirements are making it difficult and sometimes impossible for doctors to accept new Medicare patients. Moreover, physicians are spending more time second-guessing the regulators and the enforcers about whether they should be providing a particular service, instead of-and without hesitation-doing what is in the best interest of the patient.

The biggest problem in this area of Federal regulation is that there is no "bright line" as to what constitutes illegal or improper conduct. The presumption running through these regulations is that physicians are violating the law and are guilty of defrauding the government, unless they can document otherwise. We need rules and regulations that are understandable, fair and, most importantly, provide clear guidance about what constitutes proper and improper conduct. Instead, we find the current environment to be confusing and ambiguous-where law-abiding doctors are placed in an increasingly hostile and adversarial relationship with the government.

In an effort to ensure that the regulatory requirements placed on physicians do not adversely affect access to quality patient care, the AAOS supports remedies that are consistent, predictable and clearly understood by physicians. The AAOS has identified a number of specific areas where Congressional changes are necessary.

Complex and Contradictory Regulations and Increased Documentation Requirements

Many rules promulgated by HCFA are so confusing that they convey no clear indication of how the agency will deal with a particular practice, leading physicians to be unsure about their duties and liabilities. We need better guidance to negotiate the complex maze of regulatory requirements.

For example, orthopaedic surgeons have been perplexed about the in-office ancillary service provisions of the physician self-referral law commonly known as "Stark II" (Section 1877 of the Social Security Act) and HCFA's proposed rule requiring suppliers of durable medical equipment (DME) to obtain a surety bond. The proposed rule to "Stark II" excludes DME from the in-office ancillary service exemption, thus prohibiting the disbursement of DME in-office. Yet, under the surety bond proposed rule, HCFA states that physicians will not have to meet the DME surety bond requirement—if they are providing these items incident to patient care. It seems that HCFA is recognizing that DME is distributed by physicians in-office, even though the proposed rule to "Stark II" seems to prohibit it.

Thus, it appears to the AAOS that HCFA has two proposed rules that have contradictory statements. Are physicians in the various practice arrangements allowed to disburse DME incident to patient care without violating the "Stark II?" Do physicians need a surety bond to disburse these items in office? If they have a surety bond, and are designated as suppliers by HCFA, then how is "Stark II" applicable?

Since DME is such an integral, customary, and appropriate part of patient care, commonly provided to patients as an in-office ancillary service, the blanket prohibition in "Stark II" makes little sense. The AAOS strongly urges the Subcommittee to revisit this issue, so physicians have clear guidance about the disbursement of DME.

In addition to this DME issue, the AAOS is greatly concerned about the enormous complexity of the proposed rule related to the "Stark II" physician ownership and self-referral statute. The AAOS maintains that HCFA's proposed rule issued in January 1998 does not provide clear, unambiguous guidance for compliance. Instead, it has added even more confusion to what activities are permissible with regard to the ban on physician self-referral. While the AAOS is hopeful that the final rule for "Stark II" will address many of these concerns, Congressional oversight is necessary and legislative remedies may be appropriate to achieve Congress' intent and to provide clear guidance to physicians.

The AAOS also is concerned with HCFA's increased documentation requirements for physicians when they perform and bill for evaluation and management (E&M) services. There seems to be a presumption that physicians who make errors in coding these services on Medicare claim forms are guilty of defrauding the system-unless they can prove otherwise. Even though HCFA has attempted to ease these documentation requirements, physicians still can run afoul of the rules and regulations.

For example, when coding modifier −25 is used with CPT codes for E&M services, they may trigger an audit even though their usage is perfectly legitimate, saves on paperwork, and reduces the administrative burden for both physicians and claims reviewers. Modifier −25 is used in billing when additional services are provided to beneficiaries beyond the services described by E&M codes. This modifier was intended to reduce the documentation requirements imposed on physicians. However, because their usage may trigger an audit, physicians are forced to submit

claims for each additional service supported by separate documentation for each service in order to avoid triggering audits.

In sum, complex and contradictory regulations and documentation requirements present the physician with a maze of nearly incomprehensible rules for which non-compliance may be inevitable even for those with the best of intentions of filing appropriate claims for services provided under the Medicare program.

Aggressive and Overreaching Authority by Federal Agencies

We believe HCFA and the Department of Health and Human Services has overstepped their authority in their efforts to eliminate Medicare fraud and abuse by using aggressive and overzealous enforcement techniques against physicians without sufficient evidence of intentional wrongdoing.

For example, the Anti-Kickback Statute was, in theory, intended to promote the integrity of the health care system. While it has achieved this goal in practice, the statute also has stifled innovative business practices that could have saved the government money. The 1972 statute was originally enacted to address bribes and kickback arrangements in the health care arena. Congress broadened its scope in 1977 to address "any remuneration" giving the Office of Inspector General of the Department of Health and Human Services (OIG) great latitude in interpreting its mandate and applying this law to business arrangements far beyond kickback and bribes. While Congressional intent was to prevent unscrupulous behavior, the statute has allowed the OIG to develop a confusing patchwork of complex regulations and advisory opinions concerning joint ventures, leases, discounted services and personal service contracts that significantly limit innovation in the integrated health care delivery marketplace.

HCFA also has taken broad latitude in interpreting its authority by implementing initiatives such as the "Who Pays? You Pay." campaign. This initiative attempts to enlist Medicare beneficiaries to inform on their physicians if they suspect their Medicare bill is fraudulent. Unfortunately, it has the serious potential to damage the physician/patient relationship by creating an atmosphere of distrust between the doctor and patient when an open and honest relationship is essential to effective care and treatment.

The OIG also recently unveiled its "Compliance Program Guidance for Individual and Small Group Physician Practices." This compliance program significantly raises the stakes for hardworking and honest physicians who currently make every attempt to comply with the law. Not only is the creation of a plan extremely labor intensive and expensive, it has the potential to shift the burden of proof to the physician.

The OIG has stated that it only prosecutes offenses that are committed with actual knowledge of the falsity of a claim, reckless disregard or deliberate ignorance of the truth or falsity of a claim. However, by having an effective plan in place, virtually any innocent billing error could trigger OIG action or prosecution since a compliance plan in place will indicate that the physician knew or should have known that a certain activity violated the law. While OIG officials may claim that the presence of an effective compliance plan will be taken into consideration if punitive action is necessary due to alleged billing errors, evidence of a compliance plan could be interpreted to transform the knowingly and willfully standards of law into per se violations.

Limited Due Process

Through pre-payment reviews and post-payment audits conducted by carriers, HCFA engages in audits of physicians on a random basis without probable cause. Even while HCFA acknowledges that much of what is uncovered in these reviews and audits are simple billing mistakes, lack of documentation or disagreement on treatment procedures, claims submission has become legally treacherous for physicians. Fear of triggering an audit has actually led to "downcoding"-a practice of underbilling Medicare for services provided to Medicare beneficiaries-in order to reduce the chance of triggering an audit.

Under the current scheme, physicians are exposed to purely random audits without probable cause and without knowing of the criteria used by HCFA or its carriers to make its determinations. And once an audit is triggered, physicians are subject to recoupment of alleged overpayment, penalties and interest through the use of extrapolation techniques. The only remedy for physicians once they receive an overpayment notice is to open their practice to a statistically valid random sampling of claims to contest HCFA's findings, which, by HCFA's own admission, is very disruptive to a health care practice. Physicians would like the government to define the rules, parameters and standards that outline the scope of these audits as well as clearly identify the criteria used to trigger audits.

Fraud and Abuse Recommendation

The vast majority of physicians are honest and dedicated individuals who make every attempt to comply with Medicare's complex requirements. Their primary goal is to provide the highest quality care to their patients. Physicians understand the need for regulations in the health care system. However, the rules that they are being asked to comply with and support should be presented in a clear and precise manner so that they can practice their profession without fear of punishment because they could not understand what was expected of them.

The AAOS is very pleased that the Subcommittee is taking an active role to ensure the Medicare program functions efficiently for all stakeholders. **In considering further legislative changes to the Medicare program, the AAOS has several recommendations:**

- Require HCFA to simplify and clarify regulations related to the Medicare program so that they are less burdensome and more easily understood by physicians particularly with regard to the use of DME as an in-office ancillary service;
- Recognize the costs incurred by physicians to comply with the numerous Medicare regulations;
- Establish adequate due process protections and a threshold requirement of probable cause when investigating health care professionals providing services under the Medicare program;
- Develop mechanisms to hold HCFA and other government agencies accountable for oversight and review activities;
- Delay when a law goes into effect, as well as all enforcement activities, until final regulations are issued;
- Eliminate the prohibition of administrative or judicial review of Medicare payment and review methodology; and,
- Eliminate the "scoring" of budget savings as a result of fraud and abuse activities. As long as the pursuit of fraud is viewed as a "bounty" or revenue raising activity, cost-containment measure, or a way to expand program benefits, overzealous investigations of physician coding and billing activities will continue.

Again, we appreciate the opportunity to share with the Subcommittee our views concerning payment and fraud and abuse provisions of the BBA, and we look forward to working with you to ensure quality patient care under the Medicare program.

Statement of Edward A. Eckenhof, American Medical Rehabilitation Providers Association

Mr. CHAIRMAN:

This statement is submitted on behalf of the American Medical Rehabilitation Providers Association (AMRPA). AMRPA is the national trade association representing approximately 325 freestanding rehabilitation hospitals, rehabilitation units in general hospitals, and other outpatient rehabilitation providers. The majority, if not all, of our members participate in the Medicare program. For rehabilitation hospitals and units, Medicare accounts for approximately 70% of all discharges and revenues. Therefore, even temporary changes in Medicare reimbursement can threaten the security of a great number of facilities and consequently, the patients we serve.

BACKGROUND

Rehabilitation hospitals and units provide medical care and various therapies to patients who, because of disease, injury, stroke or similar incidents, have impairments in their ability to function, either physically or cognitively. Our goals are to help them regain their maximum level of functional capability and to return them to independently living in their own homes. More than 80% of patients admitted to rehabilitation hospitals and units return to their homes, in spite of the fact that many have experienced severe disabilities. Many of the conditions producing the need for rehabilitation are associated with aging, a significantly high percentage of patients in rehabilitation hospitals and units are covered by the Medicare program. In 1997, over 70% of patients admitted to such facilities were covered by fee-for-service Medicare. Accordingly, the policies of the Medicare program largely determine the availability and quality of rehabilitation services. And, there is little room for error.

Rehabilitation hospitals and units are currently reimbursed for providing Medicare services under a payment methodology mandated by the Tax Equity and Fiscal

Responsibility Act of 1982 (TEFRA). This arrangement, which was intended to be temporary, reimburses facilities on the basis of reasonable, subject to a payment ceiling (known as the "TEFRA limit").

Over time, this system developed a number of negative incentives, which led to the industry to advocate the implementation of a prospective payment system (PPS) for inpatient rehabilitation facilities. In recognition of the need to modify payment methodology, in the Balanced Budget Act of 1997 (BBA 97), Congress enacted a PPS for inpatient rehabilitation to be implemented over two years, starting with cost reporting periods beginning on or after October 1, 2000. BBA 97 calls for a2% reduction in total expenditures for rehabilitation services from that which would have been spent absent the PPS. It also included several provisions aimed at reducing costs during the transition period until full PPS implementation. These included a 15% cut in inpatient capital reimbursement and reductions in bonus incentive payments and the TEFRA limits.

These interim measures, imposed by the BBA and intended to reduce Medicare costs during the period prior to PPS implementation, now threaten the financial security of the nation's rehabilitation providers as well as the access to services relied upon by rehabilitation patients.

Earlier this year, the Health Care Financing Administration (HCFA) announced that it is delaying the implementation of the rehabilitation inpatient PPS until cost reporting periods beginning on or after April 1, 2001. Since HCRA has not yet promulgated the rehabilitation PPS rulemaking, this timeline is now highly questionable. These significantly delays in the development of the PPS system render it unlikely that facilities will begin the transitions to the PPS until the end of 2001, more than a year later than originally planned.

Overall Medicare outlays for services delivered by rehabilitation hospitals or units have been reduced by more than $600 million over three years. And although rehabilitation spending comprises just 2.3% of total Medicare spending, rehabilitation hospitals and units have been forced to absorb almost 4.3% of BBA 97 spending reductions. Moreover, the sought-after cost reductions have already been realized. The Medicare Payment Advisory Commission's (MedPAC) June, 2000 Report to Congress, for example, noted that from 1997 to 1998, Medicare margins for rehabilitation facilities decreased from 6.3% to 1.8%.

The financial impact of the delayed implementation of the PPs and the realization of Medicare cost savings that were the impetus for the reimbursement changes, as well as the creation of a national budget surplus, make imposition of further financial burdens on the rehabilitation sector both unnecessary and especially risky. Congress should take action to ensure both the short-term financial stability of the rehabilitation hospital industry prior to the implementation of the rehabilitation PPS and the long-term financial capability of rehabilitation providers to offer care to an aging population that will increasingly need its services.

I. CONGRESS SHOULD ENSURE THE CONTINUING AVAILABILITY OF REHABILITATION SERVICES THROUGH ELIMINATION OF THE 2% REDUCTION IN TOTAL PAYMENTS AND A TEMPORARY 1% INCREASE IN INCENTIVE PAYMENTS.

BBA 97 reduced both the total expenditures for inpatient rehabilitation services under the PPS and changed the current payment methodology, including the bonus incentives payments, that previously has been used to encourage and maintain the most efficient provision of services. As implementation of the rehabilitation PPS continues to be delayed, these changes to the TEFRA payment system continue to the overall decline in the financial stability of the rehabilitation hospital industry.

Section 4421 of the BBA 97 mandated that, in setting the rehabilitation PPS payment rates, the HHS Secretary reduce total expenditures for inpatient rehabilitation services by 2% from what these would have been absent a PPS. Thus, in determining the rates to be paid under the rehabilitation PPS for FY 2001–02, only 98% of the total amount that otherwise would be paid under TEFRA is to be taken into account. In light of the significant reductions in Medicare spending for rehabilitation services since enactment of the BBA, the additional 2% reduction in FY 2001–2002 reimbursement could devastate an industry already trying to cope with the fiscal restraints resulting from BBA 97 initiatives.

The long-term financial security of the rehabilitation hospital industry would be bolstered substantially by elimination of this reduction. The scheduled reduction was originally enacted as part of the overall BBA 97 effort to obtain savings under the Medicare program. Clearly, as demonstrated by Medicare reimbursement reductions for rehabilitation facilities, BBA 97 savings have already been achieved. Thus, there is not longer any reason for Congress to require this additional reduction in

rehabilitation PPS reimbursement, particularly when one considers the additional hardship that it will reduce.

Additionally, the BBA 97 imposed several cost-savings measures. These included reduction of bonus incentive payments, the program under which PPS-exempt hospitals and units, including rehabilitation facilities, were eligible to obtain an incentive payment that was the lesser of 50% of the difference between their costs and the TEFRA limit, or 5% of the limit. Section 4415 of the BBA 97 reduced the applicable percentages to 15% and 2%, respectively. The negative effect of this provision as was further compounded for facilities that has TEFRA caps lowered to the 75th percentile under another BBA 97 provision. The industry estimates that, as a result of these two provisions, the rehabilitation hospital industry lost approximately $144 million in payments in one year (based on FY 1997). A modest, yet significant, restoration in the form of a 1% increase in bonus payments until full implementation of the rehabilitation PPS would help to alleviate interim financial concerns and restore a more meaningful incentive to increase productivity.

II. UNTIL THE PPS SYSTEM IS FULLY IMPLEMENTED, CONGRESS SHOULD RESTORE FULL CAPITAL PAYMENTS FOR PPS-EXEMPT REHABILITATION HOSPITALS AND UNITS.

Because rehabilitation facilities and other PPS-exempt providers are reimbursed on a cost basis, Congress exempted them from capital cuts. The rationale for full reimbursement of capital for providers under cost reimbursement is that such providers have no opportunity to make up for the loss of capital payments through operating efficiencies. If costs go down, so does reimbursement. Section 4412 of the BBA changed this. It imposes a 15% reduction in capital payments for PPS-exempt (TEFRA) hospitals and units for FY 1998–2002. This reduction in capital payments was not driven by policy considerations, but instead was implemented solely for budgetary reasons.

As noted above, rehabilitation providers are heavily dependent on Medicare fee-for-service, which covers 70% of rehabilitation admissions and an equally high percentage of revenues. By comparison, other PPS-exempt hospitals (e.g., psychiatric, children's) are far less Medicare-dependent. As such, the capital payment reductions to PPS-exempt hospitals have a comparatively greater detrimental impact on the renovation of plants and the building of more modern facilities by rehabilitation hospitals than by other PPS-exempt hospitals.

In terms of precedents, capital payments to acute care hospitals were decreased with implementation of the acute care PPS only after four full years, and only gradually over time. This progressive implementation initially included a 3.5% cut in FY 1987, with gradual increases to 15% in FY 1989. Rehabilitation providers are being forced to absorb capital reimbursement cuts much more quickly than were acute care hospitals.

A 15% cut in capital reimbursement costs PPS-exempt providers at least $62 million in one year along. If capital and bonus incentive payments are not stored in the short run, all rehabilitation providers will continue to receive payments below cost. Therefore, Congress should restore full capital payment for PPS-exempt rehabilitation hospitals and units.

III. CONGRESS SHOULD PERMIT AN EARLY OPT-IN TO INPATIENT REHABILITATION PPS.

Under BBA 97, the inpatient rehabilitation PPS will be implemented gradually over a two-year period. During the transition, facilities' payments will be calculated using a combination of TEFRA payments and new PPS payments. in year one, these payments will consist of the aggregate of two-thirds of a facility's TEFRA payments an done-third of its PPS payments; in year two, facilities will receive payments based on one-third TEFRA and two-thirds PPS. By the third year, all facilities will be paid 100% under the inpatient rehabilitation PPS.

As noted above, the impatient rehabilitation PPS was originally intended to go into effect for cost reporting years beginning on or after October 1, 2000. HCFA announced earlier this year that it is delaying implementation of the system until cost reporting periods beginning on or after April 1, 2001. Since HCFA has not yet promulgated the rehabilitation rulemaking, this timeline is not highly questionable. Because most facilities' cost years start later in the year, many facilities will not begin the transition until the end of 2001 or even later, depending on the final implementation timeline.

Whihle the transition period remains extremely important for many rehabilitation facilities, some facilities believe that they can continue to provide high quality, cost-effective care while moving directly to full PPS in the first year. In fact, these facilities perceive that trying to live under two payment systems for two years—TEFRA

and PPS—could lead to conflicting payment and service delivery incentives. It is important to ensure, however, that rehabilitation facilities which are not interested in taking an early election to full PPS retain the ability to transition to full PPS over a two-year period.

Permitting immediate movement to full PPS would reward facilities able to revise their costs and service delivery patterns quickly to meet or come in under their PPS limits. Congress provided such an election for the skilled nursing facility PPS, including necessary funding, in the Balanced Budget Refinement Act of 1999 (BBRA). Congress should look to this precedent and allow an early opt-in. This change would preserve facilities' continued financial viability, thereby furthering their capacity to carry out their primary mission, the delivery of care to persons with disabilities.

CONCLUSION

AMRPA believes the patients' continuing access to quality rehabilitation services is currently at risk. The confluences of reductions in total payments for services, including reductions in bonus incentives and capital payments coming on the heels of dramatic decreases in Medicare margins for rehabilitations services already have resulted in huge losses for the rehabilitation hospital industry. With the following actions, Congress can provide vital relief for rehabilitation facilities and preserve the ongoing availability of rehabilitation services for the nation's increasingly aging population:

1) Congress should ensure the short-term financial stability of the rehabilitation hospital industry prior to the implementation of the rehabilitation PPS by increasing the incentive payment by 1%, and ensure the industry's long-term financial stability by eliminating the 2% reduction in the total amount to be paid under the PPS for FY 2001–2002

2) Congress should restore full capital payment for PPS-exempt rehabilitation hospital and units.

3) Congress should permit an early opt-in for those rehabilitation facilities able to more quickly adopt Congress' plan.

In addition to the above priorities, AMRPA supports a three-year extension of the moratorium or outpatient therapy caps. These caps, imposed by the BBA 97, bear no relationship to patients' clinical needs. The current moratorium, instituted by the BBRA in response to the expressed concerns of patients and providers, applies to calendar years 2000 and 2001. This, however, is unlikely to provide HCFA with sufficient time to adequately research and develop appropriate mechanisms to replace the arbitrarily derived limits on beneficiaries' access to needed rehabilitation services embodied in the cap. An extension of the moratorium should provide HCFA adequate time to complete its studies and to develop methodologies that will control costs, while protecting patients' treatment needs.

We thank the Committee for this opportunity to submit testimony. AMRPA looks forward to working with Congress as we face the future.

Statement on Association of periOperative Registered Nurses, Denver, CO

OVERVIEW

AORN (the Association of periOperative Registered Nurses) is the professional association representing approximately 43,000 operating room nurses across the country. AORN applauds Chairman William M. Thomas for his leadership in examining possible refinements to the Balanced Budget Act of 1997 (BBA). For the reasons outlined below, AORN respectfully requests the inclusion of H.R. 3911, the Medicare Certified Registered Nurse First Assistant Direct Reimbursement Act of 2000, in any BBA refinement package.

BACKGROUND

The BBA confirmed and expanded the role of non-physician assistants at surgery. For example, the BBA increased the reimbursement rate received by Physician Assistants (PAs), Nurse Practitioners (NPs) and Clinical Nurse Specialists (CNSs) for assisting a surgeon at surgery... The BBA also removed restrictions on the type of areas and settings in which first assisting services of non-physician first assistants may be covered by Medicare. (SeeSections 4511 and 4512.) Regretfully, the BBA failed to appropriately recognize the first assisting role of the certified Registered Nurse First Assistant (CRNFA).

AORN URGES MEDICARE COVERAGE ELIGIBILITY FOR THE SURGICAL FIRST ASSISTING SERVICES OF CERTIFIED REGISTERED NURSE FIRST ASSISTANTS

As this Subcommittee examines possible Medicare refinements to the BBA, AORN respectfully requests the inclusion of H.R. 3911. This important legislation calls for Medicare reimbursement for the surgical first assisting services of Certified Registered Nurse First Assistants (CRNFAs) at a rate of 13.6% of the surgeon's fee. This is the same rate at which Medicare currently reimburses non-physician first assistants.

As first assistants, CRNFAs provide high-quality cost-effective care and perform the same first assisting tasks and duties as surgeons, physicians, physician assistants, nurse practitioners and clinical nurse specialists who may currently receive Medicare reimbursement for first assisting services. Reimbursing CRNFAs for their surgical first assisting services would address this fundamental inequity while improving the quality and cost efficiency of the Medicare system.

MEDICARE REIMBURSEMENT FOR THE SURGICAL FIRST ASSISTING SERVICES OF CRNFAs ALREADY ENJOYS BROAD BIPARTISAN SUPPORT ON THE WAYS AND MEANS COMMITTEE

With strong bipartisan support from his colleagues on the Ways and Means Committee, Rep. Mac Collins (R–GA) introduced H.R. 3911, the Medicare Certified Registered Nurse First Assistant Direct Reimbursement Act of 2000, on March 14, 2000. This legislation would provide Medicare reimbursement for the surgical first assisting services of CRNFAs at 13.6% of the surgeon's fee. The principal sponsor (Representative Collins) and seven of the cosponsors (Representatives English, Foley, Johnson, Lewis, McDermott, Shaw and Thurman) serve on the Ways and Means Committee. Five of those cosponsors (Representatives English, Johnson, Lewis, McDermott and Thurman) serve on the Ways and Means Health Subcommittee.

Cosponsors to date include Representatives Lois Capps (D–CA), John Cooksey (R–LA), Nathan Deal (R–GA), Diana DeGette (D–CO), Philip English (R–PA), Mark Foley (R–FL), Elton Gallegly (R–CA), Paul Gillmor (R–OH), Porter Goss (R–FL), Jim Greenwood (R–PA), Peter Hoekstra (R–MI), Nancy Johnson (R–CT), Patrick J. Kennedy (D–RI), John Lewis (D–GA), Jim McDermott (D–WA), Charlie Norwood (R–GA), Charles Pickering (R–MS), Clay Shaw (R–FL), Ted Strickland (D–OH), Mike Thompson (D–CA), Karen Thurman (D–FL), and Robert Wise (D–WV).

Further, Representative Collins and eight of his colleagues joined together in a June 27, 2000 letter addressed to Chairman Thomas and others, which urged inclusion of H.R. 3911 in any appropriate legislative vehicle. Signatories included Representatives Capps, Collins, Deal, DeGette, English, Foley, Greenwood, Norwood and Pickering. The letter, a copy of which is attached, prsuasively argues that:

With respect to quality of care, CRNFAs provide a patient-centered continuum of care in the preoperative, intraoperative, and postoperative phases of the patient's surgical experience.CRNFAs often work in tandem with one or a small group of surgeons; this maximizes communication and coordination and minimizes the risk of medical error. In addition, in comparison with other non-physicians who first assist, CRNFAs have significantly more experience and expertise directly in first assisting.

As for cost-effectiveness, CRNFAs seek reimbursement for first assisting at 13.6% of the surgeon's fee; this is the same as currently is received by PAs and NPs who first assist. By contrast, physicians who first assist receive 16% of the surgeon's fee. Health claims data from the Health Care Financing Administration (HCFA) reveal that physicians file more than 90% of the first assistant at surgery claims for Medicare reimbursement... Use of CRNFAs would therefore be a high quality yet cost-effective alternative for the nation's health care delivery system, affording additional flexibility to surgeons, hospitals and ambulatory surgical centers.

We feel strongly that increased use of CRNFAs in surgical first assisting likely would result in positive patient outcomes such as lower recidivism rates, decreased complications from surgery, higher patient satisfaction levels, and overall lower expected costs per patient.

Many nurses, surgeons, and others in our districts have expressed their support for H.R. 3911. Some of us have witnessed CRNFAs first assist at surgery.

In conclusion, we strongly support extending Medicare coverage eligibility to CRNFAs for their surgical first assisting services at a rate of 13.6% of the surgeon's fee and we respectfully urge that you include this proposal in an appropriate health legislative vehicle.

WHAT IS A CRNFA?

A CRNFA is a registered nurse first assistant (RNFA) who obtains national certification, a voluntary process. An RNFA already is a technically skilled, highly educated nursing professional who renders direct patient care as part of the perioperative nursing process. The certification process raises an already high quality standard and recognizes those RNFAs who have achieved excellence in patient care. The RNFA seeking certification must meet rigid requirements before applying, including:

1. Current licensure as an RN, without provision or condition, in the United States;
2. Certification in perioperative nursing (CNOR);
3. Completion of a minimum of 2000 hours of practice as an RNFA that includes preoperative, intraoperative, and postoperative patient care;
4. Completion of a formal RNFA program that meets criteria established by the Certification Board Perioperative Nursing including training equivalent to a one-year comprehensive post-graduate program involving both classroom and clinical studies in anatomy and physiology, assessment skills, asepsis/infection control, and an extensive surgical assisting curriculum. During the required clinical internship, the prospective RNFA spends a defined number of clinical hours under the supervision of a surgeon preceptor; and
5.A Bachelor and/or a Master of Science Degree in Nursing.

CRNFAs are recognized by the American College of Surgeons, the American Nurses Association, the National League of Nurses, the National Orthopedic Nurses Association, and the 50 State Boards of Nursing. Indeed, at their annual meeting in June 2000, the American Nurses Association House of Delegates adopted Policy Number 3.37, which supports federal recognition and reimbursement for CRNFAs as first assistants.

HOW WOULD CRNFAs SAVE THE HEALTH CARE SYSTEM MONEY?

Health claims data from the Health Care Financing Administration (HCFA) reveal that physicians file more than 90% of the first assistant at surgery claims for Medicare reimbursement. Physicians receive 16% of the surgeon's fee for first assisting. **CRNFAs are requesting only 13.6% of the surgeon's fee for their first assisting services.** Use of CRNFAs is a high quality yet cost-effective alternative for the nation's health care delivery system, affording additional flexibility to surgeons, hospitals and ambulatory surgery centers.

CRNFAs are equally as cost-effective as other non-physician providers (PAs and some NPs) who currently are reimbursed at 13.6% of the surgeon's fee for first assisting. Moreover, CRNFAs receive more advanced education and training in first assisting than any other non-physician provider who first assists. For example, PAs commonly complete much less than the 2,000 hours of surgical assisting currently required before RNFAs may take the CRNFA certification exam. NPs are not required to have any extensive training in first assisting and yet receive direct reimbursement.

In addition, CRNFAs and RNFAs are the only providers—aside from the rare physician making house calls—who sometimes provide post-operative care by actually visiting patients at home following surgery. The result is better continuity of care and positive patient outcomes such as lower recidivism rates, decreased complications from surgery, higher patient satisfaction levels and overall lower expected costs per patient. Until H.R. 3911 is enacted, enabling CRNFAs to receive direct reimbursement, there is no incentive to use these high quality, cost-effective providers for first assisting in surgery.

WHO CURRENTLY REIMBURSES CRNFAs?

Though some commercial insurers provide coverage for the services of CRNFAs, reimbursement is inconsistent and varies on a state-by-state, case-by-case basis. Although payment by BlueCross/BlueShield plans differs by state; generally, if the CRNFA is not a contracted provider, BlueCross/BlueShield will pay the patient directly for CRNFA services. Many Medicaid plans also provide direct reimbursement.

COST ESTIMATE

H.R. 3911 is currently being scored by the Congressional Budget Office. An independent cost estimate by Muse & Associates determined that coverage eligibility for CRNFAs under Part B of the Medicare program would cost $7.2 million in 2000, increasing to $25.1 million in 2004 for a total cost over a five-year period of $84.6 million.

SUMMARY

As BBA Medicare refinements are considered, AORN respectfully urges this Subcommittee to extend Medicare coverage eligibility to CRNFAs for their surgical first assisting services. Working in collaborative practice with surgeons, CRNFAs are cost-effective to the patient and to the health care delivery system Because CRNFAs would be reimbursed under Medicare at a lower rate than physicians who first assist, and because CRNFAs routinely provide much-needed patient assessment, education and counseling, inclusion of H.R. 3911 in any BBA refinement package could well decrease the frequency and length of hospital stays resulting in improved patient outcomes and net savings to the Medicare program.

AORN appreciates this opportunity to submit its views with respect to BBA Medicare refinements. Please contact our Washington Counsel, Karen S. Sealander of McDermott, Will & Emery, at 202/756–8024 at any time with questions.

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

Statement of Charles F. Pierce, Jr., Florida Hospital Association

Mr. Chairman and Members of the Subcommittee:

My name is Charles F. Pierce, Jr., and I am President of the Florida Hospital Association, an association that represents 230 Florida hospitals and health care systems with over 200,000 hospital employees.

America's health care system sits at the crux of a great paradox. In the midst of a booming economy and escalating surplus, the facilities you and I and millions of others have come to rely on for our health care needs face unprecedented financial pressures and uncertainty about their future. Hospital leaders with as much as 20–30 years of experience report they have never experienced anything like their current financial situations. A snapshot of hospitals in Florida following enactment of the Balanced Budget Act shows the magnitude of this somber reality:

- Reductions in Medicare payments to Florida hospitals are estimated at $3.6 billion.
- Almost 32% of all Florida hospitals reported losses in 1998.
- Over half of all hospitals saw a drop in net income from the previous year.
- Changes in bond ratings were dominated by five times as many downgrades as upgrades.

The Balanced Budget Act cut too deeply in hospitals across the nation. Because Florida has the highest percentage of Medicare beneficiaries in the nation, the impact is exceptionally severe and deeply disturbing. There are 2.8 million elderly in Florida and the numbers are growing. Patients are older and sicker, requiring more intensive services and support. Florida's hospitals are expected to meet the needs of these seniors despite BBA reductions amounting to $1 billion in the first two years of its implementation and an additional $2.6 billion in the next three years—even after the BBRA of last year. Though hospitals continue to scrutinize and squeeze their budgets, the cost savings they realize do not begin to match the size of the mandated Medicare cuts. What does the additional reduction of $3.6 billion mean to our hospitals?

Even after the partial relief offered by the BBRA, Florida's 27 rural hospitals, which serve over 500,000 citizens, are expected to lose $50.6 million. These cutbacks will have alarming consequences among communities solely dependent on the health care services these facilities provide. Without additional relief, how will our rural hospitals continue to serve these remote communities?

A number of services, particularly outreach services that undergird the health needs of some of the most vulnerable in our society, have been closed. Martin Memorial Medical Center in Stuart, Florida, was forced to close an urgent care center for residents of the isolated community of Indiantown, many of whom are migrant and unskilled workers. The care center lost money every year, but Martin Memorial continued to support it as part of its community mission. This year, the hospital could no longer afford to absorb the cost of the center. "It was a heart-wrenching decision to announce we couldn't finance the center any more," Martin Memorial CEO Dick Harman reported.

Bethesda Memorial Hospital in Boynton Beach had to make a similar, difficult decision when it closed its clinic for poor pregnant women in southern Palm Beach County.

Mercy Hospital withdrew from the Dr. Rafael Penalver Clinic in Little Havana, Miami, after losing $3.6 million in three years.

And Shands HealthCare, an eight-hospsital system providing care to patients from each of Florida's 67 counties, has had to close all but two of its home health care units because it lost more than $20 million annually after the BBA was enacted.

These are not isolated incidents. Over the last two years in Florida, 34 hospitals experienced the closing of 271 acute care beds, 5 obstetrics programs, 295 psychiatric and substance abuse beds, and 122 skilled nursing beds. Without relief, these kinds of safety net programs and—more importantly—the poor and needy people they serve, will suffer and their access to basic health care will be jeopardized.

Of great and growing concern is the reality that the BBA has forced health care providers to reduce or eliminate other community and senior services. Nationally, over 3,000 independent home health agencies have closed their doors in the past three years. Already, 75 Florida communities have lost home health agencies, and now they have none. Baptist Health Care of Pensacola has had to close two rural health clinics and one home health agency. Memorial Healthcare System in Hollywood, Florida, could not expand its much-needed skilled nursing unit because the BBA reduced its funding by $623,000. These are just a few of the many examples of what is occurring in Florida. We are deeply concerned that almost 20% of all long-term beds in Florida belong to organizations that have filed for bankruptcy. "We've seen some serious problems develop," said Jim Booth, CEO of Interim HealthCare, one of the largest home health agencies in South Florida. "Due to cutbacks in reimbursement, some chronically ill patients are not getting the necessary care." If Congress does not intervene soon, where will our elderly seniors receive the care they need?

Our hospitals are delaying the purchase of much-needed new and replacement equipment and postponing important renovations. For Baptist Health Systems of South Florida, the BBA delayed by one or more years a more accessible outpatient facility, which would enable more people in the local community to receive basic health care services. This major health care system also is concerned that its ability to invest in critical medical equipment will be significantly limited in the future. Without relief, how will our hospitals keep pace with the latest technology and treatment opportunities our citizens deserve and have come to rely on? As hospitals struggle with the severity of the BBA's impact, they are confronting other social and economic factors that also dangerously strain their ability to provide necessary health care services. For example:

- There are 2.5 million Floridians (44 million nationwide) who have no health insurance. That number is growing. Crowded emergency rooms provide their only medical recourse. Federal law requires hospitals to stabilize and evaluate anyone who comes into the emergency room, yet no reimbursement accompanies this unfunded mandate. This means that hospitals must absorb these costs. In 1998, Florida hospitals provided over $1.2 billion in uncompensated care.
- New drugs and medical technology result in higher costs for patient care with no increased payment for them. As you have heard in great detail, the average price for new drugs continues to skyrocket and consumes an alarmingly higher proportion of what it costs to treat patients.
- Severe shortages of nurses—currently Florida has over 4,800 open nursing positions—and shortages of other allied health professionals are causing labor costs to spiral. Hospitals not only pay higher wages, but also offer signing bonuses and increased benefit packages. These costs are rising as Medicare is reducing payments.
- New regulations initiate major, costly compliance issues. Florida hospitals must comply with regulations from 26 federal, 11 state, and 6 voluntary agencies. For example, the estimated nationwide cost of implementing HIPPA is $43 billion—dwarfing Y2K compliance costs. Where will the funds come from?

Indeed, Florida hospitals are facing unprecedented financial pressures and need your help. We support enactment of legislation (HR3580) that provides a full market basket update for fiscal years 2001 and 2002 under Medicare. BBA set the update at market basket—a measure of hospital inflation—minus 1.1 percentage points for each year. Elimination of the remaining two years of the BBA-mandated market basket reductions provides an estimated $7 billion relief nationally, with $716 million for Florida hospitals. This bipartisan bill, which has been co-sponsored by 19 members of the Florida delegation, will simply re-establish a realistic link between cost increases and appropriate payment rates. Under BBA, hospitals have seen costs increase by seven percent while payments were updated by less than two percent. The scenario will worsen during the next two years if no action is taken.

Additionally, we urge Congressional approval of legislation (HR3698, HR3710) to protect federal disproportionate share hospital (DSH) allotments from reductions beyond FY 2000 levels and allow payments for uncompensated care to grow at the rate of inflation. The Medicaid DSH program is the primary source of financial support

for safety net hospitals that provide care to the underserved and our most needy citizens. HR3698 and HR3710 provide substantial relief for struggling safety net hospitals, while still achieving significant savings in the DSH program.

Funding for these changes must come from the projected federal surplus and not from payment reductions to hospitals in other areas.

Enactment of these bills provides a framework for Congress to remedy the damage caused by the Balanced Budget Act. Additional repairs will be necessary. There must be a balance between slowing Medicare's growth and responsible program financing. The Florida Hospital Association is encouraged that the Florida Delegation and their bipartisan colleagues in Congress, as well as MedPAC, health care providers, and citizens across the nation are aligned in their conviction that something must be done to reverse the devastating impact of the BBA on hospitals. In Florida, something must be done quickly.

We look forward to working with you to strengthen our hospitals' ability to fulfill their mission—to provide quality care to the citizens in their communities.

Thank you.

Charles F. Pierce, Jr.

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

Statement of Honorables Bob Franks, Rodney Frelinghuysen, Marge Roukema, Frank LoBiondo, Jim Saxton, and Chris Smith

Mr. Chairman, thank you for providing us with an opportunity to describe the harsh impact of the Balanced Budget Act on the hospitals in our state and to suggest legislative remedies.

New Jersey hospitals comprise an industry that generates more than $10 billion in yearly economic activity for the Garden State. Hospitals employ more than 150,000 individuals and return financial successes back to the community through such benefits as enhanced medical facilities, equipment, outreach programs, clinics, jobs and purchasing power. Monies are returned—not to Wall Street investors—but to the very heart of where care is delivered, the community.

The Balanced Budget Act of 1997 (BBA) made the most sweeping changes in the Medicare program since its inception in 1965. Realizing its impact on the economy, hospitals supported balancing our nation's federal budget. However, the Medicare changes contained in the BBA, payment reductions and program requirements went beyond initial intent. The fiscal assumptions used by the Congressional Budget Office (CBO) underestimated the financial impact of the reductions even in the first year.

New estimates show that hospitals are slated for at least $76.7 billion in reductions compared to the expected $44 billion when the law was enacted.

The Balanced Budget Refinement Act of 1999 (BBRA) restored $17 billion of the estimated five year Medicare reductions, of which an estimated $123 million benefits hospitals in our state. However, the BBRA, with its significant slant toward rural areas, provided less than 10 percent of the total BBA reductions. In New Jersey, the BBRA represents an increase of just six percent over the original BBA cuts.

Looking at the financial health of hospitals, one must examine hospitals' entire book of business. In New Jersey, hospitals are seeing increasing pharmaceutical and technology costs, increasing personnel costs, a nursing shortage, a rising number of uninsured and managed care payment delays and denials.

With that said, our hospitals, are in their worst financial shape in decades. More than 60 percent of New Jersey hospitals are experiencing a loss on operations. On average, total margins or profitability is a negative 1.6 percent, and Medicare margins remain below the national average. Further, the most severe BBA reductions come in the remaining two years of the five-year plan, with 53 percent of the reductions yet to come. More must be done to address this unhealthy trend if New Jerseyans are to continue to have access to high quality healthcare services provided by hospitals, health systems and post acute care providers.

MedPAC has also come to the same conclusion. In its report to Congress last month, MedPAC stated "Hospitals' financial status has deteriorated significantly over the past two years." The report goes on to recommend increasing hospital inpatient payments between 3.5 and 4.0 percent.

It has become apparent that the financial problems facing New Jersey hospitals are rooted in different areas and therefore require varied solutions. Our hospitals are working hard to do their part by implementing changes that will help them survive. Here are some of the things our hospitals have pursued during this crisis:

• To become more efficient, hospitals have decreased their Medicare length of stay from 11.1 days in 1993 to 7.2 days in 1999, a reduction of 35 percent. The national Medicare length of stay has come down 21 percent.

• Through attrition and downsizing, hospitals have reduced staffing by nearly 1,800 employees in the last year.

• The number of New Jersey facilities has decreased by 11 percent. Since 1996, four hospitals have closed and another five facilities are in the process of closing.

• Due to these closures, hospitals are on target to reduce 2,371 beds. This directly addresses concerns of overbedding.

• Hospitals have reduced the average cost to treat Medicare patients in the hospital by $1,000 over the last 6 years.

• Hospitals are educating caregivers on how to improve documentation skills to decrease the number of HMO claim denials.

• Hospitals are utilizing electronic filing to reduce mistakes and produce quicker payments. Cleaner claims means more efficiently processed payments.

Even with these efforts by our hospitals, we believe there is still a federal responsibility to ease the pain from the overreaching BBA cuts. Be assured, we're proud of the first step Congress took last year to restore funding for hospitals in the Medicare, Medicaid and SCHIP Balanced Budget Restoration Act of 1999 (BBRA). The relief for outpatient prospective payment was by far the most helpful of the provisions included in this legislation. While New Jersey hospitals stood to lose $101 million in outpatient reductions, the refinement bill restored $71 million.

Unfortunately, this relief does not go far enough. The numbers speak for themselves. In 1997, the hospitals in our state were asked to shoulder $1.8 billion in Medicare reductions over five years. Last year, Congress restored $100 million to New Jersey hospitals over five years. On average, that's a yearly amount of $240,000 per hospital—not enough to even cover most hospitals' payroll for three months. In addition, the Congressional Budget Office (CBO) has acknowledged that the reductions have gone farther than economists predicted. Some are estimating that the reductions to hospitals nationally are actually closer to $200 billion over five years—instead of $116 billion.

As Congress once again begins deliberations on restoring funds to Medicare providers, there are some specific steps that we believe Congress can take to help stabilize New Jersey hospitals:

Marketbasket Update

One of the largest Medicare reductions in the BBA comes from reducing the update for inpatient care. HCFA has historically given hospitals an adjustment for the annual increase in the costs of goods and services. The BBA reduced this nationally by $5.3 billion. The BBA of 1997 instituted below-inflation updates, while hospitals continue to face, for example, rising pharmaceutical prices for new drugs, increased costs for patient record privacy and security requirements and a nursing shortage that requires extra training and recruitment resources. Restoring a full marketbasket adjustment for hospitals would help blunt the financial pain of the BBA.

Transfers

The BBA expanded the definition of transfer cases to include patients who are sent from an acute care hospital to any post-acute setting: rehabilitation, psychiatric or skilled nursing facility or home health agency. Previously, only patients sent between acute care hospitals were defined as transfers. Now hospitals that transfer patients to a post-acute facility receive a lower Medicare reimbursement if the inpatient stay is shorter than the average length of stay.

The expansion of the transfer definition to include post-acute stays is particularly punitive in New Jersey. More than 24 percent of New Jersey's seniors seek additional care after a hospital stay. Furthermore, in 1992, New Jersey hospitals' average length of stay for a Medicare beneficiary was 11.2 days but has now decreased to 7.2 days in 1999.

The expansion of the transfer definition directly contradicts the basic premise of the prospective payment system (PPS) by eliminating the incentive to treat patients efficiently in the most cost-efficient setting.

While the Department of Health and Human Services has agreed not to expand the number of cases subjected to the transfer provision until 2002, this misdirected policy should be repealed in its entirety. This provision runs counter to the incentives of the Medicare payment system by unfairly penalizing efficient providers. Furthermore, with post-acute care entities also paid on a PPS, financial benefits of transfer cases are eliminated.

Relaxation of Geographic Reclassifications

The Health Care Financing Administration (HCFA) allows for counties to reclassify into neighboring metropolitan areas if hospitals meet a strict set of criteria and petition annually. Fewer counties have pursued this ability to reclassify because the criterion is no longer as relevant. In FY 1995, 23 counties reclassified, however last year, just five counties nationally were granted a county-wide reclassification. HCFA's criteria uses a "rate proxy" to determine comparable costs—mainly because when reclassification reviews were developed in 1989 immediate cost comparison information was not readily available. Today, with the increased use of computers and electronic filing, cost information could easily be used. Rather than an outdated rate proxy, we urge an actual cost comparison be incorporated into the county-wide reclassification criteria.

Mr. Chairman, as you know, the lastest CBO reports indicate that budget surpluses are likely to exceed $4 trillion over the next decade. Congress realized these extraordinary savings, in part, from reducing Medicare payments to hospitals nationwide. The provisions mentioned above, are just some examples of relief we would support in a second Balanced Budget Refinement Act.

New Jersey is the densest state in the union and we are considered to be a wholly urban state. However, we have many areas that are far from urban. But, without federal rural designations, we were unable to take advantage of much of last year's relief that was intended to help rural areas.

Moreover, our location impacts our competitiveness. Located as we are between two of the highest wage markets in the country, government reimbursement policy impacts our ability to attract the highly skilled and professional staff that our hospitals require.

Mr. Chairman, as you craft legislation to ease the pain of Medicare providers across the nation, we hope that you will take into consideration the unique challenges we face in New Jersey in providing health care to our communities.

We look forward to working with you in the upcoming months.

Sincerely,

Statement of Louisiana Association for Behavioral Healthcare, Crowley, LA

Dear Healthcare Subcommittee Members,

In several meetings between the Louisiana Association For Behavioral Healthcare (LABH) and HCFA over the past 12–18 months, HCFA has assured Community Mental Health Centers (CMHC's) that OPPS would not put CMHC's out of business. They assured this association that transitional corridors and outlier payments would be provided to CMHC's to lessen the blow of OPPS. This statement was echoed by intermediaries in the training provided on implementation of OPPS. Over the past month, HCFA has changed their position and are not providing any relief to Community Mental Health Centers. In fact, multiple facilities have closed and are closing due to the severity of the impact of OPPS.

Compounding the payment problems is the lack of clear guidelines for providers on issues related to service provision. For example, in Louisiana, Fiscal Intermediaries have yet to provide a Local Medical Review Policy (LMRP), which addressed the changes in the Final Rule. This association was assured by HCFA that a LMRP would be published prior to the implementation of OPPS.

To expand on the problems mentioned above we are providing you with the following comments.

1. HCFA fails to follow Federal Parity Legislation in the implementation of OPPS by allowing medical providers Transitional Corridor Payments and Outlier Payments and precluding CMHC's from qualifying for any additional payments. A default rate has been given to CMHC's which calculates to $0.00 in Transitional Corridor and Outlier Payments.

2. Rural hospitals have been provided with relief from OPPS but rural CMHC's have been excluded.

3. In Secretary Shalala's meeting with Congressman Nick Lampson on July 11, 2000, she states that the cost for PHP services is actually $350.00 per day based on 1996 hospital data, yet the reimbursement under OPPS is $202.00 per day in 2000.

4. HCFA publicly admitted on several occasions that no data from CMHC's was utilized in determining the daily rate.

5. No impact studies were conducted regarding the impact of OPPS on access to care for the mentally ill. To date, Louisiana has experienced closures in excess of

50% on Partial Hospitalization Programs due to implementation of OPPS. This leaves entire parishes in this state with no access to Psychiatric Services for Medicare beneficiaries.

6. The OIG Report on Community Mental Health Centers is inaccurate, as evidenced by statements in the GAO Report. (See attached statement of facts not included in the OIG Report.)

In closing, we respectfully request immediate relief from the devastating and discriminatory effects of the implementation of OPPS.

We have exhaustively worked to rectify these problems with HCFA over the past 18 months to no avail.

The beneficiaries, already burdened with chronic mental illness, are the least able to advocate for themselves. The lack of access to mental health treatment is a real and immediate impact of OPPS.

Please help restore this desperately needed benefit.

Respectfully,

LABH

Facts not accounted for in the OIG report:

1. The five states mentioned in the report have the following three commonalties relevant to the OIG report: (from the December 1998 AABH newsletter)

- They have the highest geriatric populations;
- They have proportionately higher immigrant populations-many of whom qualify for Federal Medicare Health Insurance;
- there states have aggressively pushed to transfer medical insurance costs for its disabled populations, heavily represented by individuals with chronic mental illnesses from their Medicaid/Medical Assistance funds to the Federal Medicare System.

2. The sharp rise in the utilization of outpatient mental health services funded by the Medicare program sharply rose at the same time Medicare capped the benefit for inpatient psychiatric hospitalization. This has resulted in a decrease in the length of stay of inpatient psychiatric hospitalization and increased utilization of partial hospitalization program. In 1984 there were 130,411 state and county mental health hospitals throughout the country. By 1994 that number had dropped to 79,294. During that same time the number of total available inpatient psychiatric beds throughout the country dropped from 112.9 beds per 100,000 population to 97.5 beds per 100,000. (Mental Health United States, DHHS 1996)

3. The cost for services has risen as the acuity of patients has risen. As in all fields of Medicine, the sicker the patient, the more labor intensive the treatment. With sicker and sicker patients being treated on an outpatient basis, the need for increased care has risen. In 1975 48.5% of the total mental health expenditures in the United States went to State and County mental hospitals. By 1994 that number had dropped to 23.6%. During that same time, the expenditures for freestanding outpatient clinics, multiserve mental health organizations, other residential programs and freestanding day programs rose form 1.8% of the annual mental health expenditures in 1975 to 26.8% in 1994. (SAMHSA)

4. There was a significant shift during the past 15 years within healthcare to increase utilization of outpatient services for the mentally ill. This trend is evidenced not only by the above-mentioned statistics, but also by the trend in expenditures for additions to programming. In 1983 there were 146 additional beds added to state and county mental hospitals. In 1994 that number had dropped to 91.2. During that same time, the addition to available PHP services grew from 177 in 1983 to 273 in 1994. (Mental Health United States, DHHS, 1996)

5. The number of workers employed in the inpatient and outpatient areas from 1994 also demonstrates the shift from inpatient to outpatient treatment. In 1984 there were 117,630 patient care employees in state and county mental hospitals. By 1994 that number had shrunk to 102, 153. During that same time, the number of patient care staff employed by freestanding outpatient clinics, freestanding day-night organizations, multiservice organizations and other residential organizations grew from 71,161 in 1984 to 143,967 in 1994. (Mental Health United States, DHHS, 1996)

6. HCFA failed to provide its contractors with timely and adequate guidance on the PHP benefit-it's scope, the type of patient's it covered, the types and duration of services it covers, and the services CMHC's are required to provide. In addition, neither HCFA not its contractors monitored the claims received for the new benefit (PHP), and, when improper payments were discovered, HCFA did not respond effectively. (GAO Report-January 2000)

7. HCFA's subcontractors were unclear how to effectively implement this benefit and struggled to understand the parameters of the partial hospitalization benefit.

This created wide disparities between areas of the country on the interpretation of the benefit. Some contractors were allowing one type of patient to be appropriate for PHP services while another contractor would deem that patient ineligible for the benefit. (GAO Report-January 2000)

8. The first program memorandum wasn't released by HCFA until June of 1995. Prior to that time, many programs were using the PHP benefit for maintenance programs where patients came for a few groups a day, a few days a week. This was the first step in clarifying the types of patients for admission.

9. In July o9f 1996 Program Memorandum A–96–2 and A–96–8 were released. These directives resulted int he provide requirements to increase the level of Services provided and increased the acuity level of the type of patient's appropriate for PHP programming. From the first 1995 memorandum on, the cost for services in PHP programs directly increased. These programs were now strictly a replacement for inpatient psychiatric services.

10. The national population is turning 50 years old at a rate of 10,000 people per day.

11. HCFA projection of a cost of $15 million dollars nationally was greatly underestimated. This would have only provided less than $300,000 per state and territory for care of an already underserved population.

12. Patients denying they are mentally ill or saying they are attending a program for reasons other than psychiatric treatment is not all together rare. Many of the patients we treat are unable or unwilling to admit the severity of their illness. This is a problem that has been greatly appreciated in the Surgeon General's Report on Mental Health.

13. The OIG report fails to provide statistics on the number of denied claims that were overturned. Approximately 50% of denied claims are overturned on first line review. Others may have been denied on technical grounds, which is not reflective of fraud and abuse but represents human or mechanical error.

REPORT ON PARTIAL HOSPITAL CLOSURES

The following is a list on the closures of Partial Hospitalization Programs throughout the state of Louisiana. These are programs that have closed since 1997. Since there are no accurate or up to date records with the Department of Health and Hospitals or with the Health Care Finance Administration, this list was compiled by calling facilities, interviewing providers and meetings of the LABH.

There are probably many other closures which have not been taken into account due to lack of available information.

Facility	City/Town	Parish	Type
Lake Charles Memorial Hospital	Lake Charles	Calcasieu	Hospital Based.
Lake Charles Memorial Hospital	Welsh	Jefferson Davis	Hospital Based.
Lake Charles Memorial Hospital	Iowa	Calcasieu	Hospital Based.
Lake Charles Memorial Hospital	Leesville	Vernon	Hospital Based.
Allen Parish Hospital PHP	Kinder	Allen	Hospital Based.
Oakdale Community Hospital PHP	Oakdale	Allen	Hospital Based.
St. Patrick's Hospital PHP	Lake Charles	Calcasieu	Hospital Based.
Calcasieu Oaks PHP South Cameron Hosp	Lake Charles	Calcasieu	Hospital Based.
Charter PHP	Lafayette	Lafayette	Hospital Based.
Link Care	Pineville	Rapides	CMHC.
Phases	Slidell	St. Tammany	CMHC.
Phases	Baton Rouge	E. Baton Rouge	CMHC.
Savoy Medical Center PHP	Mamou	Evangeline	Hospital Based.
Senior Care Center	Arnaudville	St. Landry	Hospital Based.
Nakatash PHP	Natchitoches	Natchitoches	Hospital Based.
The Helping Center	Baton Rouge	Baton Rouge	CMHC.
Pointe Coupee	Shreveport	Caddo	Hospital Based.
Summitt Medical Center PHP	Baton Rouge	Baton Rouge	Hospital Based.
Dixon PHP	Denham Springs	Livingston	Hospital Based.

Facility	City/Town	Parish	Type
Louisiana CMHC	Baton Rouge	Baton Rouge	CMHC.
Community Care	Hammond	CMHC.	
Avoyelles Comprehensive	Marksville	Avoyelles	CMHC.
Lake Hospital PHP	Mandeville	St. Tammany	Hospital Based.
Comprehensive Mental Health	Monroe	Ouachita	CMHC.
CPHC	Baton Rouge	E. Baton Rouge	CMHC.
Louisiana CMHC	Slidell	St. Tammany	CMHC.
Louisiana CMHC	Baton Rouge	E. Baton Rouge	CMHC.
Interventions	Baton Rouge	E. Baton Rouge	CMHC.
Imperial Helping Center	CMHC.		
New Directions	CMHC.		
Opelousas CMHC	Opelousas	St. Landry	CMHC.
Bonding Center	Plaquemine	Plaquemine	CMHC.
Care Team	Monroe	Ouachita	CMHC.
Moosa Memorial Hospital PHP	Eunice	Acadia	Hospital Based.
Livingston CMHC	Denham Springs	Livingston	CMHC–(8–1–00).
Comprehensive Health Care	Baton Rouge	E. Baton Rouge	CMHC.

Statement of National Association for Home Care

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to submit written testimony for the record on the impact of the Balanced Budget Act of 1997 (BBA97) on the Medicare home health benefit.

Our remarks are presented on behalf of the National Association for Home Care (NAHC). NAHC is the nation's largest home care organization, representing nearly 6000 Medicare-participating home care providers, including non-profit providers like the visiting nurse associations, for-profit chains, hospital-based providers, government-run agencies, and freestanding providers.

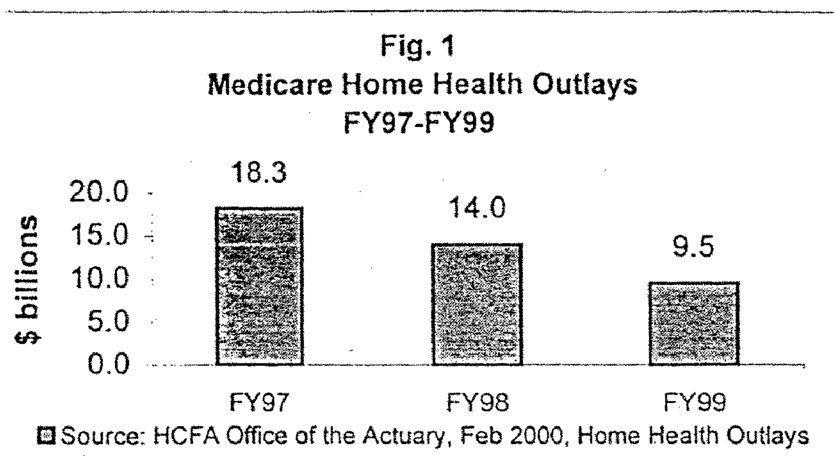
While we are greatly appreciative of efforts taken by you and your colleagues in 1998 and again in 1999 to mitigate some of the unintended damage to home care caused by BBA97, it is essential that further, decisive action be taken this year to return the Medicare home care program to a sound footing. Data recently provided by the Health Care Financing Administration (HCFA) provide a disturbing picture of the current state of the Medicare home health program. From calendar year 1997 to 1999, the number of beneficiaries served dropped by nearly one million, from 3.5 million to 2.6 million, or by close to 25 percent. Total outlays for the same period dropped from $16.7 billion to $7.7 billion, or nearly 54 percent. In those two years, home health dropped by almost 50 percent, and the average payment per patient dropped by 38.5 percent (source: preliminary 1999 HCFA/HICS data).

Home health will transition to a prospective payment system (PPS) under Medicare on October 1 of this year. This new payment system is expected to be much more appropriate in design than the existing system that was imposed by the BBA97; however, because the global budget set for the PPS restricts outlays to what would have been spent if the current system were to continue, episode payment rates are expected to be inadequate and may perpetuate many of the access problems certain classes of patients (such as wound care patients) are experiencing today. The change in the home health payment system will not correct all of the problems in home health that have resulted from the BBA97.

Recently, NAHC, along with the four other national home health associations, developed a unified legislative agenda designed to restore and preserve the Medicare home health benefit in light of the devastation wrought by the BBA97. The national associations are agreed that true relief for the home care program cannot be achieved without legislative action that encompasses both restoration of services to patients who have lost care, and the elimination of further threats to the stability of the Medicare home health program and our national home care infrastructure.

IMPACT OF BBA97 ON HOME HEALTH BENEFICIARIES AND PROVIDERS 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 BBA97 are startling and unprecedented. Since fiscal year 1997 program expenditures decreased 48 percent, from $18.3 billion in FY97 to $9.5 billion in FY99 (Fig. 1).



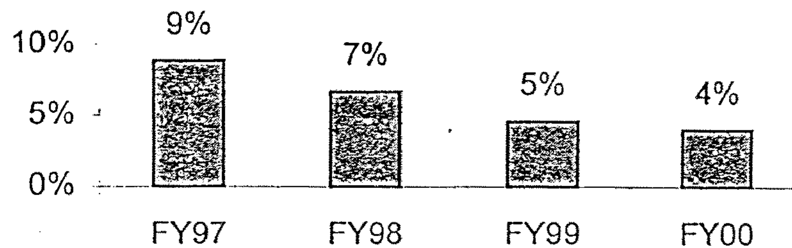
While other Medicare programs have seen reductions due to the BBA97, no other decrease has been close to what the home health benefit has experienced (Table 1). In fact, FY99 was the first year in the history of the home health benefit in which Medicare outlays for skilled nursing facility care exceeded those of home health. Less was spent on Medicare home health services in FY99 than was spent in FY94.

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

Benefit Type	FY97 Amount	FY98 ($billions)	FY99
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

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

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



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 projected home health spending over five years following enactment of BBA97. 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, more than 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

Given the level of reductions, it is not surprising that home health agencies have been closing at a rate of more than 90 per month since October 1997, leading to a recorded net loss of over 3,000 agencies nationwide as of July 2000. 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. 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 percent 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 BBA97, agencies increasingly are unable to offer competitive wages and benefits to attract qualified staff, and labor shortages are developing across the country.

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 percent 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 percent 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

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 BBA97 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 percent 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 ask-**

ing 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 BBA97 on home health beneficiaries.

Media reports have also identified access problems due to the BBA97. An editorial in the April 25 edition of The New York Times notes that spending on home care services has dropped by over 45 percent since 1997. The Times editorial concludes by calling for the restoration of the Medicare home health benefit stating that, "Congress had reason to rein in ballooning Medicare costs in 1997. But the nation's oldest and most fragile citizens should not have to suffer for good intentions gone awry."

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 BBA97 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.

NAHC has reviewed, digested and analyzed the final PPS rule as published by HCFA on June 28. The final rule addresses many of the concerns voiced by NAHC and the home care community. There are notable "improvements" in such areas as increases in low utilization payment adjustments (LUPA), per visit payment rates, billing and payment processes that enhance cash flow, and refinements to the case-mix adjuster. These changes, however, do not make up for the inadequacy of the overall funding of the home health benefit, which results in significant weaknesses in even the best PPS.

In addition, the final rule leaves unresolved some of the conflicts and concerns expressed with the proposed PPS. Of particular concern is HCFA's position on medical supplies, which may mean a dramatically expanded responsibility for home health agencies. It is NAHC's position that an agency is only responsible for those medical supplies used to treat illness or injury that occasioned the need for services.

RECOMMENDATIONS

As noted earlier, all five national home health associations—NAHC, the American Federation of HomeCare Providers, the Home Care Association of America, the American Association for Home Care, and the Visiting Nurse Associations of America—have reached a consensus on the reforms necessary to protect the Medicare home health program and the beneficiaries it serves. The associations have established two priorities of equal importance—to restore and to preserve the Medicare home health benefit. All five national home health associations agree that Congress must take the following action in this legislative session:

- Eliminate the 15 percent cut scheduled to take effect October 1, 2001.

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 percent 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 percent below their previous year's amounts by increasing services. It is much more likely that a 15 percent

cut in payments and below-inflation update factor will translate into additional agency closures, layoffs and even greater access problems.

• Restore access to care for high needs and vulnerable patients.

While outright elimination of the 15 percent will relieve the future threat or further devastation, an immediate infusion of dollars is necessary if access for certain hard to serve patients is to be restored. The following actions will help agencies throughout the country take on these patients with significantly reduced risk of financial devastation:

• Allow an additional expenditure of $500 million in each of the next five years to be used as outlier payments for services to the most medically complex and costly patients;

• Increase payments for home health services in rural areas by 10% to address the higher costs of delivering care in these areas; and

• Remove medical supplies from the per episode payments under the prospective payment system and make payments under a fee schedule for only the supplies that are actually used. Such a proposal should be fashioned so that it is budget neutral.

It is also the consensus of the five national associations that Congress should direct HCFA to:

• Confine the OASIS data collection and reporting requirements to only Medicare and Medicaid patients;

• Limit the OASIS assessment items to only the 20 questions which are actually needed to implement the new PPS; and

• Provide for an emergency payment mechanism during at least the first six months of the new payment system to ensure that there is no interruption in payments for services.

Copayments

While not a focus of this hearing, the issue of imposing copayments on home health services has recently surfaced in the context of a Medicare prescription drug benefit. NAHC and the other national associations take serious issue with any Medicare program "reforms" that restrict or eliminates any current benefits.

Home care plays an important role in the American health care system. Home care patients tend to be older and poorer that the average Medicare beneficiary, and in greater need of care. Copays would penalize the most vulnerable Medicare beneficiaries because of their illness.

NAHC urges Congress to reject any attempt to place a copayment on the Medicare home health benefit for the following reasons:

• Copays are regressive and tax the sick;

• The elderly already pay high out-of-pocket health care costs, despite Medicare and Medicaid coverage;

• Copays represent an unfunded mandate to the states whose Medicaid programs will be responsible for the copay if the beneficiary is dually eligible for both Medicare and Medicaid benefits;

• Copays would be another administrative burden on home health providers;

• Copays discourage use of cost-effective home care services, which may result in the need to use higher cost care, thereby increasing Medicare outlays; and

• Copays may require further subsidization of the Medicare program by financially ailing home health agencies since many low-income beneficiaries will be unable to finance copays.

CONCLUSION

Mr. Chairman and members of the Subcommittee, these legislative and regulatory changes would go a long way toward strengthening the home health infrastructure and restoring beneficiary access to quality home care services. We thank you for your sincere interest, and look forward to working with you and your colleagues as you draft legislation to further refine the BBA97 with respect to home care services.

Statement of the National Association of Long Term Hospitals, Stoughton, MA

The National Association of Long Term Hospitals ("NALTH") submits this statement setting forth its views concerning appropriate additional refinements to the Balanced Budget Act of 1997 ("BBA") (Public Law 105–33). NALTH wishes to thank the subcommittee for its willingness to consider further refinements to the BBA. NALTH prefaces its suggested refinements noted in this statement with a brief statement concerning the general condition of long term hospitals. Then NALTH of-

fers its comments on two specific areas in which NALTH urges the subcommittee to provide further public policy direction. Specifically, NALTH's comments focus on the implementation of a prospective payment system ("PPS") for long term hospitals, and changes to rules governing "provider based" designation which were adopted by the Health Care Financing Administration ("HCFA") on April 7, 2000 and which become effective in October of this year.

1. Condition of Long Term Care Hospitals

NALTH's hospital members are established in every region of the United States. They include a broad range of long term hospitals which are operated as independent, free standing institutions and which participate as components of hospital systems and multiple hospital organizations. NALTH's membership also includes hospitals which commenced operations prior to the inception of the Medicare program in 1966, as well as hospitals which were organized subsequent to the establishment of PPS in 1983 and subsequent to the BBA. NALTH's membership also includes hospitals located in suburban, rural and urban centers, some of which operate as referral sources for a broad geographic patient population, including interstate and, in some cases, international referrals. The scope and range of services provided by NALTH to patients is not only reflective of the statutory requirement that long term care hospitals experience a 25-day average length of stay, but is more clearly defined by medically complex patients who require a specialized multidisciplinary team of medical professionals and the immediate availability of hospital resources and physicians.

Prior to the BBA, MedPac as well as the subcommittee noted that older long term hospitals were treated differently and inequitably by the TEFRA payment system, due to older distorted cost bases. The BBA contained the following important provisions affecting long term hospitals.

1) Providing older hospitals the opportunity to change their base year period to an average of three years' operating costs;

2) Reducing the capital cost allowance by 15%;

3) Reducing the allowance of bad debts related to Medicare beneficiaries for nonpayment of Medicare co-insurance and deductible amounts;

4) Allowing state Medicaid programs to "reprice" Medicare payments to, as a practical matter, avoid paying for Medicare co-insurance and deductible amounts related to Medicare. This allowed states to avoid making payments to hospitals where Medicaid payment levels were below Medicare payment levels to hospitals;

5) Establishing two different limits on target amounts depending on whether a long term hospital was established before October 1, 1997, the effective date of the BBA;

6) Reducing loss sharing for hospitals whose costs exceeded their TEFRA target amount.

NALTH has recently competed a study of its membership which determined that 76% of their patients are admitted with Medicare benefits. A segment of these patients exhaust their Medicare day limit and "cross-over" to Medicaid self-pay or Medigap status. The Medicare program's utilization of long term hospitals (76%) is much higher than the approximate 39% Medicare utilization of short-term acute PPS hospitals. Accordingly, the above-referenced BBA provisions have a more profound effect on long term hospitals than other hospital provider types.

As part of its June 2000 report to Congress, MedPac reported that during the first year of its implementation, Medicare margins declined from 4.9% to 1.8% (Report at pg. 141). Since long term hospital financial performance is distributed in a binomial manner due to the inherent inequities of the TEFRA payment system, long term hospitals with historically distorted base year periods continue to be placed at the very bottom of Medicare TEFRA payments and remain in an inequitable payment position. Due to these circumstances and the BBA's requirement that virtually every long term hospital serve Medicare patients at a financial loss given reductions in allowable capital costs and bad debt allowance, NALTH believes it is crucial that Congress provide a refined payment structure and assurances that HCFA will phase in a long term hospital PPS commencing with cost reporting periods beginning on and after October 1, 2002 (consistent with Section 123 of the Balanced Budget Refinement Act of 1999 ("BBRA") (Public Law 106–133)).

II. Prospective Payment System Issues

It is beyond legitimate debate that a long term hospital PPS is long overdue. The current "cost-based" system is not case mix adjusted and is demonstrably unrelated to resource use. In the course of developing a long term hospital PPS, NALTH determined that the accuracy of the current TEFRA system as expressed by a relatively low correlation coefficient, (R2) a mere .19. This means that the current payment

system is inherently wasteful of federal resources and has other consequences which are undesirable from a public policy perspective. For example, it is reasonable to expect that long term hospital growth should reflect of a system which pays for hospital resources based on case mix and particular resource use, rather than simply on any cost incurred up to and over all limits on spending.

Over a 2½ year period which commenced in 1996, prior to the BBA, NALTH, in full consultation with HCFA, MedPac and this subcommittee as well as the Senate Finance Committee, developed a long term hospital PPS which reweighs current DRGs for long term hospital patient resource use. This system was developed for NALTH by the Lewin Group and includes provisions recommended by HCFA and MedPac such as a capital cost allowance and 10% outlier pool to reflect the special needs of the long-term hospital patient population. The predictive accuracy of this payment system is an R of .61 which is comparable to the current short-term hospital PPS, and is clearly a better and more reliable choice for federal payments than the current TEFRA payment system.

NALTH fully endorses the direction given to this issue by Section 123 of the BBRA which provides for a DRG-based long term hospital PPS commencing on or after October 1, 2002. Section 123 does not, however, authorize necessary PPS adjustments such as an outlier pool, area wage adjustments, payment updates, recalibration of DRGs or a disproportionate share policy. NALTH believes it is very important that Congress provide HCFA with legislative authorization and direction concerning these issues. NALTH urges the subcommittee to consider including standards in these areas in its further consideration of BBA revisions. In this connection, NALTH asks the subcommittee to consider legislation filed as S.1783.

NALTH is aware that HCFA is in the process of conducting a study of long term hospital payment systems. HCFA hopes to use this study to report to Congress by October 1, 2001 consistent with Section 123 of the BBRA. NALTH notes that since OBRA 1990, HCFA has been requested to report to Congress on the implementation of a long term hospital PPS. The question of whether or not HCFA issues the report requested by Congress should not delay the subcommittee's consideration of the legislation requested by NALTH. MedPac found and stated to Congress concerning this payment system that its "a design [is] as predictive of per discharge resource use as the acute care PPS. Main advantages of the design include its administrative simplicity and efficiency, its consistency with the discharge basis of the current long term hospital payment system, and its similarity to the DRG-based PPS for acute care hospitals. This proposal is the most developed of the long term hospital proposals and should be considered for its potential as a long term hospital PPS." March, 1999 MedPac Report, pg. 96.

NALTH is aware of recent communications with the subcommittee in which HCFA has indicated that the PPS system developed by NALTH should be based on a more recent year than the 1995 cost reporting period used in its validation study. NALTH fully agrees to do so and believes the most recent year's experience should be used as a PPS base year. NALTH also notes that the legislation it supports allows HCFA to adjust long term hospital DRGs on an annual basis consistent with the annual recalibration policy for PPS hospitals. Thus, should HCFA ever wish to revise DRG classifications or weighting factors if it finds it is appropriate to do so, it would have ample statutory authority to revise the long term hospital DRGs as well. NALTH therefore requests that the subcommittee consider legislation in this area.

III. Provider-Based Rules

On April 7, 2000, HCFA for the first time adopted new rules governing "provider-based" status. The rules are effective on October 7, 2000. The rules regulate circumstances when a provider may operate at a location outside its main campus (i.e., more than 250 yards from its main campus). The "provider based" rules are also applicable to any "facility" or "clinic" a provider may operate on its campus which would increase operating costs by over 5%.

In the absence of a rule in this area, HCFA established policy through program memoranda which were directed at assuring that a "main" hospital provider could exercise appropriate surveillance of conditions of participation and quality standards at an off campus location. The new rules, however, have other objectives. They require provider-based activities, with few exceptions [1] , to be located in the "immediate vicinity" of a "main" hospital provider. The term "immediate vicinity" requires that "at least 75 percent of the patients served by the facility or organization reside in the same zip code areas as at least 75 percent of the patients served by the main

[1] Rural health clinics owned by rural hospitals with less than 50 beds and certain outpatient activities which function like federal qualified health centers.

provider" or that 75% of the patients served at a provider based facility also receive services at the "main" provider. 42 C.F.R. § 413.65(d)(7).

The preamble to the rules states that HCFA's policy objective is the reverse of the long standing federal policy of encouraging providers to affiliate or find other ways to efficiently deliver services to a broad patient population. The preamble to the rule states: "[B]efore implementation of the hospital inpatient PPS in 1983, there was little incentive for providers to affiliate with one another merely to increase Medicare revenues or to misrepresent themselves as being provider-based, because at that time each provider was paid primarily on a retrospective, cost-based system. At that time, it was in the best interest of both the Medicare program and the providers to allow the subordinate facilities to claim provider-based status, because the main providers achieved certain economies, primarily on overhead costs, due to the low incremental nature of the additional costs incurred." 65 Fed. Reg. 18,504 (April 7, 2000).

The PPS system's goal of encouraging provider efficiency has included a broad range of socially productive activities. These include:

- Hospital systems supporting services in communities where smaller hospitals were in danger of closing due to a combination of governmental policies and market conditions;
- Redesignation of a hospital as a provider-based department of another hospital to potentially reduce costs by eliminating duplication of overhead and simplifying licensure and certification requirements; and
- Long term hospitals being able to provide specialized services without duplication of overhead in satellite facilities thereby actively reducing costs and providing for enhanced access to long term hospital services.

The preamble to the rule goes on to suggest that a major reason for HCFA's policy change is to discourage excessive payments due to payments to provider-based facilities which, in part, may duplicate payments to physicians in the case of outpatient activity or PPS payments when patients are transferred to an inpatient PPS exempt provider. NALTH submits that the answer to HCFA's concerns are found in the PPS system HCFA is implementing for most classes of providers and the transfer rule it has already implemented.

In NALTH's view, it is inappropriate that HCFA should undo by regulation provider relations which have been encouraged for over eighteen years. The rule at best will reverse cost savings achieved by providers at the behest of federal policy makers. The preamble to the rule extends to affected providers the proposition that they should ask states to license and certify provider-based activities as new health care providers which could seek a new Medicare certification. The problems with this approach are multiple. A number of states have certificate of need programs which take months or years to pursue. It is also inevitable that achieving new provider status will require a separate chief executive as well as other administration and clinical departments which are necessary for hospital certification. All of these functions, of course, result in additional costs. In the context of a new PPS excluded provider, those are all additional costs which must be paid for by the federal government.

NALTH believes that this issue is an area in which the subcommittee should become involved, and NALTH urges the subcommittee to reverse the rule in favor of further policy making by Congress after conducting public hearings in this area.

Statement of Larry S. Gage, President, National Association of Public Hospitals and Health Systems

The National Association of Public Hospitals and Health Systems (NAPH) is pleased to submit testimony to the House Ways and Means Committee Subcommittee on Health in support of adopting amendments to the Balanced Budget Act of 1997 (BBA) (P.L. 105–33) to remedy its unintended impact on safety net hospitals and health systems.

NAPH represents more than 100 of America's metropolitan area safety net hospitals and health systems. The mission of NAPH members is to provide health care services to all individuals, regardless of insurance status or ability to pay. More than 54 percent of the patients served by NAPH systems are either Medicaid recipients or Medicare beneficiaries; another 28 percent are uninsured. NAPH members are uniquely reliant on governmental sources of financing to provide care for Medicare, Medicaid, and uninsured patients.

The Medicaid and Medicare Disproportionate Share Hospital (DSH) programs are an important source of financing for uncompensated care in NAPH member hos-

pitals. In 1998, Medicaid DSH payments covered 36 percent of the costs incurred in treating the uninsured and underinsured; Medicare DSH covered another ten percent of such costs for all NAPH members nationally. State and local subsidies made up most of the difference, accounting for 45 percent of total payments for unreimbursed care.

As was recently reported by the prestigious Institute of Medicine (IOM) in its November 1999 report, "America's Health Care Safety Net: Intact but Endangered," a number of factors are threatening the financial viability of core safety net providers, including the rising number of uninsured; the impact of Medicaid managed care; and the erosion of major direct and indirect subsidies for safety net providers. The cumulative financial pressure caused by factors could not have been anticipated by the BBA.

We appreciate Congress' attention to this issue last November when it approved the Balanced Budget Refinement Act of 1999 (BBRA) (P.L. 106–113). This legislation represented a significant first step toward easing the impact of the BBA on providers. **As the Committee considers another round of BBA "givebacks," NAPH urges you to enact the top two priorities of the hospital industry: eliminating the Medicaid DSH payment reductions imposed by the BBA and repeal the reductions in the Medicare inpatient update.** In particular, we ask you to consider the BBA's effect on safety net institutions and the care afforded our nation's poor and uninsured with a relief package that does the following:

- Eliminate Medicaid DSH payment reductions imposed by the BBA;
- Eliminate further cuts to the Medicare DSH program;
- Change the Medicare DSH payment formula to reflect uncompensated care;
- Freeze indirect medical education payments at the current level; and,
- Repeal the BBA's Medicare bad debt reimbursement payment reductions.

Eliminate Medicaid DSH Payment Reductions Imposed by the BBA

While we understand that the Medicaid program falls outside the jurisdiction of the Ways and Means Committee, we believe that it is critical that any legislation to quell the impact of the BBA include provisions to eliminate any further payment reductions to the Medicaid DSH program. Under the BBA, the Medicaid program absorbed significant cuts, particularly in the DSH program, which required substantial payment reductions at a time when our nation's uninsured rates and hospital Medicaid shortfalls are on the rise. These payments—payments by state Medicaid programs to hospitals that serve a disproportionate share of low-income individuals—provide critical support for safety net providers. Without the Medicaid DSH program, these providers would be incapable of offering appropriate access to health care for many low-income Americans.

According to the BBA, a full $10.4 billion was to be cut from federal Medicaid DSH expenditures to states over the five years of the cuts, with most of the impact in FY 2000–2002. At the present time, state DSH programs are scheduled to experience a 30 percent reduction in FY 2001 and a 37 percent reduction in FY 2002. Hence, safety net hospitals across the nation are facing severe cuts in Medicaid DSH funding.

NAPH urges the Congress to include Medicaid DSH relief in any BBA "givebacks" bill it considers.

Legislation to eliminate additional Medicaid DSH reductions has been introduced in the House: the "Medicaid DSH Preservation Act" (H.R. 3698), a bill to repeal the Medicaid DSH reductions for FY 2001 and 2002 and allow for CPI-based increases beginning in 2001, introduced by Rep. Ed Whitfield (R–KY); and the "Medicaid Safety Net Hospital Preservation Act" (H.R. 3710), introduced by Reps. Diana DeGette (D–CO) and Brian Bilbray (R–CA), which also eliminates the allotment reductions imposed by the BBA. These bills enjoy widespread bipartisan support. Together the House bills have 224 unduplicated cosponsors; similar legislation has been introduced in the Senate. Clearly, this legislation would provide substantial relief for already-distressed safety net providers.

Eliminate Further Cuts to the Medicare DSH Program

Cuts to the Medicare DSH program that were required by the BBA also have made it difficult for our members to continue to provide high-quality health care services to the patients they serve. According to the BBA, Medicare DSH payments were expected to be reduced by one percent in FY 1998, two percent in FY 1999, increasing to five percent in FY 2002. While we were grateful that Congress included a provision in the BBRA to provide a one-year freeze on the Medicare DSH reductions, the conditions that necessitated this "fix" last year—i.e., rising numbers of uninsured, increasing levels of uncompensated care, escalating hospital costs—continue to plague our members. Hence, **we urge the committee to eliminate any further reductions to Medicare DSH payments and to restore DSH funding to pre-BBA levels.** In 1998, Medicare DSH payments covered ten percent

of our members' costs for treating the poor and uninsured in our communities. This funding stream is critical if our members are to continue to provide care for these populations.

Change the Medicare DSH Payment Formula to Reflect Uncompensated Care

In addition to eliminating further Medicare DSH cuts, we urge the Committee to change the Medicare DSH payment formula to better reflect the cost of uncompensated care. As you are aware, the current DSH formula is based on a hospital's "disproportionate share patient percentage," which is a measure of the proportion of care provided to Supplemental Security Income (SSI) and Medicaid patients. NAPH believes that there are a number of problems with this formula, including that it does not take into account the significant uncompensated patient care costs borne by some hospitals. The Medicare Payment Advisory Commission (MedPAC) has expressed similar concern with the accuracy of the current formula's underlying measure of care to the poor. A broader measure of care to the poor that includes uncompensated care is needed to target DSH payments to those hospitals most in need.

Congress acknowledged the shortcomings of the current formula for calculating Medicare DSH payments in the BBA, which required the Health Care Financing Administration (HCFA) to submit a report to Congress proposing a new formula for making DSH payments more equitably. The Secretary's report, which was due to Congress by August 5, 1998, is now long overdue. We hope the report will be issued soon. In addition, the Committee required HCFA to begin collecting data on uncompensated care as part of the BBRA last fall.

We understand that the Committee is considering changing the formula to eliminate discrepancies between urban and rural providers. For a number of years, the Prospective Payment Assessment Commission (ProPAC) and then its successor, MedPAC, have recommended changing the formula to eliminate urban/rural disparities and include uncompensated care. Both organizations have done extensive analyses of the DSH formula, which have been available to policymakers. The reasons for implementing change are more urgent than ever—Medicaid enrollment has been declining as a consequence of welfare reform, the number of uninsured continues to rise—making the current proxy for low income care inadequate and increasing the burden of uncompensated care on safety net providers. **In this year's BBA relief package, NAPH strongly urges the Committee to consider implementing a two-phased formula change for Medicare DSH that includes uncompensated care in the formula in a second phase.**

Freeze Indirect Medical Education Payments at the Current Level

As the committee considers legislation to alleviate the unintended consequences of the BBA, we urge you to prevent further cuts to Medicare's Indirect Medical Education (IME) payments and to provide relief for our members who serve as teaching hospitals.

As you know, under the BBA, IME payments were scheduled to be reduced by 29 percent over four years for a total of $5.6 billion. While the BBRA included some IME relief, it provided only a one-year delay of the full implementation of the 29 percent cut. Hence, the BBA IME reduction continues to pose a significant threat for our members. With average total margins for teaching hospitals projected to be near zero, IME relief in this regard is critical. Without IME relief, safety net teaching institutions will be forced to cut the programs that provide training for our nation's physicians, nurses and other health professionals as well as essential research programs.

In particular, we urge the committee's immediate consideration of the "Teaching Hospital Preservation Act of 2000" (H.R. 4239, S. 2394), legislation would stabilize IME payments and protect Medicare beneficiaries' access to teaching hospitals.

Repeal the BBA's Medicare Bad Debt Payment Reimbursement Reductions **We urge the committee to repeal the BBA provision that significantly reduced payments to hospitals and other providers for bad debts incurred as a result on non-payment for covered services derived from deductibles and coinsurance left unpaid by Medicare beneficiaries.** This provision has had a disproportionate effect on safety net providers, who, in abiding by their mission to provide care regardless of ability to pay, often fail to receive payment for the services they provide. Under the BBA, Medicare reimbursement for bad debt payments were cut by 25 percent in 1998; by 40 percent in FY 1999, and from 2000 forward, these payments will be cut by 45 percent. As the committee considers legislation to alleviate the impact of the BBA on providers, we urge you pay particular attention to the effect of payment cuts, such as the bad debt payment reductions, on safety net providers, who already are confronting a significant burden of uncompensated care.

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We appreciate the opportunity to share our concerns and urge the committee to take action on these important issues. We look forward to working with you further to develop legislative solutions to the problems of our nation's poor and uninsured.

Statement of Ellen J. Kugler, National Association of Urban Critical Access Hospitals

Introduction of NAUCAH

The National Association of Urban Critical Access Hospitals (NAUCAH) is a nation-wide coalition of hospitals that stand at the forefront of caring for the urban elderly and poor in the U.S. today. Established in 1993, NAUCAH defines "urban critical access" according to several key measures of the population and communities that its members serve.

1. The hospital must be located in an urban area, which is defined by the census bureau as a Metropolitan Statistical Area (MSA).
2. A minimum of sixty-five percent of the hospital's patients must have their health care paid by Medicare.
3. A minimum of ten percent of the hospital's patients must have their health care paid by Medicaid.
4. The hospital must be large and therefore vital to care in its community—at least 250 beds.
5. The hospital must be private and non-profit.

Approximately 275 hospitals in the U.S. today meet all of these criteria. Urban critical access hospitals are very much a part of the health care safety net in the U.S. today. In some of the communities in which they are located, they work along-side public hospitals in caring for the urban elderly and poor. In most communities in which urban critical access hospitals are located, they are the primary sources of care for the urban elderly and poor, if not the only source—their safety net. It is fair to say that without urban critical access hospitals, it would be difficult for many of the poor and elderly in these communities to find the health care services they need.

We appreciate the Chairman's leadership in the assistance provided last year under the Balance Budget Refinement Act. However, because an overwhelming majority of care provided at NAUCAH hospitals is to elderly and low-income patients, and the Balanced Budget Act had a disproportionate impact on these facilities, there are a few issues for which we request additional assistance.

Restore Medicare Bad Debt to 100% for Medicare DSH Hospitals

Historically, Medicare has reimbursed hospitals 100 percent of unpaid co-payments and deductibles. The Balanced Budget Act of 1997 (BBA) reduced this reimbursement percentage to 55 percent. This reduction has had a significant impact on NAUCAH hospitals. NAUCAH hospitals, by definition, treat a large number of low-income seniors who are the poorest and often sickest of the elderly. Low-income seniors, at or near the poverty level, are most likely unable to pay their co-payments and deductibles.

NAUCAH hospitals, therefore, have higher portions of Medicare bad debt than other hospitals, and reductions in these payments impact them to a greater degree.

Another BBA provision, one that requires additional co-payments on the part of beneficiaries, has increased Medicare bad debt costs. So, bad debt costs are increasing at the same time as Medicare's payments for these costs are decreasing. These reductions and others included in the BBA have negatively impacted the viability of NAUCAH hospitals throughout the country.

NAUCAH hospitals rely on Medicare payments for their survival. These hospitals have few other payment sources to draw from to cover this Medicare shortfall. Bad debt payments help NAUCAH hospitals fulfill their missions—providing care to all, without regard for ability to pay—and at the same time help Medicare fulfill its goal—to not burden others with Medicare costs.

Congress should restore Medicare bad debt payments for Medicare DSH hospitals

Freeze Medicaid Disproportionate Share Reductions at FY 2000 Levels

When Congress modified the Medicaid program in 1984, it recognized that hospitals which serve unusually large numbers of Medicaid recipients and other low-income patients, including the uninsured and the underinsured, would be negatively impacted by these changes.

To assist these hospitals, it mandated Medicaid Disproportionate Share Hospital (DSH) payments over and above fees for services provided to Medicaid recipients. Hospitals use these supplemental payments to help shoulder their disproportionate share of the financial burden of caring for poor, uninsured, and underinsured patients.

In the Balanced Budget Act of 1997 (BBA), Congress cut $10.4 billion over five years from the federal Medicaid DSH program through a system of strict state DSH caps. Some State DSH allotments will be reduced by as much as 40 percent over this five-year time period.

Cuts of this magnitude are extraordinarily difficult to absorb, and render monumental challenges for all critical access hospitals.

At a time when our nation's uninsured rate has climbed above 43 million, and is rising at more than 100,000 people every month, it seems counterintuitive to reduce much needed Medicaid DSH payments to our nation's safety-net hospitals.

NAUCAH supports the passage of H.R. 3710, H.R. 3698, S. 2299 and S. 2308. All bills freeze Medicaid DSH cuts at fiscal year 2000 levels, thereby, mitigating the fiscal year 2001 and 2002 reductions.

Congress should freeze Medicaid DSH reductions at FY 2000 levels

Preserve Medicare Disproportionate Share for the Urban Safety Net

Medicare Disproportionate Share Hospital (DSH) payments are an important part of the overall revenue of private safety-net hospitals. Disproportionate Share payments are made as part of the Medicare inpatient program and are intended to help ensure Medicare patients access to hospitals that also treat a significant number of low-income individuals.

This program is especially important for private safety-net hospitals since they treat a significant number of both Medicare and low-income patients.

The Medicare DSH program pays hospitals based on a formula that includes Medicare, SSI and Medicaid. The program pays about $4.7 billion to over 1,700 hospitals nationwide.

In 1997, as part of the Balanced Budget Act (BBA), Congress required the Secretary of Health and Human Services to propose recommendations for a new Medicare DSH formula. Due to the lack of available and accurate data, however, HCFA had not made revisions to the DSH formula.

In 1999, Congress revisited the DSH formula. As part of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), Congress acknowledges that accurate data is not available and requires HCFA to begin collecting the data necessary to develop a new formula that takes into account the cost of serving uninsured and underinsured patients. Data will be collected on state and local indigent care programs, as well as uncompensated care (bad debt and charity care). It is expected that HCFA will devise a standard definition of uncompensated care before attempting to collect accurate and updated uncompensated care data. Data on offsetting revenue is also expected to be collected.

Recommendations

- No new DSH formula should be implemented until accurate data is available to measure the impact on hospitals.
- If the DSH thresholds are changed to add rural hospitals, new funding should be allocated to support the additional payments.

Congress should preserve Medicare DSH payments at their current level for urban private safety net hospitals. Any change in thresholds for rural hospitals should be funded with new money so as not to impose additional reductions on private safety net providers.

Restore Medicare DSH Payments

Under the Balance Budget Act, Medicare DSH payments were reduced by five percent over five years. As part of the Balance Budget Refinement Act, Congress froze one year of these reductions.

By freezing the reductions, Congress has acknowledged that hospitals that treat a significant number of low-income and elderly patients are ill-equipped to deal with significant Medicare reductions.

The Medicare and Medicaid program covers most of the patients treated at urban critical access hospitals. Because of the communities they serve, they treat very few patients covered by private insurance. Thus, the Balanced Budget Act reductions in Medicare and Medicaid have created severe financial hardships.

NAUCAH requests restoration of full Medicare disproportionate share payments.

Statement of Ortho-Clinical Diagnostics, Johnson & Johnson

Thank you for providing the opportunity to submit a statement for the record on the important task before the Subcommittee of addressing refinements to the Balanced Budget Act of 1997 (BBA). We appreciate the Subcommittee's commitment to identify appropriate refinements to the major reimbursement changes wrought by the BBA—changes that have had an impact not only on the primary care providers but also on the entire supply chain that is so critical to quality patient care.

We wish to express our support for additional funds for providers to assure patient access to the safest possible blood. We support the proposal of the American Association of Blood Banks (AABB), America's Blood Centers (ABC), and the American Red Cross. The proposal would (1) Increase the Medicare hospital inpatient "market basket" by approximately 0.45% to cover the added costs associated with blood safety enhancements that are FDA recommended and/or adopted as the standard of care and (2) Direct HCFA to develop a specific mechanism in the hospital market basket to account for changes in costs for blood and transfusion therapy-related products and services from year to year.

Ortho-Clinical Diagnostics has a rich history in and a deep commitment to blood research and technological advances to ensure blood safety. Led by pioneers such as Dr. Philip Levine, one of the discoverers of the Rh factor in blood, the Company has long provided the medical community and patients with important technology used in transfusion medicine. Our products span the transfusion medicine continuum, from infectious disease testing at donor screening centers to blood typing and crossmatching products used in hospitals. We are constantly striving to improve our products and to develop new technology to respond to patient needs. In addition, Johnson & Johnson is a major contributor to organizations and initiatives dedicated to increasing blood donations and maintains a program of regular on-site blood drives targeted to its employees. For the past four years, Johnson & Johnson has been #1 in corporate blood drives, and last year collected nearly 40,000 units of blood.

We feel compelled to add our voice to those of the AABB, ABC, and ARC because, quite simply, blood is a critical public health issue whose infrastructure is fragile and vulnerable. Congress needs to step in and help strengthen that infrastructure through legislation that will inject a dose of financial assistance into an ailing system.

The following are background points and underlying reasons for our support of this proposal:

- Patient access to the safest available blood supply is a national public health priority.

Current Requirements

- Americans deserve and demand access to the safest possible blood supply. In fact, safe blood is a national public health priority. Recognizing this health priority, the blood banking and transfusion medicine community, and federal government have adopted and continue to adopt incremental blood safety enhancements, including new infectious disease tests and other safety-related technologies.
- FDA currently requires the following tests be conducted on 100% of the nation's blood supply:
- Hepatitis B surface antigen (HBsAg)
- Hepatitis B core antibody (anti-HBc)
- Hepatitis C virus antibody (anti-HCV)
- HIV–1 and HIV–2 antibody (anti-HIV–1 and anti-HIV–2)
- HIV p24 antigen
- HTLV–I and HTLV–II antibody (anti-HTLV–I and anti-HTLV–II)
- Serologic test for syphilis
- Confirmatory tests if any of above are positive

Recent Developments

- Blood currently costs $80 to $120 per pint. New safety technology is expected to add $40–$50 per pint in the short term. This amount is likely to increase as new safety technology is adopted to make blood and blood products even safer. In testi-

mony before this Committee, the American Hospital Association has identified increases in the cost of blood as an additional financial issue for their members.[1]

Future Threats to the Blood Supply

• According to FDA, "There are constantly emerging potential threats to the blood supply a Examples include new HIV variants; new hepatitis agents; human herpes virus type 8; Creutzfeld-Jakob Disease; human parvovirus B19; and bacterial contamination of blood products." (Source: *www.fda.gov*) FDA has indicated it will impose testing obligations as additional relevant communicable disease agents are identified and FDA approves tests for such agents."

How Technology Creates Safer Blood

• For many years, Hepatitis C occurred among 5 percent or more of all blood recipients. In 1991, the incidence of transfusion-related HCV occurred in 1 to 4 percent of transfusion recipients. Today, after more than seven years of testing for HCV, the risk of HCV transmission through transfusion is less than 1 per 100,000 screened units of blood. New technologies such as nucleic acid amplification (NAT) and Ortho-Clinical Diagnostic's HCV antigen test (not yet approved in the U.S.) may reduce the risk to 1 per 500,000 to 1 per 1,000,000. (Source: *www.aabb.org*) Today, the risk of getting HIV from a single blood transfusion is about 1 in 676,000.

• New blood safety technology is routinely adopted in foreign countries sooner than it is available here. While there are a variety of reasons for this phenomenon, the reimbursement and regulatory environments are among the factors that contribute to lack of access to such technology for American patients. For example, we understand that leukoreduction is now mandated in at least 9 countries. Another example is our own company's HCV Core Antigen Test—one that we believe is substantially equivalent in performance to current NAT testing. The test is available outside the United States for single unit testing rather than as a pooled test, in an Elisa microwell plate format that is an established technology. Even the smallest of blood centers are familiar with this technology. France—a country well known for its blood safety vigilance—has recently approved this test for donor screening. We intend to submit an application to the FDA for U.S. approval.

The Transfusion Process and the Potential for Errors and Accidents

• The transfusion process requires blood typing and crossmatching testing to ensure that the recipient's blood is compatible with the donor's blood. In addition, it requires processes, procedures, and trained personnel to ensure that the right unit of blood actually goes to the patient.

• There are only two suppliers of the important blood typing and crossmatching testing products that are so critical to a safe transfusion: our company, Ortho-Clinical Diagnostics and a small company called Immucor. Both companies are challenged by the dynamics of the marketplace. There is little financial incentive to continue to supply these products thus creating a precarious supply chain. Failure to supply the market with these products for whatever reason—financial, production, FDA—could cause major problems in the transfusion process.

• Errors and accidents in the transfusion process contribute to unacceptable mortality and morbidity. The risk of a fatal transfusion reaction caused by errors such as administration of an ABO-incompatible unit to a patient is estimated to be as high or higher than the risk of receiving HIV or HCV-infected blood. The recent Institute of Medicine study highlighted the need for the medical community to respond to medical errors and accidents. Insufficient hospital reimbursement for blood can result in staff and resource cutbacks that can increase the risk of errors and accidents in the blood transfusion process.

The Need for Adequate Reimbursement

• Safety enhancements add to the cost of each blood component transfused in the United States. Adequate Medicare reimbursement is necessary to ensure patient access to new technologies that improve blood safety. Because the vast majority of blood products and services are provided in the inpatient setting, it is especially im-

[1] "The cost of blood also is on the rise. The Food and Drug Administration soon will approve new blood screening techniques to make our blood supply safer. But quality improvements will increase the cost of blood by $40 to $50 a pint, a 50 percent jump. New techniques, such as "viral inactivation," are expected to double or triple the cost of blood. However, the cost of these new techniques is not included in today's measure of hospital inflation." *Statement of Don Richey, Administrator, Guadalupe Valley Hospital, Seguin, Texas, on behalf of the American Hospital Association,* July 25, 2000

portant that inpatient reimbursement rates accurately reflect increases in the cost of these products and services

- Inadequate reimbursement has an adverse impact on all parts of the blood continuum, including manufacturers. Economic factors affect decisions to develop new technology that may improve patient care, reduce error, and ensure the safest possible blood products and services. New threats to the blood supply will require new technology to address those threats. Without adequate reimbursement, the health and vitality of the innovators in this industry—who develop the new technology to make blood and blood transfusions safer—is jeopardized.
- Non-profit organizations dominate the blood collection industry. These organizations are well known for their ability to collect blood within local communities for both routine and emergency use, and for their community ties, name recognition, and a remarkable dedication to blood safety and availability goals. They are an important component in the blood supply chain. Many of these entities and hospital blood banks have suffered financially due to inadequate reimbursement and the effects of the Balanced Budget Act of 1997 and managed care cost-cutting measures.
- Additional costs of testing and other safety measures without concomitant reimbursement will adversely affect blood centers' other cost activities—such as donor recruitment—that could also adversely affect the blood supply.
- As the Department of Health and Human Services (HHS) stated in its "Five Point Plan on Strategies to Increase the Blood Supply:" "The economic and competitive pressures of health care today make it nearly impossible for blood banks to recover the cost of new innovations, even when such measures are required. These economic limitations are a strong disincentive for change."
- The Congress and the Administration has recognized the importance of appropriate blood reimbursement in the outpatient setting. (See Attachment.) This same rationale should be the basis for appropriate adjustments to reimbursement methodology for blood used in the inpatient setting.

In conclusion, we urge the Congress to help providers achieve our common public health mission to ensure patient access to the safest possible blood. We urge enactment of a Balanced Budget Refinement Act—Part 2—that includes provisions to increase the market basket by approximately .45% and that directs HCFA to develop a mechanism for blood and transfusion-related products that would more accurately and specifically capture the increased costs of blood on an annual basis.

Thank you for the opportunity to comment.

Attachment

RECENT COMMENTS FROM GOVERNMENT SOURCES ON BLOOD REIMBURSEMENT

Whereas the Advisory Committee on Blood Safety and Availability is dedicated to insuring patient access to safe blood products and services, and whereas the Committee recognizes that fair, accurate, and timely reimbursement, including Medicare, for blood-related therapies is critical to insuring patient access to the safest possible blood, the Advisory Committee, consistent with its prior recommendations, recommends that the Secretary and **Congress support legislation to insure fair and accurate reimbursement for inpatient blood-related products and services. Such legislation should provide sufficient funding to account for increased blood-related costs, including those associated with new blood safety measures, and require that these costs be reflected in annual updates of inpatient diagnosis related groups.**"(emphasis supplied)

Letter from Michael Hash, Deputy Administrator, Health Care Financing Administration dated October 19, 1999 to Congressman Bill Thomas on the Administration's plans to adjust the Outpatient Prospective Payment System regulation to respond to concerns raised about blood

"*We would also adjust the payment for blood and blood products to reflect blood testing requirements that have been mandated since 1996, and we would expect to make further adjustments in the future if additional testing requirements with significant costs are imposed.*"

Conference Report accompanying the Balanced Budget Refinement Act of 1999

"*The parties to the agreement understand that the Secretary is committed to creating separate payment categories for blood, blood products and plasma-based and recombinant therapies. The parties to the agreement continue to be concerned that the inadequate payment for these products and therapies could represent a barrier to patient access. Accordingly, the parties to the agreement expect the Secretary to carefully analyze potential patient access issues and create sufficient payment categories to adequately differentiate these products.*"

"Five Point Plan on Strategies to Increase the Blood Supply:" The Department of Health and Human Services (HHS)

"The economic and competitive pressures of health care today make it nearly impossible for blood banks to recover the cost of new innovations, even when such measures are required. These economic limitations are a strong disincentive for change."

July 25, 2000

The Honorable Bill Thomas
Chairman
Subcommittee on Health
House Ways and Means Committee
1136 Longworth House Office Building
Washington, DC 20515

Dear Chairman Thomas:

On behalf of the Practice Expense Fairness Coalition, which represents organizations with a combined membership of over 350,000 physicians, we are submitting this statement for the record of today's hearing on additional Medicare refinements to the Balanced Budget Act of 1997 (Public Law 105–33).

Specifically, we are contacting you to (1) express our strong opposition to a proposal by the Halt2000 coalition to stop implementation of resource-based practice expense payments (RBPEs) this year as part of a Medicare giveback bill, and (2) offer an alternative that would address concerns about underfunding of physician services—while preserving the mandate that payments for physician services be based on the relative costs of each service, based on the best available data.

The Balanced Budget Act of 1997 mandated that implementation of the new practice expense payment method be phased in over four years, to allow for methodological refinements during each year of the phase in, following a one year delay in implementation. The Halt 2000 proposal would undo this carefully-crafted compromise by stopping the transition to RBPEs for all services, except office visits, at the current blend of 50% charge-based, and 50% resource-based, practice expenses. The 50% charge-based portion would perpetuate the inequities in payment that Congress resolved to end when it enacted the BBA 97 compromise. Even if a few office visit services were exempted from the halt, *the vast majority of physician services would continue to be paid in large part based on inaccurate historical charges, not data on the costs of each service.*

Our coalition has a better alternative to Halt 2000. This alternative would address concerns about underfunding of physician services, due to past miscalculations of fee schedule updates, by mandating a 3% increase in the dollar conversion factor for the Medicare fee schedule. Unlike the Halt 2000 proposal, it would not abruptly withdraw support for the ongoing transition to a payment system that bases Medicare payments on the relative costs of each service, based on the best available data.

The General Accounting Office in February 1999 reported "*HCFA's methodology uses what are generally recognized as the best available data on resource-based practice expense values*" (emphasis added). So the question is not if HCFA's methodology is fundamentally flawed—the GAO clearly said that it was not. The refinement process mandated by the BBA 97 is the way to get further improvements made in HCFA's data and methodology. In fact, HCFA's recently-published proposed rule on the CY 2001 fee schedule includes numerous changes that directly respond to concerns expressed about its data, including restoring payments for non-physician clinical staff costs for certain services done in the hospital and incorporating more recent survey data into practice expense calculations.

As Congress considers the Medicare giveback legislation, we urge you to support the Practice Expense Fairness Coalition's alternative proposal for a 3 percent increase in the dollar conversion factor for the Medicare fee schedule. Under our alternative, *every physician and every specialty would be better off than under current law. By contrast, under the Halt 2000 plan, some physicians would be worse off and others better off than under current law.* The 3 percent solution is simple and fair to all physicians. Further details are in the attachment.

Any questions that you or other members of the subcommittee may have about the coalition's 3 percent solution should be directed to Bob Doherty, American College of Physicians-American Society of Internal Medicine, 202/261–4530; Laura Saul

Edwards, American Academy of Dermatology, 202/842–3555; or Jake Culp, American Academy of Family Physicians, 202/232–9033.

Sincerely,

American Academy of Dermatology
American Academy of Family Physicians
American Academy of Pediatrics
American College of Physicians-American Society of Internal Medicine
American College of Rheumatology
American Osteopathic Association
Renal Physicians Association

A Proposal from the Practice Expense Fairness Coalition

Increasing Medicare Payments to Physicians *and* Continuing the Transition to Resource-based Practice Expenses: A True "Win-Win" Proposal for Medicine

The Practice Expense Fairness Coalition (PEF Coalition) represents organizations with a combined membership of over 350,000 physicians—*a majority of physicians in the United States.* The coalition's members include the American Academy of Dermatology, American Academy of Family Physicians, American Academy of Pediatrics, American Society of Clinical Oncology, American College of Physicians-American Society of Internal Medicine, American College of Rheumatology, American Osteopathic Association, and the Renal Physicians Association.

In the Balanced Budget Act of 1997, Congress mandated that resource-based payments for physician practice expenses be phased in over a four-year period. During the transition, practice expense payments are a blend of historical charges—which overvalued many hospital-based procedures compared to office-based services—and resource-based practice expenses (RBPEs). Under RBPEs, payments will be based on relative differences on the costs of providing services, based on the best available data.

A coalition of other physicians organizations is now urging Congress to halt the transition to RBPEs—at the current blend of 50% charge-based and 50% resource—based amounts. A small number of office visit codes would be exempted from the halt; they would be allowed to increase to the full CY 2002 RBPE levels. The Halt 2000 coalition estimates that exempting office visits from the halt will cost $2 billion in CY 2001, and $8 billion over five years. The Halt 2000 coalition estimates that average payments to physicians would increase by 3 percent under their proposal, although the impact on individual physicians would vary greatly depending on how much they stand to gain or lose under RBPEs. Some would do better, but other worse, under the Halt 2000 proposal.

The PEC Fairness Coalition strongly urges Congress to reject the Halt 2000 proposal and instead support the following alternative:

1. **Increase the Medicare dollar conversion for factor by 3 percent (the same amount of increased spending that would result from the Halt 2000 proposal).** An increase in the Medicare conversion factor *will benefit all physicians equally—a primary care physician and a surgeon will get exactly the same percentage increase. Unlike halt 2000, which asks Congress to choose sides between "winners" and "losers" under RBPEs, every physician would be better off under a conversion factor increase that under current law; no one would be worse off.* Further, a conversion factor increase would help restore cuts in the conversion factor that resulted from HCFA's mistakes in calculating the sustainable growth rate (SGR) in 1998 and 1999. Although Congress mandated last year that HCFA use more accurate data to correct the SGR, HCFA has refused to make physicians whole for the previous mistakes in calculating the SGR. Therefore, an across-the-board increase in the CF is fully consistent with Congress' desire to restore inappropriate cuts caused by policies that resulted from the BBA 97. Finally, a conversion factor increase is simple: Congress can simply direct HCFA to increase the conversion factor by a set percentage or dollar amount. By contrast, the Halt 2000 proposal would require that Congress consider very complex methodological issues and set fees for thousands of physician services.

2. **Consistent with practice expense legislation enacted by Congress in 1997 and 1999, continue to support the full RBPE transition for all services, with oversight of HCFA activities to assure that improvements are made as appropriate.**

Despite claims by the Halt 2000 campaign that HCFA's methodology is fundamental flawed, the General Accounting Office (GAO) found that "**HCFA's new methodology is an acceptable approach for revising Medicare's practice expense payments...HCFA's methodology uses values...believe that incurred costs [as proposed by HCFA] is consistent with traditional cost accounting**

practices" (Source: GAO: Medicare Physician Payments: Need to Refine Practice Expense Values During Transition and Long Term, February, 1999). The GAO did not support a halt to the transition. Rather, the GAO concluded, "Concerns about data and methodological issues can be addressed during the phase-in period." Further, **the GAO found that a coalition consisting of the same groups that are now supporting a halt in the transition "said they were pleased that we support HCFA's revision...they believe that the new methodology more effectively recognizes differences in practice expense payments among physicians specialties."**

Last year, Congress mandated that HCFA consider additional data from medical specialty societies to supplement the survey data it is currently using. HCFA has published a proposed rule to accept such data, and has already agreed to use data from a survey conducted by an association representing thoracic surgeons. Other improvements can and should be made through the refinement process, with oversight by Congress as needed. HCFA should use more up-to-date survey data that is already available from the American Medical Association. The RVUs Update Committee (RUC), a multi-specialty committee chaired by the AMA, is making substantial progress on refining practice expense data for specific services. To illustrate, the RUC recently reached a multi-specialty consensus on the practice expenses of office based evaluation and management services—the lynchpin of the entire Medicare fee schedule and the services that one might have expected would be the most difficult to resolve. If a consensus can be reached on F/M services, it should be possible to develop a consensus on refinements for other services. HCFA should also include the costs of non-physician clinical staff in the office for facility patients when supported by survey data and expert panels. Such improvements can be made under existing law and the existing process, with oversight by Congress, without Congress stepping in to halt the transition. By contrast, Halt 2000 would forever lock practice expense payments at the CY 2000 levels—precluding further refinement and improvement or updating of practice expense payments based on more recent data.

Congress should support the only true "win-win" proposal on the gable: an increase in the dollar conversion factor for the Medicare fee schedule *and* support for continuing the transition to RBPEs. Every physicians would gain equally, Congress would not have to choose sides over practice expense allocations, a change in the conversion factor would be simple to mandate and implement, and Congress would not be forced again to deal with divisive and complex issues of re-allocating practice expense payments that it thought it has resolved for good in the BBA 97. For more information about the PEF Coalition's proposal, contact Laura Saul Edwards, American Academy of Dermatology, (202) 842–9033; or Bob Doherty, American College of Physicians-American Society of Internal Medicine (202) 261–4530.

July 25, 2000

The Honorable William M. Thomas
Chairman
Health Subcommittee
House Ways and Means Committee
1136 Longworth House Office Building
Washington, DC 20515

Dear Chairman Thomas:

The Practice Expense Coalition, representing 40 physician organizations, teaching hospitals, medical schools, and clinics, is pleased that the Subcommittee is considering legislation to provide health care providers relief from the Medicare provisions enacted in the Balanced Budget Act of 1997 (BBA 97). As the Subcommittee prepares for its July 25 hearing, we would like to bring to your attention one such provision which involves the "practice expense" component of the Medicare Physician Fee Schedule

As you may recall, based on the belief that office-based specialties probably were not recouping their costs of practice, in 1994 Congress directed the Health Care Financing Administration (HCFA) to change the way Medicare pays for physicians' practice expenses. After extensive criticism of HCFA's initial flawed proposal, Congress intervened and included detailed instructions for developing the new practice expense relative value units (PE RVUs) in the BBA 97. Because of the endless string of yearly budget deficits, the only feasible way to provide additional funds to primary care physicians was through this budget-neutral legislation.

The transition is now at the halfway point, with the new system to be fully implemented in 2002. However, HCFA has failed to comply with nearly all the mandates of the BBA 97, and the current methodology and data do not (and likely will never) accurately reflect physicians' actual practice costs. As a result, practice expense payments have become seriously distorted, creating a system that lacks fundamental fairness and is having detrimental effects on our nation's physicians, hospitals, clinics and patients.

Many believe it is therefore time to acknowledge that this task is far more complex than ever contemplated and may never be possible. For example, in a response to a question from Chairman Bill Young at a February 2000 House Appropriations Committee hearing, HCFA's Administrator Nancy Ann Min-DeParle stated that "**we do not believe that it is possible to determine actual physician expenses associated with providing services to Medicare patients.**" In addition, the previous budgetary constraints have made it even more difficult for HCFA to develop a system that fairly reflects physicians' practice costs.

This problem can be fixed, however. To meet the goal of increasing reimbursement for primary care office services, while minimizing the detrimental effects for many specialists, the Practice Expense Coalition urges Congress to seize the opportunity presented by the budget surplus and amend the practice expense provisions of the Medicare law. Our proposal would:

- Halt the transition at the current blend of 50% 1998 PE RVUs and 50% projected 2002 PE RVUs practice expense values; *and*
- Allow scheduled increases for certain office and consultation services to proceed immediately to their projected 2002 amounts.

Under this proposal, the resource based practice expense values would be subject to refinement through the regular 5-year review process currently in place.

As the Subcommittee moves forward with the development of its plan to provide BBA 97 relief for Medicare providers, we ask that you consider including our practice expense proposal in your legislative package. It is a win-win solution for all physicians.

Thank you for considering our requests and for your assistance on this important issue.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery,
American Academy of Ophthalmology,
American Academy of Orthopedic Surgeons,
American Academy of Otolaryngology—Head and Neck Surgery,
American Association for Thoracic Surgery,
American Association of Clinical Urologists,
American Association of Neurological Surgeons,
American College of Cardiology,
American College of Gastroenterology,
American College of Osteopathic Surgeons,
American College of Radiology,
American College of Surgeons,
American Gastroenterological Association,
American Medical Association,
American Society for Bariatric Surgery,
American Society for Gastrointestinal Endoscopy,
American Society of Anesthesiologists,
American Society of Cataract and Refractive Surgery,
American Society of Echocardiography,
American Society of General Surgeons,
American Society of Nuclear Cardiology,
American Society of Plastic Surgeons,
American Society for Therapeutic Radiology and Oncology,
American Society of Transplant Surgeons,
American Urological Association,
Association of American Medical Colleges,
Association of Freestanding Radiation Oncology Centers,
Cleveland Clinic Foundation,

Congress of Neurological Surgeons
International Society for Cardiovascular Surgery, North American Chapter
National Coalition of Quality Diagnostic Imaging Centers
North American Society of Pacing and Electrophysiology
North American Spine Society
Outpatient Ophthalmic Surgical Society
Society for Vascular Surgery
Society of American Gastrointestinal Endoscopic Surgeons
Society of Cardiovascular & Interventional Radiology
Society of Gynecologic Oncologists
Society of Surgical Oncology
Society of Thoracic Surgeons

Summary of Proposed Practice Expense Amendment

Under current law, Medicare pays physicians on the basis of a resource-based relative value scale, which is divided into three components—physician work, malpractice and practice expenses. The practice expense relative value units currently are based on a percentage of physician charges and practice expense resource costs. For 2000, these units are based on 50 percent of charges and 50 percent of practice expense resource costs involved in furnishing a service. By 2002, practice expense payments will be based 100 percent "resource-based."

The proposed amendment would——

• Maintain for 2000 and subsequent years the 50/50 formula for determining practice expense relative value units, which would also apply for purposes of adjustments to the conversion factor for anesthesia services. There would be exception for certain office visit and consultation services, which would be based entirely on the relative practice expense resources involved in furnishing the service.

• Prohibit the Secretary from reducing the conversion factors or relative value units for physicians' services to assure that Medicare Part B expenditures resulting from the foregoing amendment are budget neutral.

• Require the Secretary in consultation with MedPAC and physician organizations to conduct a five-year review of the relative value units, with necessary adjustments for changes in medical practice and new data on relative value components. With respect to practice expense relative value units, the five-year review would not begin sooner than 2005 and would be limited to the portion of the values representing the relative practice expense resources.

• Require the Secretary in consultation with physicians to annually establish or adjust relative value units for new, revised and deleted codes, and publish an explanation of the basis for such adjustments.

• Allow the Secretary to use extrapolation and other techniques to determine relative practice expense resources to reflect coding changes, the addition of new procedures or where specific data are not available.

PROPOSED PRACTICE EXPENSE CHANGES IN MEDICARE FEE SCHEDULE (ASSUMES NO CHANGES IN CONVERSION FACTOR OR UTILIZATION)

Specialty	1998 Medicare Payments (Millions)	Currently Projected Change 1998–2002	2001 Medicare Payments with Halt and Exemption of E&M (Millions)	Change 1998–2001 with Halt and Exemption
ALL	$44,100a	0%	$45,410	3%.
Anesthesiology	$1,675	–9%	$1,606	–4%.
Cardiac Surgery	$328	–17%	$301	–8%.
Cardiology	$3931	–12%	$3,778	–4%.
Clinics	$1,428	–4%	$1,444	1%.
Dermatology	$1,091	20%	1,233	13%.
Emergency Med.	$850	–12%	$804	–5%.
Family Practice	$2,886	8%	$3,171	10%.
Gastroenterology	$1,211	–18%	$1,127	–7%.
General Practice	$976	5%	$1,048	7%.
General Surgery	$1,874	–8%	$1,833	–2%.
Hermatology Onc.	$583	6%	$629	8%.
Internal Medicine	$6,238	2%	6,564	5%.
Nephrology	$928	–6%	$909	–2%.
Neurology	$804	–1%	$826	3%.
Neurosurgery	$319	–12%	$306	–4%.

PROPOSED PRACTICE EXPENSE CHANGES IN MEDICARE FEE SCHEDULE (ASSUMES NO CHANGES IN CONVERSION FACTOR OR UTILIZATION)—CONTINUED

Specialty	1998 Medicare Payments (Millions)	Currently Projected Change 1998–2002	2001 Medicare Payments with Halt and Exemption of E&M (Millions)	Change 1998–2001 with Halt and Exemption
Obstetrics/Gyn.	$389	6%	$421	8%.
Ophthalmology	$3,399	6%	$3,694	9%.
Orthopedic Surg.	$2,000	0%	$2,050	2%.
Otolaryngology	$569	11%	$629	11%.
Pathology	$513	–5%	$500	–3%.
Plastic Surgery	$196	4%	$204	4%.
Psychiatry	$1,100	0%	$1,103	0%.
Pulmonary	$1,031	–6	$1,023	–1%.
Radiation Onc.	$619	–6%	$604	–2%.
Radiology	$2,976	–12%	$2,802	–6%.
Rheumatology	$274	19%	$319	16%.
Thoracic Surg.	$545	–16%	$503	–8%.
Urology	$1,165	6%	$1,243	7%.
Vascular Surg.	$319	–12%	$304	–5%.
Other Phys.	$1,206	–1%	$1,247	3%.
Chiropractor	4417	–8%	$400	–4%.
Nonphys Pract.	$891	2%	$904	1%.
Optometrist	$347	31%	$453	31%.
Podiatry	$949	11%	$1,028	8%.
Suppliers	$379	11%	$400	5%.

a: Numbers may not add due to rounding
*% based on total payments (not just PE values)
**Exempted codes include: 99201–99205, 99211–99215, 99241–99245, 92002, 92004, 92012, 92014. Calculators based on 1998 utilization

EXECUTIVE SUMMARY

Since 1991, the Health Center Financing Administration (HCFA) of the U.S. Department of Health & Human Services has been in the process of implementing a transition to a new system of payment for physician services under Medicare—the Resource-Based Relative Value System (RBRVS). Initially, implementation of this system involved replacing the prior system of reimbursements were based, in part, on a fee schedule intended to reflect more closely the physician work effort involved in rendering specific services to patients.

In 1994, the outgoing Congress directed HCFA to implement a further modification to the system, under which the portion of the historic fee base not paid under the work-based fee schedule—the so-called "**practice expense" component** of the schedule—would also be converted to a "resource-based" methodology.[1] Since that time, HCFA has made a concerted effort to implement such a system.

Its first effort in this direction, proposed for implementation in calendar year 1998, was stayed by Congressional action in the Balanced Budget Act of 1997, which also dictated standards HCFA must apply in modifying the approach it has previously proposed. Subsequently, HCFA has implemented, by regulation, a four-year transition to a resource-based practice expense payment methodology over the 1999–2002 period. Because of ongoing controversies over the data HCFA is using, and the methodologies it is employing to determine payments under this system, HCFA is engaged in a "refinement" process, under which the "full implementation" values for 2002 are being modified annually to reflect ongoing efforts to address these controversies.

The Moran Company was engaged by the Practice Expense Coalition, a joint effort formed by a group of concerned medical specialty societies, to evaluate this history. The question we have been asked to address is whether the technical problems that have been raised about this methodology can, in fact, be "fixed" through technical changes to the system HCFA has implemented, either by HCFA, or by Congressional action to specify a new theory of resource-based practice expense.

Our findings are as follows:

• The technical problems HCFA has faced in implementing this system are, in an important sense, inherent in the policy of "resource-based practice expense," which

[1] A third, smaller component of physician reimbursement—for malpractice expense—has also been implemented on a comparable basis.

requires HCFA to make detailed imputations of physicians overhead costs to over 7500 individual procedures[2]

• The only data available to HCFA to evaluate physician practice expense costs—the results of the biennial Socieconomic Monitoring Survey (SMS) conducted by the American Medical Association (AMA)—are, for a variety of reasons we discuss in our report, seriously deficient as a source of data for the sort of analysis a resource-based practice expense cost imputation requires.

• While the methodology HCFA has elected to employ to make these cost imputations and compute a fee schedule represents a good-faith effort to implement the policy, the methodology raises a variety of policy concerns—for example, proper payment when clinical personnel employed by physicians perform work in the institutional setting—that HCFA is unable to address with its methodology.

• While it might be possible, in theory, to visualize methodological refinements to address some of these issues, it would not be possible for HCFA to make them, since the data required to support them do not exist, and would be difficult, expensive and time-consuming to generate.

• The combined effects of these data and methodology problems represent a serious policy concern, since the practice expense relative value weights computed by HCFA for full implementation produce *very large swings in payment.* The magnitude of these payment swings is particularly large between services rendered in a facility setting (e.g., a hospital), and services rendered outside the facility setting. When this system is fully implemented the practice expense weights HCFA has computed will sharply reduce payments to physicians for treating patients in institutions, and increase payments for procedures performed in the office setting.

• The magnitude of these swings, while a logical consequences of the data HCFA is employing and the methodology choices HCFA has made, are very difficult to explain in policy terms. Even if some variation in payment by site of service was intended by policymakers, the size of the payment differentials create the potential for troubling incentive effects.

• In our judgment, the problems with the resource-based practice expense implementation cannot be "fixed" through the use of alternative sources of data (which don't exist) or the use of better methodologies (which would require non-existent data). Reversion to the prior policy, however, would reverse the stated intent of Congress to reallocate payments among professional specialties in order to enhance reimbursements for evaluation and management services policy—to freeze the transition at calendar year 2000 levels except for a defined set of common routine codes—represents a reasonable balancing of the stated objectives.

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

Statment of Wayne T. Smith, Jim Fleetwood, and Marty Rash, Rural Hospital Coalition

Good morning Chairman Thomas; Ranking Member Stark and other distinguished members of the House Ways and Means Subcommittee on Health. We submit this testimony on behalf of the patients, providers and communities in which we own or operate a rural hospital. Collectively, Community Health Systems, Inc., LifePoint Hospitals, Inc. and Province Hospital Company, Inc. represent roughly 10 percent of the rural hospitals in the United States. In terms of number of facilities, Community Health Systems is the largest non-urban provider of general hospital services in the United States and is the second largest non-urban provider in terms of revenues.

We appreciate the opportunity to discuss the Balanced Budget Act of 1997 (BBA) and its current impact on rural hospital providers, patients, and the Medicare program. As Congress considers reforms to grant necessary relief to rural providers, we urge the Congress to embrace broad reforms that give relief to the majority of the 2,100 rural hospitals. These reforms should include:

• Equalizing Medicare disproportionate share ("DSH") payments between urban and rural hospitals;

• Providing a wage index floor;

• Eliminating market basket reduction for rural hospitals in FY 2001 and FY 2002; and

[2] In the HCFA payment methodology, individual services and procedures are distinguished by use of the American Medical Association's Current Procedure Terminology (CPT), which is comprised of a set of five-digit numeric codes associated with each discrete service or procedure.

• Restructuring qualifying criteria for Medicare dependent hospitals based on their past three cost report years and the payment formula blend applicable to Sole Community Hospitals and make the MDH program permanent.

Rural Health Care Market

Rural hospitals remain the key to providing rural communities with both economic development and access to quality and affordable health care. The loss of a rural hospital to a community results in more than the loss of access to health care. The economic impact of a closing of rural hospital in a rural community cripples a community's ability to attract new doctors, jobs and industry. A recent study indicated that health care provides 10 percent to 15 percent of the jobs in many rural counties.[1] When the secondary benefits of those jobs are included, health care accounts for 15 to 20 percent of the all jobs in rural communities.

Rural hospitals have been able to survive only because of a patchwork of "special fixes" enacted by Congress in the last decade. The Balanced Budget Refinement Act (BBRA) continued this pattern and provided relief for a small number of special rural hospitals—Sole Community Hospitals ("SCH"), Critical Access Hospitals ("CAH") and Medicare Dependent Hospitals ("MDH")-which represent less than 50 percent of the rural hospitals. As a result, most rural hospitals remain in a market that is experiencing higher than expected payment reductions, a reduced number of providers and excessive regulations that are reducing access to care for Medicare beneficiaries in rural areas. The impact of these reductions and regulatory burden is evidenced by:

• The *Congressional Budget Office* (CBO) estimate that Medicare spending fell by $8 billion dollars between November 1999 and January 2000.

• The *Medicare Payment Advisory Commission* assessment that "rural hospitals have lower inpatient marginsa and rural hospitals were disproportionately harmed by the BBA."

• The *Health Care Financing Administration* (HCFA) notation in the most recent "Inpatient Hospital Prospective Payment System" regulation that "approximately one third of rural hospitals continue to experience negative Medicare margins." The rule further states that HCFA "now believes that rural hospitals merit special dispensation...

Special Needs of Rural Hospitals

Rural hospitals tend to be smaller, have difficulty attracting and keeping health care professionals and are more dependent on Medicare patients. In order to remain competitive, hospitals and the communities they serve must continue to be able to recruit additional primary physicians and expand the breadth of services offered in their hospital. To remain a vital part of the United State's health care delivery system, rural hospitals need fundamental payment reform that extends relief to **all rural hospitals** by improving wages, DSH payments and the hospital market basket update.

Medicare Disproportionate Share Payments

Since 1986, the Medicare program has made special add-on payments to PPS hospitals that treat low income patients. Concern for specific groups of hospitals resulted in Congress creating 8 different DSH formulas. (See Table 1). Each includes a threshold for the low-income share needed to qualify. Medicare's proxy for low income patients is based on two factors:

• The percentage of Medicaid patient days ("Medicaid Utilization"); plus
• The percentage of Medicare SSI patient days

Charity, indigent care and bad debts are not considered in the DSH calculation. The current program applies a higher qualifying threshold for rural hospitals (30 percent for hospitals with greater than 100 beds and 45 percent for hospitals with less than 101 beds, as compared to 15 percent for urban hospitals with greater than 99 beds and 40 percent for urban hospitals with less than 100 beds) and disproportionately weights Medicaid utilization, despite the fact that Medicaid utilization is a poor measure of overall service to the poor.

Consequently, more than 95 percent of all DSH payments go to urban hospitals and is highly concentrated in about 250 hospitals.[2]

[1] Statement by Dr. Mary Wakefield before the Senate Agriculture Appropriations Committee hearing on Rural Hospitals and Rural Economic Development

[2] According to the ProPAC 1997, the current formula weighs Medicaid patient days equally with patient days for Medicare beneficiaries who receive Supplemental Security Income (SSI) cash payments, despite the fact the former group accounts for four times as much hospital cost.

Continued

Further, the BBA 1997 requires that HCFA recommend a new payment formula for DSH adjustments that treat all hospitals equally. Recent MedPAC reports on DSH funds found little evidence of any systematic relationship between the share of poor patients a hospital treats and a per-case cost. Low income seniors and the hospitals that serve them in rural areas deserve a more equitable system.

We urge Congress to equalize DSH payments between urban and rural hospitals. Specifically, Congress should immediately equalize qualifying low income threshold between urban and rural hospitals and phase-in the sliding scale distribution formula used to calculate the DSH payment for urban hospitals over 99 beds. It is also our suggestion that urban hospitals be held harmless and that this proposal be implemented with surplus dollars. Notably, HFCA in recent testimony before the Senate Agriculture Appropriations Subcommittee noted that they would consider "improving equity for rural hospitals in the Medicare DSH formula." In a recent budget analysis prepared by PriceWaterhouseCoopers, the transition to a uniform DSH payment for rural hospitals under 100 beds is estimated to cost $709 million over five years (2001–2005). Further, a transition into a uniform DSH payment and applying an urban distribution formula in 2001 is estimated to cost $2.95 billion over five years (2001–2005).

Market Basket (MB) For Rural Hospitals

Rural hospitals have been doubly hurt by three consecutive years of below MB updates. Although hospitals have become more efficient, the industry may be running out of cost cutting initiatives. The problem is more pronounced for smaller hospitals which have less elasticity of cost to volume.

We urge Congress to eliminate the market basket reduction for rural hospitals in FY 2001 and FY 2002. A budget estimate prepared by PriceWaterhouseCoopers estimated that a market basket update for rural hospitals for 2001 and 2002 would cost $748 million for rural hospitals under 100 beds and $8.73 billion for all hospitals over five years (2001–2005).

Wage Index Floor

The current wage index reflects area differences in wage levels in the geographic area of the hospital as compared to the national average wage level. Most rural areas have a very low wage index because the index is based on a statewide average hourly wages for rural areas. The wage index formula, while recognizing hourly wage differences, does not take into account the greater number of hours per case that is required in a lower volume setting due to baseline staffing requirements and lower volume than urban hospitals. Thus, small rural hospitals may have a lower average hourly wage but will require, all things being equal, a greater number of hours spread over lower volumes to run their operations.

We urge Congress to provide a national wage index floor of .8500 to .9000 that would provide a bottom end payment boost to the most disadvantaged rural hospitals. In a recent budget analysis prepared by PriceWaterhouseCoopers, a floor wage index of .90 for rural hospitals under 100 beds is estimated to cost $382 million over the next five years (2001–2005).

Update Criteria For Medicare Dependent Hospitals ("MDH")

A rural MDH is a hospital located in a rural area with 100 beds or less with at least 60 percent of all discharges or days attributable to Medicare. The criteria for the MDH program is based solely on a hospital's 1987 cost report. Facts have changed since then. Some current MDH's may no longer qualify and other hospitals that would otherwise qualify cannot because they did not qualify in 1987.

We urge Congress to make the MDH program permanent and to revise the MDH criteria to (1) permit any three most audited years to be used to determine eligibility and, (2) that would include the current 1996 blend-in afforded to Sole Community Hospitals. In a recent budget analysis prepared by PriceWaterhouseCoopers, the proposed definition change in the MDH criteria is estimated to cost $144 million over five years (2001–2005).

Conclusion

The problems facing rural health care providers cannot likely be solved this year. *It is critical, however, for Congress to enact legislation that will extend real relief to all rural hospitals by improving wages, equalizing DSH payments, revising the MDH program and providing for a fair hospital market basket update.*

Consequently, urban hospitals with at least 100 beds benefit from a steeply graduated payment, while rural and small hospitals receive a lower fixed adjustment.

Statement of Shore Health System, Somers Point, NJ

BACKGROUND:

The Shore Health System is a free-standing, community based not-for-profit health delivery system serving the residents and visitors of Atlantic and Cape May Counties in New Jersey. We feel that it is instructive to demonstrate the impact of the Balanced Budget Act of 1997 (BBA), compounded by other negative revenue developments, on our system.

BBA:

BBA had, and continues to have, a serious, deleterious effect on the System's ability to deliver quality health care to the community. Being comprised of the essentials of a well rounded continuum of care with an acute care hospital, a nursing home, and a home health agency, the System is subject to the 'triple-witching' effect of BBA. Each of these key components of the System was adversely impacted by BBA cuts. Over the initial five (5) year time frame of BBA, the hospital faces revenue reductions of $15 million in Medicare reimbursement. The nursing home Medicare reductions are $110,000 annually, or $550,000 over 5 years. Home health agency reductions are, proportionately, the most onerous: $8.3 million, or nearly 30% of expected revenues. Consequently, the System is challenged with aggregate revenue reductions of $23.9 million over 5 years. This is approximately 5% of operating revenues over the same period. Compounding these BBA revenue reductions are severe cutbacks in New Jersey Medicaid, particularly hard hitting for the nursing home and home health agency, as well as dramatic increases in care rendered but not paid by managed care insurers and continual growth in uncompensated, but mandated, charity care and bad debts.

BBRA:

The Balanced Budget Relief Act of 1999 (BBRA) offered welcome but scant relief to the System. Relief to the hospital amounts to approximately $700,000 over the five year period, or only 5% of the total $15 million in BBA reductions. Home health agency relief was granted for only one of the five years covered by BBA. This amounts to $56,000 on total cuts of $8 million. Nursing home relief amounts to restoration of 20% in BBA cuts in only 14 of 44 patient classifications. The financial impact of this restoration is $10,000 per year based on the facility's case mix. To summarize, BBRA provides approximately $800,000 in relief on $23.9 million of BBA revenue cuts. It does not address New Jersey Medicaid reductions, managed care denials, or uncompensated care.

EFFECT ON OPERATIONS:

The System, as a not-for-profit, community based provider, has historically reinvested its surpluses into delivery of quality health care services and medical equipment. Consequently, operating margins have traditionally been thin, running in the 0.5% to 3.0% range. Conventional financial wisdom holds that operating margins in the 5% to 7.5% range are essential to assure the continued viability of a health care provider. The Shore Health System has traditionally bridged this gap in margin with the contributions and volunteerism provided by the community.

The effect of BBA on operating income of the system can be clearly demonstrated by the following:

Gain (Loss) From Operations*

Pre-BBA: 1996 $3.6 Million
1997 $0.9 Million
BBA Years: 1998 ($3.9) Million
1999 ($4.1) Million
2000 Budget ($2.9) Million

*Combined, audited results of hospital, home health agency and nursing home, excluding extraordinary items.

Bleak as these figures are, they tell only part of the story. The most egregious revenue reductions of BBA fall in the fourth and fifth years (2001 and 2002 for the Shore System). Fully 55%, or approximately $13 million, of the reductions are yet to be realized by the System. BBRA relief measures will be barely perceptible in the face of these substantial cuts.

The operating losses also tell a story of the System's rising to the challenge of BBA. A five (5) year turn-around plan has been implemented and is on target. Losses are being mitigated. This comes at a cost. The System, traditionally a lower compensation employer, has had to forego wage increases and cut benefits for several years. The first major layoff in a quarter century was implemented in 1998, followed up by a severe austerity program and downsizing of the executive team. Wage rates have slipped below competitive rates. Recruitment and retention in this full employment economy have become a daily challenge. Aggravated by a shortage of skilled nurses, the system has hit the "quality wall," beyond which further staffing cutbacks result in inadequate patient care. The consequent stress level of dedicated staff is manifesting itself in labor unrest. In the face of these staff challenges, the ever increasing cost of necessary medical technology and out of control pharmaceutical pricing compete for the shrinking pool of revenues.

FURTHER RELIEF NEEDED:

BBRA was intended to grant some relief of BBA cuts. It is not sufficient to sustain a complete recovery of America's health care system. If no further amelioration of the BBA cuts is granted, the System faces inevitable closure of both the nursing home and the home health agency, each of which are lower cost alternative means of health care delivery. More relief is needed now.

While most observers can attest to excess capacity, over utilization and, in some cases, outright fraud in health care in the past, these first three (3) years under BBA have wrung most of these ills from the system. We are now at the point of doing serious harm to our health delivery system. The ironic tragedy is that, in this era of unprecedented economic expansion, budget surpluses and full employment, the United States is in the process of dismantling the highest quality health system in the world... without a replacement system in place. Our world leadership position will suffer as a consequence. Americans, and world citizens, deserve better.

We request that the subcommittee support further meaningful financial relief of BBA and appropriate substantive funding to support this effort.

Respectfully submitted,

RICHARD A. PITMAN
President

Statement of Society of Thoracic Surgeons, and American Association for Thoracic Surgery

The Society of Thoracic Surgeons and the American Association for Thoracic Surgery are pleased to submit this statement to the House Committee on Ways and Means Health Subcommittee for the record of the July 25th hearing on Medicare Refinements to the Balanced Budget Act. The Society of Thoracic Surgeons and the American Association for Thoracic Surgery are the primary medical specialty organizations representing essentially all board-certified cardiac and thoracic surgeons in the United States.

As the Ways and Means Committee considers legislation making refinements to the Balanced Budget Act of 1997, The Society of Thoracic Surgeons and the American Association for Thoracic Surgery urge you to take action to mitigate the harmful impact of the Health Care Financing Administration's practice expense relative value rule on surgical care for Medicare patients with heart and lung disease.

Fees for cardiac surgery for Medicare patients have been reduced by 40 percent since 1987. If the year 2002 fee schedule is implemented as proposed by HCFA, there will be another twelve percent (Cumulative reductions: from $3600 to $1700). This is before calculating the impact of changes in the cost of living. If these figures are adjusted by the Consumer Price Index, the reduction from 1987 to 2002 is 75 percent ($3600 to $850).

The fee reductions from 1998 to 2002 are the consequence of decisions HCFA made in revising the "practice expense" component of the Medicare fee schedule. As you know, Congress ordered HCFA in 1995 to revise the fee schedule to accurately reflect expenses incurred, based on the belief that procedures performed in the office setting were undervalued. This was done during a time of yearly budget deficits. In order to increase payments for office-based procedures in a budget-neutral manner, reimbursement for procedures performed in the hospital setting, such as life-saving open-heart surgery, were reduced.

In implementing this directive, HCFA's original work was so poor that Congress had to stop HCFA in its tracks and provide detailed instructions in the Balanced

Budget Act of 1997 for developing the new system. In BBA '97, Congress specifically mandated that HCFA:

• Base the new practice expense methodology on generally accepted accounting principles and "**Recognize all staff, equipment, supplies, and expenses, not just those which can be tied to specific procedures,**" in determining practice expense reimbursement.

• Refine the interim Practice Expense Relative Value Unites (PERVUs) annually during this four-year refinement period.

• Consult with physician organizations regarding their data and methodology.

• Provide detailed impact analyses to test whether the new practice expense values reflect physicians' actual practices.

For the 1999 fee schedule, HCFA did revise its methodology, developing new practice expense values using information from surveys of the American Medical Association. In its 2000 fee schedule, however, HCFA again revised its approach, arbitrarily **deleting from practice expense** the costs of staff on physicians' payrolls who assist them in the hospital. HCFA has estimated that this would shift $350 million a year, when fully implemented in 2002, from reimbursement for procedures done in hospitals to procedures done in offices. This has the effect of taking more than $40,000 of costs per physician away from thoracic surgeons and transferring these values to other specialties.

This transfer violates the basic premise of the resource based **relative** value system and has reduced the practice expense reimbursement for cardiac surgery (as well as many other critical hospital procedures) by twenty percent. That translates into a further ten percent reduction in the total allowed fee—**another five percent reduction in each of the next two years.**

STS and other specialties have provided HCFA with extensive evidence that surgeons and other specialists commonly bring their own staff to the hospital to assist in patient care. This practice is becoming more frequent as hospitals cut back their staffs and surgeons develop their own teams to make continued quality improvements.

Separate reimbursement exists for some, but not all, of these physician staff. Even where reimbursement exists for services of some staff (physician assistants) the costs of these staff exceed offsetting income from fees for their work.

In addition to this arbitrary deletion of costs, HCFA has failed to comply with nearly all of the other mandates of BBA '97. We are now halfway through the four-year transition process and it is clear that HCFA will not be able to make any refinements and accomplish the admittedly overwhelming task of accurately accounting for physician's practice expenses until well after the values are fully implemented.

The consequence of continuing with this flawed system which has sharply reduced reimbursement for thoracic (cardiac) surgery is already becoming evident in reduced applications, particularly from graduates of American medical schools, for the seven years of advanced training required in this specialty. This year, eleven of the 139 residency training slots available in thoracic surgery went unfilled. And retirements of active surgeons are accelerating, even as the need for cardiac care of an aging population increases and training slots are unfilled.

We ask that Congress take into account the cumulative impact of the policies of the last ten years, as implemented by HCFA on the future availability of the thoracic surgeons and other highly-advanced specialists. Advances in preventive medicine not withstanding, these specialists will be needed to care for our aging population. **Sufficient incentives must be reestablished to encourage the best and brightest of our medical school graduates to come into these demanding professions.**

We further ask that Congress take action to correct the damage being done to thoracic surgery and other advanced, high technology medical services by HCFA's inability to follow Congress' BBA '97 directives. Specifically, in developing a Medicare refinement package, we ask that the Ways and Means Committee:

• Make clear to HCFA that Congress intends it to "recognize all expenses," not just those it arbitrarily selects, in determining practice expense reimbursement.

• In light of HCFA's inability to carry out the directive of Congress, support the Practice Expense Coalition's "Halt 2000" initiative. This proposal, supported by our society and over 40 other provider organizations, would halt the transition at the current blend of 50% 1998 PE RVUs and 50% projected 2002 PE RVUs practice expense values and provide new money that would allow the increases currently scheduled for primary care to continue.

We appreciate your consideration of our request.

TEXAS ASSOCIATION OF
BEHAVIORAL HEALTHCARE
HOUSTON, TEXAS 7706
August 7, 2000

U.S. House of Representatives
Congressman Bill Thomas
House Ways and Means Committee
Subcommittee on Health
Washington, DC 20515

Re: OFFICIAL COMMENTS REGARDING OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS)

Dear Congressman Thomas and Healthcare Subcommittee Members:

As President of the Texas Association of Behavioral Healthcare (TABH), I represent the providers, employers, and employees of various types of psychiatric services throughout the state of Texas. The purpose of this testimony is to address the loss of mental health treatment options for patients who are living with a chronic and persistent mental illness, resulting in the current crisis in the treatment of mental illness. Additionally, I have outlined the steps that the providers of PHP services and Congressional Representatives have taken over the past two years in an attempt to avoid this crisis.

A number of meetings were held over the past two years between Texas Representatives of Congress, the (TABH), providers of psychiatric Partial Hospital Programs (PHP), and Health Care Financing Administration (HCFA). The purpose for the meetings was 1) to bring to the attention of HCFA the potential crisis regarding the access to mental health care for patients as a result of unclear and inadequately and inconsistently interpreted regulations, and 2) the implementation of the Outpatient Prospective Pay System (OPPS), (which in the case of the PHP benefit was unjustly determined).

During the meetings both TABH delegates and Texas Representatives ardently pointed out that the HCFA regulations that guide the delivery of the PHP benefit had been traditionally unclear, were not consistent, and were not fairly implemented by some Fiscal Intermediaries (FI). It was debated that HCFA revise their regulations, use recent information in which to base new decisions, revise the way in which PHP programs are reimbursed, and fairly assess the current use of the benefit by mentally ill beneficiaries. It was stated by Texas Representatives that if these suggestions were ignored, the PHP programs would begin to reject Medicare patients, and the benefit would be destroyed, leaving the mentally ill patient few options for their treatment.

In addition, it was discussed that many of the Texas PHPs have already closed their programs to Medicare patients due to numerous new and overly burdensome regulations imposed by HCFA, and the lack of an appropriate per diem rate that was to be implemented with the Outpatient Prospective Pay System (OPPS) on August 1, 2000. This fact was supported by the January 2000, General Accounting Office's (GAO) report "GAO/HEHS–00–31, Medicare—Lessons Learned From HCFA's Implementation of Changes to Benefits." The closure of PHP services has left many areas in Texas without treatment programs for the mentally ill. This is especially true for the rural areas, of which there are many in such a large state as Texas.

In an effort to be more precise, I will state the situations that have occurred over the past two years in chronological order:

1. In November 1998, the Subcommittee on Oversight and Investigation—Committee on Commerce—conducted a hearing where it was reported by HCFA that 91% of all PHP admissions were medically unnecessary. Although the TABH and other state organizations were able to show that this figure was based on one state (Florida) and five centers from that state, HCFA was never willing to rescind that original figure. It is the "fact" that is still repeated throughout Congress, and one that is believed strongly by Congressional members.

2. In 1999, as a result of the November 1998 hearing, the HCFA Office of Inspector General (OIG) swept through five states, including Texas and Florida, closing programs as they went. After bringing these reports to the attention of Texas Representatives, the Representatives began to intervene on our behalf. Since that time, it has been determined that a number of these programs were illegally closed. This information can be verified by the Texas Congressional offices whose districts were affected.

3. In February 1999, a Townhall Meeting was held in Baytown, Texas sponsored by Texas Members of Congress. Over 300 people from many states were in attendance. Mr. Robert Striemer, the HCFA representative, attended the meeting. Representatives from several state organizations gave testimony on the crisis that was already occurring in accessing psychiatric treatment for the mentally ill.

4. Throughout 1999, a number of state organizations went to Washington, D. C. to bring this crisis to the attention of their Representatives. Congressman and Senators from Arizona, California, Connecticut, Colorado, Florida, Georgia, Iowa, Illinois, Kentucky, Louisiana, Main, Maryland, Missouri, North Carolina, New Mexico, New York, Ohio, Oklahoma, Pennsylvania, Texas, Virginia, Washington, Wisconsin, and Wyoming were contacted by their sate organizations. The purpose of the meetings was to educate the representatives on the significance of the PHP programs, the statistics that were misrepresented by the 1998 hearing, and the unjust treatment by HCFA.

5. In October through December of 1999, HCFA conducted a five state Local Medical Pre-Pay Review of all centers that provided PHP services. In January and February 2000, additional providers were forced to either close their centers or cease providing PHP services to Medicare patients. Again, it has been shown that many of these centers were penalized using methods of data collection and examination that did not follow the rules set forth by HCFA themselves in a September, 1999 Memorandum. Texas Representatives were again contacted. Some cases are still under review with assistance from Texas Congressional offices.

6. In May 2000, Congressman Nick Lampson hosted a meeting in his office with representatives from other Texas Congressional offices, representatives of the TABH and the HCFA administrator, Nancy Ann Min-DeParle and members of her staff. The purpose of the meeting was to inquire how the per diem rate that was set for the payment of PHP treatment under OPPS was determined. It was stated by Ms. DeParle that the rate was a "best guess estimate," and that "no formal data was gathered or examined from outpatient, non-hospital based programs in setting the rate."

7. In July 2000 a meeting was held in the office of Secretary Donna Shalala, Department of Health and Human Services (DHHS). In attendance were Secretary Donna Shalala, Administrator Nancy Ann Min-DeParle, (HCFA) and Congressional Representatives Nick Lampson, Sheila Jackson-Lee, Ted Strickland, Ken Bentsen, Joe Barton, and Charles Rodriguez. The purpose of this meeting was to ask for the delay of the implementation of OPPS for PHP services (only) until such time that an adequate per diem rate could be established and other problems could be worked out between HCFA and providers of PHP services. Secretary Shalala and Ms. DeParle denied the request.

Nationally, 65% to 80 % of the programs that were operational in 1998, and served chronically mentally ill patients, have closed. It is impossible to determine the exact number of closures, as "active provider numbers" are considered by HCFA as "active centers providing services," however most centers that have closed or are no longer providing services to Medicare patients have not surrendered their provider number, giving an entirely false statistic. Most recently, the implementation of OPPS has made it necessary for additional programs in Texas, and around the nation to close or cease admitting Medicare patients, as it has become economically impracticable to provide the services at the per diem rate currently in effect.

In addition, promises that were made by Ms. DeParle during the May meeting with Texas Representatives were breached. We were assured that the "transitional corridors and outlier payments" would be provided to PHP providers who did not have a 1996 Cost Report, "to lessen the blow that OPPS would have on providers." This same statement was made by individual FIs in the training programs presented to providers on the implementation of OPPS. HCFA has now changed their position and are not providing the promised relief to PHP service providers without a 1996 Cost Report. The response to the new information has been that multiple facilities have closed or are planning to close due to the perceived severity of the financial impact of OPPS. Furthermore, Texas PHP providers have not yet received final word from our FIs on the financial implications of OPPS. This is the second week of the implementation of OPPS.

Compounding the reimbursement situation is the continued lack of clear guidelines for PHP providers on issues related to service provision. For example, FIs in many regions have yet to provide a Local Medical Review Policy (LMRP), which addressed the changes in the "Final HCFA Rule." We were assured by HCFA that a LMRP would be published prior to the implementation of OPPS. Again, we are being asked to provide adequate PHP services without the benefit of rules and guidelines.

1. To expand on these comments, I am providing the following comments: HCFA failed to follow Federal Parity Legislation in the implementation of OPPS by allowing medical providers Transitional Corridor Payments and Outlier Payments and precluding PHP providers from qualifying for any additional payments. A default rate has been given which calculates to $0.00 in Transitional Corridor and Outlier Payments.

2. Rural hospitals have been provided with relief from OPPS, but rural PHP providers have been excluded.

3. HCFA publicly admitted on several occasions that no data from outpatient, non-hospital based PHP providers was considered in determining the daily rate.

4. No impact studies were conducted regarding the impact of OPPS on access to care for the mentally ill. To date, Texas has experienced closures of PHP services in excess of 70% due to unjust treatment and illegal closures by HCFA, and the implementation of OPPS. These closures leave entire regions of the state with no access to psychiatric treatment programs for Medicare beneficiaries.

5. The 1998 HCFA—OIG Report that Congress has used for the basis of many decisions regarding the future of the PHP and psychiatric services are inaccurate and have been misrepresented, as evidenced by statements in the GAO Report. In addition, other Committees who have held hearings regarding the 91% "error rate" report testimony to the contrary. It has been stated in a number of hearings that the method of data collection used by HCFA was flawed from the inception. Auditors were not trained or prepared, many had no experience in data collection, agencies that were contracted to collect the data were not trained, and the examination and documentation of the data was not standardized. Again, the result was a "best guess" resulting in an industry that has been unjustly punished and patients who now go without treatment. I would be glad to share with the Subcommittee my personal experience with the 1998 HCFA survey process!

I want the subcommittee to know that the TABH is not denying the occurrence of fraud and abuse of the PHP benefit in some areas of the country. Several Texas providers were closed as a result of fraudulent activities. Others went on to other ventures that were not under such close scrutiny. Also, we are in favor of the OPPS if implemented fairly with a per diem rate that is representative of the cost of providing the PHP services nation wide. It should be noted that with the closure of hospital based psychiatric services nationally, PHP service providers are mandated (by HCFA rule) to provide intense programming to extremely ill patients. The cost of providing services through the outpatient PHP level of care has escalated 800% since 1996 due to new HCFA rules and the acuity level of the patient served.

The TABH is respectfully requesting that the Members of this Subcommittee consider this testimony and take steps toward correcting the devastating and discriminatory effects that the implementation of OPPS has had on PHP services and the mentally ill patient's access to appropriate care.

The beneficiaries and their families, already burdened with chronic mental illness, are not in a position to advocate for themselves. The lack of access to mental health treatment is a real crisis that is now being felt throughout the country.

The psychiatric community feels that we have been unjustly targeted by HCFA. We feel that it has been their intention to decertify all centers providing PHP services. We may be wrong in our assumption, but it has been a constant struggle for over two years to provide needed services for these chronically ill patients. At this point it is the patient who is suffering. The patient has little access anymore to the treatment programs that allow them to remain in the community environment and benefit from community based living. Community living is the reason that state mental hospitals and mental institutions were closed, and the mentally ill citizens returned to neighborhoods to live. This treatment crisis is making it impossible for them to maintain a sane lifestyle and remain living in their neighborhoods. Please consider the patient and their needs in this situaton.

Respectfully,

JoAnne Mandel, LMSW, RN, CS

VISITING NURSE ASSOCIATION
CINCINNATI, OHIO 45202–1468
July 25, 2000

A.L. Singleton
Chief of Staff
Committee on Ways and Means
U.S. house of Representatives
1102 Longworth House Office Building
Washington, DC 20515

Dear Mr. Singleton:

The Balanced Budget Act of 1997 had a devastating effect on the providers of home health services beginning in 1998. It is our understanding, based on a series of publications including commentary by NAHC (National Association for Home Care), that between 20–30% of home health agencies have gone out of business since the introduction of the BBA. This has been caused by:

a. reduced levels of reimbursement

b. a reduction in referrals to home health agencies caused by the actions taken by HCFA to reduce the utilization of home care and the concerns of fraud and abuse by physicians

There are a number of continuing outstanding issues which we believe must be addressed by Congress if we are to preserve home care as an alternative to institutional care, i.e. nursing homes and hospitals. At the moment it is purely speculative as to the real impact of the Prospective Payment System (PPS), which will take effect October 1, 2000. Grave concern has been expressed by many that as a result of the changes for reporting the clinical assessment as well as the provision of new requirements through an information set required by HCFA, plus the level of reimbursement, that as much as an additional 10% of home health agencies may go under.

In light of the above, we would recommend that your committee consider the following:

1. Reductions effective October 1, 2001

Under the current legislation, we anticipate a further reduction in reimbursement of 15% effective October 1, 2001. Were this to be implemented, then it is likely that such action would represent the final nail in the coffin for most of the home health industry. We would strongly urge that this provision be eliminated and that an additional 15% be added back in the year 2001. As compared to hospitals where 60% of their expenses are spent in human resources, the same line item is 85% in home care organizations.

It should be noted that a comprehensive cost effective study regarding home care was issued in November of 1999 provided to the legislative body in British Columbia. The conclusion was that home care is in fact cost effective when compared to other forms of institutional care.

2. Benefits

The benefit package in home care represents an enormous discrepancy as compared to other components of health care provided in hospitals and nursing homes. Payment by employees for health care family benefits frequently requires as much as 60% of the premium costs by home care employees versus anywhere from 15–35% among nursing homes and hospitals for comparable packages. This puts a significant burden and a competitive disadvantage to retain and recruit at all levels within home care. It is not unusual that among the lowest category of employees, i.e. home health aides, that pension benefits are not provided. In part this state of affairs is a direct reflection of the inadequacies of reimbursement for services rendered for both Medicare as well as Medicaid.

3. Nursing Homes

The press has indicated that a new report is on its way to HCFA concerning inadequacy of staffing in nursing homes. One of the responses in the nursing home industry predictably is that significant additional dollars will have to be paid by payor sources if new employees are to be hired. This not only affects the issue of quality of care, but will further impact the issue of levels of payment if the nursing homes are to successfully compete in the marketplace. From a compensation point of view, inclusive of fringe benefits, home care agencies often are the lowest paying organiza-

tions within health care. If in fact the additional dollars are paid to nursing homes, which sounds reasonable based upon the issues of adequate staffing, then without similar payments to home health agencies our industry will be unable to either recruit or retain its professional and non-professional staff.

4. Cash Flow

Our organization has been a recipient of PIP (Periodic Interim Payment) which is now being eliminated under PPS. This will now provide us with a cash flow shortfall of approximately $225,000 for the federal fiscal year 2001. Our total budget is slightly in excess of $9 million with a marginal balance sheet and with no reserves. Our plight, we believe, is not unique and we would ask that either PIP be reinstated or some other mechanism be developed to ensure appropriate cash flow to meet the needs of our expense budget to pay our employees as well as our vendor obligations on a timely basis.

Many thanks for the opportunity to comment.

Cordially,

Warren C. Falberg