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PAYMENT SYSTEMS FOR MEDICARE'S HOME HEALTH BENEFIT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

SECOND SESSION

AUGUST 6, 1998

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PAYMENT SYSTEMS FOR MEDICARE'S HOME HEALTH BENEFIT

THURSDAY, AUGUST 6, 1998

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

The Subcommittee met, pursuant to notice, at 10:17 a.m., in room 1100, Longworth House Office Building, Hon. William M. 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
July 30, 1998
No. HL-23

CONTACT: (202) 225-3943

Thomas Announces Hearing on Payment Systems for Medicare's Home Health Benefit

Congressman Bill Thomas (R-CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, announced today that the Subcommittee will hold a hearing on payment systems for Medicare's home health benefit, specifically implementation of the prospective payment system as mandated in the Balanced Budget Act of 1997. **The hearing will take place on Thursday, August 6, 1998, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.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, Medicare spent more than $17 billion for 270 million home health care visits. That same year, nearly 1 out of 10 beneficiaries received home care, averaging 80 visits per beneficiary. Almost half of these visits were unskilled home health aide visits. The Congressional Budget Office predicts that Medicare home health care spending in 1998 will be even higher.

In response to rising costs and recommendations that the home health benefit be better defined and home health care agencies be held more accountable, the Balanced Budget Act of 1997 (P.L. 105-33) included several provisions, which were also supported by the Administration, to strengthen Medicare's home health benefit. These provisions require the Health Care Financing Administration (HCFA) to design and implement a prospective payment system (PPS) for home health care by October 1, 1999. The PPS is expected to establish similar payments for similar services, encourage more efficiency in home health operations, and improved the quality of care for patients served. To transition into that system, an interim payment system would be established for the two years prior to implementation of the PPS to begin moving agencies towards a more uniform payment rate.

Recently, an internal HCFA memo came to the attention of the Subcommittee indicating that implementation of the PPS for home health was in jeopardy, which means that the interim payment system would remain in effect for a longer than intended period of time.

In announcing the hearing, Chairman Thomas stated: "Because of HCFA's admitted inability to enact a prospective payment system for home health care in a reasonable time frame, home health agencies will be paid under the interim payment system for longer than Congress intended. We must now consider appropriate refinements to the interim payment system and examine creative alternatives which ensure that our seniors have access to home health care services."

FOCUS OF THE HEARING:

The Subcommittee will focus on HCFA's ability to enact PPS for Medicare's home health benefit and potential limitations on reforms to revise the interim payment system. In addition, the hearing will examine the impact of the interim payment system in the States, its effect on both new and old home health agencies, and other appropriate policies aimed at improving the home health benefit for Medicare's beneficiaries.

(MORE)

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit six (6) single-spaced copies of their statement along with an IBM compatible 3.5-inch diskette in WordPerfect 5.1 format, with their name, address and hearing date noted on a label, by the close of business, Thursday, August 20, 1998, to A.L. Singleton, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least two hours before the hearing begins.

FORMATTING REQUIREMENTS:

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

1. All statements and any accompanying exhibits for printing must be typed in single space and may not exceed a total of 10 pages including attachments. **At the same time written statements are submitted to the Committee, witnesses are required to submit their statements on a 3.5-inch diskette in WordPerfect 5.1 format.**

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

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

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

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

Note: All Committee advisories and news releases are available on the World Wide Web at "http://www.house.gov/ways_means/".

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

*****

Chairman THOMAS. One year ago yesterday, the President signed the Balanced Budget Act of 1997. That legislation represented a bipartisan agreement to shore up the solvency of the Medicare trust funds and increase the number of health care choices for our seniors.

The Balanced Budget Act also brought out necessary changes in the way Medicare reimburses providers of home health services.

Let me say at the outset of this particular hearing, Republicans and Democrats alike share faith in the value of home health care. It is an integral part of the continuum of care. We want to ensure that our seniors have access to care when they need it, or it best serves their health needs.

However, as the American populace ages and more seniors go into the Medicare program, it is imperative for us to make secure the finances of the Medicare trust fund.

We have taken several steps to ensure the long-term solvency and continuing success of Medicare. But I can tell you, as Administrative Chairman of the Medicare Commission, we still have a long way to go.

In recent weeks, the administration has reported to this subcommittee that, for a number of reasons, the Health Care Financing Administration will not be able to implement on time the new Medicare home health prospective payment system.

The delayed implementation of the new reimbursement system means that the interim payment system is more significant than it would have been, since it will simply have to be used longer.

Today, we will hear testimony on the expected impact of the interim payment system, and about the extension of this system beyond the intended two-year period as set forth in the Balanced Budget Act of 1997.

We have witnesses from HCFA, the administration, the policy experts from the General Accounting Office, Medicare Payment Advisory Commission, and the Office of the Inspector General in terms of another area that we're dealing with in home health care, fraud and abuse.

We also have witnesses from a number of home health care agencies, from all parts of the country. I look forward to not only a spirited exchange of ideas, but that all witnesses provide their solution to the current problem.

Any discussion of this issue must begin with the recognition that significant changes were necessary and are necessary. When Congress acted, spending for the Medicare home health benefit was spiraling out of control.

There are people in the home health care business who continue to manipulate innocent seniors, the media, and I'm sorry to say, Members of Congress, with half-truths and misrepresentations.

These people want to go back to the cost-based reimbursement system, or at least suspend any changes for as long as they could possibly have that suspension. Those choices are simply not options.

The IPS, no matter how poorly crafted, was designed to control escalating spending and over-utilization, and provide more efficient and effective delivery of home health care services during the tran-

sition to a prospective payment system. The IPS does not limit the amount of home health care services a beneficiary receives.

I have seen stories, as I'm sure you have, reported in the press, that hundreds of home health agencies are closing. Be assured that we intend to closely scrutinize the stated facts and the situation involved in these stories, but before these facts get bandied about, and the stories become reality, I want somebody to closely examine what occurs with the numbers.

For example, how many of these agencies are, quote unquote, "closing," but are, in fact, merging?

This was going to be an inevitable consequence, as an area that had, in large part, been a cottage industry, continues to grow and become more significant in the delivery of health care. But how many of these that are actually mergers are counted as closing?

Then, one of the more insidious aspects of past behavior: how many of these agencies closed, and then quickly applied to reopen, to take advantage of possibly higher reimbursement rates for new agencies? That was just a question.

MedPAC reports that, in 1994, there were 8,057, more or less, home health agencies. In 1997, the latest year for which we have numbers, and additional 2,525 agencies opened, so that today, we have 10,582 home health agencies serving our seniors.

And of course, remember, the administration imposed for four months, between September and January of last year and this year, a moratorium, when there were openings at approximately 100 a month, so that this number would have been far higher had there not been a temporary moratorium imposed.

Every report that we have received indicates that the number of home health care agencies continues to climb, and that patient access is not a problem.

I would draw your attention to the HCFA regulation soon to be published, which refutes accounts of mass closings. HCFA reports that it is "currently receiving many new applications from agencies wanting to become Medicare-certified. If there are any closures as a result of this payment system, it is expected other new agencies or agency expansions will offset these closures."

I thank the witnesses in advance for being with us here today. I ask them to focus, on their oral remarks, on specific recommendations to refine the interim payment system, which address both national and regional variations in home health care delivery.

I apologize to the numerous colleagues who wanted to testify.

I will tell you there has been a greater response to the desire to testify on this issue by our colleagues than on virtually any other issue that I can remember, and that it required a letter, jointly signed by myself and the ranking member, to indicate that, given the number of Members who wished to testify, that we would receive written testimony only from Members, so that we could get through the schedule in a reasonable time frame.

I expect to hear, from every witness, their solution to the problem. I don't want to hear the problem. We know the problem. We're looking for solutions, in a difficult time, in which HCFA can't do what it is supposed to do, because of the "Y2K problem."

The gentleman from California.

Mr. STARK. Thank you, Mr. Chairman. Thank you for holding this hearing in response to much concern from many of our colleagues. There has been an outcry for change in the Balanced Budget Act's home health provisions.

I would like to join with you to enact a better interim payment formula, but I'm worried that if we make changes, we may jump from one frying pan into another.

If we change the interim payment system formula, we're going to make a new set of agencies unhappy. The question before us really is, who are the agencies, or which are the agencies that would win and lose in a formula change; and, is there any good health policy rationale for that change?

You indicated that you had heard that a lot of these agencies closed. I heard that 200 for-profit agencies have closed in Texas, but 900 have opened. I don't know whether that's good, bad, or indifferent, but it doesn't worry me. If they want to make a profit, some win, some lose. That's part of the market.

Fraud, waste, and abuse remains rampant in this sector. On its face, it's fraud when for-profit agencies provide twice the number of visits to the same type of patient as the not-for-profits. Why shouldn't we, for example, just set the payment rate at the median of the nonprofit cost per case, and save us all some money?

In its regs on Medicare Plus Choice, HCFA is requiring that HMOs have a compliance plan in place. The OIG is only promising a voluntary plan for home health agencies, and I am going to urge that HCFA make a compliance plan mandatory for home health agencies in the future.

The nation really needs a long-term care program. We are in turmoil over home health care because it is really becoming, by default, our long-term care program, and nobody wants to pay for it.

I was on the Pepper Commission in the 1980s. We tried to develop a long-term care proposal, but no one wanted to pay for it then either. In Medicare Catastrophic, we moved toward better long-term care benefits, but no one wanted to pay for it, and it was repealed.

You, Mr. Chairman, are now co-chair of the National Commission on the Future of Medicare, trying to find a way to extend Medicare's future, and no one wants to pay for it.

Rather than sneak a long-term care policy through the back door of our acute care Medicare program, we should probably propose a long-term care social insurance program, and ask the public if they're willing to pay for it.

Until we do, I feel that Members will just be trying to get two ends of the teeter-totter in the air at the same time, saving money on one group over here, while this group goes down. We won't be saving money, or moving the fulcrum, and will continue accomplishing nothing.

We are just going to disadvantage new sets of providers, as we change the formula. Maybe we will be able to do that to the overall advantage of the public. I hope so.

Finally, Mr. Chairman, I would like to enter into the record a number of written statements from members on our side. Mr. Cardin and Mr. Jefferson had other meetings this morning, as did

Mr. Sanders and others. I would ask unanimous consent that those statements be inserted at this point.

Chairman THOMAS. Without objection, any Member's written testimony will be made a part of the record.

Mr. STARK. Thank you, Mr. Chairman.

[The following was subsequently received:]

Testimony of Congressman John E. Baldacci (ME-02)

Mr. Chairman, I thank you for holding this hearing today to discuss the Medicare prospective payment system for the home health care industry. In light of the recent indications from the Health Care Finance Administration (HCFA) that the October 1, 1999 deadline for implementation of the prospective payment system cannot be met, it is especially important that we take a very close look at the interim payment system and its effect on home health care across the country. I am deeply concerned that the interim payment system is forcing agencies to close their doors and thereby leaving senior citizens without necessary care. Undoubtedly, the loss of home health care for many individuals will force them into more costly nursing home care. I do not believe that this was the intent of Congress in passing the Balanced Budget Act last year; I do not believe that any of us in this room wish to see this result.

Of the many changes in Medicare under the Balanced Budget Act of 1997, one of the most sweeping was the decision to alter the reimbursement for home health care services. There is widespread bipartisan and industry support for the implementation of a prospective payment system for these institutions. The previous system for home health care reimbursement, based on retrospective reasonable costs, provided no incentive for minimizing costs or controlling the number of visits supplied to beneficiaries. A prospective payment system will encourage efficiency and discourage fraudulent billing, without compromising quality of care.

Before the PPS can be instituted, the Balanced Budget Act required that an Interim Payment System be developed. There are two limits to reimbursement. First is the aggregate per visit limit, which is 105% of the median per visit cost of care. Second is a per beneficiary limit, based on 1993-1994 costs, 75% of the limit based on the agency's own costs in 1994; the other 25% based on the costs from the census region. The per beneficiary limit does not take into account changes in patient mix since 1993-1994. To further complicate the situation, the blended figure is then reduced by 2%.

The most troubling aspect of the IPS is that the very institutions which were most efficient in providing care in 1994 are the institutions facing the most severe cuts in reimbursement. Institutions already operating efficiently have no where from which to cut fat. Though fraud and abuse was the battle cry for instituting the IPS, not all agencies have perpetrated fraud and abuse. However, all agencies are blanketed under the weight of severe reimbursement losses. What a disservice it would be for Congress to allow the most responsible institutions in the industry to be forced to close their doors and leave our seniors without proper home care.

Agencies in the New England region are being particularly hard hit. These agencies have been recognized as having been among the most efficient in the nation. Many of these institutions are small non-profits. The size of the institutions belie the fact that they tend to serve the most-rural of our communities. They are hit disproportionately hard. Should they no longer be able to operate, their loss would be

felt tremendously.

I am fearful that home health care agencies and those they serve are in jeopardy. I have been approached by agencies in my district pleading for relief. Again, I stress that many agencies serving my constituents are non-profits; they cannot afford Medicare reimbursement losses totaling up to $500,000 a year. They will be forced to close. For those agencies that are able to remain open, the level of service they are now able to provide will necessarily be cut.

At the very least, Congress and the Administration should assure the public and the home health care industry that a prospective payment system will be instituted as required by the Balanced Budget Act on October 1, 1999. The IPS was meant to be a short-term fix, and cannot be allowed to continue indefinitely. In the meantime, I would like to see reform in the interim payment system to ensure that the vital home care agencies serving my constituents can afford to continue to provide quality care. I am a cosponsor of legislation offered by Representative Pappas, and am looking into other legislative remedies to protect the quality of home care for seniors. I encourage you to continue your efforts to find an appropriate correction to this dilemma, and again thank you for this opportunity to share my concerns with the Committee.

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House Ways and Means Committee
Subcommittee on Health
August 6, 1998

Representative William J. Jefferson

Statement on Home Health Interim Payment System (IPS) Issue
(For the Record)

Mr. Chairman, I appreciate that you are allowing me to join your Subcommittee to make a statement at this hearing today. I am pleased that the Committee is considering this issue and that we are now poised to take some action that will provide relief to home health agencies that are on the verge of extinction.

I think we can all understand the need for and the merits of moving home health benefits to a prospective payment system (PPS). The concern I have is with the interim payment system (IPS) that Congress put in place until the prospective payment system can be implemented. HCFA has recently testified that it won't have a PPS ready by the initial target date, so the IPS is going to be in place for longer than expected. This is very troublesome for me and for the home health patients in my state. Louisiana is having a hard time dealing with IPS, and with PPS not even on the horizon, I worry that patients will suffer--particularly in the rural areas. Because the industry will now be relying on the IPS for a much longer period, it is necessary that we ensure it is fair, manageable, and does not impact patient care.

Since the enactment of IPS, the home health industry has experienced dramatic reductions and redistribution of payments, threatening the ability of many agencies across the nation to continue to provide care and to effectively compete with other agencies. Many of these redistributions were based on non-care related matters such as fiscal year cycles or an agency's business start-up date. As a result, many reputable agencies -- some who are the only providers in a community -- have already closed their doors. This poses a serious problem with access to home care services, and one which I believe must be addressed this year.

Since 1994, the number of home healthcare agencies (HHAs) in Louisiana has grown by 13 percent. Most of this growth can be attributed to a host of solid reasons. As a result of IPS, many low-cost, efficient home health agencies in Louisiana have gone out of business or merged with higher cost agencies (i.e. those with higher per beneficiary limits). No one would disagree that Louisiana (with 525 agencies pre-BBA) could afford to lose a few home health providers--the problem is that the wrong agencies are going out of business. Today, there are 360 home healthcare agencies operating in Louisiana. This is down from 525 agencies operating before the BBA provisions were put in place. By the time HCFA finalizes and implements the PPS, I am afraid that many- if not most- of the low-cost home health agencies in Louisiana won't

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be in business. Given that my state does not have the Medicaid resources to pick up the load of all these agencies, we are looking at a crisis that needs immediate attention.

What we have here are numerous cases of unintended consequences. The "wrong" agencies are going out of business. High-cost agencies, on the other hand, are buying out or merging with low-cost agencies. Once the good agencies are gone, there is no getting them back. Agencies that are going out of business already owe Medicare hundreds of thousands of dollars and more people will be forced into nursing homes. And we know that reimbursements for these services are more costly than a home health visit.

By the time we get to PPS, I am concerned that the only agencies that will still be in business are high-cost agencies with high per-beneficiary limits.

What can we do about this situation? I know many have lobbied in recent weeks to spend even more money on home health by placing a moratorium on IPS. But that is not a realistic solution to this issue. We can, however, pass legislation to reallocate the dollars already going to home health. We must "level the playing field" and provide relief to cost-efficient home health care providers.

I am extremely concerned to hear that this Committee may consider a formula that pushes all agencies to a national average--or close to a national average--in just two years. Fair reimbursement must be gradual, and PPS will be the vehicle to bring this about. I have joined the Coburn/McGovern bill because the formula is fair, constant, and will not throw change at agencies every year between now and PPS. It also protects the sickest patients through their outlier program. I look forward to the bill this Committee develops, and I hope it will be as reasoned as this approach.

We need to fix this dilemma and several proposals have been drafted to reform the IPS system. I am confident that we can find consensus for a proposal that will present home health agencies with at least an opportunity to survive until PPS is in place. With the few remaining days in this legislative session and the host of bills competing for floor time, our task is daunting, but we must try. We must ensure that Medicare beneficiaries continue to have access to quality home health care.

Thank you.

J.C. WATTS, JR.
4TH DISTRICT, OKLAHOMA

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Testimony by Congressman J.C. Watts of Oklahoma Regarding MEDICARE Home Health Benefit Payment System

Before the House Subcommittee on Health, Rep. Bill Thomas of California, Chairman

August 6, 1998

Mr. Chairman, in previous testimony I have commented on the necessity of providing quality home care services to tens of thousands of elderly and disabled Americans so that they may maintain a life of good health and dignity. It is a credit to you that this Committee is taking the time once again to review recent laws regarding home health care to see if these laws are serving our constituents well.

As part of the Balanced Budget Act of 1997, Congress enacted reform of the rules by which home health care agencies are reimbursed by Medicare for the services they provide. This reform was designed to secure the financial health of the Medicare system and to encourage home health care agencies to provide more cost efficient service, thereby saving taxpayer dollars.

The Prospective Payment System, or PPS, is the ultimate reform Congress passed to make home health care more cost efficient. However, it is now clear that the Health Care Financing Administration, or HCFA, will not be ready to implement PPS until April of 2000.

In anticipation of a delay in implementing the new Prospective Payment System, HCFA established the Interim Payment System to bridge the old, cost-based system with the new PPS program. Under HCFA's Interim Payment System, or IPS, home care agencies will now receive Medicare reimbursements in the form of three possible amounts, whichever amount is the lowest — **one**, the actual cost of the service provided; **two**, a per visit limit, which is an amount calculated using the number of patients in an area and the services provided in that area; and **three**, a per beneficiary limit, which is a cap on how much a home care agency can be reimbursed during the course of a year for providing services.

Mr. Chairman, we have reviewed the Congressional intent, stated the objective and yet HCFA's Interim Payment System is a nightmare. I have heard from home care agencies across Oklahoma who have expressed grave concerns about the impact of the new IPS system. The first and foremost concern is the loss of care for our patients. However we find staggering economic impact as well.

As of August 4, 1998, the Oklahoma State Health Department reports 80 agency closings since January 1, 1998. Of these agencies 45 were MEDICARE Certified. By the time this testimony is recorded it is estimated an additional six agencies will close.

Madole, Wagner, Huhun and Cole, PLLC provided the following assessment regarding the

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Oklahoma statewide economic impact of the proposed per patient aggregate limits published in the Federal Register on Tuesday, March 31, 1998.

- Using a conservative estimate of 70% (385 agencies) of the agencies in the state ceasing business with the changes since the implementation of the BBA 97, the potential impact is as follows (HCFA estimates 93% of the agencies in the country will have costs in excess of at least one of the two cost limits):
  - Loss of $259.3 million in direct salaries for home care employees, with the economic multiple factor estimating the state's total adverse salary loss between $467.7 million and $518.7 million. This does not include the impact of the loss of income tax or sales tax due to the loss of these salaries.
  - Potential number of patients not receiving care due to possible restrictions to access of care is estimated at 46,747. These patients will face the alternatives of hospitalization, nursing homes or displacement to other providers not geographically advantageous.
  - The Oklahoma home care industry directly employs an estimated 20,081 and accounts for an additional 14,831 induced jobs. With a conservative estimate of 70% agency closing, this translates to an estimated loss of 24,438 jobs in the state of Oklahoma alone.

There are some potentially grave consequences surrounding HCFA's Interim Payment System to which we as Members of Congress must be sensitive and must address during this Congress. Our home health care providers informed us that Surety Bonds, Interim Payment System and inconsistent policy changes are the top three reasons they forfeit their businesses. Mr. Chairman, we in Oklahoma are appreciative of the efforts made thus far, but it is not enough.

Simply put, HCFA's Interim Payment System does not ensure that home health care agencies will be adequately reimbursed for their services. It is wrong for home care agencies to receive too much money for their services, but it is just as wrong for home care agencies to receive too little money for their services. If home care agencies are forced to accept Medicare reimbursements for their services that are less than the costs of those services, those agencies will run deficits. Agencies cannot survive if they can't pay their bills. Under-reimbursed agencies will be not able to hire skilled staff and therapists, and the quality of the services they provide disabled citizens and senior citizens will decline.

Oklahoma is not alone; already in Texas, for example, we find that 815 home care agencies and branch offices have closed their doors in the first 10 months of fiscal year 1998.

Particularly disturbing is the new per beneficiary limit HCFA established as a reimbursement option under IPS. HCFA estimates that for home care agencies across the country that receive Medicare reimbursements, **93 percent** of those agencies will be under-reimbursed. Imagine receiving notification in mid July 1998, that your interim per visit payment rate has been calculated at $54.11 effective back to January 1998, and as a result you have been overpaid $80 thousand dollars. If you find no errors in this calculation, you are requested to identify the means

by which you will provide payment; lump sum is preferred. It has never been the intent of this Congress for these businesses to be under-reimbursed.

According to HCFA, health care agencies nationwide are expected to receive a 31 percent drop in their total reimbursements under the per beneficiary limit reimbursement system. Home care agencies in Oklahoma are expected to average a 29 percent drop in reimbursements. Many states are projected to do much worse. Home care agencies in California, for example, can expect to see a 37 percent drop in their Medicare reimbursements. Home care agencies in Connecticut are looking at 39 percent loss, while agencies in Illinois and Wisconsin can expect a 35 percent reduction. All of this translates into hundreds of home care agencies closing their doors. Clearly, this is a disparity which needs to be fixed sooner rather than later.

Also, the IPS system should have been put into effect at the same time for all agencies, and not gradually phased into an area. One home care agency shouldn't be forced to linger under the old, cost-based system while another agency is put under the IPS system. HCFA is challenged to overcome difficulties with the Year 2000, MEDICARE policy changes, and implementation of new billing process. These and other concerns are why this Committee should delay the implementation of the Interim Payment System until we can reform the system.

Ultimately, our goal should be to press HCFA to implement the Prospective Payment System as soon as possible and to eliminate the need for a convoluted and potentially harmful interim system. The thought of two more years of the Interim Payment System is unacceptable. The time to act and solve the problems caused by the Interim Payment System is now.

IPS is a complex problem that requires HCFA, health care providers, and the Congress to engage in a workable solution. To provide the time and forum for productive dialogue to take place, I have cosponsored the MEDICARE Home Health Beneficiary Protection Act of 1998, H.R. 4339. This act will impose a moratorium on the implementation of the per beneficiary limits under the interim payment system for home health agencies, and to modify the standards for calculating the per visit cost limits and the rates for prospective payment systems under the Medicare home health benefit to achieve fair reimbursement payment rates.

Thank you, Mr. Chairman for giving me time today to express my concerns about the future of home health care. Although the economic impact is significant, nothing is more important than providing our constituents who need home health care access to a quality, cost efficient provider.

Chairman THOMAS. At this time, I would ask Mr. Hash, representing the administration and the Health Care Financing Administration, if he would come forward, and as he is coming forward, to tell the gentleman from California his point is well taken about winners and losers.

However, if you could examine a number of the pieces as moving parts—and this will be a preface to any testimony, including the HCFA testimony—that if you dealt with a formula adjustment and you dealt with a per visit structure, and you dealt with an outlier approach as, for example, three parts, making adjustments in those three could mitigate the loss or gain, principally the loss, of someone in a formula shift, and so in trying to create a new interim payment system, it may be a blend of those three, which would not maximize the advantage of any, but minimize the damage, might be and most appropriate.

With that, Mr. Hash, I believe this is the first time you have appeared before the committee. Oh, it's not true? It's the second time. Well, maybe this time you'll make more of an impression on me. [Laughter.]

Chairman THOMAS. I'm just teasing. Your written testimony will be made a part of the record, and you can explain to us what your suggested change in the formula is, in your own words.

STATEMENT OF MICHAEL HASH, DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. HASH. Thank you, Mr. Chairman. I think maybe the reason you didn't recall me was that on the previous occasion, Mrs. Johnson was the chair of the subcommittee; you were unavoidably detained that day, I believe.

Chairman THOMAS. Ah, okay. So it's not Alzheimer's. Go ahead. [Laughter.]

Mr. HASH. No, sir. Chairman Thomas and Congressman Stark and other members of the committee, we want to thank you for inviting us to discuss with you today the home health payment system issues.

I would first like to associate myself, and the Health Care Financing Administration, with the sentiments that you expressed, Mr. Chairman, in your opening statement, about the intrinsic value of home health services as a part of the continuum of care for all Medicare beneficiaries.

As you know, the Balanced Budget Act included and mandated many changes in the way that Medicare pays for home health services.

The new payment systems create incentives to provide care more efficiently and to control spending. However, as you noted earlier, the prospective payment system for home care must be delayed while we address the year 2000 problem with our computer systems.

The Balanced Budget Act established the specific structure of the interim payment system that is now in place, until we have prospective payment. And it was designed, we believe, to assist in the transition from cost-based reimbursement to a prospective payment system.

Like the prospective payment system, the interim payment system does have incentives for efficiencies. We are aware, as I know you and the other Members are, of the concerns that have been raised about the impact of the interim payment system.

We have tried to make changes within our discretion, to ease the burden of the interim payment system.

Since, as you know, the system may result in overpayments to providers, I'm happy to announce this morning that we are advising our regional home health intermediaries to put into place extended repayment schedules for up to 12 months, for up to a year, to make sure that those agencies who have a repayment obligation have an adequate opportunity to meet those obligations without undue hardship. We are notifying our contractors this morning of this new, extended payment policy.

Secondly, you noted that we recently published an interim payment system regulation in which we announced some further discretionary steps that we believe will help home health agencies.

We have adjusted the aggregate cost limits per visit and the per beneficiary aggregate limits for inflation, as we are required to do.

Secondly, we have updated the data on which we base per visit cost limits so they are based on more recent cost report data than has been the case up until now.

Thirdly, we have put forward a more flexible definition for determining when a provider is considered a new provider, as opposed to an old provider.

Beyond that, Mr. Chairman, we do have little discretion within the law to go further. As you know, we have been working with your staff and with the staff of many other members of this committee, and of the House and the Senate, to provide technical assistance on a number of reform proposals that Members are considering.

We do believe that changes in this area of the interim payment system need to enjoy broad support, be budget neutral, protect vulnerable beneficiaries, and not conflict with our year 2000 priorities.

The year 2000 compliance activities, as you know, have limited the range of options that we can implement at this time.

One of our important tasks recently has been to identify those administrative actions that we think are feasible and do not increase the risk of not being compliant with the year 2000 date problem.

In that regard, we can, as we have been trying to make clear, change the per visit and the per beneficiary cost limits, as long as we continue to use currently available data.

We cannot make changes to the current claims processing system or create any new databases, or do any programming for a new claims processing system.

For example, we are not able to change the base year that is required in the statute, because that would require extensive new data gathering and programmatic changes to our information systems.

We could implement a new blend of national, regional, or agency specific rates, based on fiscal year 1994 data, which is the statutory base for the interim payment system. But changing the interim payment system, obviously, may raise budgetary concerns.

Also, if we reduce the agency-specific component within any kind of blend, there are both advantages and disadvantages that are well-known to you. Agencies with lower costs would tend to benefit from such changes, but agencies that serve special needs populations with legitimately high costs would experience payment reductions.

An outlier system, to increase payments to agencies with more costly patients, is also problematic, but could be accomplished within the constraints of our administrative limits.

A case mix adjustment system, as you know, is being created for the prospective payment system itself. That case mix system will look at the resources involved in providing care and accounting for both low and high-cost cases.

In the meantime, we cannot make outlier adjustments for high-cost cases that are based on particular diagnoses or how long a beneficiary receives home health services.

For the time being, outlier adjustments could be made only retrospectively, in combination with the settlement of home health agency cost reports and could be based only on the data that is included in those cost reports.

We are aware that there has been a proposal for creating, perhaps, a block grant of Medicare trust fund dollars to the states to pay for outlier cases. We are not supportive of that approach.

We think there are no good data that either we or the states would have available to fairly determine which agencies should get such funds. We also think such a proposal sets a dangerous precedent and raises substantial program integrity concerns.

Mr. Chairman, we do recognize the challenge of crafting interim payment reforms within these constraints. We do, however, take very seriously our obligation to work with Congress in evaluating all of the options for further payment reforms to the interim system to address the concerns raised by home health agencies and by Members of Congress.

Working together, I think we have made some progress in identifying what can and cannot be done. We, of course, want to continue seeking solutions, and join with you in solutions that protect our beneficiaries and the trust funds, and that sustain essential home health services.

I'm happy to answer any questions that you or other members of the subcommittee may have, and appreciate very much the opportunity to participate in this hearing. Thank you.

[The prepared statement follows:]

STATEMENT OF

MICHAEL HASH

DEPUTY ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

Before the

HOUSE WAYS & MEANS HEALTH SUBCOMMITTEE

on the

HOME HEALTH INTERIM PAYMENT SYSTEM

AUGUST 6, 1998

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration

TESTIMONY
MICHAEL HASH, DEPUTY ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
on
HOME HEALTH INTERIM PAYMENT
HOUSE WAYS & MEANS SUBCOMMITTEE ON HEALTH
AUGUST 6, 1998

Chairman Thomas, Congressman Stark, distinguished committee members, thank you for inviting us here today to discuss the home health interim payment system that was mandated by the Balanced Budget Act of 1997. The Balanced Budget Act mandated a number of changes in the way Medicare pays for home health services. These changes include new protections against fraud and abuse, and the creation of a prospective payment system and an interim payment system.

These new payment systems create incentives to provide care efficiently and control spending growth. Changing the way Medicare pays for home health care is vitally important. Medicare spending on home health has more than tripled since 1990, while the number of beneficiaries receiving home health services has doubled.

We have worked diligently to implement the Balanced Budget Act provisions affecting home health care. On July 31, 1998, we released final regulations on how agencies will be paid under the interim payment system. And we are working to develop the prospective payment system. However, as we testified before this Subcommittee last month, implementation of the prospective payment system must be delayed while we address the Year 2000 computer problem.

We have also worked to close loopholes that have served to invite fraud in home health care. Earlier this week, together with the HHS Inspector General, we issued guidance to help home health agencies prevent problems by establishing voluntary compliance programs.
These compliance programs include written policies and procedures for all areas where fraud or abuse might occur, an ongoing training program, periodic independent audits, and voluntary disclosure of problems.

Like you, we have heard many concerns about the impact of the implementation of the Balanced Budget Act on home health care agencies and, potentially, beneficiaries. We have made changes to the system to ease the burden on agencies, but we have little discretion within the statute to go further.

We are ready and willing to work with Congress on options for changing the interim payment system, including any proposals this committee might consider. However, we believe changes must have broad bipartisan support, must be budget neutral, must protect vulnerable beneficiaries' access to care, and must not require systems changes that would conflict with our Year 2000 priority. We must examine proposals in their entirety to assess whether they meet these criteria.

BACKGROUND

The Medicare home health benefit is crucial to millions of beneficiaries who are confined to their homes. Congress stipulated that care provided under this benefit be related to the treatment of a specific illness or injury. Beneficiaries must be under the care of a physician who certifies that medical care in the home is necessary and establishes a plan of care. They must be confined to the home and need intermittent skilled nursing care, physical therapy, speech language pathology services, or have a continuing need for occupational therapy. If these requirements are met, Medicare will pay for: skilled nursing care on a part-time or intermittent basis; physical and occupational therapy; speech language pathology services; medical social services; personal care related to treatment of an illness or injury on a part-time or intermittent basis; and medical supplies and durable medical equipment.

Unfortunately, this important benefit has been subject to widespread waste, fraud and abuse, as well as unsustainable growth. Home health care accounted for just 2.9 percent of all Medicare benefit payments in 1990 but now accounts for nearly 9 percent. Total home health spending rose from $4.7 billion (in 1997 dollars) in 1990 to $17.2 billion in 1997. During the same time period, the number of beneficiaries receiving home health doubled from two million to four million, and the average number of visits per beneficiary jumped from 36 to 80.

The number of home health agencies providing services to Medicare beneficiaries has grown about 10 percent each year, from 5,656 in 1990 to 10,500 in 1997. While some of this growth is due to changing demographics and medical advances, studies by the HHS Inspector General and the General Accounting Office document that a significant amount is due to waste, fraud and abuse.

Congress and the Administration acted to address these problems in the Balanced Budget Act by calling for a prospective payment system, establishing an interim payment system, closing numerous loopholes, and requiring home health agencies to obtain surety bonds. We are also acting to set higher standards for home health agencies, and to monitor and improve the quality of care they provide.

The Balanced Budget Act established the specific structure of the interim payment system to be used while a prospective payment system is being developed. Again, under the terms of the Balanced Budget Act, we do not have discretion to adjust this system, and we have implemented it as the law requires. We have heard concerns about the system's impact on providers, including those that have provided care efficiently in the past.

These concerns have been heightened by the unfortunate fact that we will not be able to implement the prospective payment system as originally scheduled in October 1999 because it will require extensive computer systems changes that would conflict with our obligation to ensure that our computer systems are able to pay claims on January 1, 2000.

We are proceeding with work to develop the prospective payment system, and it is our intention to publish the regulation next fall so that we can implement it as soon as feasible after the Year 2000 hurdle is cleared. In the meantime, the law stipulates that payment limits under the interim payment system be cut by 15 percent if the prospective payment system is not implemented in October 1999.

One of the primary reasons for the unsustainable growth in home health spending was that the old

cost-based payment system lacked incentives to provide care efficiently. Home health agencies were reimbursed based on the costs they incurred in providing care, subject to a per visit limit. This encouraged agencies to provide more visits and to increase costs up to their limit. More visits meant more payments to the agency, and visits per beneficiary more than doubled from 36 in 1990 to 80 in 1997.

Congress, the Administration, and the home health industry all agree that Medicare should move to a prospective payment system to control home health costs. The Balanced Budget Act calls for such a system, which we are now developing. Prospective payment rewards efficient providers by paying a set amount based on patient needs rather than on whatever providers spend. Medicare has used prospective payment for inpatient hospital services for more than a decade.

INTERIM PAYMENT SYSTEM

Until the home health prospective payment system is implemented, Congress prescribed an interim payment system, which is intended to transition home health agencies to a prospective system. The interim payment system took effect on October 1, 1997.

Like the prospective payment system, the interim payment system has incentives for efficiency. The interim payment system pays agencies the lower of: their reasonable costs; an aggregate cost limit per visit; or an aggregate cost limit per beneficiary. The aggregate per visit cost limit encourages agencies to provide services efficiently during each visit. Before the Balanced Budget Act, there was only an aggregate per visit limit. The new law reduced the per visit limit from 112 percent of the mean per visit cost of care to 105 percent of the median cost.

Congress also instituted a new limit -- the aggregate per beneficiary limit -- to promote efficiency in planning and delivering care. This limit also takes away the incentive to supply medically unnecessary visits to increase Medicare payment. There is no limit on how many visits an agency can provide to any one patient. Payment to agencies based on the aggregate per beneficiary cost limit is calculated by multiplying the agency's limit by the total number of the agency's Medicare patients.

The limit for each agency is based on two factors. Seventy five percent is determined by what the agency had been paid, on average, per patient in FY 1994, increased to help account for inflation. Twenty five percent is determined by average costs in an agency's census region. Care of costly patients is offset by less costly patients. New home health agencies -- any that did not submit a full cost report to Medicare during FY 1994 -- have an aggregate per beneficiary limit equal to the national median of the limits for other agencies.

The interim payment system, like any payment reform, presents challenges for providers. These reforms are designed to change past behavior and eliminate unnecessary services. The incentive to supply virtually unlimited visits is gone. Instead, home health agencies must focus on finding the most efficient way to produce the best medical outcome.

Requiring agencies to operate within a budget through the interim or prospective payment systems should not mean that care is compromised for any patient. Agencies are bound by their participation agreement with Medicare to provide the appropriate levels of care as prescribed by the physician.

It is important to note that, where medically appropriate, Medicare has always covered the teaching and training of the patient and his or her family to carry out certain services themselves. This training can help agencies to make sure all services in a patient's plan of care are provided within the budgets of the interim and prospective payment systems. During the past several years, these principles seem to have been eroded by the perverse incentives inherent in cost-based reimbursement.

When Congress passed and the President signed the Balanced Budget Act, we all assumed that home health agencies would be able to operate within the interim payment system. We now recognize, however, that there are a number of concerns regarding the impact of the interim payment system on agencies that have provided care efficiently.

We are doing what we can within the law to ease the impact of the interim payment system. In our FY 1999 Interim Payment Notice that went on display July 31, 1998 at the *Federal Register*, we:

- adjusted the aggregate cost limit per beneficiary for inflation;
- updated the aggregate cost limit per visit so it is based on more recent cost reports;
- allowed for flexibility in determining provider status for new vs old agencies. Those agencies which were designated as new agencies because of a change in their operational structure are now allowed to be designated as an old provider, as long as they have continued to operate under the same provider number that was filed for the 12-month cost reporting period in federal fiscal year 1994. This change would mean that those agencies would no longer be subject to the national median limit, but could have payment based on the agency/regional blend. Agencies who were affected by this policy can also remain designated as new providers if they so choose.

IPS REFORM PROPOSALS

Recognizing the desire of Congress and the home health industry to adjust the interim payment system, we have been working with Congress to provide technical assistance and are happy to work with Congress on any proposal that has broad bipartisan support, is budget neutral, protects vulnerable beneficiaries, and does not involve systems changes that could not be implemented because they would conflict with our Year 2000 work priority. Developing a proposal that is budget neutral and that has broad bipartisan support may not be easy because such a proposal would require the reallocation of existing Medicare home health spending among home health agencies. However, we recognize that changes to the interim payment system could be costly, and we stand by our commitment to work with Congress on a solution to this issue.

The Year 2000 issue does limit the range of options that could be implemented at this time to address the immediate issues surrounding the interim payment system. We can make changes in the current cost limits using currently available data bases. We cannot make changes to the current claims system, create any new data bases, or do programming for a new system.

Some reform proposals include provisions that would require systems changes that could not be implemented because they would conflict with our Year 2000 work priority. For example, changing the base year from 1994, while seemingly simple, would require extensive data gathering and programming changes and cannot be done within the time frame to affect the interim payment system. We can, however, raise the aggregate per-visit limit.

We also could change the blend of national, regional, or agency-specific rates based on FY 1994 data. The interim payment system's heavy reliance on agency-specific historical payments is a prime concern for agencies that have provided care efficiently in the past. However, reducing the agency-specific component would have both advantages and disadvantages. Agencies that have provided care efficiently, and their patients, would benefit. However, agencies serving special needs populations with legitimately high costs would potentially not be able to continue providing appropriate care to their particularly vulnerable patients.

An "outlier" system to increase payment to agencies with more costly patients is also problematic. A case mix adjustment system is being created as part of our efforts to develop the prospective payment system. It will adjust payment for the resources involved in providing care, accounting for both low and high cost cases. In the meantime, we are constrained by our systems in making outlier adjustments that would increase payment for high cost cases. We are not able to make outlier adjustments for patients based on patient characteristics or diagnoses or on how many services they receive, or on how long they receive services. We are actively looking at whether it is possible to develop an outlier payment system that would not require changing systems to track days of care per patient or other changes that would conflict with our Year 2000 work priority.

CONCLUSION

Mr. Chairman, I know you appreciate the challenge of crafting reforms to the home health interim payment system. Working together, we have made solid progress in identifying those changes that can and cannot be done at this time. Working together, we will continue to seek a solution that meets our goals. And I am happy to answer any questions you might have.

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Chairman THOMAS. Thank you, Mr. Hash. I guess my very strong desire, mentioned twice in the opening, didn't catch on. I'll do it again.

The administration, in the discussion and negotiations over the BBA, had a policy that they were offering for a change in the home health care area. The policy that the administration advocated had a blend. Actually, that's probably a misnomer.

What was it that the administration offered as a formula base; do you remember?

Mr. HASH. I think we were proposing 100 percent agency-specific.

Chairman THOMAS. I know you were proposing. That's why I said it was a misnomer, to be a blend, because it wasn't a blend.

My assumption is that you offered that in good faith, believing that to be the most appropriate policy choice among a number of alternatives in terms of the mix. In fact, as I recall, that was what the Senate carried with it to conference. The House had a different position.

What brought you, in terms of your examination of the area at the time, to propose a 100 percent agency formula?

Mr. HASH. I think, Mr. Chairman, that the rationale behind that position was related to a recognition that home health costs, on an agency-by-agency and region-by-region basis, vary quite considerably and substantially.

Since we were not able to prospectively identify those agencies which had higher costs that were the results of inefficiency, versus those that had higher costs with regard to the nature of the patients they were taking care of, we wanted to ensure that any kind of limits reflected the current experience of those agencies.

Chairman THOMAS. If I were to ask you, and you were to do as I asked, what is your suggestion for a change in the formula, would you want us to go to 100 percent agency-specific?

Mr. HASH. I think our position at this point, Mr. Chairman, is that we would like to continue working with you and your staff to——

Chairman THOMAS. Would you suggest that we go to the position the administration initially advocated, 100 percent agency-specific, since we didn't follow your advice when we wrote the law coming out of Conference?

Mr. HASH. I would like to tell you that I think we would still stand by that position, but I would say this, that given how the BBA came out in the end, I don't know right offhand what the implications of that would be for the scoring that was otherwise associated with these provisions.

Chairman THOMAS. I'm not talking about scoring right now. I'm not talking about the artificial world of the budget gimmicks that we have to deal with, which frankly impair our ability to write good policy, often.

You now have data, and we are talking about looking at a number of options, in changing the formula from the current 75/25 to a series of different mixes. In fact, in your testimony, you indicated that any change beyond the current one creates new winners and losers.

There is no—I love the quote, and I can't remember who made it—there is no Lake Woebegone, where everybody can be above average, in trying to deal with these restructurings.

I know you're constrained, but I want to make the point, you folks advocated 100 percent agency formula. That really didn't begin to deal with the enormous discrepancies, we thought, within a state, let alone between states.

I can't imagine that if you went back and huddled and decided that you were going to offer a new position, that it would be 100 percent agency specific.

Mr. HASH. I think, like you, Mr. Chairman, since last year's deliberations on this area, we have learned a lot and recognized that it is much more complex than we originally thought.

Chairman THOMAS. That's why we're here.

Mr. HASH. Right. And I think that we would definitely want to revisit that position of ours of over a year ago.

Chairman THOMAS. We are revisiting. That's why we're holding the hearing. We are asking everyone who is coming before us to assist us. To simply indicate that you're willing to assist us gets us nowhere.

We do not have enough time before we take this work period break to pull together and create a change. What we need to have, beginning now, is input from everyone who will be major players on what is suggested to be the best avenue today.

I'm not putting you on the spot. I'm putting me on the spot; I'm putting every member of the subcommittee on the spot. We have to have a solution and it has to be presented as soon as we come back, and it has to mitigate the current problems.

Now, the administration continues to advocate a budget neutral position. When you deal with a budget neutral position, there are darn few boxes inside the big box that you can move around. It may not mitigate the problem sufficiently to get a decent bipartisan support.

I would ask you, and we will try again, on the per-visit, my recollection is that the per-visit change from the administration was, in fact, what we have now, wasn't it, 105 percent on the median, changing from the mean?

Mr. HASH. I believe that's correct, Mr. Chairman.

Chairman THOMAS. You have to get people to do better than shrug their shoulders. It's 105 percent of the median. The current change was, in fact, the administration's advocated change. Would you stick with that? Or, based upon our experience and your examination, would you suggest a change?

Mr. HASH. Mr. Chairman, I think what we would commit to, and what we have committed to, is that in the time frame you're talking about, we need to sit down and actually explore the implications of each of these kinds of changes, and come to a consensus about what is the most appropriate way that we can address the kind of problems that have been identified with the current system.

Chairman THOMAS. Okay. What about an outlier policy?

Mr. HASH. I think we indicated that we could put into place an outlier policy that was related to the settlement of agency cost reports, and——

Chairman THOMAS. What would that be, specifically?

Mr. HASH. It would have to be designed specifically on the basis of legislation since, as you know, the statute does not permit any outlier payments.

Chairman THOMAS. I'm anxious to write legislation, as are all members of this subcommittee. what is your suggestion on an outlier policy?

Mr. HASH. We would like to work with you with regard to that, Mr. Chairman.

Chairman THOMAS. I appreciate that.

Mr. HASH. I'm trying to say, Mr. Chairman, that at this point, we are exploring, as are you, different options, and we would like to continue——

Chairman THOMAS. Mr. Hash, we didn't put ourselves in the box. We didn't come in front of this committee and say we can't do what we committed to do, and we can't carry out the policy we advocated, fought for, and required to be in the law or the President wouldn't sign the agreement.

You folks have reneged on your end of the deal. Now, I know that's not a full, fair way to put an argument, in terms of Y2K, but we are here because the policy that we guessed at wasn't very good. We can't keep guessing.

There are people out there who are not going to be able to be with us in September, and it isn't because of fraud, it isn't because of wasteful resources. It is because Congress, in its inability to have accurate data, didn't do a good job in setting up an interim payment system. We are going to have to do that when we come back.

The reason it is even more critical than it would be otherwise is because whatever we come up with has to last for a longer period of time, because you aren't going to be able to do your job in the time frame that you said you were going to do it. It is very difficult for us when, here we go again, no specific recommendation.

Now, I noticed in your written testimony, "Congress required," "Congress required," "Congress required." That was a mutually agreed arrangement. And as you indicated—and the per-visit was exactly what the administration advocated—you people are equal partners in being where we are today.

I have a number of proposals I would like to offer to you, but there is no sense in going forward, because the answer will be, "We would like to work with you, and we will, over the period, look at them, and we will get back to you."

What we are trying to do is communicate through our friends who do the communication in a greater way, and among our members, is we have to have specific changes that minimize the downside, that certainly, as best we're able, minimize the cost.

But cost, frankly, at this point, is somewhat secondary to making sure that the policy is as good as we can get it, given the fact we're going to have to live with it longer than we thought, because you're not going to be able to hold up your end of the agreement.

Mr. HASH. Mr. Chairman, as you have noted, we are not able to implement the prospective payment in a timely manner. With respect to the interim payment system, as you know, we have put it in place. We have put the regulations in place, and we are operating it.

We are not in any way saying, or trying to leave the impression that we are not open to suggestions and to working with you to make changes to address the kinds of problems that the members have heard about. We think that over the next month, working together, we can find some solutions that we can all agree on.

Chairman THOMAS. I'm not saying that you're not open to suggestions. What I'm saying is that we have to come up with solutions.

Saying you're open to suggestions sounds as though you're a third party waiting for us to come up with the solutions. You're supposed to be a partner. You're supposed to be part of the solution, not part of the problem.

We have got to get serious and move forward and make statements so people will have some degree of belief that when we get back, we will have a solution. That's what we need.

One last question. There are a lot of people out there hurting. There are a number of people who have closed. I believe, as I said in my testimony, some of them were mergers, consolidations, some may have even closed because of an advantage of being a new agency, rather than an old.

Have any of these agencies applied to HCFA for an exemption from the rules, for whatever reason they may provide?

Mr. HASH. I am not aware of that, Mr. Chairman, if they have.

Chairman THOMAS. Is HCFA examining the possibility of offering exemptions to any agencies based upon whatever evidence they may present to them?

Mr. HASH. Mr. Chairman, our review of the existing language does not provide any authority that we can find for providing for exceptions or exemptions, other than the existing authority with regard to cost limits per visit.

Chairman THOMAS. I would request that you get back to me in writing, once you go back and ask that question directly, if there are any agencies that have either been examined for the possibility of an exemption or if, in fact, an exemption has been granted.

Mr. HASH. I will be happy to do that, Mr. Chairman.

Chairman THOMAS. Thank you very much. The gentleman from California.

Mr. STARK. Thank you, Mr. Chairman. Mike, we are hearing from some home health lobbyists that they would like the administration to enforce a moratorium on the IPS system. It is my understanding that you cannot legally do that. Is that correct?

Mr. HASH. That is my understanding, Mr. Stark.

Mr. STARK. Your proposal that all Medicare+Choice plans have a compliance plan in place, I think, is excellent. Could we not require the same compliance plan for home health agencies?

There has actually been more concern, I think, about fraud and abuse in the home health sector than in managed care. If an agency doesn't have a plan to ensure compliance, I don't suppose we would want them doing business, anyway.

Could you implement this compliance plan, and require it of home health agencies?

Mr. HASH. Mr. Stark, I think that is an excellent question. As you know, just this week, the inspector general at the Department of Health and Human Services announced the development of a

voluntary compliance program for home health agencies. Of course, the inspector general will be testifying shortly, and will talk to that.

Let me just say, in connection with your specific question, that we currently have out a proposed rule for conditions of participation for home health agencies. We are analyzing the responses to that proposed rule.

Among them will be issues that are raised about various pieces or elements of a compliance program. The way we would address your concerns, Mr. Stark, would be in the context of finalizing our home health conditions of participation.

Mr. STARK. But not voluntary. I mean making it, the same as the requirement for managed care plans, a requirement of participation.

Mr. HASH. What I want to be clear about is that our conditions of participation are mandatory on home health agencies. What we would be looking to would be to coordinate those conditions of participation with the core elements of a compliance plan that makes sure that those are addressed adequately through our conditions of participation.

Mr. STARK. I think you are saying that there would be a compliance plan required, in one form or another, in the conditions of participation, and that makes it not voluntary. Is that what I hear you saying?

Mr. HASH. Yes.

Mr. STARK. Okay. You are asking us for new legislation to better protect nursing home residents. I support that idea. You asked for staff to prevent dehydration, malnutrition, background checks to keep abusive people away from nursing patients, which has been, at least anecdotally, a concern.

Why don't we mention home health agency staff? If we are requiring, or plan to require, background checks to keep abusive people away from fragile people in a nursing home situation, why should we not require the same thing for home health? In home health, the people are even more isolated, often, and we are less apt to be able to check on them and protect them?

Would you support parallel legislation that would require home health aides and staff to have background checks to keep people with a history of crime and abuse from participating the program?

Mr. HASH. Again, we do have, in our proposed conditions of participation, requirements, proposed requirements related to doing background checks.

I think the piece that is missing out of that, Mr. Stark, is making sure that, in those checks, there is access to a national database, because the states, of course, keep background records, but that would only reflect adjudications that take place within a particular state.

As we know, some of these people who have had convictions move to different jurisdictions, and——

Mr. STARK. I would like it to be as broad as it could be. But let's not defeat the better with the perfect.

Mr. HASH. No, absolutely. I would say that I think the national database is the area in which legislation would likely be required. We would be happy to work with you to take a look at that.

Mr. STARK. My time is going to expire, but let me try and say—and I have a hunch the chair will indulge me on this—what I thought I heard the chairman saying differently.

Part of why we are here today, and trying to move the chairs around on the deck of the Titanic, is because of the lack of implementation of the prospective payment system.

It would seem to me that in any legislative solution, if there is to be an outlier program to ease the fringe providers, that there is no sense in our trying to develop one only to have HCFA subsequently say, "We can't implement this."

You have staff that is better equipped and better understands the questions of outliers. You have the data. I do believe that the chairman is coming at it the right way.

It is incumbent on you, I believe, to suggest to us the structure of an outlier plan. You may choose to reserve the payment amounts until we see what the cost of changing the formula is.

You now have the month of August. Stay home from Martha's Vineyard and get us a plan that will work and that you can implement.

We may or may not be able to get the votes to pass it. But, there is no sense our sitting down here, going through a lot of concern with our colleagues, because in changing this plan, there are going to be different winners and different losers, and then trying to ease that burden by saying we have an outlier plan, and then have you come back in three months and say, "We can't do it." I think that is what he is saying.

If you don't want to give us the exact numbers, at least give us the structure, with some certainty that it is something you can do. That the data exists, that you have the staff and the legal ability to provide these outlier payments.

If you can't do it, then tell us now. If, for some reason, it is just impossible—which I guess is conceivable—then let us know.

But we—as Members of Congress—are saying, "Well, if that doesn't quite work, we'll have an outlier plan that's going to ease this burden and that burden." We may be dreaming. If so, wake us up, please.

That's all I have to say. The chairman's request is fair, and it is incumbent on your staff to follow through. We are going to hear later from the people who advise us.

It may be the Medicare Payment Advisory Commission that's going to help us come up with this solution. But, you would do it best. Other professionals would do it second best. We would be the third, at least, best people to have to devise it.

All I'm asking is, hear what the chairman is saying and put your troops to work to come up with something for us, so we can have it early in September.

Mr. HASH. If I may briefly respond, Mr. Chairman——

Chairman THOMAS. I was just going to tell the gentleman, if he had any more questions like that, we can ignore the time light.

Mr. HASH. I am happy to respond to that, because both in my written statement and in my oral statement, I want to make clear that, with regard to outlier payment policy, we have done a very careful look at what we can do.

What we have tried to communicate is that we can administer an outlier policy, one which would be administered in conjunction with the data that is included in the cost reports that are filed by home health agencies, so that the actual determination of an outlier payment would be made at the time of settling the cost reports, it would be made on the basis of the data in those cost reports.

The limitations of that are that there are not in the cost reports specific patient diagnostic information, but certainly there is cost information. To the degree we are adjusting for problems that agencies have with limits through an outlier payment, that can be done in connection with using data from home health cost reports.

Mr. STARK. There is no way that you can take certain episodes and say that "We know from experience that these are so much more expensive than others that we can prospectively adjust for those cost differences." You can't do that?

Mr. HASH. We are unable to do that.

Mr. STARK. All right. Thank you.

Chairman THOMAS. I would only indicate to the gentleman, before I recognize the gentlewoman from Connecticut, that I recall that the President had quite an ostentatious liftoff on the changes that were made.

Saying it in slightly another way, for the gentleman from California, as well, we are not interested in continuing to be on the airplane and find out there was one parachute, and it has been used, and you folks are more than willing to provide us with some kind of background and green eyeshade technical expertise.

This was a mutually-agreed-upon project, and I expect, when we come back, that the Health Care Financing Administration, under the Health and Human Services Agency of the Clinton administration, will all be out front publicly suggesting changes, and be partners in the adjustment period, as you were partners in the takeoff period of new program.

The gentlewoman from Connecticut.

Mrs. JOHNSON. Thank you, Mr. Chairman. Both of the gentlemen from California have been very polite, I believe.

I know that you have been working with us over the last few weeks. You have been working with some of us over the last few months.

I would have to say I am extremely disappointed in your testimony. In my estimation, we are at the time when we need to be talking about solutions. If you've done all the work that you've done on the outlier program, why didn't you propose something today?

I'm going to be back in my district for three weeks. I'm going to be sitting down with my home health agencies. It would have been very helpful to be able to say, "Here is what HCFA says."

You have the resources, the computers. We sit and look at the chart printouts. We can't tell whether the efficient agencies are being damaged or the inefficient agencies.

We know new agencies are coming into the system. In many parts of the country, those new agencies are going to be paid more than the agencies we are pushing out of business with the overall cost increase for Medicare.

Now, you have far better technical capability than we do. You have people with long-term experience in this area, much longer term than any of us have.

You know, you have got to be specific. What outlier policy? What size agencies? We need to see, will this help?

Let me ask you: do you think this is a crisis? Do you think the problem we face is serious enough so that, if we don't address it, it will have serious consequences for senior care?

Mr. HASH. We think that the concerns, Mrs. Johnson, that have been raised by you and by agencies are legitimate ones. They are concerns, and we want to work with you to address them.

Mrs. JOHNSON. That does not answer my question. There isn't a part of Medicare in which there aren't serious concerns, frankly. We have so many problems in this system right now.

What I am saying to you, do you consider the situation we face in home health right now a crisis? In other words, do you believe that, if we don't do something before we leave here in October, that in fact we will diminish access and quality to home health for seniors?

Mr. HASH. We believe that we do need to take action. We do not believe at this point that we have the evidence that would confirm for us that we have an access problem in home care.

We have agencies that are still coming in. We have over 170 applications pending right now for new agencies. So, on the access side, we really don't have data.

Mrs. JOHNSON. Have you done an analysis of where the new agencies are coming in and where the agencies that are closing up are going out?

Mr. HASH. We have some data on that. I would be happy to share that with you.

Mrs. JOHNSON. I think part of what we ought to be looking at is, are we creating an access problem? In spite of the larger number of agencies, are we creating deficits in rural areas because those lower-cost agencies are going out? I'm just speaking from my own limited experience in my own district.

We need to know that stuff. When we make changes in this, we have to have some understanding of are we going to create a better answer from the point of view of the survival of services.

So you do not consider this an emergency. You consider it serious, but you don't consider it an emergency. I assume from that, that if we didn't do anything about it, you would think that was not very good, but it wasn't very bad?

Mr. HASH. We have obviously taken a number of steps on our own, because we think it is a serious problem, to address many of the problems that, within our discretion, we could——

Mrs. JOHNSON. Are the steps you've taken sufficient?

Mr. HASH. No. I believe that, based on the conversations that we have had with you and others, that additional steps need to be taken, and we need to take them together.

Mrs. JOHNSON. What will be the impact of the 15 percent cut going into effect next year?

Mr. HASH. What will be the impact?

Mrs. JOHNSON. With no change.

Mr. HASH. The CBO estimates that it would remove on the order of $2.8 billion in fiscal year 2000, if that was the scoring associated with the 15 percent.

Mrs. JOHNSON. What is HCFA's estimate of the impact of that on access and quality, on home care as a service to seniors? If we do nothing, what will be the impact of the 15 percent?

Mr. HASH. We obviously do not have a specific estimate on, agency-by-agency, how it will impact them. It will definitely have a substantial impact, because that is a lot of money that is being taken out of payments to home care agencies.

Mrs. JOHNSON. Would you describe the situation that we would face then as serious, very serious, or just concerning?

Mr. HASH. I think it's very serious, because I think the Congress did not intend, nor did we, the 15 percent to be a part of the interim payment system.

Mrs. JOHNSON. I agree with you absolutely, and I would ask that, by the end of this interim, you come back with a plan that includes how do we relieve that 15 percent? Frankly, you can't do it budget neutral, and you've put that out as one of your criteria. You have to get beyond that. That's your responsibility.

Furthermore, you know the whole system. Where is there money that is not being paid as well? To whom are we paying money that we shouldn't be paying?

You're closer to the fraud and abuse people than we are. Why can't we capture the dollars we need to prevent something that is totally irrational from happening, when you've taken $2.1 billion more out of an industry than you anticipated.

Indeed, we anticipated that the baseline would be 21.4 in 1998 and it's 18.2, but it all comes out to a cut of $2.1 billion more than anticipated. When you have done that, you have to have a way to respond.

I would ask you that, when we get back, you have something concrete, and I would hope that you would have it in two weeks, instead of four weeks, so we would have some time in the district to talk to our own agencies about it, so we can get some—I mean, they are not always right. I understand that. And it's going to affect agencies in Connecticut very differently. There are going to be winners and losers.

Unless we can get some hands-on opportunity to evaluate that, and to put it with our own ideas and their input, we are not going to get a solution that will actually be a step forward, and we certainly won't be able to deal with that 15 percent. It is imperative that we not neglect to relieve that date while we are making these changes.

I hope the next time we meet, it will be concrete, a very concrete discussion. I am truly disappointed that I don't have the opportunity to go home and go over ideas that are concrete in your mind, as well as a few that are concrete in mine. Thank you.

Chairman THOMAS. I do want, before I recognize the gentleman from Louisiana, to note that the dollar amount that the gentlewoman indicated, a $2.1 billion difference in the baselines between 1997 and 1998, is partly attributed to—and the reason I'm saying this is, I don't want any witness who may come later in the pro-

gram to ascribe that to the immediate behavioral changes based upon the programmatic changes that we put in.

Because what did occur between 1997 and 1998, as I indicated, was a four-month moratorium on the startup. In addition to that, I believe that there was a releasing of the wage rates and other items that were built into the 1998 baseline, that wasn't in the 1997, which neither of those would be attributable to the BBA for baseline purposes.

Now, that is a shorthand way of saying what I said earlier, that the stupid budgetary procedures that we have to operate are not going to stand in the way of you folks and us presenting a better program for Americans who want to use home health care, and need to use home health care.

I want to underscore what the gentlewoman from Connecticut said. It is a little difficult for us, trying to look at policy when, as the gentleman from California said, you have added a new parameter that we have never had before. That is, we come up with what we believe to be proper policy, and you tell us you can't do it. You've got to be more out front than you have in the past, in an advocacy role of options, instead of us asking you whether you can do this or do that, and then we wait to find out if you can do it or not. We don't have the luxury of that kind of a timeline.

The gentlewoman from Connecticut.

Mrs. JOHNSON. Thank you, Mr. Chairman. My red light was on, so I didn't go into those details.

He brings up a very good point. What it means is, that when you come back, you need to be able to say, "We recommend a moratorium on any new agencies who are going to come in at a reimbursement rate that is above the national average," or whatever.

I mean, that might be one of the things we need to look at here, that we need to look at the extent to which we do adjust to wages. We need to look at what we think.

You also have access to monthly cost reports. Are we beginning to see a slowdown in number of visits? In the GAO testimony, that seems to be something we are beginning to see now.

I understand perfectly well that this isn't all attributed to a slowdown in the number of visits, but the things to which it is attributed are also useful to us. That's the level of analysis and assistance we need here so we do the right thing, and we actually improve the situation, rather than just sort of, in a sense, slog along in a way that we all too often have.

Thank you.

Mr. HASH. We are in complete agreement with you on that, Mrs. Johnson. We are as frustrated as you are with regard to our lack of information about certain kinds of things, but whatever we do have, we want to make fully available to you and to the other members of the committee.

Chairman THOMAS. I don't think you realize how frightening that statement is to us. [Laughter.]

Chairman THOMAS. You people are the keepers of the flame, and if you can't do it, we'll sit down and rethink how this place operates, and get people who do.

The gentleman from Louisiana.

Mr. McCRERY. Thank you, Mr. Chairman. Mr. Hash, I think you have gotten the message, so I'm not going to beat it to death. Let me just go over a couple of things.

I gather from your statements regarding the severity of the crisis, as Mrs. Johnson would put it, that you would not favor a moratorium on the IPS, the interim payment system, and that you would not favor, as the administration, going back to the old agency-specific cost reimbursement?

Mr. HASH. Mr. McCrery, let me answer that in two ways.

One is—and this is not whether we favor it or not—one is, we could not do it on our own. I want to be clear about that.

Mr. McCRERY. Yes.

Mr. HASH. The second answer, as to whether we would favor it or not, we, as the chairman has pointed out to me repeatedly, are partners, not only in the home health area, but in the Balanced Budget Act in general. So that if we were to recommend a suspension or a moratorium of the interim payment system, it would be incumbent upon us to identify how we would live up to our commitments with regard to the Balanced Budget Act.

We have not identified, as of this point, areas in the Medicare program that have not otherwise been adjusted by the BBA, that could provide the resources that would make up for the impact of a moratorium.

Mr. McCRERY. So, your answer is, no, you don't want to go back, you don't want to put a moratorium on the interim payment system; and I hear you saying that the reason you have reached that conclusion is that you don't think that this problem with the interim payment system in home health outweighs the damage that might be done to other parts of Medicare by paying for a change in the IPS, they would involve more dollars.

Mr. HASH. I think we believe that we need to do everything we can to make sure that neither access nor quality of home care services are unduly interrupted by the payment policies that are in place.

On the other hand, we have an equally strong obligation to make sure that, if we take steps in changing the current policies, that we do so in a fiscally responsible manner, to make sure that we protect the trust funds and sustain the program for the current beneficiaries and for those to come.

Mr. McCRERY. Well, let me just get right to the nub of it. Would you favor—and you need to think about this, I guess, over the recess—would you favor using some of the surplus to finance a change in the interim payment system?

Mr. HASH. As you know, Mr. McCrery, the administration, taking direction from the President, has indicated that our position is that the surpluses that are occurring in the budget should be set aside to deal with the challenges that are facing the Social Security program.

Mr. McCRERY. You would not favor using any of the surplus to solve this problem?

Mr. HASH. No, sir.

Mr. McCRERY. Just one more quick question. Did I hear you say that in any prospective payment system that you think you could come up with—and we hope you do, eventually—you would have to

have some sort of outlier adjustment as part of that prospective payment system?

Mr. HASH. I actually did not address that in my comments, but I believe the statute, with respect to the home health prospective payment, makes provision for outlier payments.

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

Chairman THOMAS. The gentleman from Nevada.

Mr. ENSIGN. Thank you, Mr. Chairman. First of all, one way or the other, whether the formulas are adjusted or not, Nevada is not really affected that much. I don't really have a dog in this fight.

What I am more concerned about is whether or not seniors across the country are going to be getting the type of care they need—and hopefully, that's what all of our concerns are.

I know that it has been expressed to you already that the committee is hopefully trying to elicit your help.

Mr. HASH. Yes.

Mr. ENSIGN. We are not trying to, just beat up on somebody that is in your position, just for the sake of beating them up, but we really do want your input, because of what Mrs. Johnson said, that you have the experts, you have everybody that we don't have up here.

We have very limited resources as Members of Congress, as this committee, compared to what the administration has. Because of that, we do want the answers coming from you, to help us with this problem.

I know you have some areas in which you have a lack of information, and that is frustrating, and I guess I can understand that. At the same time, if you have a lack of information, we have that much more of a lack of information.

What we need from you, at least, sir, is a positive, you know, "This is what we can do."

My question, though, for you, is you say you don't want to pay for this out of the surplus. If this ends up being a cost to make the adjustments, where does the administration propose to come up with the money to pay for that?

Mr. HASH. As I said before, our view on that is, as we have examined what has occurred as a result of the Balanced Budget Act, to the Medicare program, we have not been able, to this point, to identify areas in Medicare that could be further adjusted in terms of payment policies or other kinds of adjustments that would yield the kind of money that might be necessary to do some of the things that Mrs. Johnson and the chairman and others have suggested.

That doesn't mean we can't take a look, and continue to take a look at opportunities. But, as I'm sure you know, the Balanced Budget Act, in the aggregate, reduced expenditures in Medicare $115 billion over the next five years, and as a result of that, other providers and other benefits that are covered by Medicare are also feeling important changes and reductions in payments of one kind, or limits on increases in payments.

As a result of those things, we have not yet identified ways in which we could take money from another part of Medicare for this purpose, but obviously we have not said that we wouldn't continue working with the Congress to try to identify ways in which re-

sources could be applied to support the kinds of changes that are being talked about.

Mr. ENSIGN. I guess the question that would follow from that, then, is over the next four weeks, before we come back, can the administration come back with a proposal that has identified some suggestions to us to make changes? Will those suggestions have your commitment to come back with where you're going to come up with the money.

Because, if we have identified that there is a problem getting the care to seniors that need it, we have to come up with solutions. Whether they're popular or not, we have to come up with solutions, to make sure that seniors get the kind of quality care that they need.

Mr. HASH. I think it is accurate to say that we would not come forward with a proposal that implicated additional spending without also being prepared to support a way to do that. That is why we need to continue exploring if there are appropriate ways to do this.

As I said, we recognize we would need to be fiscally responsible and that we shouldn't make a recommendation that implicates additional spending without a way in which to finance it.

Mr. ENSIGN. Do we have the commitment of the administration? Can you guarantee to us, or at least reasonably guarantee to us, that when we come back, that we will have some of the answers to this, or do you think that there is no way we can say that?

Mr. HASH. I believe that, during the course of the recess, there will be a sustained effort on our part and on the part of your staff and others, to actually work through this to come to some conclusions by the time of your return.

Mr. ENSIGN. Okay. Thank you, Mr. Chairman.

Chairman THOMAS. I thank the gentleman. Does the gentleman from New York wish to inquire?

Mr. HOUGHTON. Pass.

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

Mr. JOHNSON. Thank you, Mr. Chairman. A couple of questions.

One, I'm interested in trying to find out what the problems are with the high-cost states of Louisiana, Texas, and Oklahoma. I wonder if you've done any investigation in that, since they kind of stand out, and since they are all in the same district.

Mr. HASH. I think at least our preliminary assessment of the circumstances is that, in some cases, high-cost agencies have high costs because the patients they are taking care of require more services, longer services, more intense services which, of course, means that the costs are going to be higher.

Mr. JOHNSON. Yes, but why are they different from some high retirement area, like Florida, for example?

Mr. HASH. If I may, let me finish. I think the types of patients definitely has an effect on the cost. At the same time, there is ample evidence that in some cases home health agencies have not been as efficient as they should be. The incentives of our cost-based reimbursement have rewarded increased spending.

It is very difficult to discriminate between higher costs related to inefficiencies and the incentives of cost-based reimbursement and

higher costs related to the kinds of patients that are being taken care of.

Secondly, I think another issue that implicates higher use of home care services is the extent to which state Medicaid programs provide other kinds of home-based and community-based services that are available for patients with those kinds of needs.

In states where Medicaid programs don't provide much support for that, Medicare home health is probably much more highly utilized, and in states where there is a stronger home and community-based service benefit under Medicaid, Medicare home health expenditures are lower.

There are a number of factors that influence whether there are higher or lower-cost agencies in a particular part of the country.

Mr. JOHNSON. Is that supposition, or do you have facts to support that?

Mr. HASH. I think we have information about the character of the Medicaid programs in states. What we don't have is information that at least adequately discriminates between agencies who have higher costs because they have been inefficient and agencies that truly have higher costs because of the nature of the patients they are taking care of.

Mr. JOHNSON. How often, and how many of your home health care claims are scrutinized by your fiscal intermediary?

Mr. HASH. How often?

Mr. JOHNSON. Yes.

Mr. HASH. We have, as you know, regional home health intermediaries. The claims that are submitted come in and are reviewed for coverage and other requirements of home health services, and then they are paid on the basis of interim rates.

Then, ultimately, at the end of the home health agency's cost year, they submit a cost report and we compare the results of analyzing that cost report to what we have paid them on an interim basis.

Mr. JOHNSON. But specifically, do you go into and audit those things through your fiscal intermediary?

Mr. HASH. Yes, we have——

Mr. JOHNSON. How many of them do you do nationwide?

Mr. HASH. I don't have the specific figures or percentages, but a percentage of home health claims are subject to medical review, both a randomized sample of claims as well as focused medical review in agencies that have been identified with aberrant utilization or cost patterns.

There are definitely intensive reviews of claims, selected either on a random basis or on a focused basis.

Mr. JOHNSON. You don't know a percentage?

Mr. HASH. I think roughly 3 percent, on average, of home health claims are actually reviewed by the regional home health——

Mr. JOHNSON. Okay. In District 6, which is where Texas, Oklahoma, and Louisiana are, are you using that same review process? I would suppose, since the numbers are higher, you would review more of them. Are you doing that?

Mr. HASH. I don't have the figures for your region, but I would be happy to get them. We would have some average figures about

the percent of claims that are subject to medical review and medical necessity determinations.

Mr. MCCRERY. Would the gentleman yield?

Mr. JOHNSON. Yes.

Mr. MCCRERY. Mr. Hash, in answer to Mr. Johnson's question about is it supposition on your part, or do you have any data to back up your conclusion about the reasons for some higher-cost areas, didn't, in fact, HHS conduct or commission a study in 1994 on that very subject?

Mr. HASH. I'm unaware of what study you may be referring to.

Mr. MCCRERY. Mathematica Policy Research, dated September 30, 1994. You might want to look at that.

Mr. HASH. Yes, sir. I'll be happy to.

Mr. MCCRERY. Mr. Johnson, in fact, they do have a study, which indicates that there are very solid reasons for higher costs that vary, region by region. If you would like, the gentleman from Louisiana that will testify later today has some citations from that study in his testimony.

Mr. JOHNSON. Thank you. I appreciate it.

Mr. MCCRERY. Thank you for yielding.

Mr. JOHNSON. Thank you, Mr. Chairman.

Chairman THOMAS. I would tell the gentleman, if it was data from 1994, I would say that the world has changed quite a bit since then. But since HCFA is locked into the world of 1994——

Mr. MCCRERY. And our interim payment system is based on 1994.

Chairman THOMAS. Since HCFA is locked into the world of 1994, and cannot go beyond it, it seems to me perfectly legitimate for people to present data from 1994 in refutation of a policy built on 1994, notwithstanding the fact that it may, in fact, be much ado about nothing that applies to what we're doing today, and that is one of the really sad factors we're dealing with.

Does the gentleman from Washington, a member of the committee, wish to inquire?

Mr. MCDERMOTT. Thank you, Mr. Chairman. I am interested in your statement about the Medicaid information and the extent to which those services overlap. I wonder how solid that data is, and how collated it is. It sounds like there may have been a study in 1994.

I would like to know what kind of data you have, actually, because as I look at these states, all the western states—Washington, Oregon, California, North Dakota, South Dakota—they have low utilization of home health care, whereas you have a cluster of Louisiana, Oklahoma, Texas, Mississippi, Alabama, and Tennessee all with almost two or three or four or 500 percent more average visits.

There is something going on there that I am interested in—and I have a theory what it may be, but I would like to hear your answer.

Mr. HASH. I think, in short order, I'm not sure that we have a definitive answer for those very large differences in expenditures for home care, from region to region, because that is at the heart of one of the problems we are dealing with here, how to fashion a payment policy that appropriately takes into account differences,

without locking into place differences that we would not want to recognize because they flow from inefficiency or fraud or waste or abuse.

I think, in many respects, the kind of variation, although the magnitude is greater here, but the kind of variation that you are seeing in home care is often the variation you see around the country in terms of the utilization and cost of other kinds of health care services. In that regard, home health is not fundamentally different.

What is different is the magnitude of the differences in home health expenditures from region to region. And as I say, we would be happy to share with you some of the analysis, I think, that we have, that looks at the range of factors that influence the use of home health agencies, and there are a number of them.

One of them is the presence of home and community-based services through Medicaid, but there are other factors, as well.

Mr. MCDERMOTT. I think it would be very useful for the committee to know that analysis, because Washington state has run the most efficient, along with Minnesota, runs the most efficient health care system in the country. We're at 30 visits, whereas Louisiana is at 153. The patients in Louisiana can't be 500 percent sicker than they are in Washington state.

The same is true for most health issues. For example, we got no money out of the children's heath initiative, because we already cover children up to 200 percent of poverty. So there is a real issue there.

There is a second issue; and I was in the state legislature when we did this, in fact was in the middle of the fight. That was protecting the certificate of need.

The state of Washington has a very tight certificate of need process. Many states have disbanded that whole process, or have a very loose certificate of need.

I wonder if you can tell me, Louisiana, Oklahoma, those states, do they have certificate of need?

Mr. HASH. I don't know the answer to that. I'm told approximately 22 states now have some form of certificate of need legislation on the books. I would be happy to get that information to you in more detail.

Sometimes certificate of need covers certain kinds of providers, and not others, you know, sometimes hospitals, maybe not home health agencies. But we would be happy to get that information for you.

Mr. MCDERMOTT. Our certificate of need goes down to kidney dialysis treatment stations. We do a whole series of things in the state of Washington to deny people. I think one of the things that we have to look at is this business of how much capitalization there is in a number of states.

Clearly, if the system is open, when this benefit became available under Medicare, or became a big issue, the companies went in. They would never get into the state of Washington today.

Mr. HASH. I would agree with you. I think I should recognize that the BBA, as you probably know, has put into place some additional tools for us to use in terms of more strict criteria for provider acceptance or enrollment in Medicare.

Those include things like standards for their capitalization, evidence that they actually are serving non-Medicare patients before we allow them to come in and serve Medicare patients.

These kinds of requirements are going to, we believe, be very important at the front end, as a preventive measure, to make sure that agencies do not come into the program and serve our beneficiaries when they do not meet appropriate standards.

Mr. MCDERMOTT. Do you think it is sufficient to have it all done in Washington, D.C., rather than to have it done out at the state?

I mean, the Balanced Budget Act may have been written that way, but I wonder if you think it might not be better to put it out at the state level, and let them actually look at it.

Mr. HASH. I think to the degree that states are doing that, like Washington, as you've described, we would have nothing but support for their efforts to do that.

We feel we have a responsibility, as the agency that is enrolling providers, to make sure that they meet appropriate standards, both clinical and quality standards as well as basic business standards.

Mr. MCDERMOTT. Okay. Thank you, Mr. Chairman.

Chairman THOMAS. The gentleman indicated he thought he had a theory. I didn't hear it.

Mr. MCDERMOTT. My theory is——

Chairman THOMAS. In terms of packaging, I'm requiring everyone——

Mr. MCDERMOTT. I was advancing a theory in terms of certificate of need. A tightly run certificate of need program excludes inefficient and wasteful programs. Actually, in the last, since 1994 to 1997, the number of visits in Washington state has gone down, and we have only had one agency close, where Texas has had 450 agencies closed.

There are enormous differences in what has gone on around the country, depending on the nature of how you let these home health agencies start up. We let them all start up, and now we have the problem of a lot of them saying, "We're going to have to close down." Well, they never should have been there in the first place.

Chairman THOMAS. I understand. Perhaps, in the August break, we can get at that from a potential angle of requesting what would occur if you created a moratorium in highly served areas, however you might define that, so that you can stop the ongoing change, rather than go back and review whether or not they should have been there in the first place, because they're already there.

The gentlewoman from Connecticut wanted to ask one particular question.

Mrs. JOHNSON. I just wanted to ask if you would develop some information for us that I think will be necessary for our evaluation.

I need to know whether the increase in health care utilization reflects changes in the utilization of other post-acute care services.

Are we still seeing home care keeping people out of nursing homes? Are we still seeing, and can we document, that home care is enabling people to be discharged from hospitals sooner?

Are we able to say that, in those areas like Louisiana, maybe people are in home care longer because they don't have congregate living facilities, and is that less costly or more costly to the system?

We need some information that looks at rising home care costs in the context of the overall cost of the system. That, I think, would be very helpful to us, and play into some of these other problems that we have.

Mr. HASH. We will be glad to try to provide what we can with regard to that.

Mrs. JOHNSON. Thank you.

Mr. HASH. That's an important set of questions.

Chairman THOMAS. Thank you, Mr. Hash. I want to underscore what my colleague from California said.

We can sit here dreaming up ideas, hand them to you, and you tell us whether you can do it or not. Seems to me you changed the rules of the game by not being able to do what we say you ought to be able to do.

We expect some specific model options in the area of formula change, in the area of per-visit change, and in the potential for an outlier policy.

Mr. HASH. We look forward to working with you, Mr. Chairman.

Chairman THOMAS. I would have preferred "Yes," but that's okay. Thank you very much.

Next panel, please—somewhat a cast of regulars. We welcome back Dr. Bill Scanlon, director of the Health Financing Systems, General Accounting Office; Dr. Gail Wilensky, Chair of the Medicare Payment Advisory Commission, better known as MedPAC; and Honorable June Gibbs Brown, Inspector General of the Department of Health and Human Services.

I want to thank all of you. We did take a rather long time with our first panelist, but as I think you know well, the difficulty with the Y2K problem and the need to come up with a solution required us to pursue options perhaps longer than we normally would have.

Your written testimony will be made a part of the record, and you may inform us as you see fit of your specific suggestions or criticisms or critiques of the home health interim payment system.

Dr. Scanlon.

STATEMENT OF WILLIAM J. SCANLON, DIRECTOR, HEALTH FINANCING AND SYSTEMS ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, UNITED STATES GENERAL ACCOUNTING OFFICE

Mr. SCANLON. Thank you very much, Mr. Chairman, and members of the subcommittee. I am very happy to be here today as you review the recent changes in Medicare payment policies for home health services and the need to ensure that the spending for these services and its distribution under the interim payment system are appropriate.

The goal for a long time, as you know, has been to implement a prospective payment system for this benefit, to establish and maintain control over the growth of spending, and also to better match payments with patient needs. However, in enacting the Balanced Budget Act last year, you recognized the implementation of a prospective payment system would not occur before fiscal year 2000, and an interim payment system would be needed to initiate control over payments.

As the interim payment system will be in place now longer than you intended, issues with regard to its adequacy and appropriateness become more troubling, though they might not have been so in the short term. In particular, there are questions about whether the per-beneficiary limits will excessively restrict overall payments and about the relative stringency of these limits among agencies.

One thing we should recognize is that the per-beneficiary limits were established using the average number of visits per beneficiary in the 1993–1994 period.

Most of the rapid growth we have witnessed in the number of visits per beneficiaries since 1989 had occurred by then, and would be reflected in the data used to establish these limits.

Evidence from both our past work and that of the Inspector General have indicated that utilization levels in recent years, to some degree, have been inappropriately inflated by services provided to some beneficiaries who didn't qualify for the benefit, by some beneficiaries receiving unauthorized visits, and even by, instances of visits being billed but never being delivered.

Consequently, concerns about the overall spending under the interim payment system may be unnecessary. Ensuring, however, that the limits reflect appropriate cost differences across agencies is a more difficult issue to address.

Blending historic agency-specific and regional payments to determine the per-beneficiary limits was intended to recognize that significant variation in costs across agencies and geographic areas exists, and to reduce some of the extremes.

How much agencies spent in the past does provide some indication of the types of patients they serve. Although cost data are readily available, they are admittedly very crude case mix adjusters, because cost differences can reflect multiple causes.

Agencies can have higher costs due to inefficient practices, and then they will have a higher per-beneficiary limit. Conversely, if an agency had a history of managing its costs and controlling its visits to each patient, its per-beneficiary limit will be constrained.

Unfortunately, examining costs alone cannot reveal whether an agency serves a more needy patient population or operates inefficiently. As a practical matter, therefore, in order to protect those serving a more complex mix of patients, other inefficient agencies may be rewarded.

The per-beneficiary limits based on 1993–1994 data also may prove problematic for some agencies if external factors have resulted in significant changes in their costs since then. An example would be a shift in the mix of patients that might accompany a change in the number of providers in their local market which would then have an effect on the clients available to other agencies.

An even more widespread impact could accompany a state's adoption of a so-called Medicare maximization policy. Through these policies, some states have attempted to ensure that Medicare is billed first, instead of Medicaid, for visits to patients who are eligible for both programs. This increased Medicare billing may not be reflected in the per-beneficiary limits when states have recently implemented such policies, and their agencies may be facing limits that are tighter than appropriate.

Unfortunately, attempting to calibrate the per-beneficiary limits to reflect legitimate differences among agencies without data, on the causes of those differences, inevitably leads to potential underpayments and overpayments. A well-designed prospective payment system with an adequate case mix adjustment will address these concerns and provide Medicare with better tools to control its spending.

We believe, however, that the development of the prospective payment system for home health will be a much greater challenge than prior efforts to create one for hospitals or skilled nursing facilities.

For home health, for example, defining what is the unit of service, which most conceive of as an episode of care, should contain may prove very difficult. At present, no consensus exists on what constitutes a needed Medicare-covered visit or what a visit should entail, basic information essential to the appropriate definition of an episode and the design of prospective payment.

We need a candid and realistic assessment of when the prospective payment system and adequate accompanying oversight mechanisms can be implemented. Depending on the delay, it may be important to consider how to make agency-specific adjustments to the limits to better account for appropriate variations in current costs. Potential adjusters that could be developed include information on the proportion of Medicare patients that are Medicaid eligible as well, patient length of stay, and the proportion of beneficiaries that were recently hospitalized. Research that HCFA currently has underway to develop the prospective payment system could very well guide this kind of an effort. Without adjusting the limits, the extent of overpayments and underpayments is likely to increase over time.

Let me say in conclusion that you have taken very positive steps in giving HCFA the tools to maintain control over the growth of home health spending. The goal should be to move as quickly as possible to take full advantage of those tools. In the meantime, we need to remain attentive to the effects of the interim system and seek to ensure that agencies are paid appropriately for the mix of beneficiaries that they serve.

Thank you very much. I would be happy to answer any questions that you may have.

[The prepared statement follows:]

United States General Accounting Office

GAO

Testimony

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

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MEDICARE

Interim Payment System for Home Health Agencies

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

GAO/T-HEHS-98-234

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the recent changes in Medicare's payment policies for home health agencies and the need to ensure that the level of payments and their distribution are appropriate. Medicare spending for home health care has risen dramatically in recent years. By 1996, this benefit consumed 9.3 percent of Medicare expenditures, up from 2.5 percent in 1989. Changes in the law and program guidelines have contributed to the rapid growth in the number of beneficiaries using home health care and in the average number of visits per user. These changes have not only resulted in accelerating costs but also a marked shift from an acute-care, short-term benefit toward a more chronic-care, longer-term benefit as a result of changes in patient mix and treatment patterns. The increased use of home health care has not been matched by a commensurate rise in spending for claims review and program monitoring. As a result, some of the visits provided and people served may not meet Medicare's coverage criteria.

In response to this rapid cost growth and concerns about program abuses, the Balanced Budget Act of 1997 (BBA) included a number of provisions on home health payment and provider requirements. Specifically, the law requires implementation of a prospective payment system (PPS) for home health agencies in fiscal year 2000. Until then, an interim payment system that incorporates limits, based on historical spending levels, that are applied to cost-based payments will be used to constrain program outlays. The interim limits will differ for each provider to reflect the substantial variation in home health spending across agencies and geographic areas. BBA also prohibits certain billing practices determined to be abusive, strengthens participation requirements for agencies, and authorizes the Secretary of Health and Human Services to develop guidelines on the frequency and duration of home health services to use in determining whether visits should be covered.

My comments today focus on the rise in Medicare spending for home health services and the reasons for this growth, the objectives of the home health interim payment system enacted by BBA, and concerns about the level and distribution of home health payments. The information presented is based primarily on our analysis of BBA and on our previous work on Medicare's home health benefit. (A list of related GAO products is at the end of this statement.)

In summary, a well-designed PPS will provide the Medicare program with the best means to rationally control home health spending. Until such a system is implemented, the interim payment system will help constrain the growth in outlays. However, concerns have been raised about the interim payment system. Specifically, the industry has expressed doubts about whether payments will be adequate and whether the payment limits will appropriately account for differences in patient mix and treatment patterns across agencies. Another concern is that inefficient providers will have unduly high

limits because the limits are based on historic payments that reflect inappropriate practices.

Previous analyses by us and the Department of Health and Human Services' (HHS) Office of Inspector General have demonstrated that Medicare has been billed for home health visits that may not have been needed, were not consistent with Medicare policies, or were not even delivered. Thus, concerns about the overall adequacy of payments under the interim system may be unwarranted, since the limits were based on historic costs, a portion of which were inappropriate. Whether the payments to individual agencies will reflect legitimate differences across agencies is more difficult to determine. Costs vary widely across agencies, which reflects differences in patient mix and levels of efficiency. In protecting legitimate cost differences across agencies, the interim system may unavoidably reward some inefficient agencies. Furthermore, the interim system may also be too restrictive for agencies with costs that legitimately increase more rapidly over time. Because the interim payment system will be used for a longer period than originally intended, we believe it is even more important to better take account of appropriate variation in agency costs.

BACKGROUND

To qualify for Medicare home health care, a beneficiary must be confined to his or her residence (that is, "homebound"); require intermittent skilled nursing, physical therapy, or speech therapy; be under the care of a physician; and have the services furnished under a plan of care prescribed and periodically reviewed by a physician. If these conditions are met, Medicare will pay for part-time or intermittent skilled nursing; physical, occupational, and speech therapy; medical social service; and home health aide visits. Beneficiaries do not pay any coinsurance or deductibles for these services.

The Health Care Financing Administration (HCFA), the agency within HHS responsible for administering Medicare, uses six regional claims processing contractors (which are insurance companies) to process and pay home health claims. These contractors pay the claims submitted by home health agencies on the basis of the costs they incur, subject to predetermined payment limits. They are also responsible for ensuring that Medicare does not pay claims when beneficiaries do not meet Medicare's coverage criteria, when services claimed are not reasonable or necessary, or when the volume of services exceeds the level called for in an approved plan of treatment. They carry out these responsibilities through medical reviews of claims, performed either before or after a claim is paid, and occasionally through site visits to the agencies.

REASONS FOR HOME HEALTH COST GROWTH

Congressional changes to home health payment policies, enacted in BBA, were made in response to dramatic growth in the cost and use of the benefit. From 1989 to 1996, expenditures for home health care increased from $2.5 billion to $18.1 billion--an

average annual increase of 33 percent. Home health payments in 1996 represent 9.3 percent of Medicare outlays.

The growth in spending was due primarily to an increase in users and in visits per user, rather than rising payments per visit. The payment per visit has been held in check by existing Medicare payment limits. In 1989, 50 Medicare beneficiaries per 1,000 enrollees received home health care. The average user in that year received 27 visits. By 1996, 99 beneficiaries per 1,000 used home health care and received an average of 76 visits. The payment per visit went from $54 to $62 over this period.

Changes in Medicare eligibility and coverage rules played an important role in the increased use of this benefit. At Medicare's inception in 1965, home health care was primarily a posthospitalization benefit, and there was an annual limit on the visits covered for each beneficiary. These restrictions were eliminated by the Omnibus Reconciliation Act of 1980 (P.L. 96-499). This did not lead to a surge in spending growth, however, because the manner in which HCFA interpreted coverage and eligibility criteria limited the number of home health users and covered visits. In the late 1980s, however, HCFA's coverage criteria were struck down by a U.S. District Court. As a result, it became easier for beneficiaries to receive these services. In addition, other court decisions made it more difficult for HCFA's claims processing contractors to deny certain services.

The combination of these changes essentially transformed the home health benefit from one focused on patients needing short-term care after a hospitalization to one that serves chronic, long-term-care patients as well. We found that from 1989 to 1993, the proportion of home health users receiving more than 30 visits a year increased from 24 percent to 43 percent and those receiving more than 90 visits tripled, from 6 percent to 18 percent. Moreover, about a third of beneficiaries receiving home health care in 1992 did not have a recent prior hospitalization.

The importance of long-term users to Medicare home health spending has continued to increase. The majority of visits in 1996 (59 percent) were for the 15 percent of users who received 150 visits or more. Almost one-third of this high-user group received over 300 visits in the year. About half of home health users received fewer than 30 visits, which accounted for 9 percent of total home health visits in that year.

Concurrent with this dramatic growth in service use has been a rapid rise in the number of home health agencies. By 1994 there were almost 8,000 home health agencies, about 40 percent more than in 1989. And, by 1996, there were almost 10,000 Medicare-certified agencies. For-profit providers contributed disproportionately to this growth so that by 1994 they represented 48.5 percent of the total, up from 35.3 percent in 1989.

Recent evidence demonstrates that some home health services have been provided to beneficiaries who did not meet Medicare's coverage criteria, and in some instances the services were not provided at all. We have reported on a number of examples of

noncovered services that were billed to Medicare. Of particular concern is whether beneficiaries actually are homebound when they receive these services. Operation Restore Trust, a joint effort by federal and several state agencies, found very high rates of noncompliance with Medicare's coverage conditions. It documented abuses of the homebound criteria, instances in which services were billed for but never provided, visits that were not authorized by a physician, and visits to beneficiaries who otherwise did not qualify.

Home health spending growth has slowed markedly in recent years. Between 1995 and 1996, outlays rose 8 percent, compared with the average annual growth rate in the early 1990s of 33 percent. Preliminary estimates indicate that expenditures actually declined from 1996 to 1997. This was due to an overall reduction in visits provided. The number of beneficiaries receiving home health care fell enough to more than offset a slight increase in the number of visits per user.

There is no definitive explanation for this downturn. Some speculate that the sentinel effect of Operation Restore Trust and pending payment constraints may have changed agency behavior. Other possibilities include increased use of managed care and the maturation of the home health industry. Without a better understanding of the contributing factors and, more importantly, without additional experience, it is not clear whether the reduced use is a trend that will continue or merely a temporary aberration.

OBJECTIVES OF THE INTERIM PAYMENT SYSTEM

BBA mandated a prospective payment system for home health services beginning in fiscal year 2000. The PPS would establish a fixed, predetermined payment per unit of service, adjusted for patient characteristics that affect the cost of care (termed "case mix"). The Congress supports a PPS for home health agencies, as well as for other facilities, because it has the potential to improve provider incentives to control costs while delivering appropriate services. Under a well-designed system, efficient providers would be financially rewarded. Conversely, inefficient ones would need to better control their costs to remain viable. If a PPS is not properly implemented, Medicare will not save money, cost-control incentives will at best be weak, and access to and quality of care could suffer.

Recognizing the difficulty of designing such a system, coupled with the need to immediately control spending, BBA imposed an interim payment system on home health agencies until a PPS could be developed. The interim system builds on the cost limits already in place by making them more stringent. Previously, agencies were paid the lower of their actual costs or a limit based on 112 percent of the average cost per visit, adjusted for the number and mix of visits they provided. BBA changed the calculation of this per-visit limit so that it is based on 105 percent of the median per-visit cost. A new annual per-beneficiary limit was added as well. It is the average payment for all home health services for each beneficiary who received care. The limit is calculated as a blend

of 75 percent of the agency's updated, per-beneficiary payment and 25 percent of the comparable average regional amount. The base year for these calculations is the facility's cost reporting year that ended in federal fiscal year 1994.

This interim payment method provides incentives to control per-visit costs and the number and mix of visits for each user. For agencies with per-visit costs considerably below the limits, however, there is no incentive to provide visits more efficiently. The objective of the per-beneficiary limit was to rein in the growth in the number of visits provided to each user. However, most of this rapid growth would be reflected in the data used to establish the limits, so the limits may be inappropriately generous. Moreover, per-beneficiary limits give home health agencies an incentive to increase their caseloads, particularly with less expensive patients. Given lax home health claims review, this may even occur by adding beneficiaries who do not meet Medicare coverage criteria.

It is important to keep in mind that the existing per-visit limits as well as the new per-beneficiary limits are applied to aggregate agency costs. Thus, an agency does not need to keep the cost of each visit below the limit or to restrict the visits provided to each beneficiary to base-year levels. Rather, agencies can balance high-cost visits with low-cost ones to stay below the limits. Similarly, an agency could treat a mix of more intensive and less intensive beneficiaries and still not bump up against the per-beneficiary limits.

ACHIEVING THE APPROPRIATE LEVEL AND DISTRIBUTION OF PAYMENTS

Even with this ability to average costs across visits and beneficiaries, the industry has voiced concerns that the per-beneficiary limits in the interim system are too stringent and that reliance on agency-specific and regional costs to establish the limits rewards providers who are inefficient and thus have historically high payments. For efficient providers, the limits may be too low if changes in their patient mix or other external factors have significantly increased their costs above the base-year amounts. Concern about the overall stringency of the limits may be unwarranted because of the lack of historical payment controls. Assessing whether the per-beneficiary limits are appropriate for each agency, however, is a more difficult undertaking.

The lack of sufficient program controls over the past decade may have made it likely that a portion of the recent increase in home health spending stemmed from inappropriate use of the benefit or abusive practices. For this reason, in aggregate, payments under the interim system may be adequate. The rapid growth in spending since 1989 has been accompanied by decreased, rather than increased, funding for program safeguard activities. By 1995, fewer than 3.2 percent of all claims were reviewed to determine whether the beneficiary actually qualified for the services, needed them, or even received what was being billed to Medicare. In a study last year, we selected a sample of high-dollar claims that had been paid without any review. After they were examined by an intermediary at our request, it turned out that a large proportion of them

should not have been paid. More recently, the Office of Inspector General in its annual audit of HCFA estimated that 12.5 percent of Medicare home health spending in fiscal year 1997 was inappropriate because the services were not medically necessary or lacked supporting documentation.

Each agency's per-beneficiary limit should reflect the types and number of services needed by its patients. Because service needs vary, the use of agency-specific and regional average payments in the calculation of the per-beneficiary limit is intended to account for differences in resource needs of patients across agencies. Though historic average payments are a readily available measure, they are admittedly a crude case-mix adjuster because they will reflect differences from multiple causes. Agencies with higher costs as a result of inefficient practices will have higher per-beneficiary limits than efficient ones. Conversely, if an agency had a history of managing its costs and controlling its visits to each patient, its per-beneficiary limit will be constrained. Unfortunately, examining costs alone can not reveal whether an agency serves more needy patients or operates inefficiently. Practically, therefore, inefficient agencies may be unintentionally rewarded in order to protect those serving a more complex mix of patients.

The marked variations in home health use across geographic areas and agency types raise questions about differences in efficiency, which would inappropriately boost per-beneficiary limits in some areas. In 1995, users received an average of 132 visits in the West South Central region, in contrast with 52 visits in the Middle Atlantic region. These extremes are more likely due to differences in practice styles and efficiency among agencies rather than patient mix. We demonstrated in an earlier study that even when controlling for patient diagnosis, substantial variation in the number of visits per beneficiary remained. For example, we found that beneficiaries with a primary diagnosis of diabetes received an average of 67 home health visits in Utah compared with 22 visits in South Dakota. This three-fold variation in service use is unlikely to be due to case-mix differences that were not reflected in the beneficiaries' primary diagnosis.

Despite taking account of agencies' case mix by using historical costs, per-beneficiary limits can prove problematic for some agencies if external factors cause them to begin serving a more expensive mix of patients. New agencies entering or some existing agencies leaving a local market could have such an effect on other agencies. An even more widespread impact could accompany a state's adoption of a so-called "Medicare maximization policy." Through these policies, states attempt to ensure that Medicare is billed instead of Medicaid, when appropriate, for home health services for patients who are eligible for both programs. If such a policy is implemented after the base year, the per-beneficiary limits would not reflect the fact that some services formerly paid by Medicaid are now being billed to Medicare. As an example, Minnesota's implementation of a Medicare maximization policy in 1996 likely contributed to its agencies having much faster growth in visits per user since 1994 than occurred elsewhere.

Attempting to calibrate the per-beneficiary limits to reflect legitimate differences among agencies without data on the causes of those differences inevitably leads to potential underpayments and overpayments. The mandated PPS to be implemented in fiscal year 2000 would resolve this by basing payments on each patient's needs so that total payments reflect each agency's current patient mix. However, HCFA has announced that the PPS's implementation will be delayed to make its computer systems Year 2000 compliant. It should also be acknowledged that the development of a PPS for home health will be a much greater challenge than prior efforts to create one for hospitals and skilled nursing facilities (SNFs). In the case of SNFs, for example, a number of Medicaid programs had years of experience with case-mix-adjusted PPSs. Comparable in-depth experience for home health is lacking. Furthermore, in the case of hospitals and SNFs, the task of defining the unit of service (an admission and a day, respectively) was relatively easy. For home health, defining what the unit of service–an episode of care–should consist of may prove very difficult. At present, no consensus exists on what constitutes a needed Medicare covered visit or what a visit would entail–basic information essential to establishing an appropriate PPS.

There is the potential that the Year 2000 problem and difficulties in completing a satisfactory design could delay further PPS's implementation. Since the per-beneficiary limits are to remain in place longer than expected, a mechanism for agency-specific adjustments to them to better account for appropriate variations in current costs will take on added importance. Potential adjustors that could be developed with available information include, for example, the proportion of Medicare patients who are also eligible for Medicaid, patient length of stay, and proportion of beneficiaries with a recent hospitalization. Research HCFA currently has under way to develop the PPS might guide this effort. Without adjustment of the per-beneficiary limits, the extent of underpayments and overpayments would likely increase with time.

CONCLUSIONS

The Congress has taken very positive steps in positioning HCFA to rein in unsustainable growth in Medicare spending for home health care. Because this benefit has been largely unchecked in recent years, it is likely that these efforts will be met with opposition. The unanticipated extension of the interim payment system creates a need for HCFA to examine whether refinements to the per-beneficiary limits to distribute payments more equitably are needed while working to develop an appropriate case-mix-adjusted PPS. The goal should be to move as quickly as possible to adjust the interim payment system so that it ensures that agencies are paid appropriately for the mix of beneficiaries they serve.

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This concludes my prepared remarks. I would be happy to respond to questions from the Subcommittee at this time.

RELATED GAO PRODUCTS

Medicare Home Health Benefit: Congressional and HCFA Actions Begin to Address Chronic Oversight Weaknesses (GAO/T-HEHS-98-117, Mar. 19, 1998).

Medicare: Improper Activities by Med-Delta Home Health (GAO/T-OSI-98-6, Mar. 19, 1998, and GAO/OSI-98-5, Mar. 12, 1998).

Long-Term Care: Baby Boom Generation Presents Financing Challenges (GAO/T-HEHS-98-107, Mar. 9, 1998).

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Medicare Fraud and Abuse: Summary and Analysis of Reforms in the Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997 (GAO/HEHS-98-18R, Oct. 9, 1997).

Medicare: Need to Hold Home Health Agencies More Accountable for Inappropriate Billings (GAO/HEHS-97-108, June 13, 1997).

Medicare: Home Health Cost Growth and Administration's Proposal for Prospective Payment (GAO/T-HEHS-97-92, Mar. 5, 1997).

Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996).

Medicare: Excessive Payments for Medical Supplies Continue Despite Improvements (GAO/HEHS-95-171, Aug. 8, 1995).

Medicare: Allegations Against ABC Home Health Care (GAO/OSI-95-17, July 19, 1995).

(101766)

Chairman THOMAS. Thank you, doctor.

Dr. Wilensky.

STATEMENT OF GAIL R. WILENSKY, CHAIR, MEDICARE PAYMENT ADVISORY COMMISSION, ACCOMPANIED BY STUART GUTERMAN, DEPUTY DIRECTOR, MEDICARE PAYMENT ADVISORY COMMISSION

Ms. WILENSKY. Thank you for inviting me here to testify. I am here as the chair of the Medicare Payment Advisory Commission, and I have with me Stuart Guterman, who is the deputy director of the commission.

You have heard in some detail about why the prospective payment system was adopted as part of the Balanced Budget Act, and I'm not going to review that with you. It is in my written testimony.

You have also heard a clear description of what it is we have moved to in the interim, in terms of the interim payment before the time the prospective payment system is ready, and I'm not going to go through the detail of that, as well.

I want to mention a couple of the provisions, the effects of the provisions, in terms of what we know about the general direction of the effect, and then make some suggestions about where we might go from here.

Because of the introduction of not only a per-visit cost limit, which had been part of the prior payment strategy, and also the change, as you know, going from 112 percent of mean cost to 105 percent of median cost, but also including, now, a per-beneficiary limit, as well, which, as you have mentioned, is based on 1994 data, we have set up a stress in terms of the kinds of effects that this interim payment system will have will differ according to the type of patients that will go to the agencies.

In general, because of the system that was devised, what we know is that those agencies which tend to have patients that have a limited number of high-cost visits, like after a hospital, for example, will have most of the effect, will come from the per-beneficiary cost limit, because they don't have a lot of visits, and the ones they have are very costly.

It appears, for example—and since you have Members up here from these states—that Louisiana is, at least in large part, affected more by the cost limits than, say, by the numbers of visits.

On the other hand, if you have agencies that serve people with a lot of chronic conditions, who have a lot of visits, which perhaps, knowing a little bit about the demographics of the country, is more associated, we think, with a place like Connecticut, they are much more likely to get impacted by the per-beneficiary limit rather than the visit limits, for cost.

These were not unreasonable additions to bring to the payment. The problem is, we don't know what is going on in these visits, and we don't have information about case mix.

The basic problem that you are now going to deal with is that you are going to try to make changes that either will increase costs, and then the issue is can you negotiate a way to pay for some additional money, or that will create winners and losers.

You are fundamentally going to be left in the position of not knowing very well, at least, whether the money that you shift is going to more efficient agencies or going to agencies who have less sick or less complicated cases.

My first plea is that, while we come up—and we will, certainly, at MedPAC, be glad to assist you in any way; we have, I know, been providing some analysis during the last few weeks, for some of the Members' requests—is to start working on getting better information.

It doesn't have to be perfect information. It is certainly possible to have approximation of information early on at the same time we start instituting some more specific efforts to get what goes on in the visit and to get case mix information, so that we can move off the problem of not knowing whether agencies have low costs because they are efficient, or whether they have low costs because they have less sick patients.

The additional issues which we had raised as part of our recommendations, which you may want to think about, depending on what other steps you take in order to fix the problem that you are now concerned about, which is whether too much money is coming out of this system and more impact may be occurring in terms of some of the agencies, is whether you want to consider the recommendation we made with regard to a modest co-payment on the part of beneficiaries, subject to an annual limit, and secondly, after 60 visits, to have an independent case manager review the case plan for the beneficiary so that the big spenders of home care money—that is, the people who have over 100 or 150 visits—who are a small part of the population, 15, 20 percent, but who account for most of the money in the system, know that they are getting an independent assessment about whether they have the right plan of care for them, not by somebody who is related to the home care agency, and not by the physician who has been asked to sign off, because there is a lot of pressure that that physician is frequently put under.

So my plea, again, as you go forward and try to deal with the uncertainties of not knowing why these differences occur, is to start early, soon, as soon as possible, on collecting as good data as you can in the interim, and then better data over time. It will help resolve these problems, which are obviously causing you and your constituents a lot of concern.

Thank you. I will conclude my oral presentation at this point.

[The prepared statement follows:]

MedPAC
MEDICARE
PAYMENT
ADVISORY
COMMISSION

Home Health Payment Policies

presented to

Subcommittee on Health
Committee on Ways and Means
United States House of Representatives

Gail R. Wilensky, Ph.D.
Chair

August 6, 1998

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Good morning, Mr. Chairman. I am Gail Wilensky, Chair of the Medicare Payment Advisory Commission (MedPAC). With me today is Stuart Guterman, the Deputy Director of the Commission's staff. I am pleased to be here to discuss Medicare's payment policies for the services provided by home health agencies. During my testimony, I will refer to several charts. These charts are appended to the end of my written testimony.

As you know, Mr. Chairman, payments to home health agencies have been one of the fastest growing components of Medicare spending. From 1987 to 1996, Medicare Part A payments for home health services increased more than ten-fold, from $1.7 billion to $17.5 billion (Chart 1). During that time, home health spending rose from just over 3 percent to more than 13 percent of total Part A benefit payments. Although 1996 ended a period of eight consecutive years with double-digit growth, the increase in spending on home health care and the level and distribution of home health use across Medicare beneficiaries raise concerns about how this benefit is provided and paid for.

In response to these concerns, the Congress addressed home health payment in the Balanced Budget Act of 1997 (BBA). A prospective payment system (PPS) for home health care was mandated to begin in October 1999, and an interim payment system (IPS) was put into effect until that time. The IPS puts new limits on aggregate payments to each home health agency, based on nationwide average costs per visit and a blend of agency-specific and regional average costs per beneficiary. These provisions are intended to constrain the growth of program payments and put into place a set of incentives to encourage the appropriate use of home health care.

In MedPAC's March 1998 *Report to the Congress: Medicare Payment Policy*, the Commission made several recommendations addressing specific aspects of home health payment policy in the context of the changes mandated by the BBA. This morning, I will briefly review home health payment policy before and after implementation of the BBA. In addition, I would like to discuss some issues that have arisen more recently with regard

to the policy currently in place and some considerations in developing appropriate policy responses.

First, however, let me summarize the factors that have contributed to the tremendous growth in home health spending in the past decade and trends in home health providers, costs, and payments.

Home Health Spending and Utilization

Trends in home health spending have reflected policy changes made over the history of the Medicare program. Prior to 1980, up to 100 home health visits were covered under Part A if they were preceded by a three-day hospitalization. If more than 100 visits were required and the beneficiary was eligible for Part B, an additional 100 visits would be covered, subject to the annual Part B deductible. Beneficiaries who did not have a prior hospitalization or who were not eligible for Part A benefits could receive up to 100 home health visits under Part B, subject to the Part B deductible. Home health was a small portion of program spending throughout this period.

The Omnibus Budget Reconciliation Act of 1980 eliminated the hospital stay requirement under Part A, the deductible requirement under Part B, and the 100 visit limits under both Part A and Part B. As a result, utilization jumped, with spending doubling in the succeeding three years. In response, the Health Care Financing Administration (HCFA) used administrative means to tighten the criteria for coverage. By 1987, home health spending was at about the same level as it had been in 1984. This reflected relatively constant rates of home health use and visits per user over that period (see Chart 2).

HCFA's actions sparked a legal challenge, however, and in 1988 the court ruled that restrictions implemented by the agency were contrary to the intent of the existing legislation. As a result, HCFA loosened its coverage requirements, and home health use

increased sharply. Between 1988 and 1995, the number of home health users more than doubled, from 1.6 million to 3.5 million, and the rate of home health use increased from 51 to 95 per 1,000 beneficiaries. The number of home health visits burgeoned from 37.1 million to 266.2 million, as the number of visits per person served rose from 23 to 77. Even after a slowdown in home health use in 1996, there were about 7 home health visits for every beneficiary in the Medicare program.

Growth in the use of home health care has been associated with changes in the mix of services. Skilled nursing and home health aide visits represent the bulk of services provided by home health agencies. In 1988, skilled nursing visits accounted for 51 percent of total visits provided to Medicare beneficiaries; by 1994, this proportion had fallen to 42 percent (see Chart 3). By contrast, the proportion of home health aide visits rose from 34 percent to 48 percent over the same period.

Beneficiaries' use of home health services shows two distinct patterns. More than half of all users had fewer than 30 visits during fiscal year 1996, but this group accounted for less than 9 percent of all home health visits (see Chart 4). Almost two-thirds of these visits were in the skilled nursing category. By contrast, about 15 percent of home health users had 150 or more visits, but this group accounted for more than half of all visits. Among the group with heavy use, only about one-third of visits were in the skilled nursing category, while more than 60 percent were provided by home health aides.

Age, disability, and race are associated with the duration of home health care use (see Chart 5). In fiscal year 1996, home health users who were age 85 or older, disabled, or black were most likely to have received home health services without a 60-day break over the entire year.

Home Health Providers, Costs, and Payments

The home health industry has expanded with the increase in utilization during the 1990s. Between 1990 and 1997, the number of Medicare-certified home health agencies nearly doubled to about 10,600, growing at an annual rate of 9.0 percent (see Chart 6). About 27 percent of all home health agencies are based in an acute care or rehabilitation hospital or a skilled nursing facility; the remainder are free-standing.

Patterns of care differ across types of home health providers (see Chart 7). In 1996, patients served by hospital-based agencies accounted for about 38 percent of all home health episodes, but 44 percent of short ones (30 days or less). Free-standing agencies were more likely to have served patients with longer episodes.

Different types of home health providers exhibit different patterns of costs per visit as well (see Chart 8). In 1995, agencies run by visiting nurse associations generally had lower per visit costs than other types of agencies. Size (as measured by the number of Medicare-covered visits furnished) also appears to be related to costs, with larger agencies having lower costs per visit. These differences may be related to practice protocols, economies of scale, or the mix of patients served.

The pattern of payment-to-cost ratios across agency types is consistent with the pattern of relative costs described earlier (see Chart 9). In 1995, agencies run by visiting nurse associations generally had costs below their limits, and large agencies also had relatively high payments relative to their costs. Again, these differences may be due to any number of factors, including case mix.

Home Health Payment Policy Before the Balanced Budget Act

Prior to passage of the BBA, home health agencies were paid the lesser of their costs and an agency-specific limit on payments, derived from average per-visit costs for each type

of visit. There are six types of Medicare-covered home health visits: skilled nursing, nursing aide, physical therapy, speech therapy, occupational therapy, and medical social services. The agency-specific, per-visit cost limit does not actually affect the payment amount for any individual home health visit; instead, it applies to total payments for the agency.

An example will help illustrate how this works. For simplicity, assume that an agency provides only two types of visits--skilled nursing and home health aide--and that average costs for these visits are $150 and $50, respectively. Prior to passage of BBA, an agency's per-visit cost limit was equal to 112 percent of the national average cost for each type of visit, multiplied by the number of visits of each type provided by the agency. If this hypothetical agency provided 50 nursing visits and 50 aide visits, its agency-specific limit would be the sum of 50 times $150 (for the nursing visits) and 50 times $50 (for the aide visits), or $10,000. If the agency's actual cost for nursing visits was $152 on average ($2 more than the per-visit limit), while the cost of aide visits was $48 ($2 less than the limit), Medicare payments to the agency would exactly cover its costs, even though the costs for nursing visits exceeded the limit for that category.

Per-visit cost limits control average per-visit payments for home heath services, but they do not limit the number of visits provided by agencies. Because the growth in home health spending has been primarily from an increase in the number of home health visits, as opposed to the cost per visit, these cost limits have been largely ineffective in controlling aggregate spending on home health services.

Home Health Interim Payment System

The BBA made two fundamental changes in home health payment policy. First, beginning with cost reporting periods in fiscal year 1998, it established an interim payment system. Second, it requires payment for home health services under a prospective system

beginning with cost reporting periods in fiscal year 2000. Today, my comments will emphasize the impact of the interim payment system.

Under the IPS, a home health agency is paid the lesser of its costs, its agency-specific per-visit cost limit, and a new, agency-specific per-beneficiary limit. Payments are limited compared with the pre-BBA rules in two ways. First, per-visit cost limits are based on a new formula. Before BBA, these limits were based on 112 percent of mean costs by visit type. Under IPS, they are based on 105 percent of median costs by visit type. The per-visit costs used to calculate agency-specific limits are lower, but as before, these limits do not constrain the number of home health visits an agency may provide.

The second important IPS change is the implementation of a new limit on agency spending that is based on 1994 per-beneficiary costs. Analogous to the per-visit limit, this per-beneficiary limit does not actually affect payments made on behalf of any individual Medicare beneficiary; instead, it applies to total payments for each agency.

Again, an example will help illustrate how the policy works. This time, imagine a home health agency that serves 3 beneficiaries. In 1994, the agency's per-beneficiary cost for home health services was $3,500. Using formulas specified in the BBA, this historical amount is updated to about $3,850 for fiscal year 1998. The per-beneficiary payment limit for the agency would be $3,850 times 3, or $11,550 in fiscal year 1998. Actual payments would be the lesser of the agency's actual costs, its per-visit cost limit, and its per-beneficiary limit.

Per-beneficiary limits may prove to be a more effective method for controlling home health use than per-visit limits have been. While per-visit limits control neither the number of home health users nor the number of visits per user, per-beneficiary limits do provide for the control of home health use by implicitly limiting the average number of visits per home

health user. Growth in spending can still occur through growth in the number of users, however.

Whether per-visit cost limits or per-beneficiary limits are binding for a given agency depends in part on the nature of the agency's business. In general, agency-specific per-visit limits will probably have a greater impact on agencies that primarily serve beneficiaries who need a limited number of high-cost visits, perhaps following a hospital discharge. On the other hand, per-beneficiary cost limits will probably have a disproportionate impact on total payments for agencies that primarily serve beneficiaries who receive care over an extended period of time. Still other agencies will be unaffected by either of these limits.

Interim Payment System Issues

The parameters for calculating interim payment system limits are clearly important and have been the source of recent controversy. For agencies with high per-visit costs, the choice of statistics (mean or median) and the threshold for calculating per-visit limits (112 percent or 105 percent) clearly matters.

Under the IPS, the calculation of agency-specific per-beneficiary limits, which are equal to 75 percent on agencies' historical costs and 25 percent on region-wide historical costs, has been especially contentious. Agencies with historical costs below their regional average complain of being penalized for past efficiency because their lower costs are built into lower per-visit limits without concern for recent changes in case mix. Proposals to change the blend from one weighted toward agency-specific costs to one weighted toward regional or national costs draw complaints from agencies that insist their higher-than-average historical costs can be attributed to their service of sicker beneficiaries. In addition, there is significant variation in home health use by geographic region (see Chart 10). Using

regional costs in the calculation of per-beneficiary limits builds this variation into Medicare payment policy without clear evidence that differences are related to beneficiary need.

Any change in the formula for calculating limits will yield winners and losers. The problem is that in the absence of either clinical standards for the provision of effective home health care or reliable information about case mix across agencies, HCFA cannot determine whether relatively high or low agency spending is a function of relative efficiency or differences in patient population. Even if HCFA had the information it needed to sort this out, there would be an additional problem: under the IPS, home health agencies face incentives to limit average per-visit and per-beneficiary costs, while beneficiary incentives remain unchanged.

Home Health Copayments

In its March report to Congress, MedPAC recommended modest copayments for home health services, subject to an annual limit. Home health and clinical laboratory services are the only major Medicare benefits that do not require beneficiary cost-sharing, and the Commission believes that copayments for home health would serve an important function by making beneficiaries more aware of the cost of the services they receive. The economic principle is simple. From a beneficiary's perspective, home health services are essentially free. If these services provide even a tiny benefit, they will seem worthwhile to a beneficiary who does not face the real cost of providing them. A copayment would change beneficiaries' cost-benefit calculations: they will be more conscious of the cost of using additional home health care, and they will use fewer services if they value additional services less than the copayment amount.

The Commission has considered the burden that copayments would pose for Medicare beneficiaries. To the extent that cost-sharing is covered by Medicaid or other supplemental insurance, beneficiaries will not be burdened, but they also will not face incentives to

discriminate between services they value more or less than the cost of the copayment. Nonetheless, the Commission believes that cost-sharing will help curb the use of home health services that have marginal value to the beneficiary.

Because the Commission is concerned that cost-sharing may also affect the use of necessary home health services, it recommends that copayments be modest and subject to an annual limit to protect vulnerable beneficiaries.

In addition, the beneficiary notice that accompanies billing for copayments may provide a safeguard against fraud and abuse. Until recently, home health patients were not notified when Medicare was billed for home health benefits on their behalf. Medicare has begun to send summary notices of submitted bills that contain information about charges and dates and types of services. Copayments may be even more effective in encouraging beneficiary review of the services billed to Medicare.

Long-Term Users of Home Health Care

In its March recommendations to the Congress, MedPAC also addressed the special needs of the small share of Medicare beneficiaries who use home health services for extended periods. These individuals are characterized by more chronic and fewer acute care needs. They are more likely to be very old or disabled. The Commission is concerned that it may be difficult to balance the needs of these beneficiaries with the needs of those who use short-term skilled nursing and therapy care. It may be easier to focus on developing a payment system for home health services for the latter group first.

In addition, MedPAC recommends that a case manager review the plan of care of Medicare beneficiaries who receive home health services for extended periods. The case manager should be independent of the agency that serves the beneficiary, determining whether the services to be provided address the patient's needs and making

recommendations to the certifying physician about appropriate changes to the plan of care. The Commission believes that this process could improve outcomes for long-term users of home health care and slow the growth of Medicare spending.

Conclusion

The BBA enacted several changes in the way that Medicare pays for home health services and mandated the development of a new prospective payment system. These changes were intended to curtail strong incentives under the previous system to increase the number of home health users and services per user. In the short run, the parameters of the system may raise questions about the distribution of payments and the financial viability of home health agencies.

MedPAC has analyzed home health payments, utilization, and costs, and has made several recommendations to address both short run and underlying structural issues related to the home health care benefit. We will continue to devote considerable attention to these issues in the future.

This completes my formal testimony, Mr. Chairman. I will be happy to answer any questions from you or other members of the Subcommittee.

Chart 1. Medicare Part A Benefit Payments, by Type of Service, 1980-1996

Year	Inpatient Hospital		Skilled Nursing Facility		Home Health Agency[a]		Hospice	
	Payments (In Billions)	Percent Change	Payments (In Billions)	Percent Change	Payments (In Billions)	Percent Change	Payments (In Billions)	Percent Change
1980	$ 24.1	22.0%	$ 0.4	3.9%	$ 0.8	16.2%	$ 0.0	—
1981	29.1	20.7	0.4	3.8	1.0	22.9	0.0	—
1982	33.8	16.3	0.5	18.0	1.3	31.9	0.0	—
1983	37.1	9.6	0.5	12.2	1.6	25.0	0.0	—
1984	40.5	9.2	0.5	0.2	1.8	15.4	[b]	—
1985	44.2	9.1	0.5	0.7	2.0	7.8	[b]	437.5%
1986	45.7	3.4	0.6	4.9	2.0	1.3	0.1	74.4
1987	45.1	-1.2	0.6	10.4	1.7	-12.4	0.1	52.0
1988	47.5	5.2	0.8	29.3	2.1	19.1	0.2	33.3
1989	52.1	9.7	2.8	242.5	2.5	19.9	0.2	55.9
1990	56.9	9.3	2.5	-11.5	3.7	51.1	0.3	37.1
1991	60.6	5.5	2.5	-0.3	5.2	40.3	0.6	77.8
1992	68.6	14.2	3.5	42.4	7.2	37.0	0.8	46.2
1993	72.6	5.8	5.0	40.4	10.3	43.3	1.1	25.6
1994	76.1	4.9	6.7	34.5	13.0	26.1	1.5	40.6
1995	82.8	8.8	8.9	33.8	16.1	23.9	1.9	26.2
1996	86.8	4.8	10.7	19.4	17.5	8.8	2.0	6.1

NOTE: Does not include administrative expenses.

[a] Includes a small amount of home health payments from Part B.

[b] Hospice payments were $8 million in 1984 and $43 million in 1985, respectively.

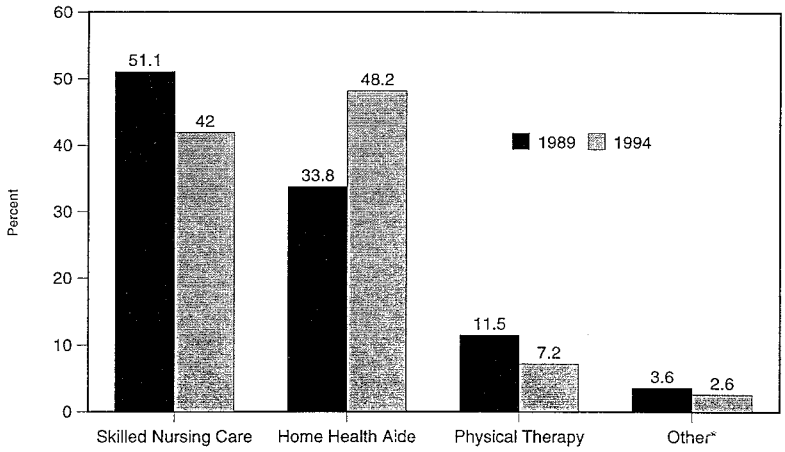
SOURCE: Medicare Payment Advisory Commission analysis of data from the Health Care Financing Administration, Office of the Actuary.

Chart 2. Medicare Part A Home Health Care Use, 1983-1997

Year	People Served		Visits	
	Number (In Thousands)	Per 1,000 Enrollees	Number (In Thousands)	Per Person Served
1983	1,318	45	36,899	28
1984	1,498	50	40,420	27
1985	1,549	51	39,449	25
1986	1,571	51	37,997	24
1987	1,544	49	35,587	23
1988	1,582	51	37,130	23
1989	1,685	58	46,297	27
1990	1,940	65	69,389	36
1991	2,226	72	98,650	44
1992	2,523	80	132,494	53
1993	2,868	87	168,029	59
1994	3,175	93	220,495	69
1995	3,457	95	266,261	77
1996	3,583	88	283,939	79

SOURCE: Health Care Financing Administration, Office of the Actuary, December 1997.

Chart 3. Share of Home Health Visits, by Type of Service, 1989 and 1994



* Includes speech therapy, occupational therapy, medical social services, and other health care disciplines.

SOURCE: Medicare and Medicaid Statistical Supplement, 1996 *Health Care Financing Review*, 1996 Statistical Supplement.

Chart 4. Home Health Visits Per User, Fiscal Year 1996

Number of Visits Per User	Share of Total Users	Share of Visits: Total	Share of Visits: Skilled Nursing	Share of Visits: Home Health Aide
Total	100.0%	100.0%	100.0%	100.0%
1-9	22.2	1.5	2.8	0.2
10-29	28.9	7.1	11.1	2.1
30-49	13.0	6.9	9.4	3.4
50-99	14.6	14.0	17.2	9.6
100-149	6.7	11.2	11.5	10.7
150-199	4.7	11.0	9.2	12.9
200-249	2.8	8.6	7.0	10.3
250-299	2.0	7.6	5.6	9.9
300+	5.0	32.1	26.3	40.8

NOTE: Columns may not sum to 100 due to rounding.

SOURCE: Medicare Payment Advisory Commission analysis of a 20 percent sample of 1996 home health claims from the Health Care Financing Administration.

Chart 5. Characteristics of Home Health Care Users, by Episode Category, Fiscal Year 1996

Characteristic	Episode Category: Short	Medium	Long	Very Long	Continuous
Age					
< 65	22.4%	23.9%	3.0%	2.9%	11.5%
65-74	25.5	27.4	2.6	2.5	8.7
75-84	21.6	26.2	2.7	2.5	10.9
85+	18.9	23.9	2.6	2.6	13.2
Medicare status					
Aged	22.2	26.0	2.6	2.5	10.8
Disabled	21.8	23.7	2.9	2.9	12.3
End-stage renal disease	25.1	26.1	3.2	3.6	5.9
Race					
White	23.2	26.2	2.6	2.5	10.3
Black	14.6	22.9	2.9	3.0	15.9
Other*	22.4	27.0	3.1	2.9	8.4

NOTE: Rows will not sum to 100. Remaining shares represent cross-over episodes which are those with a 60-day gap either before the first visit or after the last one, but not both. Short, medium, long, and very long episodes are a series of home health visits preceded and followed by a 60-day period without home health use. Short episodes lasted 30 days or less, medium episodes lasted 31 to 120 days, long episodes lasted 121 to 165 days and very long episodes lasted 166 to 366 days. Continuous episodes are those without a 60-day service gap; these lasted longer than 12 months.

* Includes Native Americans, Asians, Hispanics, other, and unknown races.

SOURCE: Medicare Payment Advisory Commission analysis of a 20 percent sample of 1996 home health claims from the Health Care Financing Administration.

Chart 6. Number of Medicare-Certified Home Health Agencies, 1990-1997

Type of Provider	1990	1992	1994	1996	1997	Average Annual Increase
Home health agency	5,793	6,419	8,057	9,886	10,582	9.0%
Hospital-based	1,543	1,786	2,207	2,593	2,702	8.3
Free-standing	4,135	4,526	5,720	7,104	7,676	9.2
Rehabilitation hospital or SNF-based	115	107	130	189	204	8.5

NOTE: Data are as of December of each year unless otherwise noted. SNF = skilled nursing facility.

SOURCE: Health Care Financing Administration, Center for Medicaid and State Operations.

Chart 7. Distribution of Home Health Episodes, by Type of Agency, Fiscal Year 1996

Agency Type	Share of All Episodes	Episode Category: Short	Medium	Long	Very Long	Continuous
Free-standing	35.9%	29.7%	32.6%	37.0%	40.8%	44.2%
Hospital-based	37.6	43.9	40.2	35.6	34.0	30.0
Government	8.4	7.3	7.7	8.5	8.1	11.3
Visiting Nurse Association	17.2	18.3	18.5	18.0	16.4	14.0
Other*	0.7	0.7	0.9	0.8	0.6	0.4

NOTE: Columns may not sum to 100 due to rounding. Short, medium, long, and very long episodes are a series of home health visits preceded and followed by a 60-day period without home health use. Short episodes lasted 30 days or less, medium episodes lasted 31 to 120 days, long episodes lasted 121 to 165 days and very long episodes lasted 166 to 366 days. Continuous episodes are those without a 60-day service gap; these lasted longer than 12 months.

* Includes services provided in Skilled Nursing and Rehabilitation facilities.

SOURCE: Medicare Payment Advisory Commission analysis of a 20 percent sample of 1996 home health claims from the Health Care Financing Administration.

Chart 8. Average Home Health Agency Costs Per Visit, by Type of Agency, 1995

Agency Type	Skilled Nursing	Physical Therapy	Occupational Therapy	Speech Pathology	Medical Social Services	Home Health Aide
All	$90	$99	$101	$105	$141	$40
Urban	88	96	99	100	135	40
Rural	98	117	123	126	166	40
Large	89	97	100	103	138	39
Medium	93	104	105	109	152	39
Small	100	113	115	118	162	43
High share of aide visits	90	101	105	108	142	39
Low share of aide visits	91	97	99	102	139	42
Visiting Nurse Association	77	78	82	84	119	38
Other free-standing	88	100	103	108	138	39
Facility-based	103	109	111	112	160	42
Voluntary	91	94	95	98	137	40
Proprietary	89	105	110	113	142	40
Government	94	101	102	107	162	39

NOTE: Agencies with a high share of aide visits were those in which 40 percent or more of visits were from aides. Small agencies provided fewer than 12,500 Medicare-covered visits annually. Large agencies provided more than 25,000 visits annually. Costs were standardized using the hospital wage index and weighted by visits.

SOURCE: Medicare Payment Advisory Commission analysis of Cycle 13 home health agency cost reports from the Health Care Financing Administration.

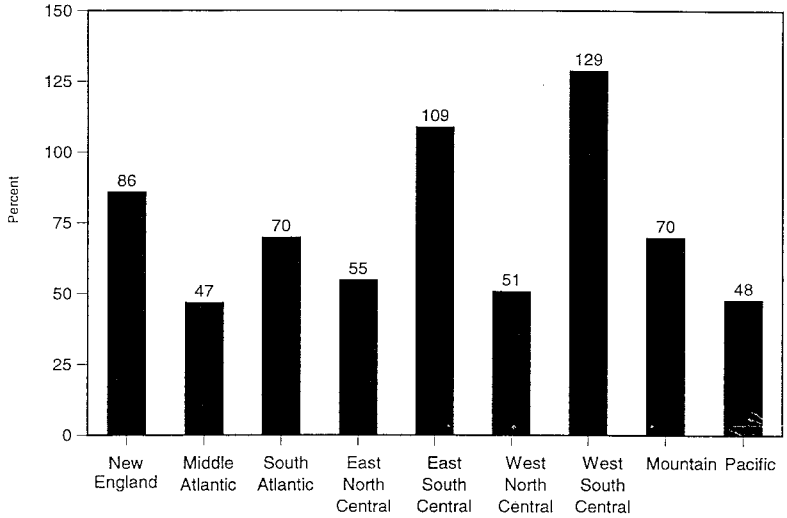
Chart 9. Relationship of Medicare Payments and Costs in Home Health Agencies, by Type of Agency, 1995

Agency Type	Payment-to-Cost Ratio	Percentage of Agencies Over Payment Limits
All	0.98	25.7%
Urban	0.98	24.3
Rural	0.98	28.8
Large	0.99	15.8
Medium	0.97	20.2
Small	0.93	35.8
High share of aide visits	0.99	21.7
Low share of aide visits	0.97	35.4
Visiting Nurse Association	1.00	5.8
Other free-standing	0.99	18.9
Facility-based	0.95	47.0
Voluntary	0.97	31.2
Proprietary	0.99	20.2
Government	0.96	34.3

NOTE: Agencies with a high share of aide visits were those in which 40 percent or more of visits were from aides. Small agencies provided fewer than 12,500 Medicare-covered visits annually. Large agencies provided more than 25,000 visits annually. Facility-based agencies include those in hospitals, skilled nursing facilities, and comprehensive outpatient rehabilitation facilities. Costs were standardized using the hospital wage index.

SOURCE: Medicare Payment Advisory Commission analysis of Cycle 13 home health agency cost reports from the Health Care Financing Administration.

Chart 10. Average Home Health Visits Per User, by Region, 1996



NOTE: Regions are based on location of the service provider.

SOURCE: Medicare Payment Advisory Commission analysis of a 20 percent sample of fiscal year 1996 home health claims from the Health Care Financing Administration.

Chairman THOMAS. Thank you very much, Doctor.

Inspector General Brown.

STATEMENT OF JUNE GIBBS BROWN, INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. BROWN. Good morning. I'm June Gibbs Brown, Inspector General of the U.S. Department of Health and Human Services.

I am pleased to be here to talk about our recently released voluntary compliance guidance for the home health industries. The guidelines are the latest in a battery of remedies addressing the extraordinary vulnerabilities inherent in the Medicare program.

Indeed, the home health program is remarkable in its vulnerabilities. In the past we have found payment error rates of 19 to 64 percent in individual home health agencies, and are 40 percent across California, Texas, Illinois, and New York.

Improper payments were made for unnecessary services, patients who were not homebound, inadequate physician certifications, and services not provided. Numerous investigations have revealed instances of outright fraud.

A recent example is a former owner of a now defunct Texas home health agency who pled guilty to conspiracy to defend Medicare. She was charged with submitting false cost reports of more than $3.6 million.

Not all of Medicare's improper payments are due to fraud, though. They probably run the gamut from innocent errors, inadequate management, financial irresponsibility, recklessness, abuse, and fraud. Whatever the underlying motives, the result is the same—significant loss to Medicare, and American taxpayers.

Fortunately, most of the vulnerabilities are being addressed through the combined efforts of the Congress, the Health Care Financing Administration, and the home care industry itself.

Many potential solutions were incorporated into the Balanced Budget Act of 1997, as well as in the regulatory and administrative initiatives of the Department of Health and Human Services.

To add to the remedies already available earlier this week, on August 4th, I released the most recent in a series of compliance guides entitled Compliance Program Guidance for Home Health Agencies. This guidance was prepared in cooperation with the Health Care Financing Administration, the Department of Justice, and the representatives of the home health industry.

It is offered to assist home health agencies in developing specific measures to combat fraud, waste, and abuse, as well as in establishing a culture of integrity that promotes prevention, detection, and resolution of misconduct. Copies have been provided for members of this subcommittee.

I wish to emphasize that this guidance is voluntary. We also encourage home health agencies to adapt these principles to their particular needs and circumstances. I am pleased to see that the home health industry has responded favorably to this guidance.

We have identified seven fundamental elements to an effective compliance program:

First, standards of conduct and written policies and procedures that promote the home health agencies' commitment to compliance and address specific areas of potential fraud. The risk areas include

claims development and submission processes, cost reporting, and financial relationships with physicians and other health care professionals and entities.

Second, the designation of a compliance officer, and other appropriate bodies, responsible for operating and monitoring the compliance program.

Third, regular, effective education and training programs for all affected employees.

Fourth, a hotline or other reporting system to receive complaints, and procedures to ensure the anonymity of complainants, and to protect them from retaliation.

Fifth, a system to respond to allegations of improper activities and enforce appropriate disciplinary action.

Sixth, audits and other evaluation techniques to monitor compliance.

Seventh, finally, the investigation and remediation of systemic problems, as well as policies to prevent employment and retention of sanctioned individuals.

One advantage of the compliance guidance is that it cultivates reform from within, rather than outside the home health agencies. I believe that each agency itself is best positioned to guarantee the integrity of its operation.

Like all recent reforms, the guidance is just the beginning, a kind of structure to be filled out and implemented by home health agencies. We are far from finished with the task of reforming home health, and we cannot drop our guard.

We hope that the new initiatives of both the Congress and the administration, coupled with the Compliance Program Guidance for Home Health Agencies, will go a long way to solving the serious problems that have plagued Medicare's home health benefit.

This concludes my prepared statement, and I will welcome any questions you have.

[The prepared statement follows:]

Home Health Issues &
HHA Compliance Guidance

Testimony of
June Gibbs Brown
Inspector General

Hearing Before:

House Committee on Ways and Means
Subcommittee on Health

August 6, 1998

Office of Inspector General
Department of Health and Human Services

Testimony of
June Gibbs Brown
Inspector General
Department of Health and Human Services

Good Morning. I am June Gibbs Brown, Inspector General of the U.S. Department of Health and Human Services. I am pleased to be here today to discuss our recently released voluntary compliance guidelines for home health agencies. The guidelines are the latest in a battery of remedies addressing the extraordinary vulnerabilities inherent in Medicare program.

Indeed, the home health program is remarkable in its vulnerabilities. Through audits, investigations, and evaluations done by the Office of Inspector General, we have found the home health benefit to be a program that grew too quickly with inadequate controls. The result has been annual losses to the Medicare program estimated in billions of misspent dollars.

Fortunately, most of the vulnerabilities have been addressed through the combined efforts of the Congress, the Health Care Financing Administration, and the home care industry itself. Many solutions were adopted in the Balanced Budget Act of 1997 (many provisions of which were promoted, developed, and refined by this Subcommittee) and in the regulatory and administrative initiatives of the Department of Health and Human Services that followed a moratorium on enrollment of new home health providers. These solutions are now being implemented through the development of a prospective payment system, increases in the number of audits, more thorough enrollment and re-enrollment procedures, and various new penalties for abusive actions.

The guidelines that I will discuss today are of this ilk--they reflect input from many sources, all concerned about preserving effective, affordable, and fraud-free home health care. And, like all the other recent reforms, the guidelines are just the beginning--a kind of structure to be filled out and implemented. We are far from finished with the task of reforming home health, and we cannot drop our guard.

We are continuing to monitor this program, and find ourselves as busy as ever investigating complaints and planning or conducting audits. However, much of the knowledge we have of problems in the Medicare home health program comes from studies and investigations carried out before enactment of the Balanced Budget Act. It is conceivable, and in fact we are hopeful, that the extent of abuse which we measured in the past has abated since the onset of intensive nation-wide interest in these problems and because of the combined focus of all parties concerned. Thus, I am somewhat reluctant to rehash well published material from the past on this subject. Nevertheless, I find a need to do so, for two reasons--first to put into perspective the environment in which the new compliance guidelines will operate, and, second, to remind us all of the risk we face in ignoring our past experiences. For if we do not stay the course with respect to the reforms that have been started, we will inevitably slip back to the point from which we are now rising. The effect will be even more waste in the home health program and possible serious financial setbacks for the Medicare program, which is already facing severe financial strain.

IDENTIFYING PROGRAM VULNERABILITIES

Our concern about home health was initially prompted by the tremendous growth in benefit expenditures. As you know, the home health benefit had been one of the fastest growing components of the Medicare program. In fiscal year 1997, Medicare expenditures for home health were close to $18 billion. This is five times the $3.5 billion spent in 1990. Home health expenditures now account for approximately 9 percent of total Medicare spending compared to 3.2 percent in 1990. Visits per home health beneficiary also increased from an average of 36 visits a year in 1990 to 80 visits in 1997. Additionally, in 1997, there were close to 10,500 home health agencies participating in the Medicare program, growing at an average rate of 100 new agencies each month.

The reasons for the rapid growth of home health expenditures are numerous. Some of the growth is appropriate and expected due to demographics, court cases which have liberalized coverage of the benefit, technological advances such as infusion therapies which can be provided at home, and a trend toward providing more care in the community rather than in institutions. However, the basic structure of the program and shortcomings in program controls opened the way to waste, fraud, and abuse.

When Medicare was established, it was not designed with potentially abusive billers and defrauders in mind. The structure of Medicare's claims system is based on the assumption that providers normally submit proper claims for services actually rendered, that are medically necessary, and that meet Medicare requirements. However, the home health benefit has been particularly susceptible to exploitation compared to other types of health services. This is because the care is provided in patients' homes with practically little or no oversight; there is limited physician involvement; there is no limit on the number of visits a home health agency can provide; there is no copayment; and, before the recent payment reforms were enacted, it was a cost based service. Further, the home health agency usually develops the plan of care and is responsible for ensuring that the care is necessary and of adequate quality. While these functions are subject to review by Medicare's regional home health intermediaries, only a small portion of claims are reviewed and most of those are paper reviews of the records submitted by the home health agency. Similarly, few cost reports are examined beyond a cursory desk review. Thus, the home health agency has primary responsibility for monitoring the care it provides and the bills it submits for that care.

The problems of fraud, waste, and abuse associated with the home health benefit are well known. We in the Office of Inspector General have reported on these problems frequently in the last several years through a large body of work including audits, investigations, inspections, and congressional testimony. The General Accounting Office (GAO) has also reported frequently on significant vulnerabilities in the home health program.

Unjustifiable Payment Variation

In a 1995 OIG report, we identified extreme variation in payments to home health agencies. For example, we compared high, medium and low cost home health agencies based on their average reimbursement per beneficiary. In FY 1993, lower cost home health agencies (those which provided less than the national average of visits per episode) averaged 30 visits per episode,

whereas the higher cost agencies provided 85. One year later, the lower cost agencies provided 33 visits per episode, while the average for the higher cost agencies jumped to 102. We found no reasonable explanations for these differences. For example, there were no differences in beneficiary characteristics, medical conditions, nor in the quality of care provided.

Improper Payments

In our work we have identified an exceptional level of inappropriate payments made under this program. Our first evidence came from audit reports and investigations of certain providers suspected of defrauding the program. Audits of specific home health agencies in Florida, Pennsylvania, and California revealed error rates in paid services from 19 to 64 percent. These were due to visits that were not reasonable or necessary, patients who were not homebound, visits which were not documented or even provided to Medicare beneficiaries, improper or missing physician authorizations, and even forged physician signatures. We also conducted a Statewide audit in Florida in 1995. We found an error rate--the percent of the home health visits paid for by Medicare but which did not meet Medicare guidelines--of about 20 percent.

In our report, "Review of Medicare Home Health Services in California, Illinois, New York, and Texas," issued in June of last year, we found that 40 percent of the total services provided during the 15-month period ending March 31, 1996 did not meet Medicare reimbursement requirements. The explanations were similar to those of the earlier audits: unnecessary services, patients not homebound, inadequate physician authorization and lack of supporting documentation. This represents $2.6 billion in charges, or 39 percent of the $6.7 billion of the universe of claims represented by the sample. In this four-state audit, we reviewed 250 claims accounting for 3,745 services from a randomly selected sample of home health agencies. For these cases, our auditors interviewed beneficiaries, family members, knowledgeable acquaintances, and certifying physicians and obtained medical review by Medicare's home health intermediary personnel.

Enrollment and Oversight

The inability of Medicare to effectively identify improper claims before payment combined with the ease of entry of home health agencies into the program makes the Medicare trust fund especially vulnerable to losses from the home health program. Medicare's initial survey and certification process was not designed to screen out potential violators of Medicare's reimbursement requirements, but primarily to assess whether a home health agency is capable of delivering quality home health services. Practically anyone who has met State and local requirements for starting a home health agency has been almost certain of obtaining Medicare certification. According to a recent GAO report "Medicare Home Health Agencies: Certification Process Ineffective in Excluding Problem Agencies" (GAO/HEHS-98-29), it has been rare for a home health agency not to meet Medicare's three fundamental certification requirements: 1) being financially solvent; 2) complying with Title VI of the Civil Rights Act of 1964, which prohibits discrimination; and 3) meeting Medicare's conditions of participation. The GAO report concluded that "home health agencies self-certify their solvency, agree to comply with the law, and undergo an initial certification survey that few fail." HCFA is currently revising its conditions of participation for home health agencies.

In other recent work, we have explored further program vulnerabilities associated with allowing problem providers into the Medicare home health program. On the same day we issued the four-state audit mentioned above, we issued another report, "Home Health: Problem Providers and Their Impact on Medicare." This report was based on a statistical analysis of home health agencies in New York, Florida, Illinois, Texas, and California which met our definition of a problem provider--one that was identified by HCFA, an intermediary, a state certification or licensing agency, or our own Office of Inspector General as having a history of significant uncollected overpayments, unreliable and un-auditable cost reports, medically unnecessary services, services not rendered, significant certification deficiencies, and referrals to program integrity or fraud units.

Here we began to see a picture of a group of providers who were able to generate large profits with very little risk to themselves or their businesses. We are greatly concerned that irresponsible home health agencies pose a threat to the home health program and the Medicare trust fund. One illustration of this is that 60 problem agencies, selected at random in our study and analyzed in detail, had a combined outstanding debt to Medicare of $321 million; their individual agency overpayments ranged from $100,000 to several million dollars. Of that amount, at least $63 million will never be recovered, because eleven of these home health agencies are no longer in business, have no assets, or have filed for bankruptcy.

Recent evidence suggests that the vulnerabilities uncovered in our sample are likely to be reflected in the program at large. HCFA reported that, in 1996, 7 percent of payments to home health agencies represented overpayments. This amounted to approximately $1 billion. Of this, close to $154 million (14 percent) has still not been collected. Further, in 1996, 89 home health agencies left the Medicare program and currently still owe $66 million in overpayments.

We believe, however, that these numbers represent only the tip of the iceberg. As noted earlier, because of limited funding, regional home health intermediaries have only been able to do a very small number of in-depth claims and cost report audits. Our four-state audit of home health agencies which involved close scrutiny of a random sample of home health claims, revealed that 40 percent of these claims, representing $2.6 billion, should not have been paid. This error rate was discovered only by conducting intensive in-person interviews with patients and their physicians and by carefully examining the underlying medical records. Improved claims and cost report reviews would undoubtedly reveal far greater amounts of overpayments, and thus of potential non-recoveries, than HCFA is currently reporting.

Inappropriate Bankruptcy Protections

Under current law health care providers can use the protections afforded by the Bankruptcy Code to avoid the imposition of administrative sanctions or collection of Medicare overpayments. Even if a home health agency still has assets after filing for bankruptcy, providers can make strategic use of two devices -- the *automatic stay* and the *discharge* provisions of the Bankruptcy Code. Under the automatic stay provision, providers can respond to the threat or imposition of an administrative sanction by filing a petition in bankruptcy and then asserting that the automatic stay bars any further sanction activity. Indeed, in 1995, the U.S. Bankruptcy Court in the Eastern District of Pennsylvania found the Department of Health and Human Services in contempt for violating the court's automatic stay after DHHS sought to exclude a podiatrist who refused to

repay his Health Education Assistance Loan. Under the discharge provision, the home health agency can assert that any overpayment or civil monetary penalty due to the Medicare program is discharged and does not survive the bankruptcy proceeding.

It is thus still possible for wrong doers to use bankruptcy protection as a way to avoid responsibility for repayment of overpayments, fines, or penalties and in some cases even circumvent a program exclusion. The cases we deal with are not those where a legitimate business declares bankruptcy because of unfavorable economic or business conditions. Rather, the bankruptcy is used subsequent to a fine or penalty to allow the agency to avoid completely any financial responsibility for wrong doing. We are also concerned about using the bankruptcy law to prevent the Secretary from suspending Medicare payments to a provider under investigation for fraud.

Examples of Damage and Vulnerability

The examples below shed light on how easy it has been to defraud the Medicare home health program and how much irreparable damage can be caused. Here is a synopsis of some of our recent audit and investigative cases involving serious losses to the Trust Fund:

- **January 1997** - A former owner of a Texas home health agency was sentenced to 27 months incarceration after pleading guilty to submitting bills to Medicare for visits her company did not make. The lengthy sentence was partially due to a prior State conviction for embezzlement. She was in business for only six months and submitted false Medicare claims for $49,000. She agreed to waive rights to $190,380 as reflected in her 1994 Medicare cost report. No fines or restitutions were assessed because of her financial condition.

- **April 1997** - Information was filed in Texas against an accountant on the basis of a negotiated plea for making fraudulent cost reports to Medicare. The plea is the result of an ongoing joint investigation by the Office of Inspector General and the FBI. The accountant prepared cost reports for various home health agencies. One home health agency owner reported being approached with a scheme in which the accountant offered to make false entries on the owner's cost report as bonuses paid to employees, and the employees would kick back the bonuses to the owner. The accountant's scheme was uncovered through the cooperation of this owner and he agreed to plead guilty and cooperate with the Government in investigating other home health agency owners.

- **August 1997** - The owner and operator of a management firm that provided accounting and management services, as well as nine home health agencies which contracted with the firm, was sentenced in Utah to serve 15 months in jail and 18 months supervised probation for filing false Medicare claims. The relationship between the HHAs and the firm was not disclosed and the owner pled guilty to filing false Medicare claims, paying kickbacks and filing false tax returns. The overpayment was $3.5 million, however assessment and forfeiture actions resulted in the recovery of only $219,470. The owner had no other assets.

- **September 1997** - The owner of a home health and limited care agency in Missouri was sentenced to serve 15 months in prison, to make restitution of $64,980, and to submit to three years supervised release. In a jury trial she was found guilty of submitting false billings to Medicare and transferring the operating and services costs from the limited care operation, which was not Medicare-certified, to the home health agency, which was certified.

- **November 1997** - The owner of two home health agencies in Texas was sentenced for making false statements in a Medicare cost report. Her family wrote off personal expenses in the cost reports, by funneling proceeds through the two home health agencies and eventually into the family's personal bank account. She was sentenced to 42 months in prison and 3 years probation and ordered to make restitution totaling more than $2.26 million and fined $111,540. She was further ordered to make immediate payment of more than $66,370, which was the profit from sale of her residence, and to forfeit two parcels of property, estimated as worth $300,000, to be paid to the Department. The home health agencies were placed on 5 years probation.

- **April 1998** - The owner of a Texas home health agency pled guilty to charges related to a false Medicare report and obstruction of justice. In June 1996, the owner filed a cost report with more than $500,000 in unsubstantiated costs, most of which were payroll and related costs never paid. In July 1996, he filed an amended report claiming another $62,000 in consulting fees, allegedly paid in cash, which could not be substantiated. Later the owner used false Internal Revenue Service forms to try to convince an auditor about the unsubstantiated costs, and tried to convince a Government witness to accept responsibility for them. His meeting with the witness was video-taped by investigators. In April 1998 he was sentenced to 18 months in prison and ordered to make restitution of $312,800.

- **June 1998** - The former administrator/owner of a Maine home health agency, pled guilty for herself and her corporation to defrauding Medicare and Medicaid. During 1993 and 1994, false cost reports were filed that were based on fictitious invoices for office improvements, supplies, computer software development, equipment purchases and rent. In addition, the corporation made false statements in failing to reveal related-party transactions.

- **June 1998** - Mother and daughter home health agency owners were indicted in Texas for making false statements about home health visits. The mother, who was an administrator of a home health agency, directed the daughter, who also worked there, to falsify Medicare claims for visits not made. As a result, the agency was overpaid $67,000. They both entered the Pre-Trial Division Program and were each ordered to make restitution of $8,041.

- **July 1998** - The former owner of a now-defunct home health agency pled guilty in Texas to conspiracy to defraud Medicare. She had been indicted on charges related to falsely claiming more than $3.6 million in Medicare cost reports. As part of her plea agreement full restitution will be made by the former owner.

RECENT INITIATIVES TO REDUCE FRAUD AND ABUSE

It is clear from the description above that the Medicare home health program was vulnerable from every single entry and control point, and no one approach would do. We needed a battery of remedies to address all of the vulnerabilities simultaneously. While many different organizations and individuals were involved in the program, each one was lacking the responsibility, resources, or motivation to worry about it or to take action to plug the leaks. The solution would have to respond in kind--it would need to systematically respond to every vulnerability and engage all the players involved in it through both incentives and formal control systems.

In our recommendations, therefore, we emphasized the need for structural reforms in the payment method, steps to keep unsuitable home health care providers from participating in the program, and measures to improve program controls.

The Balanced Budget Act, signed into law August 5, 1997, contains a number of important provisions to help prevent Medicare fraud and abuse and to promote responsible program enforcement. These measures, which include moving to a prospective payment system, will help to control the rapidly growing cost of home health benefits. Additionally, the Secretary has made significant changes to program operations to crack down on abuse in home health. All of these actions are consistent with and responsive to our past recommendations. The combined impact of enactment of the new legislation and strong administrative actions should go a long way to address problems in the home health industry.

Prospective Payment System

The most fundamental reform brought about by the Balanced Budget Act is the establishment of a prospective payment system for the home health benefit. We have been, and continue to be, strong advocates of such a system. The Act gives the Secretary of HHS authority to establish a prospective payment system for home health services. Instead of open-ended billing, HCFA will determine, in advance, what it will pay for a unit of service, how many visits will be included in that unit and what mix of services will be provided. Payment for a unit of home health service will be modified by a case mix adjustor to account for variations in cost due to differences in patient case-mix. Under this system, it will no longer be profitable for home health providers to provide unneeded services. Upon implementation of the prospective payment system, periodic interim payments will be eliminated.

In the meantime, while the prospective payment system is being developed, the BBA prescribes an interim payment system which limits both prices and global payments per beneficiary.

Enrollment of New Providers

Legislative Changes. The Balanced Budget Act addresses a number of serious vulnerabilities in the process of enrolling home health agencies into the Medicare program. For example, it authorizes the Secretary to collect Social Security numbers and Employer Identification numbers from providers. The OIG, HCFA, and the GAO have been in general agreement in recent years that this authority is critical to monitor provider billing activities effectively and to keep excluded

or other problematic providers from coming back into the program under the cloak of new business arrangements.

Additionally, the new law authorizes HCFA to refuse to enter into contracts with felons. The Secretary could stipulate, for example, that individuals convicted of embezzlement not be allowed to enroll as a Medicare provider even if the conviction did not occur in connection with a health care business. The OIG will also be able to exclude from the Medicare program entities owned or controlled by the family or household members of excluded individuals. For example, some excluded providers have been able to escape the impact of their sanctions by expediting transfers on paper of their ownership and control interests in health care entities to family or household members while retaining true, silent control of the businesses. We were also pleased to see the new "Three Strikes, You're Out" provision that mandates a lifelong exclusion from participation in any Federal health care program for any provider who is found guilty of health care fraud for the third time.

Administrative Remedies. From September 15, 1997 until January 13, 1998, the Administration placed a moratorium on admitting new agencies into the Medicare program. The moratorium was called in response to reports of "the steadily increasing volume of investigations, indictments, and convictions against home health agencies." The moratorium was intended to stop the admission of untrustworthy providers while HCFA strengthened its requirements for entering the program. HCFA used this time to develop the new surety bond regulations (as mandated by the Balanced Budget Act), capital requirements to ensure adequate operating funds, and procedures to better scrutinize the integrity of home health agency applicants. Prior to the moratorium, Medicare was certifying an average of 100 new home health agencies each month.

The Department has also proposed a requirement for home health agencies to re-enroll in Medicare every three years. As part of the re-enrollment process, agencies will be required to submit an independent audit of their records and practices. If the agency does not meet the strict new enrollment requirements, they will not be renewed as providers in Medicare. This will help to detect and deter fraudulent practices. Additionally, HCFA now requires agencies to serve a minimum of 10 private-pay patients prior to seeking Medicare certification. Serving private-pay patients will demonstrate experience and expertise in the field before an agency is allowed to serve Medicare and Medicaid's vulnerable populations. Further, HCFA will increase the number of claim reviews from 200,000 per year to 250,000 and the number of home health agency audits will double.

One key change that has been implemented by HCFA is a requirement that home health agencies supply information about related businesses they own. Often, unscrupulous home health agencies funnel fraudulent activities through subsidiaries or front companies that do not really exist. Home health agencies are also required to provide information pertaining to individuals and entities deriving financial benefit from the Medicare program. For example, information is required as to the identity of each person with an ownership or control interest in the enrolling entity or in any subcontractor that the enrolling entity has a direct or indirect ownership interest of 5 percent or more. Similar information is required for managing and directing employees. Home health agencies will have to file the form for the every-three-years recertification HCFA is planning.

Regional home health intermediaries will now be required to develop information systems which will enable them to scrutinize related business interests far more closely than in the past. For example, intermediaries will check on the accuracy against information such as state and local business registrations, bankruptcy, lien and judgement records. A history of related business problems, including bankruptcies, serious legal actions, felonies, a lack of business activity and slow payment to creditors would trigger medical reviews or audits of the home health agency in question and effectively serve to screen out prohibited providers. Knowing that a related business has a history of bankruptcy, for example, could help HCFA make certain the home health agency doesn't walk away from an overpayment debt owed Medicare.

OIG HOME HEALTH COMPLIANCE PROGRAM

Along with the program improvements described above that are largely HCFA's responsibility, my office will continue its audits, inspections, and investigations to prevent, detect, and curb abuses. However, protecting the integrity of the health care systems requires more than just investigating past violations of law and punishing wrongdoers. Therefore, we have also engaged in numerous proactive efforts designed to help the industry comply with Medicare program requirements by identifying and preventing potential health care fraud. Key among our preventative efforts has been our attempt to develop compliance program guidance in collaboration with members of the health care industry.

Earlier this week, on August 4, I released the most recent in a series of compliance guides, entitled "Compliance Program Guidance for Home Health Agencies." This guidance, prepared in cooperation with the Health Care Financing Administration, the Department of Justice, and representatives of the home health industry, is offered to assist home health agencies in developing specific measures to combat fraud, waste and abuse, as well as in establishing a culture that promotes prevention, detection, and resolution of instances of misconduct.

These voluntary guidelines are part of the OIG's continuing efforts to work with health care providers to promote compliance with the applicable statutes, regulations, and program requirements of the federal and other health care programs. In addition to the home health agency guidance, we have already released the first two compliance guidelines, which focused on the clinical laboratory industry and hospitals. We intend to provide similar guidance to other industry sectors, including billing companies, durable medical equipment and hospice in the coming months. In addition, the OIG has issued fraud alerts, advisory opinions, and other guidance as part of an ongoing effort to promote the highest level of ethical and lawful conduct by the health care industry.

Fundamental Elements

The Compliance Program Guidance for Home Health Agencies, like the guidance provided to hospitals and clinical laboratories, is premised on the OIG's belief that a health care provider should use internal controls to efficiently monitor adherence to applicable statutes, regulations, and program requirements. There are seven fundamental elements to an effective compliance program.

Written Policies and Procedures - The development and distribution of written standards of conduct, as well as written policies and procedures that promote a provider's commitment to compliance and address specific areas of potential fraud, such as claims development and submission processes, cost reporting, and financial relationships with physicians and other health care professionals and entities.

Compliance Officer - the designation of a compliance officer and other appropriate bodies (e.g., a corporate compliance committee), charged with the responsibility for operating and monitoring the compliance program, and who reports directly to the CEO and the governing body.

Training - the development and implementation of regular, effective education and training programs for all affected employees.

Lines of Communication - the creation and maintenance of a process, such as a hotline or other reporting system, to receive complaints, and the adoption of procedures to protect the anonymity of complainants and to protect whistleblowers from retaliation.

Disciplinary Guidelines - the development of a system to respond to allegations of improper/illegal activities and the enforcement of appropriate disciplinary action against employees who have violated internal compliance policies, applicable statutes, regulations, or federal health care program requirements.

Auditing and Monitoring - the use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified problem areas.

Corrective Action - the investigation and remediation of identified systemic problems and the development of policies addressing the non-employment or retention of sanctioned individuals.

Using these seven building blocks, the OIG has identified specific areas of home health operations that, based on prior Government enforcement efforts and input from industry representatives, have proven to be vulnerable to fraud and abuse.

Examples of Risk Areas and Preventative Measures

Kickbacks and Improper Referrals. Kickbacks and improper referrals are problems affecting many segments of the health care industry, and we advise home health agencies to have policies and procedures in place with respect to compliance with Federal and State anti-kickback statutes, as well as the physician self-referral law. Arrangements that may run afoul of the anti-kickback statute include when a home health agency: pays a fee to a physician for each plan of care certified; provides items or services for free or below fair market value to beneficiaries of federal health care programs; provides nursing or administrative services for free or below fair market value to physicians, hospitals and other potential referral sources; or provides salaries to a referring physician for services either not rendered or in excess of fair market value for services rendered.

Medical Necessity of Services. The medical necessity of services provided to patients and billed to government and private health care insurance programs is another area requiring the scrutiny under a home health agency's compliance program. We strongly advise that an agency's compliance program ensure that claims are submitted only for services that the home health agency has reason to believe are medically necessary and were ordered by a physician or other appropriately licensed individual. Providers should not bill for services that do not meet the applicable standards. The home health agency is in a unique position to deliver this information to the health care professionals on its staff and to the physicians who refer patients. We recommend that home health agencies formulate policies and procedures that include periodic clinical reviews, both prior and subsequent to billing for services, as a means of verifying that patients are receiving only medically necessary services.

Coverage Criteria for Reimbursement. In addition to ensuring that claims submitted for reimbursement accurately represent medically necessary services actually provided, home health agencies should confirm that such services are supported by sufficient documentation, and in conformity with any applicable coverage criteria for reimbursement. Our guidance suggests that a home health agency's written policies and procedures concerning proper billing should reflect the current reimbursement principles set forth in applicable regulations. In addition to medical necessity, particular attention should be paid to issues associated with Medicare coverage criteria such as homebound status of beneficiary, physician certification of plan of care, and qualifying services to establish coverage eligibility.

Screening Employees. Since providers of home health services have frequent, relatively unsupervised access to potentially vulnerable people and their property, the OIG believes that a home health agency should establish policies concerning whether it will employ individuals who have been convicted of crimes of violence or financial misconduct, as well as crimes directly related to the delivery of health care. In our guidelines, we recommend that home health agencies conduct a background investigation, including a reference check, as part of every employment application. As part of its compliance program, the home health agency should prohibit the employment of individuals who have been recently convicted of a criminal offense related to health care or who are listed as debarred, excluded, or otherwise ineligible for participation in Federal health care programs. A criminal background screening not only identifies applicants who may have been recently convicted of serious crimes that relate to the proposed employment duties, but also may deter those individuals with criminal intent from entering the field of home health. Slightly over a quarter of the states require, and several home health agencies voluntarily conduct criminal background checks for prospective employees of home health agencies.

Potential Risks Related to Prospective Payment. Once the Department of Health and Human Services institutes the prospective payment system, home health agencies will have to guard against new types of fraud, abuse, and waste that might arise in such a reimbursement system. Potential risks may include failure to report or mischaracterization of a change in patient conditions used to establish the charge, denial of medically necessary care resulting in under-utilization, and duplicate billing of charges subsumed within the payment. Accordingly, we have recommended in our guidance that home health agencies should prepare in advance to implement policies and procedures to properly address any potential risk areas associated with the prospective payment system.

Benefits of the Compliance Program

There are a number of tangible and intangible benefits that can be realized from the voluntary adoption of compliance measures. Perhaps most importantly, a provider will have taken steps to ensure that it is operating at a high level of ethical and lawful behavior and thus enhance its reputation as a good corporate citizen. In addition, an effective compliance program can reduce a provider's risk of submitting improper claims, and thus protects the organization from the disruption and potentially disastrous consequences of a fraud investigation. Finally, in the event that improper conduct occurs despite the existence of an effective program of compliance, we consider the existence of an effective compliance program as a mitigating factor when determining whether to impose administrative sanctions against the organization.

Copies of the Compliance Program Guidance for Home Health Agencies, as well as other materials developed by this office as part of its effort to identify and curb health care fraud, are available on the Internet at *http://www.dhhs.gov/progorg/oig*.

CONCLUSION

Earlier in my testimony, I mentioned that the vulnerabilities in the Medicare program were so numerous and pervasive that no one solution would be enough to protect it. The compliance guidelines which we just issued are, therefore, a part of the battery of remedies that have been established through legislative or administrative action. One difference between these guidelines and other reforms, though, is this--they cultivate reform from within rather than from outside of the home care industry. It is the home health agencies themselves that are best positioned to guarantee the integrity of their product. We hope that the new initiatives of both the Congress and the Administration, coupled with our Compliance Program Guidance for Home Health Agencies, will go a long way to solving the serious problems that have afflicted Medicare's home health benefit.

This concludes my prepared statement. I welcome any questions that you may have.

Chairman THOMAS. Thank you, Ms. Brown. You indicated a couple of examples, and I know in your written text there are a number of examples, and they seem to be, a significant percentage of them, from one state.

I know that when you launched your Operation Restore Trust, you did so initially in just five states, I believe.

Ms. BROWN. That's right.

Chairman THOMAS. What was the rationale for choosing Florida, Illinois, Texas, New York, and California?

Ms. BROWN. Those states represented a cross-section of the country, and a great deal of the Medicare money was spent in those states. (so) We felt that we could get some experience in looking in those concentrated areas and then expand to the rest of the country.

Chairman THOMAS. The assumption would be that the bulk of the examples that you would have available would be atypical, because you drew those states initially?

Ms. BROWN. That's right. They aren't typical of the proportion of problems in those states, but only that we have finished those at an earlier point in time.

Chairman THOMAS. I wanted to make that point, and that as you do the nationwide examination, unfortunately, you'll have a number of examples that you could present from every state——

Ms. BROWN. I believe so.

Chairman THOMAS [continuing]. Unfortunately, in the Union.

Dr. Wilensky, this problem is even more difficult for us than some others that we have tried to deal with, because of the computer situation at HCFA, but also the game that apparently a majority of my colleagues believe is important to play, and the administration indicated it was going to be, perhaps, a requirement as well, and that's budget neutrality.

The difficulty I think some of us are having is that we could not believe the lack of information that had been collected, or the usefulness of the lack of information that had been collected, when everyone knew this is one of the fastest-growing expenses in the Medicare area, so that a lot of what we've been doing, frankly, is guessing.

We are now at the stage where we are examining, if you will, our first guess, and we need to look at options.

How critical is it, in your opinion, as we look at options to ease the transition for a longer period of time, now, as Dr. Scanlon indicated, to try to do this in a revenue neutral environment?

Can you move enough parts around to have any kind of a meaningful impact in a revenue neutral environment, or should we look at possible additions of modest sums, or significant sums, in making these adjustments?

How critical is it to do it with no new money, or how critical is it to do it minimally right for the period we are going to have to live with, with some addition of funds?

Ms. WILENSKY. If you knew more about either appropriate clinical standards of care in home care, and more importantly, the case mix that various agencies had, it might be possible to do this in a budget neutral way, but the fact is you don't know that.

So you will be flying blind. You can change the mix of money, and all you will know is that there will be winners or losers. You will have no reason to assume that the winners are the good guys or the agencies that have sicker patients and the losers are the ones that are profligate in their funds.

Given that that's the case—and again, I implore you, at one step, to try to engage in activities that will fix that—you obviously can make a case for putting a little more money in, both on the grounds that the surplus seems to be bigger than what was being anticipated initially, and that the slowdown in spending is greater than was anticipated in the BBA.

As you know better than I do, that does not give you any automatic call on those funds, but it is something that indicates more of an impact than was scheduled, not surprisingly. That, of course, happened at the beginning of PPS for hospitals, as well. The very first year was a bigger impact.

Chairman THOMAS. I'll borrow the gentlewoman from Connecticut's question to HCFA.

Do you consider the situation we are in, in dealing with the home health care, and the ability to maintain adequate home health care, an emergency situation? Is it a very serious situation? What kind of a context should we be examining this in, in terms of immediacy of need for action and degree of action?

Ms. WILENSKY. I don't think there is any indication yet it's an emergency. It is somewhere between serious and very serious. More money is coming out than we anticipated, and that's a fact.

My understanding is that there is a net increase of agencies, home health care agencies. There is not any available evidence that there is either a big dropoff in agencies or an access problem for the seniors themselves.

The difficulty is, by the time we actually can see either of those, we will have caused a problem. If you want to take the first step and say substantially more money is coming out of the system than we anticipated, we are at least setting ourselves up for a problem, although there is no documentation yet that we have one. So it is, at the very least, a serious problem.

Chairman THOMAS. As I indicated at the beginning, we can talk about examining the blend, but because the variation, intrastate, is as great or greater than the variation interstate——

Ms. BROWN. Correct.

Chairman THOMAS [continuing]. It is extremely difficult, just in adjusting the blend, to really deal with the problem.

We could deal with the per-visit. Since we changed it from the mean to the median, we can play with the percentage in that area.

The outlier has been mentioned, just for those who don't have the ability to deal with a case mix, either pre or post, and simply deal with the reality that some folks fall outside it.

Would those be the universe of appropriate examinations? Now, I know you mentioned a co-pay, and my colleagues here—I've discussed it with them—are not as enamored with that. Obviously, that involves a slight behavioral change in terms of choices that are made.

You indicated a limit, which would limit the impact on lower income. Of course, Medicaid takes care of that bottom end, anyway.

Have you looked, at all, along the lines of a moratorium in areas where there clearly appear to be a sufficient number of agencies, or is that a policy that probably would not be looked at if you could deal with it in terms of the blend, the per-visit, the outlier?

Ms. WILENSKY. A moratorium on going forward with the payment, or——

Chairman THOMAS. No, a moratorium on new home health agencies in those areas where—using some criteria for adequateness or number of agencies.

Ms. WILENSKY. We haven't. At least, I am not aware of it. Personally, I don't think that having a moratorium on a number of agencies is the way that I would recommend going forward to try to solve this problem.

Chairman THOMAS. Thank you very much. I believe this is the first statement that anybody has made today that indicates that one option probably is one that we ought not to pursue. Thank you very much.

Ms. WILENSKY. You're very welcome. Let me tell you, there is a blend that I was having a brief discussion on in terms of what will be arbitrary changes in blends that might provide some assistance.

That is, rather than the agency national as the primary blend, looking at the differences in the number of visits that are skilled nursing versus home health care aides, as a type of a blend on the grounds that that may be picking up some differences in the case mix.

The point is, it is possible that, having MedPAC staff work with some of your staffs, that we might be able to come up with some short-term interim fixes to try to proxy better than what we have now in terms of the intensity of need.

Again, I plead with you to try to make sure you have either legislative authority or other pushes to get going on the data. It is impossible not to fly blind without it.

Chairman THOMAS. Is our time frame that I tried to indicate—doing a lot of heavy lifting over August, so that when we come back in September, we will have to the best of our ability, the solution that is the best that we can provide on a bipartisan basis—an appropriate time frame?

That is, we need to respond as soon as possible, notwithstanding the desire the longer we go the better info we have?

Ms. WILENSKY. The fact is, you don't have much information, and you're not going to have it in the next few months, so you might as well come up——

Chairman THOMAS. Just let me interrupt you, and underscore that, in looking through what we had mandated, it isn't until October 1, 1998 that the home health care agencies are required to specify by code to the Secretary the length of the service visit in terms of 15-minute increments, so we don't even know the length of the visits.

Ms. WILENSKY. And we know, of course, nothing about the content.

Chairman THOMAS. The content of the visits. That kind of underscores what we do. The point is, though, that if we wait longer, we are not really going to have any more resources available to us for making a better judgment on the changes that might be needed.

Ms. WILENSKY. In terms of the short-term options, I think you will have as much as you're likely to have when you come back in the fall, and as you know the calendar as well as I do, if you don't do something then, it will be at least until the springtime before you can do something. I don't know that you will have substantially greater substantive information in terms of intensity or content by that time.

So my recommendation is, if you re interested in moving ahead, moving ahead in September is as appropriate as waiting another five months.

Chairman THOMAS. My assumption is you believe that we should be interested?

Ms. WILENSKY. I think that, because of the magnitude of the change, the potential for doing things you didn't intend is greater than if it had been about the amount you expected.

Chairman THOMAS. Thank you very much. Mr. Stark.

Mr. STARK. No questions.

Chairman THOMAS. The gentlewoman from Connecticut.

Mrs. JOHNSON. Thank you. I was interested in your comments about a moratorium.

You know, the Dartmouth studies show, in their comparison of Boston and New Haven, that the availability of services definitely influences the amount of services delivered, and that that amount can't always be correlated with quality of care.

So it does seem to me that, first of all, we certainly can look at the kinds of savings that would be realized if high-resource, high-utilization regions were constrained to a lower-resource, lower-utilization pattern. Look at New Haven and Boston. You know, there are some things that you can learn.

The question I would ask you is twofold.

First of all, what do we know about the payment rates of the new agencies? Do we know that, on average, or whatever, that the new agencies coming in are coming in at higher reimbursement rates—I think this is generally true in my part of the country—as opposed to the older agencies that are there?

If that is the case it is an overall loss to Medicare to have older, lower-cost providers leave the market and higher-cost new providers come into the system.

We need to look at who is coming in, what is it costing us, who is going out, and are they going out because they are low-cost, efficient providers, because that is not in our interest. In that case, we might want to have a moratorium in areas where there is already a high level of providers.

Then I think this issue of looking at what are the other services we are paying for in those areas is important, so that we can set home health care costs in the context of other services.

I would hope that you wouldn't dismiss the possibility of a targeted moratorium until PPS goes in, as one of the possible tools in constraining costs and, frankly, freeing up the dollars we definitely need if we are going to solve this problem.

If we are not going to use any of the surplus, then there has to be—and you can't solve this problem budget neutral. Then you're just going to shift around the pain. If you're going to have some

new money to put in, you're going to think about where it's going to come from.

It seems to me a moratorium in the dense, high-resource areas has some merit.

Ms. WILENSKY. You raised several issues. Let me try to briefly respond to them.

There is some dispute about whether availability of services drives demand. If it did, we wouldn't have hospitals at 60 percent occupancy. It is much more complicated than just if they're there, people will come.

The second issue is that variations exist all over Medicare, as they do all over health care, and to try to respond to them in one sector without looking at variations in other part of Medicare is very, I think, dangerous.

We have enormous variations in the service of care—Mr. McDermott raised this earlier—in terms of Florida and California versus the state of Washington and the state of Oregon and the state of Minnesota, for example.

The whole issue of should we narrow the amount that Medicare allows for in terms of variation in practice style, and at which level should we aim for, is a serious issue, one that MedPAC and its predecessor commissions dealt with, and I think it is an important issue for the Congress to deal with.

We have to be very careful to look at home care as the only service in which you are really doing, because the fact is, states differ in terms of how much home care they use vis-a-vis physician care and hospital care and skilled nursing care, and I think to put a moratorium in one area alone is to ask for difficulties, because it's not the broader context.

Finally, if it is really only the concern that new agencies are getting paid at higher rates and some of the older agencies that may be exiting, although we don't know much about older agencies exiting and whether they are efficient, you could, of course, pay them at the lower cost. You can have the payment for new agencies at whatever payment level you want.

Rather than put a moratorium on, if you think that the newer agencies are getting paid too much, there are ways to fix that.

Again, I spoke, obviously, not on behalf of the commission, in response to Mr. Thomas's comment, but on behalf of myself as a market economist, and I don't think moratoriums are a good way to go.

Mrs. JOHNSON. I appreciate, particularly as a market economist, why you would not be interested in moratoriums. But we are talking about an interim between now and a payment system that we think will be more sensitive to the product that we're trying to deliver and the price of that product.

There is a macro difference. I mean, there are certificate of need states. Mine happens to be one, too.

To look at the configuration of the services, not just home care, but the others, in those states versus other states—we certainly did find, when we looked at specialty care and Medicare, that there was a very different use of specialists and number of second, third, fourth, and fifth opinions in areas where those services were easily available.

It does seem to me, at a time when we are under such enormous pressure, that it is at least something that we have to look at. Maybe we don't call it a moratorium. Maybe we look at it in the certificate of need context.

Ms. WILENSKY. Of course, MedPAC would be glad to respond to any request for an analysis on this issue that we would have.

Mrs. JOHNSON. Thank you.

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

Mr. CARDIN. Yes. Thank you, Mr. Chairman. I thank the panelists for their testimony.

Dr. Wilensky, I accept your characterization that the situation is somewhere between serious and very serious, as it relates to the entire circumstances on home health reimbursement under the interim payment system.

As related to me, I think it has reached the critical or emergency stage in some places. Let me just give you a few of the examples that have been given to us, and get all of your input here.

There are many areas that, because we are using historical agency-specific costs, to such a high degree, that where agencies has already brought down the costs, they are being more adversely impacted than in those areas of the country that have had higher utilization and costs.

In those areas, we have reached the critical point, because of the reliance on the agency cost data, and it cries out for some change in the mix immediately.

We also have problems in rural areas, that the per-visit limit is so conservative, that there is need for a change there if we're going to be able to provide services in rural areas, where the number of patients that you can see in a given day is much less than in other areas.

Thirdly, for those agencies that have made special efforts on difficult patients, the outliers, having some form of an outlier payment seems to make some sense on an emergency basis, in order to be able to continue this type of service.

I agree with Mrs. Johnson that to try to do this without putting more money into the system is going to be impossible.

First of all, as you pointed out, Dr. Wilensky, the dollars have already been stretched more than we thought they would be, and there is at least some indication that there we have gone too far.

Secondly, the politics of trying to deal with taking money from someone to pay others just won't work. We're going to have to come up with some new money in this area.

My point—and I would like to get all of your reactions, if I could—is that I think we've passed the very serious situation, as it relates to these three specific points in some agencies and that, if we don't take action quickly, we do run the risk, in areas of our country, of seeing services actually be eliminated and not available.

Ms. WILENSKY. There is some question that, if you wait until you can document the problem, you will, in fact, have gone much farther than I believe that you wish to.

On the other hand, we clearly, as I said, don't have any national system, and it is much easier to do it if it is not budget neutral,

particularly when you don't have very good information on which to take money out of the pie.

The outlier payment, I think, is actually not one I have given a lot of thought to. Personally, I think it is one, particularly if you were to demand more information to justify the outlier payment, that might help in the short term, while we are getting better data.

It is a very skewed distribution of monies in home care. As I mentioned earlier, something like 15 percent of the patients use, or the beneficiaries, use more than 150 visits, but they account for a very large amount of the dollars.

That means that you actually might be able, depending on whether you used number of visits or the cost per visit, or either, as an outlier potential, to demand supporting data for these cases, so at least you would have a little better sense that, in the outlier payments, that you had some idea about what you were paying for, although you didn't know compared to what.

I think that might well be a way to start, while we go collect better data.

Mr. CARDIN. Dr. Scanlon, if we wait and do nothing, what is the risk here? Are there going to be agencies that are going to close? Are there going to be services that are not going to be provided?

Mr. SCANLON. Both could potentially happen. I think that, as you have indicated, the issue is localized. It applies to particular agencies; it may apply to particular areas, and that's where the concern needs to be.

As Dr. Wilensky indicated, we have been operating without information. We have a payment system that is designed with very few refinements, and it impacts unevenly across agencies.

For the agencies that are seriously affected, some are critically affected, and they believe there is a crisis today, not at some point in the future.

More generally, with regard to access and quality of services overall. I agree that we are not at a crisis point now.

Mr. CARDIN. Could any of you help me? On the three areas that I mentioned, am I right on those three areas to be concerned about?

Is there a priority within those three that is more critical than others? Are we in more danger in rural areas, more danger on difficult patients, or will there be more problems because we're using the historical cost in the formulas? Is there any relative concern here?

Ms. WILENSKY. Those are the areas that you would think to look at. Again, to the best of my knowledge, there is no information suggesting we have a problem now.

The rural areas we worry about, because of the density, lack of density; the very sick patients, because in this and other areas, health care is so concentrated. Although there has been so much rapid growth and spending in this area that it is hard to feel like, early on, this is an industry that has been strapped for funds.

Again, there are probably some agencies in some parts of the country that are very low-cost, and that will find themselves in difficulty. I can't give a response whether or not, in order to protect them, to put in money in a generalized way.

Mr. CARDIN. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you. The gentleman from Louisiana.

Mr. MCCRERY. Thank you, Mr. Chairman. Dr. Wilensky, I would like for you to explore with me—because I know you have, in your various capacities over the last few years, looked at this—explore with me the possibility of instituting a co-pay for home health services, or instituting an option for home health agencies to impose a co-pay, if they so chose. Do you have any thoughts on that?

Ms. WILENSKY. Yes.

Mr. MCCRERY. And if possible, a partial solution to the problem we find ourselves in?

Ms. WILENSKY. I believe in a co-pay for two reasons, particularly one that is rather modest, and that is subjected to an annual limit, so that, for the small numbers who have a great number of visits, it is not imposing a major burden.

In the first place, I think that it will help in some of fraud detection. It focuses attention in a way that doesn't always occur when you have a free service, so I think it would assist in some of the activities that the inspector general has been concerned with.

In the second place, it gives you a little money. That is, if you allow for a co-pay, either on an optional or a regular basis, it would give you a little more money to distribute elsewhere, and it will have or it may have, depending on how you define it, some impact on behavior.

Again, as you know, there has been a very rapid increase in the number of users and in the number of visits per use, basically a doubling over a few years, and while that appears to have slowed down in 1997, you have a lot of years for which that was growing like crazy.

I think it is a way to try to provide you with some additional funds, and also try to have some involvement by the patient.

I and MedPAC commissioners were concerned that it not be too burdensome for the elderly. Therefore, we were talking about a modest, in the neighborhood of $5, subjected to an annual limit of maybe a couple hundred dollars, so that the people who have these extensive numbers don't get materially impacted.

Mr. MCCRERY. Thank you.

Chairman THOMAS. I thank the gentleman. The subcommittee will stand in recess until about 20 minutes until 1:00, at which time we will be pleased to entertain the last panel. Thank you very much.

[Recess.]

Chairman THOMAS. I want to thank the last panel for their patience, but I assume they have an ongoing interest in the subject matter.

I would call Jerry Knight, chief operating officer of the Visiting Nurse Health System, on behalf of the Visiting Nurse Associations of America; Mary Ann Brock, owner and administrator, Guardian Homecare, Bellaire, Texas, on behalf of the Texas Association for Home Care; John L. Indest, chief executive officer, Health Care Resources, New Iberia, Louisiana, on behalf of Home Care Association of Louisiana.

Ruth Odgren, vice president of Operations, Visiting Nurse Service System, on behalf of the Tri-County Visiting Nurse Association, Plainfield, New Jersey; and Denise Palsgaard, president, California

Home Care and Hospice, Inc., Merced, California, on behalf of the National Association for Home Care.

Thank you all. Any written testimony that you have will be made a part of the record.

I would ask you, in the time frame that you have, if you would address us, hopefully, on the specifics as we indicated, of any potential solutions, and I would hope that the solutions do not totally consist of a moratorium, to go back two, three years ago, pretend the current trends don't exist, or any of those kinds of options.

With that, why don't we just start with you, Mr. Knight, and we'll go right across the panel.

Let me, before you begin, indicate these microphones are very unidirectional. You have to pull them down and speak directly into them. Thank you.

Mr. Knight.

STATEMENT OF JERRY KNIGHT, CHIEF OPERATING OFFICER, VISITING NURSE HEALTH SYSTEM, ATLANTA, GEORGIA, ON BEHALF OF THE VISITING NURSE ASSOCIATIONS OF AMERICA

Mr. KNIGHT. Mr. Chairman and members of the subcommittee, my name is Jerry Knight, and I am chief operating officer of the Visiting Nurse Health System in Atlanta.

Founded in 1948, VNHS is the largest not-for-profit home health agency in Georgia, providing care to over 20,000 patients annually. We are a very cost-efficient agency, and let me tell you what that means.

According to 1995–1996 Medicare cost report data, our Medicare home health program cost per patient was $2,084, compared to Georgia's statewide average of $5,054. In 1997, our number of home health visits per patient was 38, compared to the national average of 80 visits per beneficiary.

Our low utilization is not an accident. It is an intended outcome for our organization. This has meant over $5 million in savings to the Medicare program over the prior five years.

In fact, it is this very philosophy that has created the serious financial problem for our agency, and many others that have been efficient providers. The interim payment system penalizes VNHS for its cost-consciousness.

I am pleased to present recommendations of the Visiting Nurse Associations of America, an organization of nearly 200 members and nearly $4 billion in revenues annually, on how Congress can address this problem.

The VNAA and VNHS are grateful to you, Mr. Chairman, for holding this hearing and for your commitment to act this year. Refinements to IPS are even more critical today because of the expected delay of the Medicare home health prospective payment system.

We are also grateful for the support of so many Members of Congress for legislation that tries to address these problems.

Two IPS provisions are problematic, and must be addressed now: one, the formula for calculating the agency-specific per-beneficiary cost limit; and second the reduced per-visit cost limit.

We estimate that at least 50 percent of our members are affected by the new per-beneficiary limit, while another 25 percent are subject to the lower per-visit limit.

The impact of the per-beneficiary limit is harsh. Many agencies will actually be reimbursed on the basis of their calendar year 1993 cost. VNAA now estimates that its members will experience average reductions in payments of 25 percent.

We can't compromise patient care and outcomes and quality, and may be forced to make tough decisions about our participation in the Medicare program.

The other primary problem is the low per-visit cost limit in BBA 1997, which penalizes agencies that have had higher per-visit costs but low numbers of visits and low overall per-patient costs. This is where it hits home, Mr. Chairman.

For example, it costs VNHS, in the aggregate, close to $80 to make a home health visit. Under IPS, we will be reimbursed $8 less than our cost per visit. In 1998, we anticipate a loss of over $2 million from the 267,000 projected Medicare visits because of this reduced per-visit cost limit.

Here are VNAA's specific recommendations on how to amend BBA 1997 to address these concerns:

First, change the formula for the per-beneficiary limit to a blend of 75 percent national and 25 percent regional, retroactive to October 1, 1997.

I must stress at this point that retroactivity is an extremely important issue to the organizations we represent and to my particular agency.

This must be based on fiscal year 1994, as we heard earlier, because HCFA apparently cannot calculate a new base year because of its Y2K difficulties. Therefore, it is very important to update these numbers by the home health market basket index in each of the four years between fiscal year 1994 and fiscal year 1998.

Second, raise the per-visit limit to 112 percent of the mean, the pre-1997 level.

Third, because PPS will be significantly delayed, eliminate the imposition of the 15 percent payment reduction that is now scheduled for October 1, 1999.

We understand that the need to maintain budget neutrality may affect Congress's ability to act on this last issue until next year.

Changing the per-beneficiary limit formula affects different agencies in diverse ways. VNAA believes that a transition might be considered as agencies move to a more appropriate per-beneficiary limit formula, as well as an outlier provision for those organizations that care for unusually high-cost patients.

VNHS, and our VNAA colleagues in New Orleans, Dallas, Houston, and other Sunbelt cities, are proof that cost-effective and medically effective home health care is alive and well in the South. If we can do it, why can't other agencies?

If VNAs and other cost-effective providers are the model you want for Medicare for the future, then act on our recommendations this year.

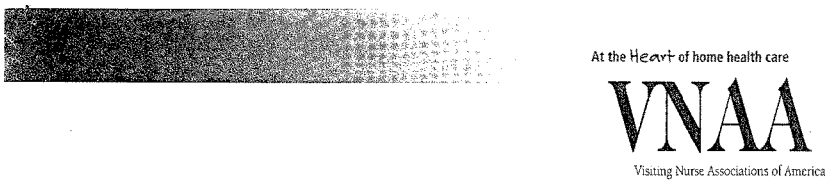
We have been gratified that you, Mr. Chairman, and other Members of Congress, have been willing to listen to VNAA's concerns

about IPS, and we look forward to developing a workable solution this year.

In addition, we are willing to bring some of our top financial folks from around the country to work with the subcommittee, then HCFA, to work out the details of some of the issues that have been troubling us all morning.

This concludes my testimony, and I would be happy to answer any questions.

[The prepared statement follows:]



STATEMENT OF THE VISITING NURSE ASSOCIATIONS OF AMERICA

TO THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON WAYS AND MEANS

UNITED STATES HOUSE OF REPRESENTATIVES

PRESENTED BY

JERRY KNIGHT

CHIEF OPERATING OFFICER

VISITING NURSE HEALTH SYSTEM

ATLANTA, GEORGIA

AUGUST 6, 1998

10:00 A.M.

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Mr. Chairman and Members of the Subcommittee:

My name is Jerry Knight, and I am Chief Operating Officer of the Visiting Nurse Health System (VNHS) in Atlanta. Founded in 1948, the Visiting Nurse Health System is an accredited, community-based home health organization that provides care to over 20,000 patients annually in the Atlanta metropolitan area. VNHS is the largest not-for-profit home health care company in Georgia. We provide comprehensive medical and hospice care and social services to the sick, elderly and individuals with disabilities. Our mission is to provide care to all patients regardless of their ability to pay. In 1997, VNHS provided over $13 million of uncompensated care.

VNHS is the preferred provider of home care for a majority of hospital systems and managed care companies in Atlanta because of our compassionate, ethical and cost-effective reputation. According to 1995-96 Medicare cost report data, our Medicare home health program cost per patient was $2,084 compared to Georgia's statewide average of $5,054. In 1997, our number of home health visits per patient was 38 compared to the national average of 80 visits per beneficiary. VNHS has invested in training and technology that assist our staff in promoting independence and self care to our patients and their families. Our definition of quality can be described as the intersection of acceptable outcomes, satisfied patients and fiscal responsibility. Our low utilization is not an accident—it is an intended outcome for our organization. This approach is not new for our agency, but has been in place since the early 1990's. In fact, it is this philosophy that has created the serious financial problem for our agency and many others that have been efficient providers. The IPS per beneficiary limit formula penalizes VNHS for its cost consciousness. Those agencies that maximized revenues in the early years of this decade are the beneficiaries of the formula. We believe this is the wrong signal to this industry and diverts the efforts of Congress and the home health industry to reengineer the Medicare home health benefit.

I am pleased to be here today to present the recommendations of the Visiting Nurse Associations of America (VNAA) on how Congress can respond to the current challenges facing VNAA

members as the Health Care Financing Administration (HCFA) implements the Interim Payment System (IPS).

VNAA is the national association of 187 Visiting Nurse Agencies (VNAs) , which operate 400 units across the nation. Our members created home health care over one hundred years ago, and it is our hope and intention to provide high quality home care for at least the next hundred years. Our members are not-for-profit, community-based agencies, and we are proud of the fact that VNAs are low cost, high quality providers of home health care services. Visiting Nurse Agencies care for nearly 10 million people every year and represent 25% of all not-for-profit freestanding home health care services in the United States. Like the VNHS, VNAs' costs are generally well below state, regional and national averages. In 1995, VNAs generated almost $4 billion in total patient revenues.

The VNAA and the VNHS are grateful to you, Mr. Chairman, for holding this hearing in order to discuss refinements to IPS so that it serves as an effective bridge to a prospective payment system and achieves its intended goals of rewarding cost-efficiency, controlling expenditures, and preserving beneficiaries' access to needed home health services. Refinements to IPS are even more critical today because of the expected delay of the Medicare home health prospective payment system (PPS). VNAs believe that implementation of PPS will provide incentives to providers to deliver only the necessary amount of medical care in order for patients to achieve the best outcomes for their conditions. However, we are very concerned that HCFA's Y2K problems will significantly delay the move to PPS. Thus, the home health industry will need to be on IPS for a much longer period of time. Making adjustments at this time is essential if historically lower cost agencies are to continue to serve the patients in their communities.

IPS was put in place to control spending and over-utilization of the benefit during the transition to prospective payment. Data from HCFA's Office of the Actuary show that not only is IPS controlling expenditures, it is exceeding its goal. According to HCFA, fiscal year 1998 home health expenditures will be at least $500 million less than FY 1997, totally $17.3 billion. Mr.

Chairman, VNAA would like to make clear that we support the overall goal of IPS and do not favor its repeal. We agree with Congress that the problems that had developed in the system had to be addressed in a fundamental way to preserve the benefit. However, VNAA believes that IPS must be changed this year to correct the provisions that have unintentionally threatened the survival of VNAs and other low-cost home health providers. Without immediate action, more VNAs will be forced to close their doors, discontinue participation in the Medicare program, or to layoff essential staff and cut programs.

To date, seven VNAs have closed and other closures are pending. All these agencies were providing essential services in their communities. They simply could not continue under the current IPS. The VNHS of Coastal Georgia in Savannah -- the oldest home health care agency in the Southeast -- closed its doors effective July 31, 1998, because it was particularly hit hard by the per-beneficiary limit. In 1997, this agency served 306 patients. The VNA of St. Louis decided to stop treating Medicare beneficiaries because it could not sustain a 45% reduction in Medicare reimbursement. Because the VNA of St. Louis was the only home health agency in the community receiving United Way funding, its discontinued participation in Medicare leaves a tremendous void for indigent patients. We do not believe that Congress wanted to place these agencies and their patients in these kinds of situations. I want to emphasize that this problem is not limited to VNAs, but affects all home health agencies that have an average cost per patient below their regional average. This includes organizations such as Easter Seals, county public health departments providing home health care, hospital-affiliated systems, and for-profit agencies that have been efficient Medicare providers.

Two IPS provisions are problematic and need to be addressed this year: 1) the formula for calculating the agency-specific per-beneficiary cost limit; and 2) the reduced per-visit cost limit now set at 105% of the median. We estimate that at least 50% of our members are affected by the new per-beneficiary limit, while another 25% are subject to the lower per-visit limit.

The impact of the statutory formula for the per-beneficiary limit is very harsh for VNAs and for

all other low-cost providers. Because the formula is based primarily on an agency's FY 1994 costs, low-cost agencies that were actively controlling costs during this period now have very low limits. Many of these agencies, such as the VNHS, will actually be reimbursed on the basis of their calendar year 1993 costs. Those agencies that had high-costs during the base year now receive much higher cost caps. Instead of rewarding efficiency, the formula rewards high costs.

When the House-Senate Conference was considering the home health provisions of the BBA'97, VNAA urged that the per-beneficiary formula be based on a minimal blend of 50% regional or national data. We realized even then that a formula that used a significant portion of agency-specific data would penalize the historically low-cost providers. However, in the context of that conference, our recommendation was not accepted. The Senate proposed a new limit based entirely on agency-specific data, while the House position mirrored the final outcome. At that time, we could only anticipate the outcomes of the formula because reliable information was not yet available. VNAA now estimates that its members will experience average reductions in payment of 25 percent. For agencies that have traditionally been very cost-effective, there is little room to find new efficiencies of that magnitude without affecting essential patient care services.

The other primary problem is the low per-visit cost limit included in the BBA'97, which penalizes agencies that have had higher per-visit costs, but low numbers of visits and low overall per-patient costs. For example, it costs the VNHS, in the aggregate, close to $80 to make a home health visit. Under IPS, we will be reimbursed $8 less than our costs per visit. In 1998, we anticipate a loss of over $2 million from the 267,000 projected Medicare visits because of the reduced per-visit cost limit. We believe that this is a direct penalty on our efforts to keep Medicare costs down. As mentioned above, our average cost per patient and number of visits per patient are significantly below state, regional and national averages.

Nationally, per-visit costs have remained relatively constant under the previous limits, having increased less than 5% in the past seven years. Increasing the per-visit cost limit to its pre-

BBA'97 level should not lead to a significant increase in home health spending.

Here are VNAA's specific recommendations on how to amend the BBA '97 to address these concerns. **First**, change the formula for the per beneficiary limit to a blend of 75% national and 25% regional data, retroactive to Oct. 1, 1997. This must be based on the fiscal year 1994 cost data since HCFA apparently cannot calculate a new base year because of its Y2K difficulties. Therefore, it is very important to update these numbers by the home health market basket index in each of the four years between FY 1994 and FY 1998. **Second**, raise the per visit limit to 112% of the mean, the pre 1997 level. **Third,** eliminate the imposition of the 15% payment reduction that is now scheduled for Oct. 1, 1999. Under any IPS formula, some agencies are going to see significant revenue problems that will bring many of them to the edge of bankruptcy. The 15% reduction will be more than enough to push many of them past the failure point. We urge a careful reconsideration of this issue.

We have tried to develop recommendations that can be budget neutral. That has also been the goal of H.R. 3567, the Medicare Home Health Equity Act of 1998, and S. 1993, the Senate companion legislation. These bills incorporate many of our recommendations. H.R. 3567 was introduced by Congressman Michael Pappas (R-NJ), and enjoys the bipartisan support of 99 other House Members. S. 1993 was sponsored by Senator Susan Collins (R-ME), and she has been joined by 24 of her Senate colleagues. VNAA deeply appreciates the support of Congressman Pappas, Senator Collins and the Members who have cosponsored this legislation. We understand the need to revise the language of the bills to address the implementation problems identified by HCFA and to maintain budget neutrality. We are prepared to work with this Subcommittee on any refinements that may be needed in order to allow Congress and HCFA to act this year. It is VNAA's goal to achieve a workable IPS formula so that our members can continue to serve Medicare patients without breaking the 1997 balanced budget agreement.

We realize that changing the IPS per beneficiary formula affects different kinds of agencies in the various regions of the country in diverse ways. One of the challenges facing this

Subcommittee is how to accommodate as many legitimate concerns as possible without straying too far from the original goals of IPS. The introduction of H.R. 4370 by Representatives Coburn, McGovern and Weygand, and other Members, is an important step in the effort to identify the middle ground. VNAA appreciates these Members' energetic efforts to advance resolution of this problem.

As the Subcommittee evaluates possible solutions, VNAA believes that a transition should be considered as agencies move to a better per beneficiary formula, like the one in H.R. 3567. This may have particular value considering the expected delay of the PPS. We believe that the 75% national/25% regional data makes sense as the basis for the IPS formula, but introducing it over a 2-3 year time frame deserves careful consideration.

Since everyone, including VNAA, is grappling with the need for some kind of outlier system to protect agencies with unusual patient mixes, a transition may help. HCFA says it cannot implement an outlier because of the Y2K problems. A transition would allow deferral of the outlier until a time when HCFA can deal effectively with the data issues.

Retroactivity is critical if agencies are to get any relief this fiscal year. We have heard from many sources that HCFA can't implement a retroactive provision. However, we believe that the issue needs to be more carefully researched. Since cost reports are audited and adjustments made after the close of the cost year, why can't retroactivity be exercised through that audit mechanism? For this one time, the fiscal intermediary could treat the cost report like a tax return and make an appropriate adjustment based on actions that Congress takes now. Agencies that would face repayment situations could be given extended payment plans with no interest or penalties. Agencies that would benefit from the revised formula would know that some relief would be forthcoming, and that recoupment of losses will be possible.

It has been argued that our proposed formula change will somehow harm patients served by high cost agencies. Some allege that high costs are not always a sign of inefficiency or inappropriate

practices. It is argued that these high costs may reflect a more severe case mix than those experienced by the lower cost agencies. Let me respond by noting that neither the General Accounting Office nor the Inspector General for the Department of Health and Human Services has been able to attribute the vast disparity in Medicare home health spending to case-mix or any other factor. Our own experience speaks for itself. VNAs throughout the country have provided high quality home health care for the full range of patients at very cost effective rates. Our patient outcomes are excellent. In most communities, we are the providers of last resort, taking the most difficult cases regardless of ability to pay. Frankly, we believe that nay home health agency that exercise proper management and follows standard care protocols should be able to provide services at costs comparable to our own. However, we have included in our recommendations to Congress an exceptions process to address extraordinary situations.

VNAA's recommended changes have been criticized as promoting a regional formula fight, one that pits states and regions against each other. However, our own analysis concludes that the average home health agency in seven out of nine HCFA census regions would fare better under a 75/25 national/regional per beneficiary formula using FY 1994 data updated by a full home health market basket index, than under the current IPS formula. Since all new agencies move to a national average per beneficiary limit, they would see improvement from our proposed formula since the national average would increase. States with many new agencies, like Texas, would benefit significantly compared to the HCFA figures. Finally, the change in the per visit limit also helps agencies with high per visit costs, but with fewer visits per patient. This pattern is common in states like California where aggressive managed care plans have limited the number of visits that could be provided.

Our recommendations do not result in a regional battle. Any conflict would be between high cost and low cost agencies. We think Congress intended to put pressure on high cost agencies, and our recommended changes in the IPS formula would accomplish that goal. A criticism of this approach is that changing the per-beneficiary formula will create new "winners" and "losers". It is important to note that our recommendations would create far more winners than

losers. As referenced earlier, we know that the average agency in seven out of nine HCFA census regions would be better off under a 75% national/25% regional formula using the proposed per-beneficiary formula. The losers under the current IPS formula are those agencies that have consistently been fiscally responsible providers in the Medicare program.

We have been gratified that you, Mr. Chairman, and other Members of Congress has been willing to listen to VNAA's concerns about the IPS formula, and we look forward to developing a workable solution this year. While VNAA has strongly articulated it own views on how the formula could be improved, we are ready to work with the Members of this Subcommittee to find a formula that addresses the different concerns of each Member and ensures that Medicare beneficiaries continue to have access to high quality home health care.

If Congress acts this year on our recommended changes to IPS, VNAs and other cost-effective agencies will be able to meet the needs of all patients, whether long or short-stay, or high or low-cost. We urge the Subcommittee to act soon, and we look forward to the opportunity to work closely with you on changes to IPS that will ensure that Medicare beneficiaries continue to receive medically-necessary home health care.

This conclude my testimony. I will be happy to answer any questions the Members of the Subcommittee may have.

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

Ms. Brock.

STATEMENT OF MARY ANN BROCK, PRESIDENT, ADMINISTRATOR AND CO-OWNER, GUARDIAN HOMECARE, INC., HOUSTON, TEXAS, ON BEHALF OF HERSELF AND THE TEXAS ASSOCIATION FOR HOME CARE

Ms. BROCK. Thank you very much. I agree with you that we need to find a solution. I thank you, Mr. Chairman and members, for this opportunity. I am in Washington on a mission.

Chairman THOMAS. Ms. Brock.

Ms. BROCK. Yes.

Chairman THOMAS. If you can turn your head, would you move the mike? It is very unidirectional.

Ms. BROCK. Yes, sir.

Chairman THOMAS. Thank you.

Ms. BROCK. Thank you, Mr. Chairman and members, for this opportunity. I am in Washington on a mission. I am representing myself as an owner of Guardian Home Care, a typical independent owner of a small agency, and the 1,200 agencies that are members of the Texas Association for Home Care.

I have approximately 100 patients on service, and 60 full and part-time employees who have already been adversely affected by IPS.

I believe we do have an emergency situation. I believe you are going to have at least 75 percent of the agencies in Texas closing within the next month or so.

When we talk about closing, we are not talking about closing and then reopening, as you mentioned earlier, but closing and staying closed. Texas is not a CON state, as we were asked earlier.

I agree with Mr. Hash from HCFA that this is a situation that is much more complex than originally thought out. That 75 percent of our agencies close that means that we will not be able to make payroll, that we will not be able to pay our bills, and that we have financial obligations that we will not be able to meet. We will go into bankruptcy, both corporately and personally.

I think that we need to look for a reasonable solution, and look at all the different issues with the transition period.

I believe that we are guessing and that we are flying blind at this point, and that we need to have a transition period to discuss all the different options, so that we don't come up with a plan that we would have difficulty implementing, and becoming the same problem that we're in now.

When we discuss the 12-month repayment schedule that Mr. Hash discussed earlier, there are a lot of agencies that are not meeting payroll now, and they may not be able to meet a 12-month repayment schedule.

You've discussed fraud and abuse on occasion, many times. I believe that we have a zero tolerance and that we support the compliance mandates and criminal history checks for all employees.

We need to move to PPS as soon as possible—the costs, due to a desire to be profitable and manage quality through clinical outcomes monitoring.

I agree with Congresswoman Johnson's concern that HCFA does not have a plan, and the committee, without involvement of the home health agency sector, encapsulizes the information without good implementation projections.

I believe that we need to have a 75 percent national and 25 percent regional for all agencies, with no pre and post-1994 issues. We need to treat all agencies equally in a community, with the same per-beneficiary, per-patient limits.

We need to have outliers based on diagnoses, such as insulin-dependent diagnosis or COPD. Those are patients that are high-utilization, high-cost.

When we talk about the outliers—and Mr. Hash referenced the fact that the outliers could be reimbursed on the end of the year cost report, that's going to cause a big cash flow problem, and I don't think that that would work at all.

The retroactive implementation will close agencies. Going back to the 10–1–1997 cost limits per patient, per beneficiary, is undoubtedly going to close agencies across Texas and across the United States.

The patients should not be forced to go to a higher per-beneficiary, per-patient provider, but should be allowed to select a home health agency by quality.

I think that we should use the surplus to manage IPS, and take some of those funds in order to help the problems that we have now.

I think that we should cut costs. I think that we should tighten homebound status and institute guidelines.

I think that co-pays, when we go into PPS, are realistic. I think, at this point, when you have patients that you are talking about $5 co-pays, they're not going to be able to afford to do that.

I think that we need to look at the patient issues. We're going to have a lot of patients that are in nursing homes and emergency rooms and go into the hospital prematurely, because they're not being taken care of properly at home.

We have insulin-dependent diabetics that are real committed to their independence and staying at home, and so are their families, and they're going to end up in a critical situation and end up in the emergency rooms.

I think that we need to look at increased access and substantial savings, already realizing expected—excuse me.

I think that we need to look at the 15 percent on 10–1–1999, and go ahead and use some of the already realized savings to that point, look at the decrease in utilization and the cost savings that we have already achieved, and use that to offset some of the percentage.

I don't want to create new winners and losers. Dr. Scanlon mentioned that less than efficient agencies might be rewarded if we use the system that we have now, or possibly in a new system.

In Texas, the length of stays in hospitals has decreased over the last five years. Nursing home admissions have been flat.

In Texas, we have the highest number of poverty-level elderly in the country, and I think that is one of the reasons that we have high utilization in Texas. Those patients are committed to independence and they want to stay at home.

Thank you very much, and I appreciate you letting me speak. I think that we need to work towards a solution for IPS that is not going to close down all the agencies throughout the United States. Thank you.

[The prepared statement follows:]

Testimony of Mary Ann Brock
Owner, Guardian Homecare, Inc.
Houston, Texas

Before the House Ways and Means Subcommittee on Health
August 6, 1998

Representing herself and the Texas Association for Home Care

Mary Ann Brock

Mary Ann Brock is President, Administrator and Co-owner of Guardian Homecare, of Houston, Texas. She attended college in Houston and worked in various positions in medical practices before choosing to focus her skills and energies in the home health care field. She has been intensely involved in home care in the Houston area since 1987. Prior to becoming Co-owner of Guardian Homecare, she held management positions with a number of other agencies and was intensely involved in every aspect of those businesses, including general management, marketing and sales, business development and financial management. Ms. Brock is eminently qualified to testify as a home health care expert, and we are pleased to have her here with us today.

Priorities for IPS Change

1. Delay implementation of IPS until FY 1999

Agencies were expected to operate for many months without knowing what their per beneficiary limits would be, or what their interim visit rates would be under the per beneficiary limits. The per beneficiary rates turned out to be 25 % to 40% lower in Texas than the best estimates, which has created a retroactive crisis. An alternative to IPS must be a known factor by agencies before implementation.

2. Ensure that payments to agencies are sufficient to care for high-cost and/or long-term patients

IPS's greatest defect is that it has too little money in it to care for anyone other than the healthiest patients. Either the payment system must have additional funding to recognize the needs of different beneficiaries, or new coverage limits must be imposed.

3. Eliminate discrimination in payments between 'old' or 'new' agencies

There is no relationship between what agencies were spending in FY 94 and their patients' needs today. All agencies in a community should receive the same reimbursement for the same types of patients.

4. Restore the per-visit cost limits to at least1996 levels

As utilization drops, cost per visit increases; therefore, the reduction of both per beneficiary and per visit limits is a double whammy which makes it next to impossible to operate within.

5. Eliminate the additional 15% reduction in payments scheduled for FY 2000

This reduction is scheduled regardless of savings achieved through IPS implementation. The amount of cut should be determined and triggered only if specified spending levels are exceeded.

6. Eliminate proration provision of the BBA except in cases where there is obvious intent to circumvent the limit

The proration provision discriminates against the beneficiary who happens to get sick more than once in a year. Apply proration only in circumstances where agencies actively attempt to circumvent reimbursement limits.

7. Establish payment system prospectively

8. Maintain periodic interim payments (PIP) until 12 months after the implementation of a prospective payment system.

Written Testimony of Mary Ann Brock
Owner, Guardian Homecare, Inc., Houston
for the Ways and Means Health Subcommittee
August 6, 1998

THE PERSONAL IMPACT OF THE INTERIM PAYMENT SYSTEM

Thank you Mr. Chairman and members for this opportunity. I am in Washington on a mission. I want to help you understand the personal impact of the Interim Payment System (IPS). I am representing myself, as an owner of Guardian Homecare, a typical independent owner of a small to medium size agency, and the 1200 agencies that are members of Texas Association for Home Care. I have approximately 100 patients on service and 60 full and part-time employees who have already been gravely and adversely affected by IPS. I would like to discuss the structural problems of IPS and how implementation has adversely affected my agency, my patients and my employees, as well as most of the home health agencies in Texas and throughout the country. I agree that we must look at alternatives and corrections to IPS, but we must also have time to formulate a comprehensive plan that is practical enough to be implemented and addresses our many concerns. The plan that we have now ignores reality and is purely based on budgetary constraints. We cannot afford to go back to the drawing board after this next revision. I suggest caution in implementing any changes without a complete look at the consequences from all angles. We must remember that the elderly and their families like home health care. It allows them to maintain their independence as long as possible and have control over their destiny. Properly used, home health care is cost efficient in our health care system. *A moratorium* would be my first choice while we work together on a plan that won't compromise the care and health or lead to the early deaths of many of our elderly.

PATIENT CARE IMPACT

I want to talk about the aspect of patient care and the impact on my patients first, as this is the most important issue. I have approximately 100 patients, with the majority being high cost, high utilization patients. The acutely ill patients are not the majority. The largest problem that faces us today is dealing with and planning for the chronically ill patients. These patients can be managed at home with the support of appropriate personnel. The care can make the difference in whether or not they can care for themselves again with new limitations. We need to eliminate the points in IPS that discriminate against long term patients (acute or chronic), medically complex patients, and patients that are sick more than one time in a year. I understand the desire to be in compliance with the Balanced Budget Act (BBA) and the budget neutrality issues, but *we must reduce the IPS cuts* to ensure the safety and welfare of our elderly. It is wrong to discriminate against the long term care patients. These patients are equally entitled to Medicare benefits and must have equal access to needed care.

These elderly patients and their families are committed to independence, staying in their homes and caring for themselves and their spouses. *It is the commitment to independence that keeps them going.* These elderly people have great spirit and grit and are what has made America great. They have worked their whole lives, lived through the depression, served in the armed forces, raised families and paid taxes. I would like us to look at the messages we are giving them for all of their hard work and service. I would also like for us to look at the message that we are giving to our children as to the value of the elderly and the way we want to be treated as we approach our later years.

I, as an agency owner, did not seek out sicker patients. Rather, due to the budgetary constraints and the existing discharge planning system within our hospitals, physician offices, clinics and rehab units, these patients have been referred to home health agencies to deliver care in their home environment, as a positive alternative to nursing homes or other institutions.

I would like to paint a picture of two of my patients, their disease processes and their care. Both of these patients, like so many others, are managed very well at home. It is their belief, as well as my own, that this option should remain open to them. Both of these patients appear in the information I brought to Washington D.C. last week, "The Personal Impact of IPS". There are pictures of them as well as personal letters from them or their family members.

Mrs. Lee Diesler
When I make a home visit to a patient such as Mrs. Lee Diesler, age 78, I see an insulin dependent bed bound, diabetic patient, that is being managed well with the love and care of her husband, Mr. Marvin Diesler, age 73. Mrs. Diesler has a skilled nurse visit in the early morning and the late afternoon to check her blood sugar and give her insulin injection. As the result of a recent hospital stay, she also has several foot wounds that are healing well at this time. The skilled nurse does dressing changes on these areas daily, as well as a head to toe nursing assessment every visit. She has a home health aide visit twice daily to help with foley care, bathing and feeding. She also has bowel incontinence. Although Mrs. Diesler has a feeding pump and peg tube through her abdomen to her stomach she is encouraged to eat small amounts. This is a long term, high cost, high utilization patient that is managed very well at home. We would all be fortunate to have Mr. Diesler as our patient advocate when we become infirm. Mr. Diesler has health issues of his own. Due to his poor eyesight, he is unable to perform the wound care, check Mrs. Diesler's blood sugar level or give her insulin injections. He also has two metal knees and a heart condition, which prevents him from turning her, bathing her or giving her the personal care she needs. Mr. Diesler does some of the cooking and feeds Mrs. Diesler some of the time. Though they live on a low fixed income he pays for a housekeeper to cook and do housecleaning four hours a day. Mrs. Diesler was in a nursing home, but was transferred back home at her husband's request due to her rapidly deteriorating condition while staying at the nursing home. He wants his wife of many years to stay at home with him and feels a nursing home would accelerate her death.

Mrs. Nell Dudley
Mrs. Nell Dudley , age 72, is a wound care patient that we had on service several months and just recently discharged. Mrs. Dudley had cancer 25 years ago and in February of this year went back to M.D. Anderson Cancer Center, fearing the worst. She had drainage under her skin in the left chest wall. When surgery was done, her bones were found to almost be destroyed in her chest in that area. She was diagnosed with Osteomyelitis, which is an infection in the bone. A chest wall resection was performed and her stay in Anderson was almost a month. The only reason she was allowed to return home was because Medicare would pay for a skilled nurse to come to her home twice daily. When she was admitted for care, we began her wound care for a wound, 4cm wide and 2cm deep, a fairly large wound. Our skilled nurses made twice daily visits to her home to irrigate her chest tube with 120-180 cc of Dakins Solution. The irrigation of the chest tube was ordered to relieve the chest drainage. When the chest tube was not irrigated there was very little drainage in the drainage bag. When the chest tube was irrigated, it affected the area deep inside her chest and large amounts of yellow and green liquid drained in her drainage bag, which is good. After the skilled nurse finished the irrigation, the wound was packed with wet to dry saline soaked gauze, and then covered with another piece of 4 x 4 gauze. The 4 x 4s were always covered in yellow drainage before the next skilled nursing visit. This nursing intervention wicks the infection from the body. After attempting to teach Mrs. Dudley several times, it was found that she was unable to perform the irrigation and dressing change due to the area in which it was located. There was no caregiver available. The bed of the wound was always pink or red, which is also a good sign. The chest tube was attached to her skin with two stitches. At one point during her care, the stitches came out and the area became infected. The skilled nurse treated that area with saline and applied triple anti-biotic ointment and 2X2 gauze. It healed well. Mrs. Dudley had a good home environment, good nutrition, and the will to recover.
The wound decreased in size and had healed quickly due to the twice daily skilled nursing visits. After 2 months, we decreased the visits to one time daily and her wound continued to heal to .6cm deep and 1cm wide. At the end of her care, the wound was a pin point area that was dressed topically until it closed completely. She is now discharged from service. When discharged she was planning to begin driving again. She also has Congestive Heart Failure and is on Lasix and Potassium. During her care she experienced cramps, and through a lab draw was found to have a high Potassium level, which the physician addressed. Mrs. Dudley feels that she would not have recovered as well or as quickly as she did, if she were not at home. She may have been devastated after such a long hospital stay to be transferred to yet another institution. In the long run, it is better for the patient and much more cost effective for Mrs. Dudley to have been at home while recovering.

Through the advances in medical technology wound care has changed in recent years. Many wound care patients do not heal as quickly or completely as Mrs. Dudley. Each one is different. Many are on service for extended periods of time and function well at home, even with an active wound, because they have the nursing support they require and are in the environment that they have created and have the will to remain independent.

I, as well as most home health agencies, have patients such as Mrs. Lee Diesler and Mrs. Nell Dudley. These patients are entitled to benefits. We do not have a provision in IPS to deal with these patients and the consequences of their abandonment. In many areas there are not enough hospital beds or nursing home beds to deal with the immediate problems of the care of these patients. If we do not move to immediately amend the IPS we will have a catastrophic problem. By the end of 1998, many more--some experts say 75% of the agencies in Texas alone--will go bankrupt. The patients that require daily care will not have daily care. First, we will fill up the nursing homes. For the patients that fit the criteria, their families will have to liquidate their assets to pay for care until they are poor enough to get Medicaid. Which means the taxpayer foots the bill anyway. Due to the shortage of beds, patients will have to be placed wherever a bed is available, which means often, not close to a family members residence. This causes a great emotional strain on the patient and family. We all know that patients recover, progress and stabilize much faster if they can have contact with their families on a daily basis. They are also less likely to become depressed. After these beds are filled to capacity (and we are not counting on the ever increasing numbers of new sick patients that need care), we will see a tremendous influx of patients to emergency rooms and urgent care centers. Others will remain longer in the hospital due to the shortage. Many will have to be hospitalized, have surgery, go to rehab units, or to skilled nursing facilities, all as a result of loosing the right to stay at home through the support of home health care. Since home health care is not an option for them, they too will be put on waiting lists for nursing homes.

In Texas, we have the highest number of elderly living below the poverty level in the nation and they tend to have had poor medical care all their lives. We have increased numbers of chronic illness such as, Insulin Dependent Diabetes and Chronic Obstructive Pulmonary Disease. We have higher utilization patients, partially due to the fact that the system has "worked successfully this way." The states will have a much higher burden of responsibility through Medicaid. Do they have this understanding? Do the states have a plan, or will patients die prematurely? It is estimated that this could cost Texas alone $226 million dollars a year in new Medicaid costs.

Agencies will have the responsibility of making sure their patients are transferred to the appropriate agency or alternative. With the mass exodus from home health care, many patients will not be planned for and will only be noticed when they are in a critical situation or have died. Many live by themselves with no family close by to monitor their condition. Who will make certain that these patients don't slip through the cracks? Especially since the cracks will be large gaping holes. Do we want to see these patients abandoned and neglected and the consequences highlighted on the 6 and 10 o'clock news?

Many patients are able to live with family members that work or have other responsibilities because they have the support of home health care. These patients will have to go into nursing homes. We, as a society, are not set-up to take care of our elderly as we did 50 years ago. We are much more mobile and many of us do not live where we

grew up or live close to our parents. We are not equipped to spend 24 hours a day, 7 days a week, to care for our parents. My mother is 70 and very independent, but out of 4 daughters, only one doesn't work now and probably will go back to work when her 2 year old goes to school. We have jobs, children, and responsibilities and can't just stop working because we have an elderly family member that needs care. We are a very productive society. Most women work in jobs outside the home. Most families need both spouses to contribute financially, some such as myself, in excess of 40 hours a week. We pay taxes, spend a great deal of money, save a great deal of money. We are good for the nation's economy. *But there is a price to pay for independence and revenue in tax dollars*. Imagine if you will, the decreased tax revenue if a person stayed home to care for each elderly person who is managed at home now. Many of our elderly are successfully taking care of themselves and their spouses with the support of home health care.

Many home health care agencies have closed throughout the country, and Texas is no exception. According to the Dallas Morning News, 800 home health agencies in Texas have gone out of business since September of 1997. At this stage, most patients and employees have been absorbed by the existing agencies. I know many owners, large and small, including myself, that are literally "holding their breath" to see what will happen with IPS in this legislative session.

We have many patients that come on service for a short while, reach their goals, are stabilized and are discharged. They may drive again and lead active, productive lives. One of the problems with home health care is that one patient's cost does not equal the cost of another patient. That is why all our efforts to come up with an accurate case mix adjuster and out-lyers have been so difficult. In very few agencies, do the low cost, low utilization patients offset the high cost, high utilization patients to achieve the new lower aggregate caps per patient.

I think a transitional period is essential to plan appropriately for the thousands of patients that cannot be served at home. We must have time to plan with the patients, their families and the physicians who order their care. *I do not agree* with the shift to nursing homes and other institutions, nor am I convinced that taxpayers will save money from the shift.

FINANCIAL IMPACT

I know that these patients and most others will not be able to be managed at home on the $3,371 per patient per year cap my agency is forced to adhere to under the IPS system. Since my agency started on April 1, 1994, I am considered a new provider, and as such, must be in line with the per patient, per year caps calculated on a national basis. All agencies should be treated equally under the law in a given community, regardless of their base year. This is especially disastrous in Texas, as we have had higher per patient costs. I, like most of my fellow owners, have continued to care for these patients. My current cost per visit is $83.26. This would allow me to do only 40 visits per patient per year. This will obviously not meet the needs of our patients on service. The Texas

Department of Health has had grave concerns regarding patient abandonment of the elderly due to the impact of IPS.

At a recent seminar on IPS, in May of 1998, our fiscal intermediary, Palmetto Government Benefit Administrators (PGBA), stated that they recommended that we continue to provide adequate patient care as per our policies, even if it meant increased frequency levels.

I received a letter from PGBA dated May 19, 1998 changing my per visit rate to $81.85 for every discipline, based on my previous year's cost report. In the past, PGBA, which includes the southwest region of the United States, was reimbursing agencies with different costs per discipline, with a separate payment for supplies, based on cost. Which means that a skilled nurse visit was paid at a higher rate than a home health aide per visit and supplies reimbursed separately. Please keep in mind that all our costs and overhead go into the formulated visit rate. In that same letter I was told "As a result of this review, your agency has been underpaid $118,711 for the fiscal year which ended March 31, 1998."

One month later, I received a letter dated July 15, 1998, stating that my interim payment visit rate was being changed to $72.50 per visit for each discipline, inclusive of all supplies used, and that "Because of the decrease in your interim payment rate, your facility has been overpaid a total of $54,060 for the fiscal year which ends March 31, 1999. To avoid a withholding of your interim payments to recoup this overpayment amount, you should take one of the following actions within 15 days from the date of this letter.

-submit documentation to the Medical Reimbursement department that demonstrates our determination of the debt is in error, or
-submit a documented request for an extended repayment schedule, including information showing the sources that will be used to repay the overpayment, to the Medicare Reimbursement department(Note: If submitting an extended repayment schedule the first payment under the proposed plan must be included, and the check should be made payable to Medicare Federal HIB and mailed to the address noted in the following bullet), or
-submit a check for the entire amount of the overpayment. You facility's check should be made to Medicare Federal HIB ....."

I was given no notice that I would be sent this letter with a possible demand payment within such a short period of time from my year end of March 31, 1998. During the PGBA seminar in May of 1998, that I mentioned previously, I asked specifically how the per patient per year cap would be monitored and when we would be notified of our status in regards to the aggregate cost. I was told that the plan was to look at the IPS limits on an aggregate basis after the 98-99 cost report was submitted in 1999, and at that time, determine each agency's cost limits in relation to IPS.

I then received another letter dated the same date, July 15, 1998, stating that "Based on the application of the per beneficiary limits, applied in the aggregate, we have calculated an interim reimbursement rate of $32.10 for your agency.....we are allowing 21 days from the date of this letter for you to provide more accurate data...."

With the assistance of my CPA, I have responded within the 15 days for the first July 15th letter. On July 31,1998, my per visit rate was changed to $72.50 as verified on-line with PGBA. We were expecting a payment of over 9,000 for previous visits billed, on July 31, 1998 and that payment was also held by Palmetto for the over-payment due from us. We spoke with PGBA on July 31, 1998 and were told that they have a back-log of responses from providers and ours got missed. They would begin paying us at the previous rate again, but PGBA was doubtful our $9,000.00 would be paid to us. As of Monday, August 3, 1998, PGBA is currently holding payments to us until the 54,060 is re-paid to PGBA. My CPA calculated under the new IPS limits, the overpayment should be around $17,100, not $54,060. We have done exactly what was outlined in PGBA's instruction, to no avail. I have a payroll to meet on August 7, 1998, that is dependent on these payments. I need help now, with this most serious problem. When we call PGBA we get a voice mail and our calls are not returned. We are sending a letter in response to the second July 15th letter from PGBA, but my experience has been that it will not be processed properly either.

On a regular basis, PGBA has computer problems and our payments are paid late. We are accountable to everyone. To the Department of Health, to HCFA through our fiscal intermediary and to our patients and employees, just to mention a few. Who is HCFA accountable to? Why are we the only ones to suffer consequences?

I have heard it said several times lately, that home health agencies can simply lock their doors and go home. We are a corporation in the state of Texas. We have legal responsibilities, to our patients, employees and to the companies we owe money. As a home health care agency owner, I have my own personal money in my agency, that varies as to the amount, depending on the need. I do not however, have the funds to make up my next payroll, nor the ability to borrow any additional funds at this time. I have signed leases for office space. Generally office leases obligate the agency for 2-5 years. I have one that expires in one year for my branch and four years for my parent office. I have signed computer, telephone and furniture leases. Some with personal guarantees. If my agency closes and I am forced to file for bankruptcy, I will have to file for personal bankruptcy also. I may loose my personal assets and my credit will be ruined.

I have employees that I am responsible for, both legally and morally. Can we as agency owners continue to ask these people to work, when our payments are being held up or taken from us? I have wonderful employees. Many are women and other minorities. Many are single parents. As payroll is 80% of my recurring costs. I, like most of my fellow agencies have decreased salaries at an average of 15%. My employees cannot adjust to another decrease, due to their existing financial obligations. If 75% of the home health agencies in Texas close, the financial impact to the employees and the owners will

be devastating. Many will go on unemployment, and since their jobs are so health care specific, they will need to be retrained in other fields.

The loans that we have for our working capital will not be paid back. All of the financial burden will fall on the owner. We have corporations to shield us from such a disaster, but since we have no tangible assets, we have had to take personal liability for most of these debts. We feel great stress in these times of strife. Not because the work is hard, or the hours long, but because we have so little control over our destinies and the consequences are so great. These issues impact the large agencies as well as the hospital based agencies. The personal impact of IPS will be felt by all of us.

Co-pays have been discussed throughout IPS reform. Never has Congress implemented co-pays in a health care setting that was not allowed to make a profit. Co-pays make no sense in a business where I am not allowed to retain assets, because I have no way of balancing my uncollected co-pays against my non-existent assets. Hospitals and physicians cover their non-collectibles with retained earnings. How do you suggest I cover this cost? Shall I take it out of the salary of the bookkeeper who didn't collect, or should I take it out of the salary of the nurse who did not keep the patient alive long enough to collect?

So where does this bring us?

Representatives of the industry, including state and national home care organizations, have been actively working over the past nine months to develop alternatives to the current IPS. Our charge by key Congress persons was to come back with something the entire industry could agree on and that was budget neutral. We have suggested a number of creative and realistic approaches, but someone always throws up a road block: CBO won't score it, HCFA says they "can't"; it's not politically do-able in an election year, or something else. Under those circumstances, the only solution is to scrap the IPS until development of a case mix adjusted PPS.

The most obvious and severe defect of IPS is that there is not enough money in the formula to care for the patients. I believe Congress was significantly misled about the financial impact of IPS. If "budget neutral" is defined within the same constraints as applied by CBO with a 66% gaming factor (thus ripping 3 times the savings out of the system over what is needed), then we will only be rearranging the deck chairs on the Titanic. It is obvious that cramming 1998 patient needs into 98% of 1993-94 costs is a formula for disaster and the needs of the long term and/or medically complex patients cannot be met.

On the other hand, if "budget neutral" is defined as staying within the budget targets outlined in the BBA, then we believe this can be achieved with limited appropriate controls and clarifications in coverage. HCFA now projects a 2.8% decline in Medicare home health payments from 1997 to 1998 and only a 2.3% increase to FY 1999. Projected payments for Medicare home health services for the first two quarters of FY 1998 are already 35% lower than payments for the same period in FY 1997. According to

preliminary HCFA data from October 1997 through March 1998, home health payments have dropped almost $4 billion. It should also be recognized that one portion of the health care delivery system cannot be drastically reduced without effecting other parts of the health care continuum.

A home health payment system must recognize the different needs of different patients, as you do in all other health care settings. Not only does IPS discriminates against medically complex and long term care patients, but it also discriminates--through proration-- against the elderly person who just happens to get sick more than once a year. Again, you have never imposed such restrictions on Medicare beneficiaries and providers before. The BBA directed HCFA to develop normative standards, and these should be in place at least for the most common diagnoses/conditions prior to implementation of any capitated system. If this is not possible, then a reasonable state/national, state/regional, or regional/national blend could be determined to accommodate the average patients who are on service for a given period of time (e.g. 120 days) and then prior approval and/or targeted case management could be utilized for all patients requiring care beyond that time. These visits would be considered outliers and paid on a per visit basis outside the cap. This is very similar to the current PPS demonstration project and would truly serve as a transition to PPS. The annual per beneficiary cap, prorated among agencies serving the same patient during a given year, even if the illnesses or conditions are totally unrelated must also be removed.

Regardless of the method of reimbursement, it must match the coverage expectations of the program. For instance, the coverage guidelines clearly allow daily nursing visits with no end in sight for the diabetic who is not able to self inject and has no informal caregiver available, able and willing to perform the injections. Also, with regard to utilization of home health aides when a skilled need is present, the differences between "medically necessary" and "custodial" must be clarified. If it is not the intent of Congress to pay for long term care home health aides, then the coverage should state there is an end in sight or limit the number of visits. Under the current IPS, to say that coverage has not changed, only the reimbursement, is absurd because it is clear that costs cannot be reduced 60% and more without reducing utilization to which the patient can claim they are "entitled."

Treat agencies equally in reimbursement. All agencies within a community should have the same ground rules.

Agencies must have advance notice of reimbursement changes.
Although BBA 97 was passed in August, 1997 and effective for agencies beginning as early as last October, it was not until rules were published the end of March that we could estimate what our true limits were. These limits were 25% to 40% lower for Texas agencies than had been estimated by industry sources. Agencies began receiving calculations for their per beneficiary limits and resulting interim visit rates from the fiscal intermediary in June and July, which has resulted in drastic cuts in visit rates and demands for huge overpayments. Agencies must have time to plan and implement changes prior to application of new reimbursement rather than having it effective retroactively.

To ensure appropriate utilization levels are maintained and that desired savings are achieved, Congress should direct HCFA to clarify coverage through rules and institute targeted case management or prior approval of care lasting longer than a certain length of time or number of visits. An alternative or addition to this is for Congress to revise the formula for determining a per beneficiary cap which reflects more current utilization levels and regional differences, and then only implement it if home health spending limits outlined in the BBA 97 are exceeded.

Please help us to care for these patients in a realistic way, so that they can continue to live their lives with the dignity and control that they have worked their whole lives for. Please help the employees that work long hours and are devoted to their jobs and their patients. Please help me the independent home health care owner, not loose everything I have worked all my life for. The foundation of American business is bases on small business. IPS deteriorates the very infrastructure that our country was built on. Please give HCFA a clear message that you support the continuation of home health care and the very real fact, that they are accountable to you.

Providers want very much to work with this committee and other members of Congress to find a solution to the mess IPS has created. I believe consumers and other taxpayers also want to find a workable solution. We are committed to work with you in this direction.

Thank you very much.

Chairman THOMAS. Thank you, Ms. Brock.

Mr. Indest.

STATEMENT OF JOHN L. INDEST, CHIEF EXECUTIVE OFFICER, HEALTH CARE RESOURCES, NEW IBERIA, LOUISIANA, ON BEHALF OF THE HOME CARE ASSOCIATION OF LOUISIANA

Mr. INDEST. Mr. Chair, too, I do thank you for the opportunity to be able to address this subcommittee and the rest of the subcommittee members.

I appreciate your acknowledgement of the inherent problems that we are experiencing in IPS, and have changed my remarks, because I assume that you realize that, hopefully, IPS, as it stands today, is not a workable solution.

I also appreciate your commitment to our industry, to the elderly people and the homebound, that we serve, and finally, the urgency that you have expressed that something needs to be done about this matter.

When Congressman Johnson asked the HCFA representative about whether they considered the problem urgent, serious, in crisis, probably that answer, if anything, more today scared me than anything else.

We are in crisis. There is no doubt. I don't know where they're coming from. But if they would like to come to Louisiana, I would love to drive them around and show them that we are in crisis.

I would like to talk to you about the solutions that you had requested of me, and address some of those points.

I and the Home Care Association of Louisiana fully support—and if it is mandated, that would be fine—a corporate compliance program for Medicare home health agencies. I think that is a good idea.

We believe that we need to get away from an agency-specific per-beneficiary limit and go to some sort of blend. While I will be the first to admit that I would love to see a moratorium, a blend is necessary. This blend should not be agency-specific, because then we are rearranging the winners and losers.

I can tell you that, in Louisiana, across the street from each other, we have agencies with a $3,000 per-beneficiary limit and an agency with close to an $18,000 per-beneficiary limit. They are literally advertising the fact that they can provide more care than someone else.

I am also familiar with agencies that are saying, "I have two provider numbers, both with high per-beneficiary limits, and am willing to sell one for prime dollars."

It is becoming a tool, in our state, that is just, in my opinion, unacceptable.

I would recommend that we go to 110 to 112 percent of the mean, versus 105 percent of the median.

We do need to establish an outlier program, an outlier plan. My understanding is that many of our national associations have tried to work with HCFA on this. The one thing that was stated earlier about an outlier program, tying it to a cost report causes me concern.

If you tie it to a cost report, which is filed five months after the close of your fiscal year, by the time your fiscal intermediary starts

to look at it and owes you money back, you could be out of business.

I think pro-ration is a bad idea that causes headaches that can't be taken care of.

I'm concerned about implementation of OASIS in the midst of all of this, there is no funding that will help us implement this very costly program that is being proposed.

I would continue the PIP payments for home health agencies until the enactment of prospective payment.

It seems that, as of late, our fiscal intermediary, PGBA, has increased their claims review, and I do not condemn this. I think claims review keeps us all honest, as long as we have a right of appeal, which everyone should have a right to.

It also seems that, finally, statistical information is being used to target aberrant behavior among home health agencies. I've been in the home care business for 15 years and have never seen this done before. But lately, it's being done, by the OIG, by the United States Attorney's Office; by HCFA. I consider this a good way of proceeding, and it certainly is happening in Louisiana.

I believe we must go retroactive to 10–1–1997. I don't know anyone in business who could see the Balanced Budget Act that was enacted in August of 1997, it became effective 10–1–1997. No one knew the rates. The national rates were published 3–31–1998. Agency-specific rates, some have them, some still don't.

We are shooting in the dark. This is intolerable. To go back is a must for us. The final nail in the coffin is that most of the rates that are published are in error.

I would hopefully eliminate the 15% reduction—a lot of the rates that are being sent out to the home health agencies are in error, and subject to review.

Chairman THOMAS. It was the Louisiana pronunciation. But Jim immediately told me what that was. [Laughter.]

Mr. INDEST. I'm sorry.

Chairman THOMAS. That's OK.

Mr. INDEST. Then, on top of that, I'm a Cajun.

Chairman THOMAS. That's why he told me what you said. [Laughter.]

Mr. INDEST. Mr. McCrery is from the north, but I appreciate the interpretation.

I would like to address, just for a second, co-pays. I think co-pays are something that should not be acceptable in the home health agencies. Co-pays are a tax on the sick. Those patients who will be subject to the most co-pays will be the sickest patients.

Any home health agency can cite you statistics, instances where we enter a patient's home and, if we are going to ask them for $5 a visit, they don't have the money to buy all of the medicines that the physician has prescribed for them.

Or, like someone pointed out to me last night, because they like their home health agency, they will come up with the $5 and not buy another medicine that they were supposed to have.

I, too, appreciate the opportunity to address this subcommittee. Questions were brought up about CON, high utilization in Louisiana. Those are certainly areas that I would love to address upon further questioning.

Thank you.

[The prepared statement follows:]

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Testimony of
John L. Indest, RN, BSN, MS
Before The
Ways and Means Subcommittee on Health
August 6, 1998

I would like to first thank you, Mr. Chairman and the members of this committee, for providing me with the opportunity to express my views relative to the effect that certain elements of the Balanced Budget Act of 1997 have had on home care agencies in my home State of Louisiana. I am also aware that I have been asked to explain to this committee the reasons why Louisiana leads the nation in home care visits per beneficiary. I will first direct my comments to the issue of high utilization in Louisiana.

It should be first acknowledged that while Louisiana does lead the nation in visits per patient served (150 for calendar year 1996), there are other states that have relatively high numbers for the same period of time (GA, AL, MS, TN, OK and TX). However, let me direct my thoughts on this matter to Louisiana. It should also be noted that there are wide variations of home care usage within the state itself. As a result of the interim payment system for home care services the annual per beneficiary rate for agencies range from approximately $2,000 to over $20,000. In the past the home care industry has been requesting that HCFA conduct appropriate studies to determine an accurate and reliable explanation for the utilization variances.

1. Louisiana has a high percentage of patients with chronic diseases. While I did not have access to these numbers during the time this testimony was prepared, it is common knowledge that there is a large percentage of citizens in Louisiana with diabetes, congestive heart failure, chronic obstructive pulmonary disease, hypertension and cancer. This assertion seems to be substantiated by a study conducted by Mathematica Policy Research, Inc. that was prepared for the Department of Health and Human Services. The date of the study was September 30, 1994. The study concludes that... "home health agencies in the highest use regions are not overproviding care. Rather, they are probably providing appropriately higher levels of service in response to the needs of very frail patients who may have access to relatively few alternative sources of care and few resources to purchase those available. It seems likely that home and community-based and residential sources of care that could serve as alternatives to the long term use of the Medicare home health benefit may be quite limited in this region. Thus, home health agencies in the region may serve patients for as long as is justifiable."

2. The Louisiana home care Medicaid benefit is another reason for high Medicare utilization numbers. The state of Louisiana limits home care agencies to a total of fifty (50) home care visits per calendar year per patient. This includes all visits (Skilled Nursing, Home Care Aides, and Physical Therapists). Additionally, Louisiana has imposed prospective rates of reimbursement for these services that makes it virtually impossible for a home care agency to provide patient care.

3. In the past there has been a great deal of opposition from various groups in Louisiana to placing some type of Certificate of Need or moratorium on the establishment of home care agencies. Numerous efforts were made by the state home care association in the mid to late 1980's and the early 1990's to limit or stop the growth of home care agencies. These efforts were consistently met with effective opposition from the Department of Health and Hospitals, the governor's office, and the hospital association. It was not until the mid 1990's that moratorium legislation was passed. However, the state was already grossly overpopulated with home care providers.

4. In the past it was a common practice of the Fiscal Intermediary to conduct a new provider workshop prior to or immediately following the issuance of Medicare provider number. While it is the duty of any person entering business to understand the business that he/she is entering, this workshop was seen as a opportunity for the fiscal intermediary to control potential overpayments by properly educating the home care provider about all aspects of operating a home care agency. This is no longer the case. While new provider workshops are periodically held, they are obviously not achieving the results that were attained years ago. In the home care meetings that I attend and the informal discussions that are held during these meetings I am constantly amazed at the very basic questions that are asked and the lack of knowledge of the home care benefit that is demonstrated by many of the participants. It is not uncommon to walk into a home care agency and to find that the personnel do not know if the fiscal intermediary manual exists or if there is a copy of the HIM 11 on site. Most do not know what a HIM 11 is !!

5. In the mid 1980's a new provider was placed on 100% medical review until such time that the agency could demonstrate a good working knowledge of the Medicare regulations. Also, at the end of one (1) year of operation an agency could expect that the Fiscal Intermediary would make a site visit to review a sampling of patient files. While there were often denials issued for non-covered services, the experience was a learning one for all involved. One thing was certain, if the agency did not understand the Medicare coverage guidelines prior to the visit, these guidelines were understood after the visit. Over the years the percentage of claims that have been reviewed by the intermediary has steadily declined. From the high of 100% review for all new providers it is my understanding that review decreased all the way to 2% of claims.

6. The mid to late 1980's and into the 1990's were a time of economic downturn in Louisiana. Much of the state is dependent on the oil and gas industry and it was this very industry that was in a downturn. Naturally entrepreneurs began to look at other sources of income. National trade journals were touting home care as the business to be in. The owner could collect a decent salary, the costs associated with the business were paid, and some profitability could be had in accessing the health insurance market. Entry into the market was easy, with little or no capital outlay. An association with just a very few referral sources virtually guaranteed success in the business.

7. As new players came into the market and the challenges of home care became apparent, many providers sought out consultants and/or management companies to assist with agency operations. The cost of the services provided were generally reimbursable and this was exactly how many of these groups were able to sell their services to the home care agencies. Many of the agencies were told that their cost report problems would go away by simply increasing the number of visits provided to the patient. Without a good basic knowledge of the home care benefit these providers blindly followed the advice of their hired "experts". Therefore the utilization figures for these agencies dramatically increased.

With these comments expressed it should also be known that since 10/1/97 over eighty (80) home care agencies have closed their doors in Louisiana. This does not take into account the branch office locations that have also closed. Many of the home care providers that I speak with have significantly curtailed utilization numbers.

As has happened throughout the nation, IPS has had devastating effects on the home care industry in Louisiana. There are numerous stories where the Fiscal Intermediary has issued letters to the home care providers giving the per beneficiary rate and a dollar amount owed back to the intermediary. Upon checking it is discovered that the computations are erroneous. Despite the fact that an appeal period is available to the provider the intermediary initiates recovery of the monies prior to completion of the appeal process. Telephone calls to the intermediary usually go unanswered or they are diverted to another person who suggests that someone else be called. Before the matter can be settled the agency is out of business due to a lack of funds needed to continue operation. Serious questions remain in the Medicare accounting community concerning whether IPS can be completely implemented or not. Concerns dealing with proration of costs, calculating the per beneficiary limit based on the calendar year for the beneficiary, the agency's fiscal year, and taking into account that multiple agencies may visit the patient throughout the course of a year make making sense of IPS a nightmare.

Under IPS agencies will be forced to choose the types of patients that they are willing to accept for care. It will be the sickest and the most frail that will suffer the most. Wound care patients and others requiring an intensive level of service will be avoided by the agency trying to survive. One may comment that these patients will go to other health care providers. However, they will not be welcomed back into the hospital, they are dealing with DRGs and are not willing to take the patient back for any extended period of time. In Louisiana nursing homes are full. There are few alternative services left for these people to access. IPS is creating a system where patients will be forced into more expensive health care settings. While savings will be realized in one sector of the health care continuum (home care) cost increases will be experienced in other areas.

My feelings are that the cost savings from home care that Congress is seeking is currently being achieved without IPS. In Louisiana today a home care agency is subject to receiving an on-site visit from HCFA, the Fiscal Intermediary, the Office of Inspector General (OIG), the U.S. attorney's office and the state department of health and hospitals. It is common knowledge throughout Louisiana that these different groups are all active. This alone has had a chilling effect on home care in our state and has given cause for any agency to closely examine the

eligibility of any patient admitted and the need for any services rendered. In the past none of this scrutiny was evident.

How therefore do we attain the objectives of Congress and not completely devastate the home care industry? I believe that IPS is a poor idea that should be done away with. Place HCFA and national industry representatives on notice that PPS needs to be placed on the fast track. Set a reasonable implementation date and do not settle for less. Encourage the various "policing" agencies that were mentioned earlier to continue their efforts in a reasonable manner. Audits should be conducted based upon subjective data that would indicate a variance from the norm.

For many years now home care has been a significant part of the overall health care system in the United States. In my own opinion, home care is a vital part of health care in the United States. While I would agree that there are areas of the benefit that need fixing, I do not adhere to the belief that the industry needs to be devastated. I not only feel that I am here today representing the interests of the providers of home care but even moreso the interests of those patients who are unable to properly express their feelings about home care. Please let this segment of the population be your guide in determining what course of action you will take. It is so easy to make decisions based upon statistics and reports, they are so sanitary, so black and white. Regardless of what decisions are made the needs of the homebound patients of America will not go away.

Chairman THOMAS. Thank you. You can certainly submit those, in terms of additional writing, if you want to direct it to that, as well, if we don't give you ample opportunity to get your point out.

Mr. INDEST. Thank you.

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

Ms. Odgren.

STATEMENT OF RUTH ODGREN, VICE PRESIDENT OF OPERATIONS, VISITING NURSE SERVICE SYSTEM, ELIZABETH, NEW JERSEY, AND PRESIDENT, HOME HEALTH ASSEMBLY OF NEW JERSEY, ON BEHALF OF TRI-COUNTY VISITING NURSE ASSOCIATION

Ms. ODGREN. Thank you. Thank you, Chairman Thomas and the rest of the subcommittee, for allowing me to come and testify on behalf of Tri-County Visiting Nurse Association in Plainfield, New Jersey.

I am also the president of the Home Health Assembly of New Jersey, which represents the majority of the home care agencies in New Jersey, as well.

For those of you who are not aware, New Jersey is the fourth lowest state in total overall Medicare home care cost. We have a certificate of need in place in the state of New Jersey, and we also have very strict and stringent regulations.

I would like to just talk for a minute about two issues that have been brought up in the testimony, about ways to sort of game the system, that are unavailable to home care agencies in the state of New Jersey.

First of all, it is regulatorily impossible to close your organization in New Jersey and reopen. It's not an option.

Secondly, if Tri-County Visiting Nurse Association was merged into or acquired by another home care association within the state of New Jersey, at its per-beneficiary limit of $1,950, whoever acquired them would cost the system more money than Tri-County VNA costs the system right now, because, to my knowledge, it is also in the lowest region the fourth lowest state, and the agency with the lowest per-beneficiary limit, so I don't know that anybody would want us.

This year, Tri-County VNA, when we looked at our per-beneficiary rate and the effect of the change in the per-visit rates from 112 percent of the mean to 105 percent of the median, was anticipating about a half-a-million dollar loss on a budget under $4 million.

We have made some adjustments. We have reduced some of our staff. We have suspended our pension payments to our staff for the rest of the year, which was not an easy decision.

We have reduced the amount of money that we pay our staff for using their automobiles to see patients. The Federal IRS limit is 32.5 cents. We have reduced the amount that we are paying our employees down to 20 cents.

We believe we have cut as much as we can from our budget, and we will still anticipate being $2.5 million in the red at the end of the year.

We don't have cash reserves. We are a voluntary, not-for-profit organization established in 1894, and we do not have a large ability to borrow money to offset that loss.

In my written testimony, I pointed out two, which I would consider outlier cases, that cost the Medicare program between $8,000 and $9,000 for each of those patients.

Had those patients been unable to get home care because the agency no longer existed or a higher-cost agency existed—or what may happen, and I believe is happening across the country, forcing agencies to pick categories of patients they can no longer admit across the board.

For instance, Tri-County Visiting Nurse Association could develop a policy that says, "We are no longer able to admit anybody who requires daily care or care more often than that. We can't afford to. We need to be here for the bigger picture."

Then, what would happen is, those patients that I used as examples in my written testimony would end up in sub-acute skilled nursing facilities, to the tune of $450 for the first 20 days of care, and 80 percent of that, or $360 for the next 80 days.

It costs the Medicare program between $8,000 and $9,000 for those gentleman in Plainfield, New Jersey in home care. It would have cost the Medicare program, in a skilled nursing facility, in excess of $30,000 to provide the same service in a skilled nursing facility.

Therefore, I think that IPS needs to be changed. It needs to be changed for this current fiscal year, and not next year or a year after, and I think that we need to go to a blend that is more acceptable:

Seventy-five national/25 regional; 112 percent of the mean; delete the 15 percent per-visit limit cap reduction of 10–1–1999; continue PIP until HCFA can put in place a prospective payment system; and everything needs to be retroactive to 10–1–1997.

I have listened today to some of the ideas about co-pay and outliers, and I'm certainly willing to listen to that. I don't have enough information. Obviously, a lot of us don't have enough information to make those decisions right now.

I thank you for listening to me, and I do implore you to do something this year, because I do believe the Tri-County VNA, and many other community-base VNAs in the state of New Jersey, will not exist in and of themselves, come the first of 1999. Thank you.

[The prepared statement follows:]

Ruth Odgren
VP Operations, VNSS

Appearing on behalf of:
Tri County Visiting Nurse Association

In its current form the Interim Payment System (IPS) may cause Tri County VNA to close its doors. Current estimates show that Tri County VNA will lose approximately one half million dollars by year-end.

For a voluntary not for profit home care agency, raising a half a million dollars to subsidize Medicare patients is impossible. Fund raising should supplement charity care, not insured care.

Tri County VNA was established in Plainfield, NJ in 1894, incorporated as a voluntary, not for profit organization in 1915 and began providing services to Medicare beneficiaries in 1966.

Tri County VNA has a long history of meeting the home and community health needs of the most vulnerable populations. For example the 1997 demographic data shows:

75% reside in an urban setting
24% are between ages 65 and 84
44% are over age 85
81% are Medicare/Medicaid beneficiary

One thousand and seven (1007) Medicare beneficiaries received services in 1997. Tri County VNA has a history of efficient use of the Medicare Home Health Benefit. For Example in 1996:

The national average of visits per Medicare beneficiary	73.9*
NJ visits/ beneficiary	43**
Tri County VNA/beneficiary	28***

***8 states average in excess of 100 visit/beneficiary**
****New Jersey ranks 4th lowest of all states visits/beneficiary**

*** Tri County VNA is fully accredited by the Joint Commission on Accreditation of Health Care Organization (JCAHCO) and licensed by the New Jersey State Department of Health (NJSDH).

1998 Per Beneficiary Limitations (IPS)

1998 National Average limit/beneficiary	$3,356.00
Regional Limit/beneficiary	$2,548.29
Tri County VNA limit/beneficiary	$1,950.00

The 1998 estimated cost to provide services to Medicare beneficiaries at Tri County VNA is $2,464, well below the national average, but at a loss of $500 per beneficiary.

The impact of the Interim Payment System has affected staff as well as the agency as a whole. Our goal is to have as little impact on beneficiaries as possible.

In order to reduce costs of providing services under IPS, Tri County VNA has reduced staff, as well as benefits to current staff.

As of July 16, 1998 the reimbursement to staff for use of their vehicles while making home visits was reduced from .32 to .20/mile driven and as of August 3, 1997 thru December 31, 1998 we have suspended payments to our pension plan. As of April 30, 1998 Tri County VNA was at an operating loss in excess of $100,000. This loss was directly attributed to the per visit cap reduction to 105% of the median. This translated into a 15% cost cut to Tri County VNA.

The combination of the decrease in visit limits and the low per beneficiary cost limit will have a devastating effect on an extremely efficient local VNA.

Tri County VNA, like other small local providers in New Jersey will be looking at other ways to survive IPS. One possibility is to set policy around categories of patients accepted for care. High end cost frail elder patients who live alone in urban settings are most vulnerable to these cuts. I will share two examples with you:

Patient A:

- 66 year old male
- Admitted April 2, 1998
- Medicare beneficiary

- Diagnosis: Slow healing leg wounds
- Secondary to non insulin dependent diabetes mellitus and venous insufficiency
- Lives alone (wife in hospital)
- Wheel chair bound
- Treatment changes periodically with expectation that wounds will heal
- Skilled nursing visit daily
- Home health aide visits 2 hours' 3 days/week to assist with personal care and activities of daily living

Cost of care to patient:	$ 9,000
Cost over per beneficiary limit	$ 7,100

Patient B:

- 81 year old male
- Admitted twice in 1998
- Diagnosis: Venous ulcers
- Home bound due to inability to ambulate
- Daily wound care - skilled nursing
- HHA 3 times/week for 2 hours
- Physical Therapist to assist with use of walker and cane
- Lives alone in urban housing

Cost of services	$ 3,600
Cost over beneficiary limit	$ 1,700

These patients represent many that require services of a home care agency and may fall through the cracks under the Interim Payment System.

Agencies such as Tri County VNA may develop policies to restrict admission of patients who require daily services in order to survive for the larger population.

In summary, the Interim Payment System causes an unfair distribution of Medicare dollars. Why are some beneficiaries afforded more service (for the same condition) than others are?

Points to consider:

- IPS fails to recognize changes in need and service since 1993 (lower length of hospital stay and increase in age of population);
- IPS sets up a system that will focus care in high cost settings, i.e. ERs, Hospitals and skilled nursing facilities;

- IPS will negatively impact the home health care to the most vulnerable, the frail, urban elderly;
- IPS fails to recognize changes in technology, both in the direct patient care arena and in the management of information;
- IPS will facilitate a home care system that may refuse care to high end users of home care.

On behalf of Tri County VNA, its patients and staff and other local home health providers, particularly in New Jersey, I ask that you do what is necessary to make the Medicare home health benefit equally as accessible to all who need it.

Chairman THOMAS. Thank you, Ms. Odgren.

Ms. Palsgaard.

STATEMENT OF DENISE PALSGAARD, PRESIDENT, CALIFORNIA HOME CARE AND HOSPICE, INC., MERCED, CALIFORNIA, ON BEHALF OF THE NATIONAL ASSOCIATION FOR HOME CARE, ACCOMPANIED BY MARY SUTHER, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, VISITING NURSE ASSOCIATION OF TEXAS AND CHAIRMAN, BOARD OF DIRECTORS, NATIONAL ASSOCIATION FOR HOME CARE

Ms. PALSGAARD. Thank you, Mr. Chairman. My name is Denise Palsgaard. I'm a registered nurse and president of California Home Care and Hospice in Merced, California, home of the next U.C. campus. The Chamber of Commerce asked me to say that when I got here.

Mary Suther, chairman and CEO of the VNA of Texas, and chairman of NAHC's board of directors, is accompanying me here today.

NAHC appreciates the opportunity to testify on solutions to the very serious problems resulting from IPS, and deeply appreciates the support you, Chairman Archer, and members of this subcommittee have shown for reforming IPS. IPS reform in this session is urgently needed.

The per-beneficiary limit, the per-visit cost limit reductions, the October 1, 1999 15 percent reduction, and the effect of IPS on elderly and disabled individuals most in need of home care top the list of issues that must be addressed.

NAHC fully appreciates the sensitivities surrounding the concept of an IPS moratorium. However, the IPS problems are so many and so serious that another solution simply may not exist that would fix the problems for home health providers in all parts of the country, and provide a solution that could be put in place before October 1, 1998.

NAHC is joined by the American Federation of Home Health Agencies, the Home Care Association of America, and the Home Health Services and Staffing Association, in supporting this position.

Absent a moratorium, there are specific issues that must be addressed to adequately reform IPS. Unless reforms are implemented retroactively to October 1, 1997, many of the home health agencies that Congress most wants to help just won't survive to see the life raft.

I sit here as one of those small companies. We have 45 employees, myself as the administrator, and we are a very cost-effective agency. That has, like many on the panel, gotten us a very low-cost per-beneficiary limit.

Some of the things we have done is to implement a 10 percent across-the-board pay decrease to our 45 employees. We have tried to look at other cost savings. Because we were so cost-effective anyway, that was very difficult to do.

I agree with Mr. Indest, that my agency is in a crisis, and I believe that what will help that crisis is reform in this session.

I also think that it is very interesting, as a registered nurse, that many folks don't understand the crisis.

I would invite them, certainly to come and do home visits with us, and then, on the other end of my spectrum, to sit in a bank, as I did Monday, and ask for another line of credit because I need to make payroll, when my receivables well could make payroll, but they're stuck in a system that won't let the money go. And bankers are tough people to address.

I think that those are crises, and they are real; and that is just this week.

Specifically, Congress should revise the per-beneficiary limit, implementing a regional blend that will help level the playing field in all regions of the country.

Under this approach, each census region would be assigned the greater of one or two blends—either 75 national and 25 regional, or 75 regional and 25 national. Payments would be set at the percentage of the blends necessary to ensure that total expenditures are no greater than budgeted levels.

Eliminate the 15 percent October 1, 1999 reduction. Raise the per-visit cost limit to 110 percent of the mean from 105 percent of the median. Establish a funded outlier policy based on costs incurred in caring for patients. Pro-rate the per-beneficiary limits only where agencies transfer or prematurely discharge patients for purposes of circumventing the limits. Maintain PIP for home health agencies until 12 months after implementation of PPS.

Other elements of IPS that should be addressed include the application of extending the savings from the freeze to the per-beneficiary limits; setting the base year at fiscal year 1994; and denying providers the opportunity for exemptions and exceptions to the per-beneficiary limits.

Some of these issues can be resolved administratively, and do not need a legislative fix. We urge the Committee to insist that HCFA reverse its decisions in each of these areas.

While resolving these issues would not fix all the IPS problems, it would certainly address some important points that would make a legislative solution within the required budget parameters that much more feasible.

Specifically, HCFA chose to apply the recapture of the savings of the freeze provision to the calculation of the new beneficiary limits in addition to the per-visit cost limits, setting the per-beneficiary limits at artificially lower rates. The new limits didn't even exist at the time of the original rate freeze.

HCFA assigned new providers a rate that reflects national rather than census data, giving some new providers much lower and others much higher reimbursement levels than other providers in the same areas.

HCFA chose to pro-rate the per-beneficiary limit in all cases, rather than only in cases where home care agencies act to circumvent the limits. HCFA is not allowing any exceptions to the per-beneficiary limits, even though using a five-year-old base year does not account for many changes in the amounts and types of services provided to patients.

We deeply appreciate your leadership, Mr. Chairman, and the support of other members of the subcommittee, to fundamentally reform IPS this year, and we look forward to working closely with you to resolve these issues. Thank you.

[The prepared statement follows:]

Mary Suther
Chairman of the Board
Val J. Halamandaris
President

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TESTIMONY

BEFORE THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

August 6, 1998

presented by

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ON BEHALF OF

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Mr. Chairman,

The National Association for Home Care (NAHC) appreciates the opportunity to testify on solutions to the very serious problems resulting from the new Medicare interim payment system (IPS) for home health care.

NAHC is deeply appreciative of the support you, Mr. Thomas, and the other members of this Subcommittee have shown for the development and implementation of a prospective payment system. We also greatly appreciate the attention you, Chairman Archer, and the Members of this Subcommittee have shown to the problems created by the interim payment system. We are pleased to have the opportunity to express our concerns about the devastating impact this new system is having on home health agencies and the patients they serve, and the importance of fundamentally reforming IPS in this legislative session.

NAHC is the largest national organization representing home health care providers, hospices, and home care aide organizations. Among NAHC's nearly 6000-member organizations are every type of home care agency, including nonprofit agencies like visiting nurse associations, for-profit chains, hospital-based agencies and freestanding agencies.

As the Subcommittee heard last month, HCFA's latest move to delay implementation of PPS by at least six months makes it even more imperative that Congress move to fundamentally reform the interim payment system (IPS) in this legislative session.

Benefit Reductions Go Far Beyond the Rate of Growth

Prior to passage of the BBA, the Congressional Budget Office (CBO) projected 13.8% growth in home health outlays for 1997. An updated projection of Medicare outlays by the CBO indicates that in 1997 home health outlays actually increased by only 4.8%. In fact, CBO's recently issued revised baseline indicates that the slow-down in home health growth has been so significant that the savings CBO anticipated from IPS (put in place for fiscal years 1998 and 1999 by the BBA) would have been achieved without any legislative changes. Further, more recent HCFA statistics indicate that in fiscal year 1998, total Medicare home health outlays will actually decline by approximately three percent, rather than grow by 4% as CBO predicted in its 1998 baseline.

CBO's new baseline now projects that spending on home health will be reduced by $26 billion over five years. This is $9.9 billion more than the $16.1 billion in savings Congress targeted in the BBA. The HCFA midsession review now reveals that spending over five years is expected to be reduced by $37.1 billion, $21 billion more than Congress intended in the BBA. There is evidence that the actual reductions in home health reimbursement over five years will exceed $48 billion. What many Members of Congress may not have been aware of is that CBO anticipated that IPS would reduce home care spending by $48.3 billion; however, the savings were reduced by a 2/3 "behavioral offset" under which CBO expected home care providers to "game" the system. The Small Business Administration, in a recent written opinion, concluded that there is no factual basis for this offset.

Based on an analysis provided for NAHC by The Lewin Group, an estimated 92% of agencies will be faced with reimbursement cuts that average 32% in FY1998. A reduction of this magnitude could result in Medicare home health expenditures falling to $12-$13 billion, a dramatic reduction from both the $21.1 billion CBO originally projected for FY1998, prior to passage of the BBA, and the $18.2 billion currently projected.

Problems Created by the Interim Payment System

BBA made dramatic changes in the reimbursement system for Medicare home health services. These changes became effective for cost reporting periods beginning on or after October 1, 1997, and are intended to remain in effect until October 1, 1999, when Congress has mandated the implementation of a new PPS for cost reporting periods beginning on or after that date.

Under the new IPS, agencies are reimbursed the lowest of their (1) actual allowable costs; (2) aggregate per-visit cost limits; or (3) a new aggregate per-beneficiary limit. A number of significant problems have emerged as a result of the IPS, and we urge Congress to fundamentally reform the system in this legislative session.

1. Reduced Per Visit Cost Limits – 21% Reduction

IPS reduced the per-visit cost limits in two ways. First, the limits are calculated based on 105% of the median per-visit costs of freestanding home health agencies, rather than the previous method of 112% of the mean. Second, the new cost limits do not take into account the market basket price increases that occurred between July 1, 1994 and June 30, 1996.

The combined effect of these two provisions represents a 21% reduction in the cost limits. HCFA estimates that 65% of all providers will be over these limits. NAHC's data indicates that the percentage of those over the limits is even higher.

2. The New Per-Beneficiary Limits Are Inequitable

The per-beneficiary limit is a blended limit -- 75% agency-specific data and 25% census region data -- with FY1994 as the base year. The idea behind the agency-specific component of the limit was that it would serve as a proxy for case-mix. The problems with the per-beneficiary limit are many.

The new per-beneficiary limit has been of tremendous concern because of the inequities it creates. The per-beneficiary limit has been an extremely divisive issue in the home care community because certain types of providers and certain geographic areas are affected differently by these limits.

Many agencies that have been in existence for years that have worked to get their costs down and become more efficient in anticipation of a PPS have been harmed by the per-beneficiary limits. They end up with lower limits, based on the agency-specific data, and are penalized for their own efficiency.

The per-beneficiary limit is based on data (costs of care and type of patients) that reflect a home care agency's practices from four or five years ago (FY1993/1994). The per-beneficiary limit does not reflect any changes in practice that occurred from the base year to today.

As in all segments of the economy, costs increased in the last four to five years. Many home care agencies provide a wider range of services in 1998 than they did in 1993 or 1994. Many home care agencies serve a very different type of patient -- sicker, more high tech, more complex cases -- than they did in 1993 or 1994. None of these changes are reflected in the limit.

While in theory the per-beneficiary limit is supposed to allow home care providers to "balance" their sicker patients with less acutely ill patients, providers are finding it increasingly difficult to adequately serve patients with heavier care needs because the limit does not accurately reflect case mix.

3. Combined Effect of the Per-Visit and Per-Beneficiary Limits

HCFA estimates that 93% of all Medicare home health providers will have their reimbursements reduced by one of the limits. For comparison, only about one-third of home health agencies incurred costs exceeding the per visit cost limits in FY1997.

4. Additional 15% Reduction in Limits

On October 1, 1999, regardless of whether HCFA has developed PPS, home health expenditures are to be reduced by an additional 15%. This further reduction would be devastating to providers and would severely jeopardize the ability of beneficiaries to access care and restrict the level of care they could receive in their homes. The additional 15% reduction is unnecessary because the budget target will be achieved without it. Although the CBO estimated that the BBA would cut Medicare home care expenditures by $16.2 billion over five years, the reductions in per-visit cost limits and the per-beneficiary limits will likely cut home care expenditures by close to $50 billion over the same period.

5. No Appeals or Exceptions Mechanisms

There is no formal, uniform mechanism under which providers can appeal the limit calculations or otherwise ensure that they can accommodate the care needs of the sickest patients.

6. "New Provider" Rates and Definition

Although HCFA addresses the issue of the "new provider" definition in the new per-visit cost limit notice, the serious problem of the new provider rates under IPS remains unaddressed. New providers, those who do not have a full base year ending in FY1994, are to receive the "median of these limits," which HCFA has interpreted to mean national averages rather than census division limits, an interpretation which leads to highly inequitable results.

Some new providers who deliver care in census regions with limits which are below the national average will have higher limits than existing agencies in the census division. In other areas, the opposite effect results. In Louisiana, we are told, one agency has a per-beneficiary limit estimated to be $3000 per year, and a competing agency in the same city has a limit of $13,000.

7. Publication of Per-Beneficiary Limits

It is important to remember that HCFA did not publish the new per-beneficiary limits, which went into effect on October 1, 1997, until April 1998. Nearly 2/3 of all home health providers were on IPS before the actual limits were published. In effect, they have been "flying blind," making business and care decisions on best guesses. Many agencies expected higher limits than they were actually given and based their business decisions on inaccurate best guesses.

8. Beneficiary Impact

The most devastating impact of the IPS, however, is on beneficiaries. IPS is reducing access to home health services significantly and restricting the level of care received by patients in their homes.

The inadequacy of the new reimbursement limits leaves providers with the choice of restricting access to their services or financially destroying the agency by delivering care to patients that push the agency's operating costs above the reimbursement limits. Patients who need the most care are most at risk for cutbacks or being denied access to care.

These beneficiaries tend to be the oldest, sickest, poorest, and most frail Medicare beneficiaries. With too-low Medicare payments, providers have cut back on staff, leaving them unable to care for all who need home care. Patients who need care the most either are not receiving care, or are being cared for in more costly settings like emergency rooms, hospitals, and nursing homes.

It is important to note that although the reimbursement system has dramatically changed, the Medicare coverage criteria (except for the venipuncture exclusion) have remained the same. Providers must lower both their costs and their utilization rates in order to remain viable under IPS. Lowering either of these without adversely affecting patient care or the quality of services, however, is proving extremely difficult.

Home health costs have grown much more slowly than both the health care market basket and the consumer price index (CPI). Therefore, it is nearly impossible for many providers to reduce only their costs of care, while continuing to comply with quality standards, and stay under the new cost limits.

Providers must also reduce utilization levels, which could have a drastic impact on beneficiary care. Cutting the number of home care visits could place some Medicare beneficiaries at risk of receiving less care than they need to remain in their homes. Lower utilization also requires family caregivers, who already provide a majority of home care services, to carry an even larger burden.

To lower utilization and costs, some home care providers are being forced to selectively admit patients. Beneficiaries who require high-intensity services for a short period (e.g. infected wound patients who require two or three dressing changes a day) or long-term patients who require services over an extended period (e.g. a multiple sclerosis patient with limited skilled care needs, but who requires extensive home health aide services for help with activities of daily living) are no longer "desirable" types of patients. Without home care, these patients could end up with increased numbers of acute-care episodes, increasing costs to Medicare, or end up in nursing homes at higher costs to state Medicaid programs.

HCFA has failed in its duty to educate beneficiaries and guide home care providers on the issue of appropriate versus inappropriate discharges from care. Because of a complete failure to address this important issue by HCFA, NAHC has attempted to develop educational materials for both providers and beneficiaries. Our best efforts, however, cannot take the place of guidance from HCFA since this is an unclear area of the law which calls for official explanation of responsibilities.

It is critical that providers understand how to appropriately discharge patients from service, should that be necessary, and that beneficiaries understand how IPS affects them and their home care benefits.

IPS Studies

Two recent studies on IPS echo many of home care's concerns about the impact of IPS on beneficiaries and providers. A recent study commissioned by The Commonwealth Fund found that changes in Medicare payments for home health care resulting from the BBA have the unintended consequence of reducing access to services for the oldest, poorest, and sickest Medicare beneficiaries. These individuals tend to need the most home care, for the longest periods of time. The report also found that:

- IPS places new financial pressures on home care providers to reduce high volume, or longer-stay, episodes of care.

- Most longer-stay patients are not using the Medicare home health benefit solely or predominantly for long-term care. These individuals tend to have substantial acute care needs as well.

- The home care agencies most affected by IPS will not necessarily be the most inefficient. Agencies serving more patients with greater care needs than they served in FY1994 will likely have difficulties maintaining the provision of appropriate care.

A study by The Lewin Group, entitled "Implications of the Medicare Home Health Interim Payment System of the 1997 Balanced Budget Act" concluded that:

- The sickest and most fragile patients may have difficulty accessing services, experience reductions in service, or be shifted to less appropriate care settings as a result of the per-beneficiary limit, which is based on 1993-94 cost data.

- The IPS was enacted to restrain growth of the Medicare home health benefit. However, growth in the benefit has already been restrained without the implementation of IPS. The growth rate in home care for 1996 to 1997 sharply decelerated, changing from a projected 13.8% to only 4.8%.

- Agencies most affected by the new per-beneficiary limit include: 1) those that have had an increase in severity in their case mix since 1994; 2) small agencies serving a large number of high-use patients; 3) rural agencies where alternative sources of care are less likely to be available; 4) agencies that have added services since 1994, the cost of which will not be included in the per-beneficiary limit calculation; and 5) new providers and agencies resulting from mergers or acquisitions.

- The IPS requires agencies to hold down their costs without regard to past efficiency or current patient mix. Agencies that cannot make cost reductions in the short time frame will likely experience financial losses and potential closure.

Specific IPS Reforms

While NAHC fully appreciates the sensitivities surrounding the concept of a moratorium on IPS, NAHC believes that the problems created by IPS are so many and so serious that another legislative solution simply may not exist that would 1) fix all the problems, 2) fix the problems for home health providers in all parts of the country, and 3) provide a solution that HCFA could put in place before October 1, 1998.

For example, while changing the blend used to calculate the per beneficiary limit to 50 national/50 regional would help a segment of the home health community, it would not sufficiently help the majority of home health agencies. It would also benefit some parts of the country by taking from other parts, a regional issue that must be dealt with.

The ideal solution, then, would be to place a retroactive moratorium on IPS, coupled with budgetary fail-safe devices to ensure that the moratorium would maintain the budgetary integrity of the Balanced Budget Act. NAHC has proposed that the per beneficiary limits be triggered only if home care expenditures, under a moratorium, outpaced projections. The 15% additional reduction could also be used as an additional budgetary safeguard, which would also be triggered, and only to the degree necessary, to maintain budgetary integrity. For example, if Medicare home care expenditures under a moratorium outpaced projected rates, the reduction would go into effect up to the percentage necessary to bring expenditures into line.

Absent a moratorium, there are specific issues that must be addressed to adequately reform the interim payment system. NAHC urges Congress to act quickly and comprehensively in enacting legislation to address these concerns.

Solving any one of these issues alone will not fully address the need to reform IPS. Any legislative proposal needs to be measured according to how well it addresses these issues. Since a valid case mix adjuster does not currently exist to solve the IPS problems, any IPS change is likely to leave some of the sickest patients without access to care and some reputable, efficient home health agencies closing.

Prioritized IPS Reform Items

It is crucial that these reforms be implemented retroactively to October 1, 1997.

- **Revise the per beneficiary limit, implementing a choice blend, sometimes referred to as an equity blend.** This blend helps level the playing field in all regions of the country. Under this approach, each census region would be assigned a payment limit equivalent to the greater of a blend of 75% national and 25% regional average costs, or 75% regional and 25% national average costs.

  Actual payments to home health providers, under this blend, would be set at the percentage of the blend necessary to ensure that total expenditures are no greater than budgeted levels.

- **Eliminate the automatic 15% October 1, 1999, reduction in reimbursement.**

- **Raise the per visit cost limits to 110% of the mean, from 105% of the median.**

- **Establish a funded outlier payment policy that is preferably based on costs incurred in caring for patients rather than the number of days or visits an individual has been on home care.**

- **HCFA should prorate the per beneficiary limits only in situations where agencies transfer or prematurely discharge patients for purposes of intentionally circumventing the limits.**

- **Maintain period interim payments (PIP) for home health agencies until 12 months after implementation of PPS.**

Other Important IPS Issues

Other elements of IPS that have caused hardship for home care agencies and patients include the application of extending the savings from the freeze to the per-beneficiary limits; setting the base year for calculating the per-beneficiary limits at FY1994; and denying providers the opportunity for exemptions and exceptions to the per-beneficiary limits.

While we understand that HFCA may not be able to address the base year problem, it is still any issue that causes significant problems for home care.

Any legislative solution that continues the distinction between old and new providers would need to assign the median of the cost limits for the census division for new providers.

Copays

NAHC continues to have serious concerns with proposals to couple an IPS fix with home care copays.

Because home care expenditures have declined so dramatically since implementation of IPS, we believe an IPS fix can be made budget neutral without the need for additional offsets.

Copays would hurt the same group of home care patients who are most at risk under IPS -- those who are the sickest, frailest, oldest, and poorest.

Copays cannot be administered in such a way as to be fully collectable. This means that under any cost-based reimbursement system, copays will always mean a significant additional loss to home care reimbursement.

Administrative Fixes

Some of the issues listed above can be resolved administratively by HCFA, and do not need a legislative fix. The Small Business Administration's Counsel to the Office of Advocacy issued an opinion which agrees that HCFA overstepped its bounds in several key areas of IPS implementation, and took administrative actions which dramatically worsen the effect of IPS on patients and home care providers. Specifically, HCFA should immediately reverse their actions in the following areas:

- HCFA chose to **apply the "recapture the savings of the freeze" provision to the calculation of the new per-beneficiary limits,** in addition to the per visit cost limits, setting the per-beneficiary limits at artificially lower levels. The new limits did not even exist at the time of the original rate freeze.

- HCFA assigned **new providers the median limit** that reflects national home care data, rather than census division data, giving some "new providers" much lower, and others much higher, reimbursement levels than other HHAs in the same geographic areas.

- HCFA chose to **prorate the per-beneficiary limit in all cases,** rather than only in cases where home care agencies act to circumvent the per-beneficiary limits. This approach ignores the long-standing rights of patients to choose any HHA they wish.

- HCFA is not **allowing any exceptions to the per-beneficiary limits,** even though using a five-year-old base year does not account for many changes in the amounts and types of services provided to clients by an agency.

We urge the Committee to insist that HCFA immediately reverse its decisions in each of these areas. While resolution of these issues would not adequately address all the difficulties in IPS, it would certainly address some important points. Furthermore, administratively addressing these issues would help Congress develop a legislative solution to IPS that fits within the required budget parameters.

CONCLUSION

The Medicare home health benefit is a vital part of the fabric that protects our nation's most vulnerable individuals.

NAHC, along with many Members of this Subcommittee, has long pressed for the development and implementation of an episodic PPS for home health that would include an adequate case mix adjuster to account for the costs of care of intensive care patients. This system would create important incentives for efficient delivery of services, while ensuring that high-cost chronically-ill patients can continue to receive needed services.

We deeply appreciate your leadership, Mr. Chairman, and the support of other members of the Subcommittee to fundamentally reform IPS this year. We look forward to working closely with you to resolve these issues.

Chairman THOMAS. Thank you, Ms. Palsgaard.

I guess my basic comment to all of you is that I continue to be very, very frustrated, although there are some specific instances where there has been some useful information provided to us; and frankly, this is not new with this particular industry.

When we were trying to work out a program to deal with this, when we were writing the Balanced Budget Act, we had somewhat similar cooperation.

Virtually all of you want to go back to the 112 percent of the mean. Virtually all of you want to eliminate the 15 percent reduction. None of you have provided any way in which we could find those dollars.

Your proper answer would be, "That's up to you." My answer is, the Congressional Budget Office tells us that eliminating the 15 percent is a $4.1 billion cost.

The idea that we should just go ahead and let folks pick their own poison in terms of the blend in their particular area, on its face, is pretty naive.

The reason we are going with these structures—if you will recall, the administration offered a 100 percent agency blend—the reason we are going with some kind of a structured blend is to begin to move in the direction of what will be in place on a prospective payment system. It may not be going in place on time, but it is going in place, shortly after they indicated.

If everybody is going out of business in this current structure before the minus 15 percent is in place, then there won't be anybody in business when the prospective payment system goes into place. I see all of you nodding your heads.

Ms. Brock, you just testified that 75 percent of the home health agencies in Texas will be out of business this month or shortly thereafter. Is that correct?

Ms. BROCK. Sir, I believe it is correct.

Chairman THOMAS. All right. That means 1,500 home health care agencies will close in the state of Texas.

Ms. BROCK. That's true. And I think that there have been a tremendous amount of new agencies since 1994, so we have to take care of that, and we have to adhere to that——

Chairman THOMAS. I understand all that. But I'm looking at the data in 1994, not in terms of the number of agencies, but in terms of the number of visits and patients.

In 1994, there were 20 million visits for 211,000 patients and the average visit per patient was $96.75. In 1995, 28 million visits, 245,000 patients, $116. In 1996, 33.7 million visits, 259,000 patients, $130 per visit.

In 1997, 35.8 million visits, 257,000 total patients—interestingly, fewer patients, but 2,000 more visits between 1996 and 1997—to increase to $139 per patient.

In fact, if you look at it between 1994 and 1997, the increase in the number of home health agencies went up 85 percent. And you are going to come in front of this subcommittee and testify that, within the next month, 75 percent of the agencies are going to close in Texas?

Ms. BROCK. As of my last year's cost report, the end of my last year's cost report, on 3–31–1998, I was being reimbursed $81.85

per visit. At this point right now, I am at $32.50 a visit, and I have an overpayment due back to Medicare immediately of $54,000. I have——

Chairman THOMAS. I understand. That's the reason we're holding the hearing.

Ms. BROCK. Right.

Chairman THOMAS. We're trying to make adjustments. But for you people, as an industry, to come in front of me and tell me that 75 percent of the agencies in Texas are going to close within a month is either a scare tactic—which, guess what, it doesn't work—or naivete, which, if you've been selected by your various groups to testify and represent the sophistication level of this industry, then what you have asked in terms of the solution fairly well reflects that, that what you want is nothing.

I said at the beginning of the hearing, we have to go forward with the changes in this industry because it is rife with fraud, people are being ripped off, and those that are honest agencies have got to figure out ways to come to the surface. Frankly, we don't have the tools that we would like, but we have got to make sure that this industry rights itself.

I would much prefer a peer group review inside each of the operations, going after the bad apples, so that when you sit here and tell me that 75 percent of the agencies in Texas are going to close, we can all agree that those should have closed, because of the way they operate, and if they shouldn't have, we would be sitting down and working on solutions that would resolve it.

It is just extremely difficult for us, in terms of trying to put together a solution for your problems, to be told the answer is a moratorium, the answer is don't do anything, the answer is, let us pick whatever rate we want in our area, repeal or go back to previous law and, by the way, we're all going out of business.

It just is simply not reflected in all of the evidence that we're getting. If that's the position you wish to maintain in our determining how we are going to change your industry, then just sit back. We will do what we believe what we believe is the appropriate thing to do, and the information that you provide to us, we will simply disregard. That's not a healthy relationship, when the committee reaches out and says, "Give us some solutions."

Now, I would say that the testimony from Ms. Odgren from New Jersey, based upon my knowledge of how narrow the range between home health agencies is New Jersey, one of the narrowest ranges between the high and the low, and at the same time, very few visits, creates a real problem for us in trying to determine how we evaluate it with the gentleman, Mr. Indest, from Louisiana, which has one of the greatest ranges between and the high and low, and the evidence he gave with the folks across the street is clearly evident, but what it also sounded to me like was that this is one of the hot new investment areas, and that there are people who have gone into this because clearly it appears to be a way to make money. At least it was in the past.

Here is Entrepreneur Magazine for August of this year: "Have health care experience? Here's a business just for you. The demand for quality health care at affordable prices is rapidly increasing,

and you can turn that demand into a highly profitable home health care agency.

"Many treatments that once required hospitalization can now be done on an outpatient basis. If you have experience as a nurse, therapist, or medical assistant, you can take advantage of these advancements by caring for patients in their own homes, or if business skills are your forte, you can provide health care supplies and hire health givers to work for you"—et cetera, et cetera. This is a new investment opportunity.

My guess is that perhaps your argument is that was true pre-BBA; it isn't any more, and what you are doing is indicating to me that there is going to be a settling out in the industry. Frankly, it was overdue.

Our job is to make sure that the good people, who do a good job, survive; those who weren't don't. And, frankly, we are doing it with very little information and data.

We do know this, for example. On average—and perhaps all of you are not average, or above—on average every home health care agency had costs increasing faster than inflation. When we did our caps in terms of the rates, we used market basket to update them.

Why are costs going up faster than inflation? Is it management?

Ms. ODGREN. I would be happy to respond to that. I think that some of the things that have caused the costs to go up faster than inflation—and again, I can only speak from New Jersey, I can't speak from any other part of the state—is that the length of stay between 1993 and 1998, in New Jersey hospitals, for Medicare patients has decreased by three days. So there is a three-day period of acuity that wasn't there before.

I don't think it's a single reason. I don't think it's a single reason. I think there's a number of reasons.

Chairman THOMAS. The ripple effect of other changes is an absolutely legitimate argument, if we have empirical data to back it up. We're trying to look at those factors.

Ms. ODGREN. I got the hospital length of stay on Medicare patients data yesterday, from the New Jersey Hospital Association, so that's the information that I was given.

Chairman THOMAS. The approach we need to take is to get as accurate of information as we can, to be able to make the best decision that we can, in largely a dollar neutral world.

You heard a lot of us willing to go find more money to help fix this problem but, frankly, from my position, the industry has to be far more responsive, far more open, and far less hectic in trying to create impressions that are not backed up by careful analysis of fact.

There are several organizations, national and other, that are doing your industry no service whatsover by blast-facting nonfactual information, by attempting to run around and create difficulties for those of us that are trying to approach this in a rational way by stirring up Members with information that those Members do not have the ability to evaluate.

I would hope that, other than go back to current law, put in a moratorium, let us pick our own rates—and there are a couple of others that you have offered that, obviously, we will be looking at—is simply not a conducive way to be able to make decisions.

The gentlewoman from Connecticut.

Mrs. JOHNSON. Thank you very much, Mr. Chairman. I just have a brief couple of questions, as I have to leave.

First of all, it is as frustrating to us as it is to you that we are bound by budget rules, but you can only run a nation with certain rules, and that is just simply the way it is. So it isn't possible to do what you're proposing we do. It just isn't possible.

What we have to do is, what are those things that we could do that would be helpful to you, that are also affordable and wouldn't draw money out of some other sector in a way that would be destructive.

There are two things that I would say.

First of all, Ms. Brock, I think you have an enormously good case, and somehow you have to all get together or be heard better, and I think, frankly, your own Congressman can help you be heard better by the regional HCFA people.

You should not be getting letters that tell you one week your rate is going to be this, and two months later your rate is going to be that. In her testimony she detailed how she got one rate, and they said that they had underpaid her $117,000, and then two months later, a much lower rate, and she had been overpaid.

You can't run a business this way, and you can't go to the bank and get a loan this way. That is something that we've got to fix, just the mechanics of moving the payments out.

If you listened carefully, you might have heard the GAO say that he thinks the two causes were the moratorium and also the slow rate of payment.

We can probably help you on that, just being able to get your money moved through in a way that you can stay alive if you deserve to stay alive, and not lose your own personal investment as a small businesswoman. That's——

Chairman THOMAS. Will the gentlewoman yield briefly?

Mrs. JOHNSON. Yes.

Chairman THOMAS. I want the record to reflect accurately what has occurred.

In terms of the letter that was sent initially, that was on the per-visit. In fact, the letter said: "A review of your interim rates incorporating the per-beneficiary limitation will be addressed in a separate letter."

The separate letter was, in fact, the per-beneficiary cost. It wasn't that they said one thing and then said another.

Mrs. JOHNSON. Okay. Thank you. I did skim through her testimony. Nonetheless, I think the point that you can't get information about what your costs are in a timely fashion, and then you can't get paid in a timely fashion, is a problem in a period of such——

Chairman THOMAS. I would tell the gentlewoman she, in skimming, read the testimony correctly. The testimony misrepresents the letters and the content of the letters in a specific way. One was the per-visit, which said, "Another letter will be coming," which is the per-beneficiary.

It was not that they sent a letter with one rate and then sent a second letter with a second rate. It was two different rates because it was two different subject matters.

Mrs. JOHNSON. All right. It does need to be looked into more carefully, though, because if under rate you were underpaid $117,000 and at the other rate you were overpaid—so, anyway, the point is that, really, these things ought to be worked out with the administrators in a way that just merely payment flow isn't the problem.

I am a big supporter of continuing PIP, and I can tell you that, at least in my area, the regional people have really been willing, once I brought that to them, because they're not interested in seeing agencies die just because the bureaucratic mechanism didn't allow, you know, honest reimbursement under our current system to flow.

I will just urge you to try to deal with those problems, and some of us can maybe help you.

I am very surprised that all of you are willing to move into the future with a system that drifts toward national and regional data, and excludes entirely agency data.

The more I've thought about it, and I think about the spectrum of cases that you deal with, and the inability of the national system, no matter how good, to ever really judge efficiency, or really be patient-specific, I don't know why you would want to go to a system that has no agency-specific data in it.

Yes.

Ms. ODGREN. I'll respond to that, as well. I think because the people, for the most part, that I see that are sitting here, are on the low end of the per-beneficiary limits, and so—I mean, I understand what Chairman Thomas was saying, but I don't think it is the people that he is the most concerned with that are necessarily the people sitting at this table, because they're not here to testify, because they're not being hurt.

So, if we are at the very low end, as an individual agency, it would make sense that a national and a regional board——

Mrs. JOHNSON. That might make sense in the short run. What I would ask you to think about is, do you really want that in the long run? If you have any follow-on thoughts about that——

Ms. ODGREN. I will.

Mrs. JOHNSON [continuing]. Yyou know, please let me know. Because while right now, it might look good to you, because it would raise your rates, in the long run, are we going to have a system that serves us, if it is blind to actual costs?

Ms. ODGREN. Right. But, in the long run, we're going to have the prospective payment system, which we're all looking for. I mean, hopefully, not in the real long run. I'm trying to exist in the short run.

Mrs. JOHNSON. Yes. Thank you very much. Thank you, Mr. Chairman.

Chairman THOMAS. The gentleman from Maryland.

Mr. CARDIN. Thank you, Mr. Chairman. As I've indicated earlier, I have a major concern that we move forward quickly, because of the urgent situation, so I agree with the thrust of all of your testimonies.

Let me talk a little bit about the per-beneficiary problems and the way that the current interim payment is handled.

I must tell you, I can relate much more with New Jersey and California than I can with Texas or Louisiana or Georgia, because of the number of average visits per use. I come from the state of Maryland, which is at 34 average visits per user in 1997. California was at 47 and New Jersey was at 41, compared to Texas at 134 and Louisiana at 153 and Georgia at 93.

I guess I have a question for each of you. That is, if you come from a state that has a high average use per beneficiary, why shouldn't we expect you to do something about that, and get that number down to a more reasonable level?

If you come from a low-user state, how did you do it? Maybe you should be sharing the secret with other states, and help us save money on home health care.

Mr. INDEST. If I may respond?

Mr. CARDIN. Sure.

Mr. INDEST. Since our state has the dubious honor or the highest.

In my written testimony, I was very candid about what I feel are the problems in Louisiana. I have served for numerous years as chair of the Government Affairs Committee of our State Home Care Association. I've been in business since 1983.

We tried, on numerous consecutive years, to get a CON, some type of sensibility to the rapid growth of home care in Louisiana. As an industry, we tried to do that.

We were very naive about the process. We found out the first two years, it was the Governor's office that was shooting us down.

Mr. CARDIN. Let me just suggest and support what Mr. Thomas has said, then. Why didn't you come forward and ask us to help you in the interim payment, to put a reward on some action by your state to reduce what I believe you are saying is unreasonable utilization?

Mr. INDEST. I might be misunderstanding your question. I'm not asking for a reward. I do not support the wide variety in per-beneficiary limits in Louisiana. I think that any business needs to be on a level playing field, and what I support is a level playing field for the home care providers in Louisiana.

Mr. CARDIN. Good. How do you do it? Can you tell us something of how you were able to get it down? You're being penalized under the current formula for your success. But how did New Jersey and California do it?

Ms. PALSGAARD. Well, I can speak for California and specifically the Central Valley, because they're the people that I'm most around.

I do think one of the reasons is that we have had, in the last few years, a big push for seniors, for managed care. In some other kind of environment, perhaps you have to look at exactly what the doctor is ordering and what you can provide.

Also, perhaps we have just been able to look at the issues of the fact that, as a businessperson, we want to be very cost-effective, because we were looking at the prospective payment proposal that we have all been looking forward to happening in our industry.

Our agency was looking at being just as cost-effective as we could with our mission always being the highest quality care possible to our patients and following the physicians' orders for what care is needing to be provided.

I really can't speak for other parts of the country. I see the statistics like you do, and I believe that, just in California, we're just trying to work within all the regulations and within all what is allowed under the Medicare home care benefit, and try to do a very good job for the patients——

Mr. CARDIN. Let me compliment you on what you have done in California, but let me just, I guess, underscore the point that Mr. Thomas has made.

That is, your associations could do us a service to look at this, and give us recommendations where we could come in with a more rational formula—even if it's the interim formula, forget the PPS—so that you don't lose money as you're losing today, because we're paying for the inefficiencies of unjustified per-visits in other parts of the country, or among other agencies, if it's not the full state, if there are problems with different practices within different agencies within a state.

Obviously, there is some waste here. It's difficult to understand these numbers. We can't afford that, particularly when we are trying to find revenues in order to deal with the problem currently.

It would be useful if you could help us, and rather than just say, "Well, add more money and hold everybody harmless," if we could get at where we are paying for services that perhaps are not needed, to be able to use those resources to deal with the legitimate problems that you have brought to our attention.

Chairman THOMAS. I thank the gentleman. The gentleman from Louisiana.

Mr. MCCRERY. Thank you, Mr. Chairman. Each of you has a home health agency. Do you know what your per-beneficiary visit cap is and, if so, would you just let us know? Mr. Knight?

Mr. KNIGHT. Mine is about $3,300 in Atlanta. As I said in my oral presentation, the per-beneficiary cap is not the issue that confronts my particular agency.

Mr. MCCRERY. Yes, I'll get into that. I just want to know if you know what your cap is. Ms. Brock?

Ms. BROCK. About $3,300.

Mr. INDEST. We do not know yet.

Ms. ODGREN. $1,950.

Mr. MCCRERY. About $2,000?

Ms. PALSGAARD. A little over $3,000.

Mr. MCCRERY. A little over $3,000?

Ms. PALSGAARD. Mm-hmm.

Mr. MCCRERY. Okay. Mr. Indest, let me get the good stuff out first.

You include, in your written testimony, a reference to a report that was done for HHS which justifies, to some extent, the higher cost in Louisiana and some other high-cost states vis-a-vis other states that have lower costs, and they refer to such things as availability of alternative delivery systems.

In your testimony, you refer to a higher incidence of cancer and some other diseases that carry with them higher costs in the home health field.

Would you like to elaborate on that? Do you think there is really that much difference between Louisiana, Texas, and some other

high-cost states and, say, New Jersey and Connecticut, and low-cost states?

Mr. INDEST. The Mathematica study that I quoted came from our national association, the National Association for Home Care. I don't have the full study, but I quoted that section of it that gave some explanation for the increase.

Again, I am being extremely candid. I think that is an explanation but I don't think it is the full explanation as to why we have high utilization in Louisiana, and that's all I can speak for.

Louisiana has been an open state for home care. Those people in Louisiana are reading the magazine that the chairman read from, and I stated that in my written testimony.

Mr. MCCRERY. Let me stop you before you get into too much more trouble. [Laughter.]

Mr. MCCRERY. How about, let me ask about the proposal from the VNA that we go to a new blend of 75 percent national and 25 percent regional. How would that go over in Louisiana?

Mr. INDEST. I think that would hurt Louisiana.

Mr. MCCRERY. I think you can leave off the "think."

Mr. INDEST. Yes. It would hurt Louisiana substantially.

Mr. MCCRERY. So you would not be in favor of that new formula?

Mr. INDEST. I would not be in favor of that. No, sir.

Mr. MCCRERY. I want to ask you now another tough question. In looking over the data for the number of home health agencies in various states, I've picked out some states that are approximately the same size as Louisiana.

Alabama has 183 home health agencies; Arkansas, 206; Georgia, 98; Kentucky, 109; Mississippi, 70; Missouri, 275; North Carolina, 162; Tennessee, 238; Louisiana, 514. What is your explanation for that?

Mr. INDEST. Well, the last time I started to make it, you stopped me, because you didn't want me to get into any more trouble.

Mr. MCCRERY. Yes, but now I'm prepared for you to go there.

Mr. INDEST. Number one—and I can only speak to certain of those states—Mississippi, I think, has a CMN, and that has been in effect for a long time. I think the same is true for Alabama.

As far as Louisiana is concerned, I spoke about the problems we had with the downturn in our economy in the 1980s. A lot of people, and I have people that I know of who were in the oil and gas business, and they read the magazines and said, "Well, you know, this looks like a great business to be in."

It used to be, and I stress "used to be." I would think, in most states, if you had two physician friends who were high referrers to home care, legitimate referrers to home care, and you could get them to refer to you, you had a home health agency.

Mr. MCCRERY. It's an interesting point, about the oil and gas industry. Surely, there's nothing to that. But it does appear that Texas, Oklahoma, and Louisiana have the highest proportion of home health agencies in the United States for the population. [Laughter.]

Chairman THOMAS. Would the gentleman yield?

Mr. MCCRERY. Be glad to yield.

Chairman THOMAS. I would want to point out that Kern County, California, which is three counties away from Ms. Palsgaard's oper-

ation, produces more oil than the entire state of Oklahoma and that, if it were a state, this one little county in California, it would be behind only Texas, Alaska, and Louisiana in oil production; and we only have 48 visits. So the series is going to stop right there. There is no connection to oil and gas.

Mr. MCCRERY. That's probably true, but it is an interesting coincidence. In California, you have other things to do besides oil and gas.

Mr. Indest, it's clear to the members of this panel and to the Congress and, obviously, to the Clinton administration, that there were problems in the home health industry that needed to be addressed. Utilization was going way out of control, costs were going way out of control. We had to do something.

It is clear to us now that the steps we took to try to get us to a prospective payment system, which all of you told us you wanted, and we said, "Yes, it sounds like the solution," the interim steps were not the best that we could have devised, evidently.

We are in a bit of a problem, due to the budget rules and the reluctance of the administration to suggest any plans that are anything but budget neutral.

I don't know what to tell you. I've been telling folks back home, Mr. Indest, that we are going to do something, and we are going to do something. Unfortunately, I can't report to you today that that is something that we are going to do is going to help.

We are looking to you all for more suggestions, if you have any, short of "Let's go back to the old system," because that isn't going to happen. We would like to have them.

I will tell you, too, that this reshuffling of the formula is just picking new winners and losers, and that's not acceptable to me, nor is it acceptable, I would think, to any of the other high-cost states. We have to find a way to wean some of these agencies, while not hurting the good actors in the program.

Thank you all very much for your help, and we look forward to receiving more input.

Mr. INDEST. If I just might say, the executive director of our state home care association is with me today, and we will take you up on your offer of getting in touch with your office——

Mr. MCCRERY. Good.

Mr. INDEST [continuing]. To hopefully come up with a solution.

Mr. MCCRERY. Thank you.

Chairman THOMAS. The gentleman from Washington, a member of the full committee.

Mr. MCDERMOTT. Thank you, Mr. Chairman. This is a bit like a busman's holiday. I feel like Mr. Knight and Ms. Odgren and the lady from California, Ms. Palsgaard, are sort of the people that have been going through my office, one after another, for the last three months in the state of Washington.

As I listen to this discussion, it seems like what we have done is we have slammed the barn door when the cow is way down the road, and now we are trying to figure out what do we do with it. It seems——

Chairman THOMAS. Excuse me. The cow or the barn door? [Laughter.]

Mr. MCDERMOTT. Either. A good question.

Chairman THOMAS. I'm trying to follow you, but I didn't know which one you meant.

Mr. MCDERMOTT. The issue that, it seems to me, that we have to decide on this committee is how much do we try and micromanage this situation, and how much do we let it be decided by the states, because Mr. Cardin and I and Oregon and New Jersey are going to be in bad trouble here, very quickly.

I don't know how you stay open when you're $2 million in debt. What do you say to a banker when you say, "Well, I got $ 2 million in debt and I would like some more line of credit"? You don't make it up in the volume, so to speak.

The question is whether or not we might just block grant the money to the states, give everybody a per capita amount, and let them all figure out how to do it, because I know that New Jersey and California and Maryland and Washington would be able to figure out how to do it. There would be a lot of pain in some places like Texas, but at least you would decide it down there.

What troubles me is Texas and Louisiana seem to have the problem that the state legislature and the Governor and people at that level were unwilling to step up and do what had to be done.

I think that the committee is caught between—I mean, many of my colleagues on the other side don't like big government. They don't want Washington to decide everything. This looks like a perfect issue to give a block grant to the state and say, "You do your home health care agencies on the basis of we'll give everybody $10 per person in the state, and you can go down the road and figure out how to deliver the care," because that would force a process in the legislature.

The other way, sitting up here trying to figure out, should we take back the 15 percent? Well, that gives us a short term break. That's like taking your foot off the air hose for a patient who is on oxygen for about 20 minutes.

Ultimately, it is going to come back down in some kind of crazy way, if we don't figure a way to break this disparity between the high and low states.

I would like to hear what your view is. I suggest to the chairman that maybe we ought to lift the 15 percent cut, but give every legislature exactly two years, or one year, to come up with a certificate of need process, to weed out, according to some national characteristics, who is capitalized properly, and then you get these wildcatting entrepreneurs out pretty quick.

I don't think the fact that Texas lost 450 nursing home agencies worries me very much. I figure that's a real shakeout, and it's going to have to get worse.

I would like to hear how you think, besides having us do all the work and just shoveling more money to you, what is it that has to happen at the local levels that we can mandate and say, "You people solve it your own way locally." Yes.

Ms. ODGREN. I would like to speak to that. I think Mr. Cardin has asked earlier, you know, how do we do it. I think you're hitting on some of the issues.

I do believe, in New Jersey, we have a combination of two things that keep our per-visit and our cost per visit low.

One is, we are a CON state. We are high-density population, particularly frail elderly, a larger growing over 85 population, and that we have the certificate of need in place. We have no more than 60 Medicare-certified home health agencies in the entire state.

I think, for those of you who understand cost-based reimbursement, if you have, I'm just going to say a million Medicare-eligible home care patients in the state of New Jersey, and you're cost-based reimbursed, it's going to cost you more per beneficiary if you have 500 agencies versus 60 agencies, because you're paying the administrative overhead for every one of those agencies.

I think, when you talk about whether it's state block grants or thinking of some way, you have to, until we get to a prospective pay system, while we are still in a cost-based reimbursed system for home care, that the more agencies taking care of the same amount of patients is going to cause you to spend more money. That is one thing.

Second, I have to say that the region we are in, which includes New York and New Jersey, I believe has one of the toughest fiscal intermediaries in the Medicare program, and I think that we have not been allowed to exploit the Medicare program.

We are allowed to provide to Medicare patients what conditions of participation say that Medicare beneficiaries are allowed. We have very few people that get daily home health aides.

We get what is called a 488 called in, which is the HCFA, the intermediary's check to call the record in and check medical necessity, check homebound status, and check all of that.

I do believe those two factors have kept our visit number per beneficiary low, and then our cost per visit low, because of the CON issue.

Mr. McDERMOTT. I have a Visiting Nurse Association in Seattle that has an average of 17 visits per case.

Ms. ODGREN. Are you a high-Medicare managed care?

Mr. McDERMOTT. Yes. Sure. We've had it for a long time. We have a 30-visit average. We have some that are obviously below that, one is 17.

When you take a 15 percent cut in that, you are up against the wall. I think that there is clearly going—and if the Visiting Nurse Association goes out of business, it will be the oldest, the longest-standing agency in the state that will go bankrupt around the 1st of October.

They're bankrupt now, but they're going to have to say it publicly, at some point. That's why I think that the chairman is right in calling this hearing.

I don't have a clear answer. I don't know how we mandate tough fiscal intermediaries in Medicare, because we have one, too.

Chairman THOMAS. Will the gentleman yield?

Mr. McDERMOTT. Yes.

Chairman THOMAS. We did in the BBA. At least, we began the process.

I believe the gentleman from Louisiana's attempt to find some linkage between Texas, Oklahoma, et cetera is the fact that it's in the same region and that, while we mandated Section 4614, normative standards for home health care claim denials, including the frequency and duration of home health services which are in excess

of normative guidelines the Secretary shall establish, by regulation, we set up a process to begin to examine the out line and figure out why regions utilized the home visits more than others, and HCFA will not implement this section.

We are currently at war over their failure to do a number of things under the BBA, including what is an obvious step to begin to get adjustments on usage between regions.

Now, I agree with everything you said about getting people to look at their state level, and that is one of the reasons it bothers me a little bit, but there is easy stuff that we can do here that we have already done.

I know the gentleman is not aware of every particular segment, but this one was important to me because they kept telling me they had no standards, they couldn't apply anything.

I said, "The least you can do is a relative comparison between what one region is doing and another which produces the outliers, then make them explain why they're doing more than the others."

We are hearing some of the reasons: the certificate of need; the very tough intermediaries; managed care as a kind of a third party overseer for what is going on, versus wild entrepreneurial areas with no certificate of need, with a regional intermediary that is not doing the same thing that somebody else is doing.

All those could be put into the normative standard structure, and it would be a useful tool, had they begun the process of implementing that section.

As a matter of fact, it was supposed to apply to services furnished on or after October 1, 1997. We should have had a half to three-quarters of a year of experience in looking at this data. We don't have it because HCFA won't do the job that the law said they should do.

Mr. MCDERMOTT. Mr. Chairman, could I just ask, though, the bill passed when?

Chairman THOMAS. It was effective immediately. It was on the beginning of the fiscal year of 1997. That was the effective date on the bill.

Mr. MCDERMOTT. What I am suggesting is that perhaps having it effective immediately, you can't have the rules and regulations prepared that quickly. I mean, you got to give them a little time. You may say they haven't done enough, but I——

Chairman THOMAS. It's normative standards. They already have the data coming in by region. All you have to do is compare the regions.

Mr. MCDERMOTT. I would like to work with you on it. The reason I came to this hearing is because I think every Member of Congress is going to be in trouble in their district after the 1st of October when these home health agencies, the really effective ones, and the old standing ones, are announcing in the paper that they are going bankrupt.

That is going to be a real crisis for a lot of people in the election.

Chairman THOMAS. I agree.

Mr. MCDERMOTT. I really think this is something we must do something with.

Chairman THOMAS. I would tell the gentleman that, although I have heard that suggestion, block grants to states, the problem is

that money then would be going to the states which have refused to take what I would consider reasonable and appropriate steps.

The next problem is that during the next Congress, you are back lobbying for a larger block grant to maintain the same discrepancies that weren't corrected in the first place by the state that was getting the money, so it doesn't have to make the tough decisions. To me, that is a circular problem.

We've got to go to the heart of it and figure out a way to create a system which, on a cooperative basis, the people who are doing a good job have got to get far more aggressive in their associations and demand that the people who are trying to maintain the old system, who are presenting arguments of "Don't do anything, just bail us out, because it's a crisis," that will not carry the day.

Go back inside. Get your associations to get serious about who is responsible and who is not in your area of activity. What you do is important. You've got to look inward.

We will help you in terms of trying to make the system as fair as possible. But there has to be a settling out in this industry, and all of us want the settling out to be the quality care folk.

Mr. MCDERMOTT. Mr. Chairman, I was making my suggestion about the block grant following the aphorism of Benjamin Franklin that the imminence of hanging tends to focus men's minds.

If they know that they have a fixed period in which they are going to be faced with real problems, there would be action in those states, there is no question about it, or else they would pay the price.

I think that's our problem. We either micromanage it, or we do it bluntly. I'm not sure I know how to micromanage from this level, but I do know how to be blunt.

Chairman THOMAS. My concern is, that listening to the recent testimony, I don't know that the message would necessarily get through. It would probably create more chaos.

The gentleman from Louisiana had a couple of additional questions.

Mr. MCCRERY. Thank you, Mr. Chairman. Mr. Indest, in your testimony, written testimony, I think you say that, since sometime in 1997, Louisiana has lost 80-something home health agencies. Is that correct?

Mr. INDEST. Those are statistics I received from my state home care association.

Mr. MCCRERY. Okay. Do you have any statistics on how many new agencies have been created since that same point in time?

Mr. INDEST. One thing that I stated in my written testimony, that I did not state earlier, currently in Louisiana, I think, as of two years ago, there was a moratorium on the establishment of home health agencies.

I do not have those statistics, but with a moratorium I would hope that none.

Mr. MCCRERY. So there is a net decrease of 80-something since this went into effect?

Mr. INDEST. Yes, sir.

Mr. MCCRERY. I want to explore for a minute with all of you the question of co-pays, because every time we mention co-pay, industry just says, "That won't work."

What I am talking about, and I think the chairman is talking about, is the possibility of giving agencies the option to charge a nominal co-pay, $5 per visit, where there is some cap on the number of visits that you could charge a co-pay for, and then you, the agency, could discriminate at your will.

If you think some of your patients are unable to pay, don't charge them, but those who are, charge them, and then you have some income to supplement your activity.

What's wrong with that?

Mr. INDEST. Could I respond to that, Mr. McCrery?

Mr. MCCRERY. Anybody. Yes, anybody.

Mr. INDEST. Am I understanding you to say that we will be able to charge the co-pay and keep that money?

Mr. MCCRERY. Yes.

Mr. INDEST. It will not be deducted from our cost of doing business?

Mr. MCCRERY. Well, we can work on that.

Mr. INDEST. I think my understanding of co-pays is that it is a built-in loss to the home health agency. If you don't collect it, you're already operating in a cost-based system——

Mr. MCCRERY. We can discuss this. But it doesn't make any sense to me to give it to you in one hand and take it away in another. That doesn't help you.

Mr. INDEST. You've just painted a very different light on the way I understand co-pay.

Mr. MCCRERY. I mean, let's just explore this for a minute. We're stuck in the budget, because we did some stuff that got savings, and now we can't, even though we got more savings than we thought, we can't go back and spend the extra savings. So we're stuck.

We can't give you any more money. That's what I've understood at this hearing today, from the administration and from conversations with Members of Congress. We can't find any new money to give you.

What I'm suggesting is, we give you the option to get new money yourself, from your own patients. What's wrong with that? $5 a visit. It's called balance billing, $5 a visit. Hey, a lot of folks out there can probably afford $5 a visit. Some can't. Why not leave it up to the agencies to decide?

I mean, that's a way to help you out of this interim—and we could do away with that option at the time we get a prospective payment system. I'm just trying to figure out a way to help us through this problem time that we are experiencing.

Ms. ODGREN. Thank you. I would suggest that, if we are going to look at co-pay, it really needs to be an across-the-board.

If I have a per-beneficiary limit of $1,950, in order to survive, I have to charge a $5 co-pay to those people who, on my sliding fee scale, can afford to do that, the agency down the street that has a $3,300 doesn't have to, how long am I going to be in business?

Mr. MCCRERY. Well, that's the market, you know. Maybe we should try to get back a little bit to the market. That would help. In fact, I'm of the opinion that, if people actually had to pay something for what they get, utilization would go down.

I mean, if you want to get into it, I can get into that with you, and we can just do away with all this stuff and let people pay.

Chairman THOMAS. Will the gentleman yield?

Mr. MCCRERY. That would be a lot better solution than a lot of this junk that we are trying to do in micromanaging the health care system from here.

Chairman THOMAS. Will the gentleman yield?

Mr. MCCRERY. Yes.

Chairman THOMAS. We keep talking about low income, and how difficult it is for them to operate. It's my understanding that Georgia has a co-pay.

Mr. KNIGHT. For the Medicaid system?

Chairman THOMAS. For the Medicaid system.

Mr. KNIGHT. That is correct.

Chairman THOMAS. How much is it?

Mr. KNIGHT. $2, I believe, per visit.

Chairman THOMAS. How good are you at collecting it?

Mr. KNIGHT. Not very good at all.

Chairman THOMAS. If we gave you a $5 co-pay in the rest of the income range, in terms of the patients, you would be better?

Mr. KNIGHT. If that is an option to explore, to help offset the challenge that we have on the 15 percent number for next October, we would love to work with this committee and you, Mr. Chairman, on that thought.

I think that there are other methods of managing utilization, other than that. I don't disagree that the co-payment system that exists in other parts of the health care system is working.

What I think I take exception to is the fact that it is cost reductive, as we have heard it, and as it has been presented in the past. We are not even receiving all costs from Medicare, to begin wit. There are some disallowed or nonallowed costs, and this becomes yet another opportunity for us. So——

Chairman THOMAS. I would tell the gentleman that his statement is absolutely correct. The gentleman from Louisiana is drilling a wildcatter here, and we don't know whether it's dry or not, because we haven't discussed this proposal before.

My belief is it probably a dry well, because my concept was an agency optional passthrough but, frankly, it was back to the old traditional, the money comes through and it either comes from you or it comes from the beneficiary.

The decision as to where it comes from is up to you, to provide money to be able to do something like defray the 15 percent reduction, because that would be kind of a revenue neutral way, on a passthrough basis, to remove what I consider to be a far more onerous hammer that has a $4.1 billion price tag that, if we can't get rid of that—let me say it another way, and I'll give the time back to the gentleman.

If you had a choice—which nobody wants to do in this industry, they just want us not to do anything—if you had a choice between the 15 percent reduction going into effect on its current date, or a $5 or $8 co-pay, which would replace the minus 15 percent, but it really wouldn't be a co-pay, it would be an agency optional passthrough, and you have only two choices, which one would you choose?

[No response.]

Chairman THOMAS. I know. You want moratorium. You want to go back. You have two choices. Anybody, reaction?

Mr. KNIGHT. I think, in our particular situation, it would need to be studied, because I'm not sure today that the 15 percent wouldn't be a better hit if I had to take one of the two, than the $8 co-pay. I'm not sure how that lines up.

I think that, when you think about the administrative costs associated with that, which have not been factored into any year, much less 1994——

Chairman THOMAS. I understand.

Mr. KNIGHT [continuing]. It is a little bit difficult to sit here on the fly and make a decision and answer, you know that question intelligently.

Chairman THOMAS. All I'm telling you is that that should have been the kind of discussions that you folks were making as you were thinking about coming here to tell us how to solve the problems, because those are the kind of decisions that we're going to make with or without your input. I would much rather make those kind of decisions with your input.

Ms. Brock, what do you want, minus 15 or the agency optional passthrough?

Ms. BROCK. I think both of them are going to make our lives totally impossible.

Chairman THOMAS. I understand that.

Ms. BROCK. I think if we had a smaller co-pay, that might be more realistic.

Chairman THOMAS. $5. Going once.

Ms. BROCK. I think they're both impossible. If I had to pick, I would pick the co-pay.

Chairman THOMAS. Thank you very much and thank you for making a decision. I appreciate that very much. Mr. Indest?

Mr. INDEST. Would the co-pay be, as Mr. McCrery, Congressman McCrery described it?

Chairman THOMAS. Notwithstanding your state affiliation, the answer is a flat out California no. [Laughter.]

Mr. MCCRERY. I think you should explain exactly what your proposal is, in case they don't understand your jargon.

Chairman THOMAS. The proposal is an agency optional passthrough, for example, a $5 levy. The agency could pay it, or the agency, at its option, could pass it to the beneficiary.

Mr. INDEST. If I had to state right now, I would go with the co-pay. Without thoroughly studying——

Chairman THOMAS. Agency optional passthrough.

Mr. INDEST. Yes, sir.

Chairman THOMAS. Not a co-pay.

Mr. INDEST. Yes, sir.

Chairman THOMAS. Ms. Odgren?

Ms. ODGREN. I'm just trying to think——

Chairman THOMAS. I understand.

Ms. ODGREN [continuing]. From the cost perspective.

Chairman THOMAS. All I'm trying to do is get you folks to realize the kind of decisions that we're going to have to make, and we would love to begin sharing the decision making process with you.

Ms. ODGREN. I would think that the agency optional passthrough would be the——

Chairman THOMAS. Agency optional passthrough. All right. And the brain trust decides. Ms. Palsgaard?

Ms. PALSGAARD. I think if you could look at how much the 15 percent, if you meet the budget target, how much of the 15 percent would be required to do that, or is there more. I'm just——

Chairman THOMAS. No, you don't understand the way the game is played.

Ms. PALSGAARD. I do.

Chairman THOMAS. If we change the baseline, we are obligated to find the money. It is a $4.1 billion cost. I have to replace $4.1 billion if I drop the 15 percent reduction.

I'm trying to figure out a way to soften the blow in terms of raising some money that might be a more palatable way, not necessarily out of your pocket, but out of the larger universe's pocket, rather than just yours, or you can choose the option and it comes out of your pocket.

That's the agency optional passthrough—15 percent reduction on the date that it currently occurs, or an agency optional passthrough.

Ms. PALSGAARD. For a co-pay?

Chairman THOMAS. No, an agency optional passthrough. You decide whether you want to collect it from the beneficiary or not.

Ms. PALSGAARD. I think that, if I speak as my agency——

Chairman THOMAS. I'm asking you talk for yourself.

Ms. PALSGAARD. Okay. If I speak for our agency, we have a very, very poor clientele in our county right now, and it would be very difficult for us to be able to do any kind of co-pay collection.

There are certainly people that could afford it, but the majority of the people in our Central Valley, as you know, are farmworkers——

Chairman THOMAS. What percentage are on Medicaid?

Ms. PALSGAARD. In our service area, we have——

Chairman THOMAS. Your clients.

Ms. PALSGAARD. Our clients.

Chairman THOMAS. Your clients.

Ms. PALSGAARD. Our clients have a low percentage of MediCal, probably, in Merced County.

One of the other things that I didn't remember when we were talking about the lower utilization in California was the in-home supportive service program in California, that maybe is a reason there is not as much help there.

Chairman THOMAS. That's another fallback that softens the blow on the number of visits, if there is no such agency.

Ms. PALSGAARD. I suppose, yes.

Chairman THOMAS. I just wanted to finally get you into the level of the kind of decisions that we are going to be looking at.

Mr. CARDIN. Would the chairman yield just for one second?

Chairman THOMAS. Certainly.

Mr. CARDIN. I think this is a very, very helpful discussion, but I would just put on the table that we have to realize that this is an interim situation.

Chairman THOMAS. Exactly.

Mr. CARDIN. What that is going to mean, as far as your administration of home health services, an ability to keep the network afloat until the PPS system comes into effect, I think we need your good counsel as to what these different—of course, we assumed the 15 percent was going to go in when the PPS went into effect. We never assumed that the 15 percent was going to be before the PPS.

Chairman THOMAS. That's another renege on HCFA's part.

Mr. CARDIN. I agree. We thought the new system would be in. So we never thought that you would have to implement that under the IPS.

Chairman THOMAS. Correct.

Mr. CARDIN. But now, if you are going to be asked to implement some type of a collection process, on top of the IPS, before the PPS comes into effect, what does that mean as far as the ability to efficiently administer a program, until we can get the PPS into effect?

Chairman THOMAS. Again, all of us are committed—in fact, we just had another conversation—to go try to find some money, if we can, but you have to be realistic in terms of the needs and the demands and the amount of money that this area was changing, which was absolutely necessary for all the reasons that you provided, in certain states, but there are victims in other states that were doing a good job, that we don't have the ability to select out with criteria and data yet, that we will with the prospective payment system.

If you don't want us to impose something on you that we will impose, we've got to get feedback from you on options, just like the difficult one I made you go through.

Ms. Odgren.

Ms. ODGREN. Yes. I would question, Chairman Thomas, when you gave us the option of choosing the passthrough or the 15 percent, was that to pay, the passthrough was to pay for the 15 percent?

Chairman THOMAS. Roughly, change the structure of where the money comes from so you could then deal with having an option of helping cast off that cost, because the 15 percent is yours.

Ms. ODGREN. It doesn't impact any decision that this committee will make about what will happen in 1998? I mean, is it related in any way to, you know, the blend?

Chairman THOMAS. No. What we would be doing is looking at options of where we get money, if we could sweep the floor, do some other things.

We would look at, in making changes, the possibility of including in the package reducing the 15 percent reduction but there would have to be a revenue source that assists us in replacing it.

One of the revenue sources could possibly be the agency optional passthrough, which not only produces a portion of the revenue that we have now denied, but that, if the marketing situation is such that you were able to pass it through, it might have a certain beneficial behavioral restructuring, as Dr. Wilensky testified, in terms of the MedPAC argument for what would be a traditional co-pay.

But I didn't just want to do a co-pay. I thought the agency optional passthrough would give you some decision in a marketing way that might help some, since we have so few tools available to let you make decisions on your own. That was the reason.

Ms. ODGREN. It's not really taxing the elderly? I mean, a co-pay sometimes is considered taxing.

Chairman THOMAS. But it's your decision.

Ms. ODGREN. Right. That's what I'm saying. So——

Chairman THOMAS. My assumption is you won't go taxing the poor folk that you all are dedicated to serving——

Ms. ODGREN. Right.

Chairman THOMAS [continuing]. And that there may be some individuals where it would be perfectly fine.

Ms. ODGREN. Perfectly fine to do that.

Chairman THOMAS. That's just one little exercise that we are going to have to go through about 10 times, to come up with a policy, because we are going to come up with a policy.

We are going to replace the current policy. It will create new winners and new losers. We will do it before we adjourn.

Our goal is to try to minimize simply reshuffling the dollars and creating new winners and losers. Everybody has to participate, to be as positively creative as we can. That means you folks and your associations.

If we ask for information again, to provide us with the answer that three-quarters of your agencies are going to shut down within a month, that the only options that we really should be looking at are moratoriums, you know, et cetera, or pick our own blend, then we simply have failed in our ability to include you in the process of coming up with a relook at the solution to the interim payment factor.

I would very much like to include you in the decision that we come up with. All of us would like to include you.

With that, thank you all very much. The subcommittee stands adjourned.

[Whereupon, at 2:27 p.m, the hearing was adjourned.]

[Submissions for the Record follow:]

August 4, 1998

House Ways & Means Health Subcommittee
U.S. House of Representatives
Washington, D.C. 20515

Dear Subcommittee members:

A&D Health Care Professionals, Inc. home health agency is thankful for the opportunity to present testimony at the House Ways & Means Health Subcommittee hearing scheduled for August 6, 1998.

* Our agency has experienced the devastating effects of IPS on our viability since January 1, 1998.
* We have always been a prudent spender of Medicare dollars; however, after the IPS impact necessitating "cost cuts to the bone", while reeling in "IPS turbulent waters", our wonderful care givers/staff and myself feel demoralized, devalued, stressed and, quite honestly, "scared to death"!
* The **inequity** of IPS agency specific Per-beneficiary Limits applied across our nation is absolutely ridiculous. See attachment A2.
* We are continually worried that IPS will force our agency into bankruptcy, thereby placing our current patients in serious jeopardy, especially our medically complex patients, for surely no other home health provider will take them.
* In addition to the threat posed by IPS, HCFA is discouraging physicians from ordering/certifying home care services for their patients. Hesitation by physicians to participate in home health care will cause the health status of our patient population to be jeopardized as their illnesses will exacerbate, requiring hospitalization or nursing home placement at higher costs. HOME CARE IS AN ABSOLUTELY CRITICAL COMPONENT OF THE CONTINUUM OF CARE.
*One of our paralyzed patients living with her post stroke spouse has utilized our services at a 6 month cost of $41,403.36, annualized at $82,806.72. Under current IPS our agency is reimbursed $2,660.05 per beneficiary for the entire year!!! The only other option for her is to be placed in long term care at an annual cost of $133,411.00. Additionally, her spouse would need to be placed in long term care also, at an additional cost of $45,000.00. Excess cost over home care is $95,604.28!
*IPS is causing increased anxiety among our patients and their families that the per beneficiary limit will place them at increased risk of losing health care when it is needed most.

If IPS continues, our 13 year old home health agency will be forced to close our doors. We and our fellow home care providers are "hemorrhaging" as I write this letter. We can only bleed so long before we die .... IPS reimbursement rates do not allow us to provide safe care at an acceptable standard.

The real victims are our frail elderly Medicare patients .... Please implement an immediate moratorium on IPS until an acceptable Prospective Pay System (PPS) can be established.

Thank you for having the courage to do what is right.

Sincerely,

Roselyn Argyle, RN
Owner/Administrator
RA/pc

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CHAP ACCREDITED

New HCFA Data Base Confirms Wide Disparities in the Per-beneficiary Limits

NAHC Seeks Explanation on Data Discrepancies

The National Association for Home Care (NAHC) has performed a preliminary analysis of the public-use per-beneficiary data base issued by the Health Care Financing Administration (HCFA). The data base contains information from 7,000 agency cost reports ending in federal fiscal year (FY) 1994. HCFA statistics show there were 6,497 Medicare-certified home health agencies at the end of calendar year 1993. To have been represented in the data base, an agency would have to be certified and in operation by October 1, 1993. NAHC will ask HCFA to describe any reasons for the potential discrepancy.

HCFA did not include agency provider numbers with its data base so individual agencies cannot be identified. The absence of state or county information also places limits on the comparisons by geographic area. Many of these comparisons are important to adequately comment on the notice and to prepare NAHC's lawsuit against HCFA. Therefore, NAHC has requested additional information, including the provider numbers for agencies in the data base, through the Freedom of Information Act.

Figure 1 below provides the range of agency-specific per-beneficiary limits by census region. The minimum, maximum, median (50th percentile) and mean (sum

Figure 1

Agency-specific and New Provider Medicare Per-beneficiary Limits

	Agency-specific Per-beneficiary Limits (1)				New Provider Per-beneficiary Limits (2)
REGION	Minimum	Median	Maximum	Avg. (mean)	Avg. (mean)
New England CT, ME, MA, NH, RI, VT	$1,270	$3,465	$8,881	$3,777	$3,580
Mid-Atlantic NJ, NY, PA	1,150	2,552	53,470	2,856	3,412
South Atlantic DE, DC, FL, GA, MD, NC, SC, VA, WV	937	3,239	10,859	3,439	3,104
East North Central IL, IN, MI, OH, WI	907	2,752	15,458	3,050	3,153
East South Central AL, KY, MS, TN	1,648	4,534	16,122	4,823	2,887
West North Central IA, KS, MN, MO, NE, ND, SD	691	2,250	32,911	2,534	2,919
West South Central AR, LA, OK, TX	1,330	4,720	14,639	5,155	2,942
Mountain AZ, CO, ID, MT, NV, NM, UT, WY	849	3,304	18,168	3,553	3,086
Pacific AK, CA, HI, OR, WA	1,162	3,157	26,249	3,443	3,638
Puerto Rico	1,032	1,451	3,008	1,556	2,232

Source: HCFA, Medicare Home Health Agency Aggregate Beneficiary Limits Cycle 1 Data Set

Notes:

1 The agency-specific limit is a computed based on 98% of 7.8% of the agency-specific reasonable costs in 1994 (including non-routine supplies) and 98% of 25% of the average cost per patient in the census division in 1994. Limits are wage adjusted and updated to FY98 using the home health market basket excluding the 2 year freeze period (July 1994 to July 1996).

2 The average new provider limits are based HCFA's published method of computing a new provider limit: 98% of the national median labor portion of 2870.07 (all nonlabor portion of 749.62. The labor portion was multiplied by the average wage index for providers in that census division in the cycle 1 data set.

A-2

For the Record

Statement of

Ann B. Howard
Executive Director
The American Federation of Home Health Agencies

Submitted to

The House Ways and Means Subcommittee on Health
For Hearing on the Medicare Home Health Benefit

August 6, 1998

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AMERICAN FEDERATION OF HOME HEALTH AGENCIES, INC.
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The American Federation of Home Health Agencies (AFHHA), a national association representing primarily freestanding Medicare-participating home health agencies (HHAs), urges Congress to take immediate action to stop the impending closure of numerous home health agencies and the loss of access to care for longer term and medically complex home health patients.

The new Medicare home health reimbursement system created by the Balanced Budget Act of 1997 constitutes a formula for closure of thousands of small business home health providers. A considerable portion of these agencies are owned by women and/or minorities.

A proposal to shift the per beneficiary limit from a 75 percent provider specific/25 percent regional formula for older home health agencies, even with a token outlier provision, may simply reshuffle ever-lower levels of reimbursement among providers while failing to address loss of access for the most medically complex home health patients.

A legislative change addressing the devastation of the Interim Payment System (IPS) cannot be considered a solution if it is not retroactive. A non-retroactive adjustment, while intended to make the system more fair for some providers and some areas of the country, does nothing to address the fate of thousands of so-called "new" providers, most of them small businesses. They face closure within the next few weeks as the Health Care Financing Administration's (HCFA) fiscal intermediaries issue demand letters for "overpayments" resulting from the IPS. Attachment #1 is a letter received on July 7 by a "new" home health agency in Texas informing it that its new reimbursement rate is $5.16 per visit, retroactive to January 1, 1998. This is a rate less than the minimum wage. (How would Congress suggest that this agency handle a co-payment of, say, $5.00 or $8.00?) In a number of communities in the hardest hit states, all of the home health agencies may be bankrupted simultaneously.

Updated information from HCFA's Office of the Actuary indicates that home health expenditures for Fiscal Year 1998 will be $17.266 billion. This is significantly less than the $20.7 billion FY 1998 projection made by Health and Human Services (HHS) Secretary Donna Shalala on November 25, 1997, as required by the Balanced Budget Act. Still to be factored into the figure for FY 1998 is recoupment from thousands of home health agencies considered to be in an "overpayment" situation. Indications are that the "overpayments" constitute such a considerable portion of home health reimbursement that actual expenditures could fall as low as $12-$13 billion for this Fiscal Year. The "overpayment" situation has been made worse because home care providers are only now being informed of their reimbursement rates, though the IPS took effect on October 1 of last year.

Apparently it was HCFA's intent that the IPS would have the effect of eliminating longer term and medically complex patients from the home health benefit, though we do not believe that was the intent of Congress. It is cruel to deprive Medicare beneficiaries of their right to choose to remain with their families and in their own homes. This is particularly true at a time when a new General Accounting Office (GAO) study indicates a serious threat to the life, health, and safety of nursing home residents. Nursing homes can repeatedly harm patients but suffer no sanctions while their patients "waste away" with no medical care, according to the GAO. Of the 1,370 California

nursing homes inspected, only 2 percent had either no problems or minimal deficiencies. It is indeed unconscionable that the IPS is delivering Medicare beneficiaries who have been receiving high-quality home care services to the door of such nursing homes -- and at a much higher cost to patients, the States, the Federal government, and the American taxpayer.

If Congress believes that it does not have the time or power to restore the home health benefit because of Congressional Budget Office (CBO) "budget neutrality" scoring constraints, then it should urge HHS Secretary Shalala to impose an immediate moratorium on the Interim Payment System, before the meltdown of the small business infrastructure and massive loss of beneficiary access moves into high gear later this month.

We appreciate your commitment to addressing the devastating consequences of the Interim Payment System. The per patient cap, in particular, has created irrational inequities for providers and is throwing medically complex patients beyond the scope of the home health benefit. In the absence of a case mix adjustor, however, attempting to fix the problem primarily by changing the formula for calculation of the per patient cap will address competitive issues for some providers while having a perverse impact on the very home health agencies who are, and have been, serving the needs of the most medically complex beneficiaries

AFHHA's members are primarily free standing Medicare participating home health agencies, ranging in size from very small to the largest agencies in their communities and states. Our members pride themselves on providing services of the highest quality and being extremely efficient businesses. Their per visit reimbursement in the majority of instances has been significantly below their allowable cost limits. They have insisted on appropriate utilization of home health services and have fought valiantly through the Administrative Law Judge (ALJ) process for the right of patients to receive medically necessary home health care. Their practice patterns have been validated by ALJs who have overturned approximately 98 percent of the denials they have appealed. While operating significantly below their cost caps until passage of the IPS, they may at the same time have had utilization rates higher than many of their peers in the community but totally appropriate for the medically complex patients they serve. Their resources are expended directly on patient care through visits of nurses, therapists, and home health aides rather than on additional layers of administrative expenses less directly related to care of patients.

As free standing agencies, AFHHA's members receive few referrals from hospitals, many of which have their own affiliated HHAs. Our experience is that the hospitals refer the short term less complex cases to their own agencies and the sicker more costly patients to other providers. Many of our members specialize in provision of services to longer term and medically complex patients, often in inner cities and remote rural areas. They continue to serve the sickest beneficiaries and in fact have accepted patients no other home health providers are willing or able to treat under the IPS. The per beneficiary limit created by the IPS, however, does not begin to cover the cost of care for these sickest and most medically compromised of patients. Should these providers be forced to close as a result of the IPS, their medically complex patients are not likely to be picked up by the surviving HHAs in the community.

The current IPS per patient cap, based 75 percent on a provider's cost per patient in 1993-1994 and 25 percent on the regional cost, is an imperfect formula and a crude proxy for a case mix adjustor. But it at least provides some reflection of a provider's patient mix in its 1994 base year (if it had a base year).

Congress must not seek to solve the devastation of the IPS by eliminating the provider specific portion of the per patient cap without putting in its place a strong and viable methodology which

assures access to care for longer term and medically complex patients and addresses the financial viability of the home health providers who care for these beneficiaries.

Leveling the per patient caps with a formula based on a national/regional blend could create a new category of home health "losers." The new losers would be those HHAs which disproportionately care for sicker beneficiaries, as well as the patients they serve. Let me cite an example of a very cost effective home health agency, devastated by the IPS, facing further devastation if the per patient limit is based on a 50/50 percent national and regional blend. As the third largest home care agency in St. Louis, this HHA has specialized in medically complex patients, many in the inner city, as did the two largest HHAs, the Visiting Nurse Association and another free standing agency. Both of these latter agencies have been forced to terminate their participation in the Medicare home health program because of the IPS. The surviving agency was $1 million under its aggregate per visit limits last year. The IPS has now pushed it $1.5 million over its new limits for 1998. Should the per patient cap be based on a 50/50 percent national/regional blend, this provider will be approximately $2.5 million over its IPS per beneficiary limit. It will be forced to close and the majority of its complex patients will be unable to obtain home care services from other HHAs in the community. Admirable providers, such as this one, would constitute the new "losers," depriving the most vulnerable beneficiaries of the agencies willing to serve them.

Let me also point out that many states with higher per beneficiary limits, e.g. Texas, Tennessee, and Mississippi, lack a viable Medicaid home health benefit and the rich array of community services available in other areas of the country to complement Medicare home health care. The absence of nursing home beds in some of these states results in treatment of longer term patients by home health agencies, with services that are physician ordered, appropriate, reasonable and necessary, and which meet all the other requirements of the Medicare home health benefit.

Congress was told by HCFA that the Interim Payment System was intended to *reduce the rate of growth* of the home health benefit, which grew at a rate of only 4 percent in 1997. You have achieved the savings you sought from the IPS, many times over. Reimbursement reductions, which greatly exceed projections, will continue to be guaranteed by:

1. Over 1,200 home health agencies having ceased operations since October 1, 1997.
2. Tens of thousands of home health visits dating back to October 1, 1997, which would otherwise have been made, never to be given.
3. Home health agency reductions in per patient and per visit expenditures which have already occurred and will never be restored.

The home health benefit is now in precipitous negative growth. We urge you to act to save the benefit. *Put a moratorium on the IPS and retroactively repeal the per patient cap*. Congress should not be locked into a mistake. Home health patients, their families, the providers who serve them, and the American taxpayer should not be locked into the reversible consequences of a fatally flawed reimbursement system based on a deception about its real implications.

With respect to what constitutes a "good" provider, do we believe that HMOs which provide the fewest services and may thereby be deemed "efficient," i.e., spend the least amount per enrollee, are the best, or even "good" HMOs? Are we to assume that nursing homes which provide the fewest services and least care to residents are the best facilities? Are "good" physicians the ones who prescribe the fewest procedures and drugs for their sick patients, or the physicians who prescribe the most appropriate treatments?

Likewise with home health, rhetoric which implies that cost effectiveness and low utilization of

services are synonymous is simply wrong and self-serving. A "good" home health provider is one who is extremely efficient, cost effective, insists on appropriate utilization, and is willing to fight for the right of its patients to receive the medically necessary services to which they are entitled.

We reiterate: the Balanced Budget Act of 1997 did not represent a "reduction in the rate of growth" of home health expenditures, as HCFA claimed to Congress, but rather a precipitous cut. Congress, beneficiaries, home health agencies and the American taxpayers must not remain locked into the consequences of a mistake which was based on a deception.

August 6, 1998

FOR THE RECORD

Statement
by the
American Hospital Association
for the
Health Subcommittee
of the
Committee on Ways and Means
of the
United States House of Representatives
on
Payment Systems for Medicare's Home Health Benefit

August 6, 1998

The American Hospital Association (AHA) represents 5,000 hospitals, health systems, networks, and other providers of care. We appreciate this opportunity to present our views on an issue that is of increasing importance to our members and the patients they care for: home health care services provided to Medicare beneficiaries, and the federal government's system of payment for those services.

THE HOME HEALTH INTERIM PAYMENT SYSTEM

As part of the Balanced Budget Act's (BBA) $16.2 billion in reductions from the Medicare home health program over five years, the BBA implements an interim payment system (IPS) that is projected to reduce payments to home health agencies by $3.1 billion in Fiscal Years (FY) 1998 and 1999. The IPS freezes historical base payments, locking lower-cost, efficient providers into payments well below their costs, while historically high-cost home health agencies will continue to be paid at substantially higher rates. This further penalizes efficient home health agencies such as hospital-based and visiting nurse association providers. The IPS is problematic for the two years it is scheduled to be in effect until the changeover to a home health prospective payment system (PPS). Three or more years of the IPS would only magnify the problem, and seems likely given the Health Care Financing Administration's (HCFA) decision to delay implementation of home health PPS while it updates its computer systems for the Year 2000.

Moreover, a 15 percent automatic reduction is scheduled to occur in FY 2000 whether or not PPS is implemented. We believe that this reduction, in the absence of PPS and coming on the

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heels of already-deep IPS reductions, hits efficient hospital-based and visiting nurse association home health agencies harder than others.

Prior to the BBA, hospital-based home health agencies were paid actual costs subject to a per-visit limit. Under the interim payment system, payments were reduced in two ways: a lower per-visit payment limit; and a new per-beneficiary cost limit. The formula for calculating the per-beneficiary limit allows payment disparities across agencies, even in the same market area.

The IPS also fails to recognize changes in the mix of patients served over the past several years, as more complex patients are now treated successfully at home. On the basis of these changes, researchers from Georgetown and George Washington Universities who studied the effects of the BBA on home health care beneficiaries warn of potential access problems for the very frail elderly. If an artificially low per-beneficiary payment limit affects access to the frailest beneficiaries, the resulting cost of admission into hospitals or nursing homes will ultimately be borne by the Medicare system, raising overall costs and limiting beneficiaries' ability to be treated in their own homes.

H.R. 4252

To address our concerns with the IPS, we strongly urge Congress to enact H.R. 4252, introduced by Reps. Philip English (R-PA) and Richard Neal (D-MA). The bill proposes refinements to the Interim Payment System, recognizing that changes are necessary to deal with the unintended consequences of the IPS. It does not suggest simply imposing a moratorium on IPS, thereby locking in the pre-BBA system of payment that led Congress to adopt the sweeping changes of the BBA.

The bill establishes a standardized national average per-beneficiary cost, or "efficiency standard." Agencies whose costs fall below this standard are exempt from per-beneficiary limits. Instead, they would be subject to per-visit limits of 112 percent of the national mean of freestanding agency costs. Analysts estimate that the major growth in home health expenditures have come from the number of visits, not the increase in cost per visit, and efficient providers provide an appropriate number of visits to beneficiaries.

H.R. 4252 also restores updates to home health agency costs used to establish both the per-visit and the per-beneficiary limits. Home health agencies were not compensated for inflation from July 1994 through June 1996, and these market basket updates represent reasonable increases in the cost of doing business during that period.

The bill will create a new per-beneficiary limit, based 50 percent on state average costs and 50 percent on national average costs. Use of the state average rather than agency-specific costs creates a more level playing field across agencies within each state, and recognizes what can be significant differences in state laws and state agency policies affecting home health agency benefits and payments.

Further, the blended per-beneficiary limits recognize legitimate geographic variations, while not relying on individual agency costs that reward those who are significantly out of line with the national or state average.

H.R. 4252 also eliminates the automatic, across-the-board 15 percent reduction in payment scheduled for FY2000 if home health prospective payment is not implemented and the IPS remains in effect. The impact of the IPS has been estimated by several researchers to reduce home health agency payments by more than 20 percent on average. An additional 15 percent reduction on top of that would cause severe harm.

Home health agencies that were created after 1994 would be paid the same blended rate, creating a level playing field in local markets. This avoids another penalty on providers who may have begun operations as early as 1994 and are treated as new providers under the BBA. The state/national blended payment will neither reward nor harm new providers.

Finally, the legislation restores $600 million in FY 1998 and $700 million in FY 1999 in home health care spending that had been reduced by the BBA. In addition, because HCFA has indicated that it will not implement a prospective payment system for home health in FY2000, elimination of the 15 percent across the board reduction in payments in the absence of PPS would cost an additional $4.1 billion.

In our view, it is essential that we look at sources of funding to restore some much-needed dollars for home health services. One source of revenue that must be considered is the current budget surplus. It would be shortsighted to look at the serious shortfalls in home health funding without considering use of the surplus to remedy this problem. While there are other options available to help ease the burden on home health agencies, as outlined below, the use of the surplus should also be on the table.

BENEFICIARY CONTRIBUTIONS

It is clear that a number of solutions need to be considered in order to address the serious adverse consequences of the IPS. One of the inherent problems in the current system, as mentioned above, is that very deep reductions in home health were included in the BBA, and, as is often the case, all of the reductions came from provider payments. It is important that we move toward an approach whereby all stakeholders in federal health programs, including providers and beneficiaries, be asked to sacrifice when reductions are contemplated.

One option under consideration to help address the problem is having beneficiaries share in the cost of home health care. Home health services are one of the few Medicare benefits that are not subject to any cost sharing by beneficiaries. While we share some of the concerns about the administrative feasibility of implementing a minimal fee for home health visits, we believe it is a proposal that must be seriously considered by Congress.

In fact, MedPAC supports a modest beneficiary copayment, subject to annual limits, and included this as a recommendation in its 1998 report to Congress.

One argument in favor of a beneficiary contribution is that it would help control utilization, which has increased dramatically in the home health area. However, our members believe that they are already appropriately controlling utilization through their lower per-beneficiary usage rate. In addition, based on our experience in states that have beneficiary contributions for home health under the Medicaid program, there is a significant administrative burden in collecting a small fee, and there is no recourse if the beneficiary fails to pay. There is a legitimate fear that the costs of administering this change, combined with the fact that agencies ultimately may be unable to collect it, will result in lost revenue.

Therefore, in a perfect world, we have some reservations about imposition of an optional pass-through for a minimal fee for home health services, and we know the subcommittee shares those reservations. However, one of the fundamental problems underlying the IPS predicament is that too much money was taken from home health, and more dollars need to be allocated to this area. That is one of the reasons we support H.R. 4252. Additional dollars clearly need to be found. If applying a minimal beneficiary fee to home health brings additional dollars to the program, then it is an option that needs to be given serious consideration in a final resolution of the issue. If the choice is between continuation of the current unacceptable IPS, and a package that would include both moving to a national efficiency standard that assists efficient providers and implementing a minimal fee through an optional pass-through for home health services, we believe that the new approach would be a better alternative.

CONCLUSION

Mr. Chairman, we believe that H.R. 4252 can go a long way toward improving the IPS until home health PPS is implemented. At the same time, we believe that Congress should consider the possibility of allowing Medicare beneficiaries to share in the cost of their home health visits, subject to annual limits. We look forward to working with the subcommittee and with HCFA to improve the home health care benefit for our nation's older Americans, and to improve its payment system for the home health agencies that provide their care.

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Testimony of the

American Physical Therapy Association

for a hearing of the

Subcommittee on Health of the House Ways and Means Committee

regarding the

Medicare Home Health Benefit Payment System

August 6, 1998

Combined Sections Meeting

February 3-7, 1999
Seattle, Washington

Physical Therapy '99
Scientific Meeting
& Exposition

June 4-7, 1999
Washington, DC

Testimony of the American Physical Therapy Association

for a hearing of the

Subcommittee on Health of the House Ways and Means Committee

regarding the

Medicare Home Health Benefit Payment System

August 6, 1998

The American Physical Therapy Association (APTA) appreciates the opportunity to submit comment for the Committee's concideration relating to the implementation of the interim payment system (IPS) for services provided in a patient's home. APTA is a national organization representing over 74,000 physical therapists, physical therapist assistants, and students of physical therapy.

Patient Access

APTA has grave concerns with the impact that the home health IPS provision, included in the Balanced Budget Act of 1997 (BBA), will have on patient access to rehabilitation services. As mentioned in the regulatory impact statement published in the *Federal Register* on March 31, 1998, the Health Care Financing Administration (HCFA) estimates that there will be a decrease in payments to home health agencies of $1.06 billion in 1998 and $2.14 billion in 1999 compared to payment that would have been made if it was not enacted. This is approximately a 9% reduction. In determining this reduction, HCFA accounted for home health agencies possibly changing their behavior by increasing in the number of low cost beneficiaries served, decreasing the number of visits provided, and discharging patients earlier than medically necessary.

APTA is concerned that due to the low reimbursement rates, home health agencies will be forced to cut costs by reducing the amount of therapy and other services that a Medicare beneficiary receives, despite the fact that those services are medically necessary. If a patient does not receive rehabilitation, it could result in greater costs to the Medicare program in the long run. Rehabilitation enables patients to attain their maximum level of functional independence. Patients that do not receive the rehabilitation services they need may have a greater number of falls and other accidents, which will result in readmission to hospitals and skilled nursing facilities.

HCFA noted in the regulations on the IPS that the home health agencies may have financial incentives to release patients before they have reached their maximum functional potential. If the discharged home health patient still requires rehabilitation services, the patient may be sent to receive rehabilitation services in another outpatient setting, such as an outpatient hospital department, rehabilitation agency, comprehensive outpatient rehabilitation facility, physicians'

office, or physical therapy private practice. With the exception of outpatient hospital departments, these settings will be subject to a $1500 cap on therapy services as of January 1, 1999 (section 4541(c) of the Balanced Budget Act). Home health agencies that furnish services to Medicare beneficiaries who are not homebound will also be subject to the $1500 limit. Therefore, if patients are released from home health agencies before receiving all the necessary therapy services, they may have difficulty receiving these services in other outpatient therapy settings or they may have to pay out-of-pocket to obtain these services.

As this Committee considers appropriate modifications to the payment structure for home health services, APTA urges the Committee's attention to concerns created by the imposition of an arbitrary cap on outpatient therapy services. **APTA strongly supports legislation sponsored by Rep. John Ensign of Nevada, a member of this Subcommittee, to repeal the cap H.R. 3835 $1500 cap on Part B medicare services.** H.R. 3835 presently has more than 70 cosponsors in the House of Representatives. Senator Chuck Grassley of Iowa, along with seven of his colleauges have introduced companion legislation in the Senate.

Difficulty of Providing Care under the IPS

The interim payment system is detrimental to the viability of both small and large home health agencies (HHAs). This effect extends to the numerous physical therapists who independently contract with home health agencies. IPS is causing the grave problems for small and rural home health agencies that serve a large number of chronically ill or severely ill patients. Because these agencies are unable to adjust their case-mix they are being compelled to reduce their work force and services and possibly close their businesses to patients who badly need their services.

A central criticism of the the IPS is that it does not treat all home health agencies equally for purposes of reimbursement. It is structured so that two home health agencies, which are located one block from each other could receive completely different payments. Part of this is due to the fact that the payment system is based on 75 percent of 98 percent of facility costs in the year 1994. Therefore, the majority of the payment is facility specific. One facility may have had higher costs in 1994 than another facility nearby due to a more intense case-mix. After the interim payment system went into effect the facility adjusted its case-mix so that it had patients with a less intense case-mix. Therefore, one HHA could have the same case-mix of patients as the nearby HHA but receive higher payment under the interim payment system.

In addition, old agencies (those with cost reporting periods ending during Federal fiscal year 1994) receive payments based on their 1994 cost reports while new agencies with no 1994 cost reports are paid based upon the median of the limits of HHAs with cost reporting periods ending in 1994. Therefore, agencies located in close proximity of each other may be receiving completely different payment rates. It is estimated that the new HHAs will exceed their costs by more than 3 percent than the old HHAs. It is not equitable to have two HHAs in the same vicinity receiving drastically different payments from the Medicare program.

APTA recognizes that HCFA is required to comply with the provisions in the statute that established the IPS. However, APTA asks Congress to work with HCFA to mitigate the impact

of the IPS by allowing for some type of case-mix adjustment to account for patients of unusually high expense. Exceptions or exemptions to the per beneficiary limits for certain types of high cost patients are essential to ensuring that these patients receive the rehabilitation and other services that they need.

In the regulations, HCFA provides definitions of "new providers," which will receive payment based on the median of limits from 1994 HHA cost reports. The regulation provides that the merger or consolidation of like HHAs when one HHA does not have a full FY 94 cost report receive a per beneficiary limitation calculation as a "new provider." This "new provider" will receive the national per beneficiary limitation for cost reporting periods on or after October 1, 1997, which will likely be less than the blended rate for those agencies in existence prior to 1994. In other words, an older company with 1994 cost reporting data that merges with a new company (one formed after 1993) will be considered a new agency under HCFA. This definition by HCFA will exclude the older company's 1994 cost reporting data, which may result in a lower per beneficiary limit than the older company would have received if it had never formed the merger. This proposed payment methodology may have a deleterious financial impact on these newly formed agencies. APTA feels it is inappropriate not to recognize the surviving HHA in a merger as a reflection in the variation in services and costs.

HCFA also states that the switch from a freestanding HHA to a provider based HHA or vice versa would result in the HHA receiving "new provider" status. APTA contends that this does not represent a significant amendment of operation or organization sufficient to eliminate the agency specific data. In addition, HCFA states in the regulations that a branch office that turns into a subunit receives new provider status. It would also be more accurate to enable the branch to receive the same payment that the parent provider receives.

Conclusion

Many of APTA's members are physical therapists and physical therapist assistants who furnish services to Medicare patients in a home health setting. Their patients, especially those with chronic conditions, will be impacted significantly by the new home health provisions and regulations. APTA believes that the IPS, as it currently exists, severely limits the ability of Medicare beneficiaries to receive the rehabilitation services they need and encourages the Committee to redress home health provisions from the Balanced Budget Act. In addition, APTA asks that the Committee consider its concerns relating to the negative impact of an arbitrary $1,500 cap on outpatient rehabilitation services. APTA shares the Committee's interest in developing solutions which ensure quality care, while reducing excess costs and utilization in the Medicare program. APTA is eager to work with members of the Committee to find reasonable solutions to these issues.

For more information, please contact Patrick Cooney, APTA's Senior Policy Advisor, at (703) 706-8508.

Pursuant to clause 2(g)(4) of the Rule XI of the Rules of the House of Representatives, the American Physical Therapy Association reports that it has no federal grants to disclose.

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August 4, 1998

House Ways & Means Health Subcommittee
U.S. House of Representatives
Washington, D.C. 20515

Dear Subcommittee Members,

Georgia Home Health Care Agency is thankful for the opportunity to present testimony at the House Ways and Means Health Subcommittee hearing scheduled for August 6, 1998.

- Our home care agency has witnessed deleterious effects due to the implementation of the Interim Payment System (IPS).
- The 415 patients we currently serve are now in serious jeopardy and will be without sufficient health care services should IPS restrictions force our agency into bankruptcy.
- The immediate harm to our patient population will be realized through disease exacerbation, as 75% of our patients are over 70 years old and have multiple, chronic illnesses and related health problems.
- **One typical example is a woman who was hospitalized for several days during a two-month period this year. Her hospital bill came to $46,800. Due to restrictions from IPS this Medicare Beneficiary was unable to receive the more efficient care and services offered under her Medicare Home Health Benefit. This patient could have been safely treated by home health nurses for less than $9,000. IPS is cost prohibitive and inefficient.**
- IPS is causing a myriad of health-related crises to our Medicare Beneficiaries and will escalate Medicare costs relative to the predictable negative health care outcomes resulting from decreased home care services.
- If IPS continues, our home health agency will be forced to close its doors. The rural, aging population we serve is fragile, vulnerable and requires diligent care for the many complex health problems existing within our home care clientele. The current reimbursement rates under IPS fall very short of what is needed to safely care for our Medicare patients. Therefore, we are requesting an immediate moratorium on IPS until a reasonable Prospective Payment System (PPS) is operational.

Time is of the essence. We appreciate your time and consideration in this very serious matter.

Sincerely,
Robert Ferry
Robert Ferry, BSN, RN
Director of Clinical Services
Georgia Home Health Care Agency

Great Rivers Home Care, Inc. (314) 928-8628

Carole Burkemper, R.N., B.S.N.
President

220 Salt Lick Road
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Written Testimony for the Record

August 5, 1998

The Honorable Bill Thomas
Chairman
U.S. House Committee on Ways and Means
Subcommittee on Health
1136 Longworth House Office Building
Washington, DC 20515

Dear Chairman Thomas:

Thank you for the opportunity to submit written testimony for the record to the U.S. House Committee on Ways and Means Subcommittee on Health's hearing on the Medicare home health benefit scheduled for August 6, 1998. I was honored to testify before the U.S. Senate Committee on Small Business's hearing on July 15, 1998, entitled "Home Health Care: Can Small Agencies Survive New Regulations?" You are already aware that we cannot survive. To date, over 1200 agencies out of 10,027 have ceased operations due to the impact of the Health Care Financing Administration's (HCFA's) Interim Payment System. According to the state licensing offices across the nation, more agencies are closing daily. All of the surviving agencies, including Great Rivers Home Care, cannot survive beyond the summer without congressional intervention. Tragically, the fragile elderly throughout our country are suffering now especially those in our inner cities and in rural areas. These voiceless Americans are entitled to and qualify for the Medicare home health benefit but are being denied care due to the drastic funding cuts imposed by HCFA's Interim Payment System.

The Interim Payment System has reduced funding to agencies in Missouri, as well as across the nation, 30% to 80% below the actual cost of providing care. As a result, Medicare beneficiaries, minorities in particular and women in general, are being denied access to reasonable and necessary home care which not only allows them to stay in their own home at very low cost but prevents unnecessary hospitalization, skilled nursing facility utilization, nursing home placement, and spend down to Medicaid. If home care is not available, these unnecessary costs to the Medicare program will quickly reach billions of dollars annually then will shift the cost of care to the state Medicaid programs. No state can bear this onerous burden. When Congress passed the Balanced Budget Act of 1997, the intent of the legislation was to curb fraud and abuse not to deny reasonable and necessary home health care to our nation's fragile elderly or to force quality driven, cost effective, law abiding home health agencies out of business. If a moratorium on the Interim Payment System is not enacted in the next few weeks, more home health agencies will be forced out of business. The loss of quality of life for Medicare beneficiaries will be unconscionable and the increased costs of their care to the Medicare program will be catastrophic.

Medicare does not allow home care agencies to make a profit from the Medicare program. We are cost reimbursed and nearly all of us operate with a negative bottom line. Unlike hospital systems and physician groups (which are allowed by Medicare to make a profit), most owners have been required by their lending institutions to collateralize their businesses with their personal assets. Because of HCFA's failure to assess impact of the Interim Payment System on our small businesses, we are unjustly and unfairly at risk for the losses of our homes, our property, and any and all other personal assets. HCFA has not considered these catastrophic inequities or if it has and continues this punitive, irrational, and unfair Interim Payment System with the goal to force independent, freestanding home health agencies out of business, it is unconscionable and criminal.

On March 31, 1998, HCFA published a final rule which contained a new method of reimbursement which drastically limited the costs that could be paid to home health agencies under the Medicare program. No proposed rule was ever published in the prior six month period even though our patients and our home health agencies were to be catastrophically impacted. HCFA offered no alternatives. We did not have a comment period. This is a violation of the Administrative Procedure Act (APA). The entire Interim Payment System methodology that HCFA developed is irrational, unfair, and fatally flawed not only in the terms of the existence of home health agencies but in terms of the lives of Medicare beneficiaries. HCFA did not notify agencies of their per beneficiary cost limits until 3 months after its March 31, 1998, final rule was issued and then applied the new cost limits retroactively to October 1, 1997. As a result, all agencies in the country were operating in good faith nearly 8 months without notification of their agency specific cost limits. In the last 2 months, many agencies have received overpayment notices from their Fiscal Intermediaries ranging from one hundred thousand dollars to millions of dollars. Immediate repayment demands were made by the intermediaries. Repayment schedules have been denied. As a result of the unforeseen overpayments, more than 1200 agencies have been unjustly forced out of the Medicare home care program. Some owners have declared bankruptcy. More owners will face the same desperate and tragic end unless Congress intervenes.

In view of the recent and numerous violations of federal regulations by HCFA in regard to the Interim Payment System, including the Regulatory Flexibility Act (RFA) and the Administrative Procedure Act (APA) and the recent and numerous unconscionable fraudulent activities of HCFA's Fiscal Intermediary, Blue Cross Blue Shield of Illinois, an immediate oversight hearing of HCFA would seem to be appropriate and necessary. Because of HCFA's failure to publish a proposed rule, HCFA's failure to analyze significant alternatives, HCFA's failure to provide a factual basis for the single alternative offered and HCFA's failure to assess the impact of the regulation on our Medicare beneficiaries and our home health agencies, Jere Glover, the Chief Counsel for Advocacy of the U.S. Small Business Administration, has charged that HCFA is in violation of the Regulatory Flexibility Act which requires federal agencies to ensure that their rulemaking demonstrate an analysis of the impact that their decisions will have on small business. In addition, the Chief Counsel charges that "HCFA has gone beyond what Congress intended and has effectively made the regulations punitive and unfair to legislative and law abiding home health agencies." The Chief Counsel has also charged that HCFA was not only in violation of the RFA and APA, but that HCFA did not consider the drastic impact of the Interim Payment System on Medicare beneficiaries especially the medically complex, long term patients who will lose critical home care services or the catastrophic impact on small home health agencies which are cost effective and conscientious. HCFA did not consider the patient population served by these agencies (case mix variation) or whether a particular provider had a history of operating below their cost limits (versus an agency that had a history of operating at their cost caps).

Great Rivers Home Care has been serving the major metro St. Louis area including the inner city and surrounding rural counties for nearly 12 years and is now the area's largest independent, freestanding agency. Great Rivers provided nearly 90,000 visits to Medicare beneficiaries last year. I am a registered nurse with a Bachelor of Science in Nursing from the University of Missouri in Columbia. I have worked in the Medicare home care program since it's inception in 1973. I am the sole owner of Great Rivers Home Care but have a loyal, dedicated team of 100 professionals who have continued to provide care to their patients in spite of the suspension of nearly all of their benefits due to the drastic reimbursement cuts mandated by HCFA's Interim Payment System.

Great Rivers has an excellent reputation and a long history of deficiency free annual surveys. Our rates of visit denials and cost disallowances by our Fiscal Intermediary, Wellmark, average less than one tenth of one percent. We deliver high quality care and we are extremely cost efficient. Prior to IPS, we consistently operated nearly 1 million dollars below our cost limits. Under IPS, we will be reimbursed 1.5 to 1.8 million less than the actual cost of providing care to our patients. If a 50% national / 50% regional average (Senate Bill 2323) or 75% national / 25% regional (Chairman Thomas' proposal) is mandated, we would be reimbursed 2.5 to 3.25 million dollars less than the actual cost of providing care. See Attachment A. This leaves us no hope for survival. The Balanced Budget Act of 1997 has also mandated an additional 15% reduction in reimbursement beginning October 1, 1999. Few home health agencies will survive to implement these reductions. In addition, HCFA has recently notified Congress that it cannot implement the Prospective Payment System (PPS) by the statuatory deadline of October 1999, due to computer problems with the year 2000. Sources on Capitol Hill have stated that HCFA has reported that the implementation of the new Prospective Payment System may take between six months to three years. This latest announcement by HCFA leaves all home health agencies with no hope for survival.

The two largest independent agencies in St. Louis ceased Medicare home care operations in May because of IPS. They had provided nearly 300,000 visits annually to medically complex patients in our inner city. These are the patients Great Rivers also serves. IPS has created irrational and unfair inequities for agencies such as ours, specifically, in regard to the per beneficiary limit, and as a result, effectively denies services to medically complex, long term patients. HCFA's methodology in establishing this limit was flawed and assumed that high utilization is unreasonable and unnecessary. Great Rivers Home Care has recently undergone a random 30% audit of visits by our Fiscal Intermediary, Wellmark. Out of 4000 visits, only 16 were denied and we have appealed these denials and expect 100% reimbursement. The Senators sponsoring S2323 and other Congressmen have not been adequately apprised of the reasonable and necessary long term care required by medically complex patients and they have assumed that high utilization is unreasonable and unnecessary and that agencies who provide this care are not cost effective. THIS IS NOT TRUE.

As a freestanding agency, Great Rivers Home Care receives few referrals from hospitals since most have their own home health agencies. Our experience is that the hospitals refer the short term, less complex cases to their own agencies and the sicker, more costly, long term patients are the cared for by agencies like ours. HCFA failed to analyze the unfair inequities in the Interim Payment System. Not only do hospital based agencies have the unfair advantage of a captive referral base which increases their unduplicated census, hospital based agencies generally have much higher visit costs. See Attachment B. Under the Interim Payment System, HCFA unfairly rewarded hospital based agencies with higher cost limits. Since Great Rivers and other freestanding agencies similar to ours were already operating cost effectively, we have no expenses to eliminate. HCFA has failed to analyze the budgetary impact of the survival of hospital based agencies with higher visit costs and the demise of cost efficient, quality driven, freestanding agencies.

The current per beneficiary limits are based 75% on agency – specific data and 25% on regional. Unfortunately, the Senators who have sponsored S2323 and other Congressmen are assigning per beneficiary limits based on geographical locations without consideration of an agency's case mix or cost efficiency. Although their intentions are good, they are effectively imposing unfair inequities with particularly punitive per beneficiary limits assigned to all of the midwestern and mid Atlantic states, all of which have major metropolitan areas with higher than average per beneficiary utilization due to their poor and generally minority based populations.

The agencies which serve major metropolitan areas throughout the midwest and middle Atlantic states will be impacted even more catastrophically by S2323 than the drastic cuts made under HCFA's Interim Payment System. These major metropolitan areas include New York City, Pittsburgh, Philadelphia, Newark, Cincinnati, Toledo, Akron, Cleveland, Indianapolis, Detroit, Grand Rapids, Milwaukee, East St. Louis, Chicago, Minneapolis, St. Paul, St. Louis, and Kansas City. HCFA's Interim Payment System and inadvertently S2323 unfairly discriminates against the poor, the sick, and the dying which almost always represents our nation's minorities. I am certain that the Senators who sponsored S2323 did not have this intent.

There are four major issues that were not addressed at the Senate Small Business hearing in July. Since minorities traditionally have little or no access to health care not only to prior to birth but throughout their lives, minorities develop an earlier onset of diabetes, hypertension, heart, lung and kidney diseases. As Medicare beneficiaries with few or no resources, they have higher utilization rates due to more serious complications and exacerbations of their diseases that the general Medicare population. The per beneficiary limit under HCFA's Interim Payment System and under S2323 particularly discriminates against these sicker, more medically complex, long term care Medicare beneficiaries who are frequently minorities and who live in the midwest (East North Central and West North Central) and in the middle Atlantic states.

In addition, HCFA's Interim Payment System and S2323 unjustly discriminates against women since more than 75% of the home health agencies are owned by women and more than 95% of the employees of home health agencies are women. Since women have longer life expectancies than men, Medicare beneficiaries who are women have been or can expect to be denied reasonable and necessary care under Medicare.

A third issue is that HCFA is continuing to claim that 40% of home health agencies' claims are improper. Two reports by the Office of the Inspector General (OIG report # A-17-97-0097) issued April 1, 1998, and an unnumbered OIG testimonial report issued on April 24, 1998, similarly titled Audit of HCFA, were recently discovered by the Home Care Association of America. Page 11 in the April 1, 1998, report and page 4 of the testimonial reveals the truth that less than 12% of home health agencies' claims are questionable. This new OIG 1998 evidence is far more comprehensive (based on a national sampling of 8,048 claims) than the OIG's July 1997 report (OIG report # A-04-96-02121) that falsely claimed that 40% of all home health agencies' claims were improper (based on a biased sample, an Operation Restore Trust Four-State sampling of only 250 claims).

The final issue is that HCFA has failed in its duty to properly police home health agencies. Because of its failure to carefully audit and penalize individual agencies who are guilty of fraud and abuse, HCFA has punished the entire home health industry through the imposition of the Interim Payment System and Surety Bond Rules. Not only have innocent, law abiding home health agencies been catastrophically impacted, 37 million Medicare beneficiaries who are also innocent, are at risk for loss or denial of reasonable and necessary Medicare home care benefits. Recently, President Clinton pledged $30 million to increased agency audits by HCFA. These audits should be targeted to the true fraudulent abusers of the Medicare Home Care Program.

I am outraged at the Interim Payment System exception that has been proposed by HCFA for Integrated Health Services. See attached ELI's Home Care Week Report of July 27, 1998, (copied with permission). This exemption is grossly unfair and and is surely not the result of soft money contributions by Integrated Health Services of $574,000 and by Robert Elkins, CEO, of $104,000 (Washington Post February 17, 1997). Under IPS, small business owners are given two choices. We are forced to subsidize the Medicare home care benefit or are forced out of business and into personal bankruptcy. Integrated Health Services is now potentially exempt from IPS and can provide the services the freestanding agencies formerly provided to sicker and more medically complex patients. Unlike the freestanding agencies, Integrated did extremely well in the first quarter, earning $41.5 million compared with $22.1 million a year earlier. Net revenues increased 78%. Unlike freestanding agencies, Integrated can also refer patients to its own for profit hospitals and nursing homes.

Recently, the General Accounting Office, reported that nearly one third of the nursing homes in California have been cited for violations that cause death or life threatening harm to patients. Thirty-three percent of the homes had violations that harmed patients without threatening their lives, and 35 percent had deficiencies that could harm patients if not corrected. According to the New York Times, July 28, 1998, Charlene Harrington, a professor of nursing at the University of California at San Francisco, stated that "California is symptomatic of all the states. "The General Accounting Office examined the quality of care at 1,370 California nursing homes inspected from 1995 to 1998 and found that "30 percent of the homes had committed violations that caused death or life-threatening harm to patients, or had understated the amount of poor care by falsifying medical records." At a Senate Special Committee on Aging, Senator Grassley called the situation in California "horrifying - the equivalent of a national scandal."

HCFA has illegally, immorally and unethically set the Medicare home care benefit on a course of destruction. Since nursing homes are the only alternative, health care for the elderly in the United States will deteriorate to unacceptable standards not only in the terms of the unimaginable pain and suffering of 37 million Medicare beneficiaries but in catastrophic costs to the Medicare program. THIS IS HORRIFYING AND THE EQUIVALENT OF A NATIONAL SCANDAL.

I respectfully request that you lead Congress to enact a moratorium on the Interim Payment System retroactive to October 1, 1997, and repeal the mandatory 15% additional reduction in funding which is to take effect on October 1, 1999. The Congressional Budget Office has estimated a savings of $26 billion over the next 5 years which is $10 billion more than the savings estimated as a result of the Medicare home care changes mandated by the Balanced Budget Act. As a compromise to continue to meet the Congressional Budget Office's requirements, we will accept a reduction in funding to the July 1996 cost limits. We also recommend a moratorium on new agencies until a more equitable reimbursement system can be established. This will also save millions in terms of Medicare administrative costs. For example, no new agency applications should be accepted after August 31, 1998. The exceptions to this should be the applications for a new agency in a county or parish that has lost all of its home health agency providers as a result of the Interim Payment System and the applications to purchase an existing agency that is in good standing.

Thank you for the opportunity to submit written testimony to your committee. I will be available to answer any questions. Your invaluable support will not only save the Medicare program billions of dollars but will insure the quality of life for our country's most revered citizens.

Respectfully,

Carole Burkemper

Carole Burkemper

CB/se

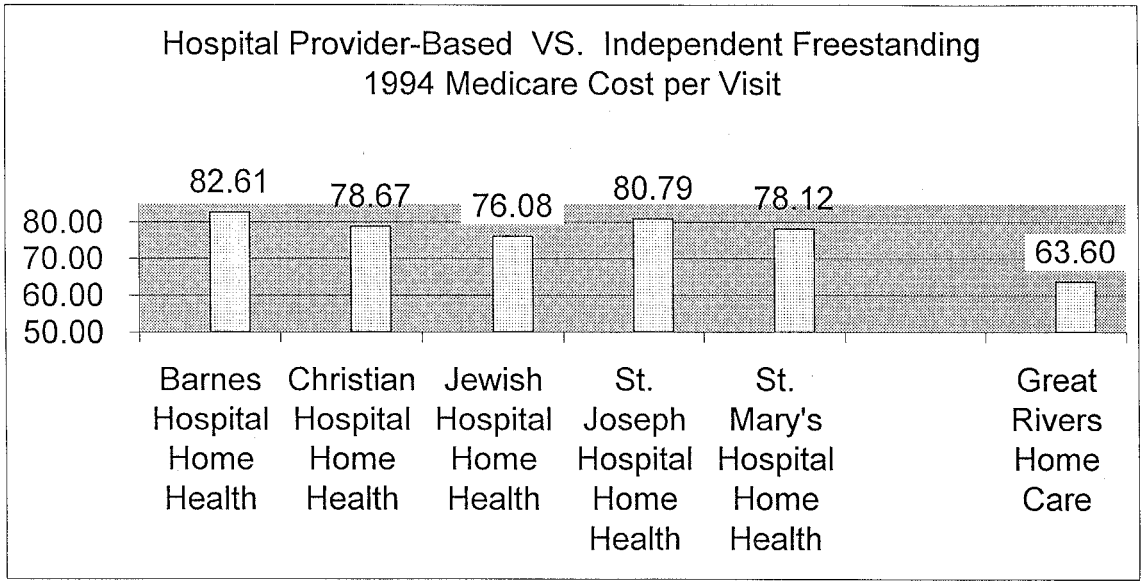
Attachments

Attachment A

Comparison of Chairman Thomas' Proposed Changes to the Current Interim Payment System

	Wage Adjusted for St. Louis	Current Beginning 10/1/97	Proposed Beginning 10/1/98	Proposed Beginning 10/1/99
Agency Costs (Great Rivers)	4,771.52	4,771.52	4,771.52	-
		75%	37.5%	0%
		3,578.64	1,789.32	-
Regional Costs	2,791.67	2,791.67	2,791.67	2,791.67
		25%	25%	25%
		697.92	697.92	697.92
National Costs	3,129.87	-	3,129.87	3,129.87
		0%	37.5%	75%
		-	1,173.70	2,347.40
Subtotal Rate		4,276.56	3,660.94	3,045.32
Less 2%		98%	98%	98%
		4,191.03	3,587.72	2,984.41
Fiscal Year Adjustment (July 1)		1.02353	1.02353	1.02353
Adjusted Agency Per Beneficiary Limit		4,289.64	3,672.14	3,054.64
Estimated Reimbursement BELOW the actual cost of providing patient care at Great Rivers Home Care		$ 1,800,000	$ 2,500,000	$ 3,250,000

Attachment B



Data obtained under the Freedom of Information Act
In 1994, Hospital home health agencies had a higher cost limit for capital overhead costs

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Finance

IHS MAY CUT SWEETHEART DEAL WITH HCFA ON IPS

While much of the home nursing industry crumbles under the weight of the interim payment system, **Integrated Health Services, Inc.** may be able to cut its own deal with the **Health Care Financing Administration** to escape the worst of IPS.

IPS shaved $0.10 per share off IHS' earnings in the second quarter of 1998, and IHS is considering selling its home care division to a market consolidator as a "worst case scenario," IHS Chairman and CEO **Robert Elkins** told investors recently. But IHS also has a way out of IPS that isn't available to any other company.

IHS' unique advantage comes from the fact that it bought its home health division from the government. When IHS bought **Jack Mills'** bankrupt **First American** empire, it negotiated a detailed contract protecting itself from losses.

"Under that contract with the government, IPS and these somewhat arbitrary changes in per-visit caps and per-beneficiary caps were addressed specifically," Elkins explained. "We believe that contract minimizes our exposure to changes in PPS and we are in discussions with HCFA and the government to address that."

IHS bought First American in the belief that the prospective payment system (PPS) would be implemented quickly, making the acquisition a profitable one. HCFA's announcement that PPS would be delayed indefinitely, coupled with the excessive changes wrought by IPS, may constitute a breach of that contract, industry observers speculate.

In other words, IHS may escape the full brunt of IPS. "We're not sure how much we're losing on home health," Elkins told investors, "because a lot of the discussion revolves around First American contracts which we feel, and our attorneys feel, and many others feel, have exempted First American from these cuts in home health."

Thus, IHS has been "conservative" in recording losses in its home health division. "We have booked some of these losses in home health that we don't think we have to take," Elkins noted. For the latest quarter, IHS might have made $0.05 to $0.10 per share more without its home health division, he estimated. If IHS resolves its discussions with the government, it may restate its recent earnings.

As it was, IHS did extremely well in the first quarter, earning $41.5 million compared with $22.1 million a year earlier. Net revenues jumped 78 percent. Analysts, however, had expected such growth, and some were disappointed that IHS didn't exceed their expectations.

The contract to purchase First American's agencies included a deferred payment of over $100 million that comes due after 2000, observers note. During the conference call, Elkins confirmed IHS is discussing that payment with HCFA.

An IPS-Exempt IHS Could Dominate Industry

The most surprising thing about IHS' situation is that it still is attempting to divest or spin off its home care operations as quickly as possible.

Industry observers note that, given an exemption from IPS, a company like IHS could pick up business from struggling or bankrupt providers across the country. Even if an IPS exemption only applied to the former First American home health agencies and not any new acquisitions, IHS could grow the First American business by providing service at higher levels than agencies under IPS could afford to match.

"It allows them to tell referral sources, 'My cost per visit limit is X, so I can make more visits than anybody else in the community,'" argues reimbursement consultant **Rick Ingber** of **Health Care Financial Systems** in Blue Bell, PA. "While other agencies are going to have to worry about their visit frequency even if more visits are justified," Ingber says, IHS could take high-cost, high-utilization patients "without a second thought."

Ingber points out that it would make sense for an IHS exempt from IPS to buy out struggling providers, rolling the patients into its existing agencies.

It is unclear whether any contractual exemption from IPS would continue to apply to First American if it were spun off or sold again.

If IHS succeeds in winning exemption from IPS, observers note, the appearance of a "non-level playing field" could undermine the foundation of IPS

itself. Ingber predicts that the industry would unite in an uproar.

He points out that First American was a notorious abuser of the system, and an exemption from IPS would seem to reward that abuse.

Despite the potential advantages, Elkins is adamant that the home health unit must go, apparently because delays in PPS have ended any hope that the former First American can contribute to IHS' bottom line. "In order for home care to work, there must be a prospective payment system," Elkins insisted.

"We are still talking to several financial partners who may end up owning part of the business, and we also still are taking into consideration a spin-out to the public. We anticipate having closure on home care by the end of the year," Elkins said.

But if everything goes wrong, including negotiations with the government, IHS may turn to a consolidator such as one of the companies that bought a piece of **Columbia/HCA's** home care division. Elkins called a sale of home care and the ensuing write-off a "worst case" scenario.

"If there's any change to the government posture toward us, we've covered the downside, we feel," Elkins added. IHS' home care operations are currently booked with a value of $350 million, but Elkins noted that "it's not worth that today." ◊

Surety Bonds

DME BOND REG TO TAKE GAO FINDINGS INTO ACCOUNT

The durable medical equipment industry may gain a windfall from the **Health Care Financing Administration's** agreement to suspend its home health agency surety bond regulation.

HCFA Program Integrity Director **Penny Thompson** testified that a new study on the HHA surety bonds to be produced by the **General Accounting Office** also will be used to revamp the DME bond regs. Although Thompson also insisted that the final DME regs would be published this fall, observers note that the completion date of the GAO report is unclear.

Testifying at a July 22 hearing of the Human Resources Subcommittee of the House Government Reform and Oversight Committee, Thompson confirmed HCFA soon would suspend its HHA bond reg officially. As a July 31 deadline for obtaining bonds approaches, providers have anxiously awaited such a notice. HCFA won't publish a final reg until it consults with Congress on the results of the GAO study.

So far, the only guidance the GAO has received on the study has been in the form of statements by staffers for Sens. **Christopher Bond** (R-MO), **Charles Grassley** (R-IA), and **Max Baucus** (D-MT). The staffers have given the GAO "an idea on what direction they want the report to go," says a Senate source, but a formal letter from the Senate Finance Committee will lay out more detailed instructions.

There was no indication from Thompson's testimony that HCFA plans to release sureties from their obligations under the HHA bonds they already have written. "We are evaluating our options to see if there is any way to accommodate" agencies that have obtained bonds, she said in her statement.

At the July 22 hearing, HCFA and the **HHS Office of Inspector General** insisted that surety bonds are necessary to protect Medicare from the fraudulent activity of home health providers. Thompson kept up HCFA's line that its previous HHA bond regs were an appropriate exercise of administrative discretion.

OIG Deputy Inspector General **George Grob** argued that bonds are "an integral element in any strategy to reduce the vulnerability of the program."

Committee members were impressed with the statistic from the OIG's July 1997 report that 40 percent of home health expenditures were inappropriate. The more recent statistic from the OIG's financial audit of HCFA that only 14 percent of home health payments were inappropriate was not mentioned, although Grob said both reports used the same methodology.

Thompson and Grob both agreed that small businesses are likely to suffer disproportionately under any surety bond regime. "If we are successful in preventing disreputable companies from joining or staying in the program, there will be small businesses that will be affected," said Grob.

The OIG recommended principles to guide the redesign of surety bond rules, among them that:

- all HHA and DME dealers should have to obtain one;
- the amount of bonds should "provide for some continuing financial protection to the Trust Fund from risks inherent in this program;" and
- providers with histories of overpayments should have to purchase bonds to cover no less than the amount of recent overpayments.

Thompson insisted that, in spite of recent actions, HCFA's "goal is not in any way to initiate war with HHAs."

She claimed that HCFA Administrator **Nancy-Ann Min DeParle** "has said that she wants to monitor very closely what is happening as a result of the whole range of activities that we are doing for home health." ◊

Civil Rights

HCFA CIVIL RIGHTS LETTER RILES MINORITY GROUPS

Providers angry with the way they believe the **Health Care Financing Administration** has mistreated minority agencies and beneficiaries are meeting the administration's recently released civil rights compliance policy statement with indignation.

"I don't feel like HCFA has lived up to its

own statement," says **Phebe Blackmon-Smith**, president of the **National Minority Home Healthcare Network** in Indianapolis, IN. "Almost every minority provider all across the country is experiencing heavy reviews and negative audits," as well as incredibly low reimbursement rates under the interim payment system, Blackmon-Smith says.

In a statement signed by Administrator **Nancy-Ann Min DeParle**, sent out to home health providers in a **Blue Cross of California** provider bulletin, she insists that "compliance with civil rights laws [is] among my highest priorities."

HCFA will "continue to ensure that persons are not excluded from participation in or denied the benefits of its programs" due to discrimination based on race, color, national origin, age, sex, or disability, the letter continues.

This statement stands in stark contrast to allegations brought by many providers that under the interim payment system and surety bonds, small, minority-owned home health agencies are being pushed out of business as large, well-capitalized home health agencies take over their markets.

Also noted by providers is the fact that IPS gives agencies an incentive not to admit the sickest beneficiaries. These beneficiaries, they contend, make up the vast majority of the minority home health patient population.

"A lot of our patients would not receive services," contends Blackmon-Smith, who says this "trickle-down effect" constitutes discrimination.

Some providers also fear that the letter may be used later to retaliate against HHAs that are unable to provide services to those sickest beneficiaries due to low per-beneficiary caps.

While a HCFA spokesperson tell **Eli** that the letter "is just a routine statement of civil rights policy, to remind folks of their obligation," industry observers wonder if the administration is gearing up to snare HHAs by turning civil rights allegations back on them.

"The issue of home care services to the chronically ill is still a very open issue," notes Burtonsville, MD-based Attorney **Elizabeth Hogue**. "Although this statement looks pretty routine, we have learned to wonder about the connections of what HCFA is doing."

Hogue hopes that the resolution of a case pending against HCFA, *O'Neal v. Department of Health and Human Services*, will shed light on HHAs' responsibilities in caring for such patients, and therefore protect agencies against complaints that could be brought due to civil rights obligations.

Hogue also notes that the statement should serve to remind providers of their civil rights obligations as Medicare contractors. "Surveyors have certainly audited our providers on these discrimination issues," she cautions. ◊

Industry Notes

OASIS RULE UNOFFICIALLY DELAYED

According to the **National Association for Home Care**, the **Health Care Financing Administration** has confirmed that it will not publish the final rule on OASIS until August. HCFA is holding the regulation while it considers a provision to compensate agencies for costs related to OASIS implementation and reporting.

The final rules on the other new conditions of participation may not arrive until March, HCFA also confirmed to NAHC. Industry veterans say that HCFA has pulled most of the staffers it had working on the COPs onto the OASIS project.

• **Medicare could "quickly reduce Part B payment rates"** if it found it was paying more than other government programs or the private sector, under a new bill introduced by Sen. **Tom Harkin** (D-IA) and co-sponsored by Sen. **Ernest Hollings** (D-SC).

The Medicare Waste Tax Reduction Act of 1998 would allow Medicare to "pay no more than any other government program" for durable medical equipment. The bill would also reduce payments for drugs and biologicals to the lower of actual acquisition cost or 95 percent of wholesale cost.

The bill would double audits of claims and comprehensive audits of providers. It would expand the Senior Waste Patrol, encouraging beneficiaries to report apparent fraud. Finally, Medicare would work more with private payors to avoid paying claims that other insurers owe and to catch fraudsters who target both Medicare and private insurance.

• **The House Appropriations Committee included** a weak statement about the interim payment system in its appropriations bill for the **Department of Health and Human Services**. "The committee understands that many home health care providers are experiencing difficulties with the HCFA's implementation of the interim payment system," reads the report accompanying the bill.

"The committee expects HCFA to work cooperatively with affected providers to address concerns with issues such as implementation of the surety bond requirement and the need for maximum flexibility in the application of the new per-beneficiary limits," the report concludes. Industry observers, noting that Congress mandated the strict rules governing IPS, say the language is an attempt to dodge the legislature's responsibility for having approved the system. ◊

HEALTH INDUSTRY DISTRIBUTORS ASSOCIATION
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Statement of the
Health Industry Distributors Association

Before the
Ways and Means Subcommittee on Health

On
Payment Systems for Medicare's Home Health Benefit

August 6, 1998

Contact:
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On behalf of the Health Industry Distributors Association (HIDA), good morning and thank you for the opportunity to provide our views on the impacts of the home health agency (HHA) interim payment system (IPS) and prospective payment system (PPS) enacted by the Balanced Budget Act of 1997 (P.L. 105-32). HIDA is the national trade association of home care companies and medical products distribution firms. Created in 1902, HIDA represents more than 700 companies with approximately 2000 locations nationwide. HIDA Members provide value-added services to patients in their homes as well as virtually every hospital, physician office, and nursing home in the country.

HIDA's home medical equipment (HME) providers are an integral component of the home healthcare delivery chain. HME providers supply the equipment and related services that help consumers meet their therapeutic goals. Pursuant to the physician's prescription, HME providers deliver medical equipment to a consumer's home, set it up, maintain it, and educate and train the consumer and caregiver in its use. HME providers also interact with physicians and other home care providers (such as home health agencies and family caregivers) as the consumer improves and his/her needs evolve. Specialized home infusion providers manage complex intravenous services, including chemotherapy, in the home.

These providers and the beneficiaries that they serve are at a great risk for negative consequences resulting from HCFA's implementation of Balanced Budget Act (BBA). Issues such as competitive bidding for Medicare Part B non-physician services, adjustments to Part B payments through Medicare's 'inherent reasonableness' authority, the interim payment system for home health agencies, the definition of 'homebound' as a qualifier for home healthcare services, payment cuts and freezes for home medical equipment (HME), and a number of other BBA provisions threaten Medicare beneficiary's access to high quality home healthcare services. Today's testimony, however, will focus on just one issue, consolidated billing for home health agency services.

HHA Consolidated Billing

HHA consolidated billing is a little-noticed provision tucked inside the legislative language implementing the HHA prospective payment system. This BBA provision (Section 4603(c)(2)(B)) states:

> *In the case of home health services furnished to an individual who (at the time the item or service is furnished) is under the plan of care of a home health agency, payment shall be made to the agency (without regard to whether or not the item or service was furnished by the agency, by others under arrangement with them made by the agency, or when any other contracting or consulting agreement, or otherwise)."*

The rationale for this provision is unclear, and no public hearings or industry consultations have been conducted.

In effect, this provision would prohibit any HME provider from billing or receiving payment from Medicare for HME services if the beneficiary is under the plan of care of an HHA. As the Social Security Act's definition of home health services includes "durable medical equipment" and "supplies" (but not "surgical dressings"), the BBA provision appears to include most home medical equipment (HME) services. Therefore, once enacted, this provision would require

HHAs to provide and bill Medicare for the medical equipment and supplies used by the beneficiaries who are under their plan of care.

On its face, this HHA consolidated billing provision may appear innocuous. In fact, this provision ignores the inherent complexities of the home health market and the separate reimbursement systems established by Medicare for HHAs and HME providers. In addition, it creates an artificial and burdensome rift in the provision of HME services which threatens the continuity of health care for homebound Medicare beneficiaries. HIDA urges this Subcommittee to support the repeal of this provision for the following reasons:

Negative Impact on Quality Medical Services

Today's HME companies are highly specialized healthcare providers that offer important support services to their home care patients such as preventative maintenance, patient education, 24-hour on call service, the professional care of respiratory and nutritional therapists, and the furnishing of supplies. In contrast, the majority of HHAs are not involved in the provision of HME services beyond incidental supplies such as bandages and catheters. Under this consolidated billing provision, therefore, HHAs would be forced to either:

1) take on a wide array of new responsibilities and costs by entering into the Part B HME business, or;

2) take on new liabilities by entering into contracts with HME providers who are already serving the beneficiaries in their area (if the HHA decides not to directly provide HME).

It is unclear how either of these options would aid the provision of high quality health services or the administration of the Medicare Program.

Ignores Inherent Differences Between HME and HHA Benefits

The Medicare Part A HHA nursing benefit is, in practice, wholly separate from the HME benefit. HHAs specialize in providing skilled nursing, therapy, and assistance in activities of daily living services. The provision of home medical equipment is not required under the HHA conditions of participation, HHAs typically do not provide HME to beneficiaries, and the majority of HHAs do not have the systems or expertise need to submit claims to the Part B Durable Medical Equipment Regional Carriers (DMERCs). HHAs are typically not prepared to handle the complex Part B reimbursement system developed exclusively for medical equipment claims and do not hold the supplier number required to bill the DMERCs for these services.

Also, Medicare has wholly separate requirements that trigger coverage for HHA and HME services. In order to receive Medicare coverage for HHA services, a beneficiary must be homebound, under a physician's care, and require medically necessary skilled nursing or therapy services. In order to receive HME services, a beneficiary must have a prescription or doctor's order and, for certain services (e.g., home oxygen), must meet certain objective diagnostic guidelines (e.g., a certain level of oxygen saturation in the blood). Therefore, a beneficiary receiving Part B covered HME services often does not meet the qualifications needed to trigger the Part A benefit, and vice versa. By combining the responsibilities for the provision of nursing and equipment services, this provision contradicts the systems and standards of the Medicare

Program, and threatens to add a considerable administrative burden to the Health Care Financing Administration (HCFA).

Disrupts Continuum of Care

In addition, this provision will impose an unnecessary break in the continuum of patient care. For instance, an HME company providing medical equipment services to a Medicare beneficiary for a chronic condition (e.g., home oxygen therapy, dialysis equipment, entail nutrition services, etc.) would be forced to stop providing those services if the beneficiary were to experience an acute episode that required the nursing services of a HHA. The HME provider would not necessarily be notified of the fact that the beneficiary has entered into the plan of care of a HHA, and the agency may not necessarily be aware that it is taking on the responsibility for these long-standing HME services. Once the acute episode is resolved, the HHA would stop providing services, and the beneficiary would once again have to find a HME provider to meet their chronic healthcare needs. This situation would cause an administrative burden for the HME provider, the HHA and the Medicare Program. Most importantly, the beneficiary could also be negatively impacted by these abrupt and repeated changes in providers.

Not Needed for PPS

In addition, this change to the home health benefit is not needed to implement the prospective payment system for HHAs. The PPS system currently under development at HCFA applies only to the HHA nursing (Part A) benefit. Beneficiaries who are paying their Part B premiums will remain eligible for Part B covered services, including HME services. Regardless of the HHA payment system, this Part B benefit will continue to cover medical equipment and supplies as it has in the past.

Conclusion

The home health agency consolidated billing provision included in the BBA should be repealed. This provision ignores the separate coverage and reimbursement criteria developed by the Medicare Program for HHAs and HME providers. If this provision is enacted, HHAs will be forced into either: (1) providing and billing for highly complex health care services that they have no experience with, or (2) taking on substantial liabilities by entering into financial arrangements with the HME providers in their service area. Neither of these options will promote access to high quality home healthcare services. In fact, HHA consolidated billing will likely create an unnatural break in the provision of healthcare services by shifting Medicare payments back and forth between HME companies and HHAs. As this provision is not needed to implement the prospective payment system for HHAs, and is expected to cause problems for beneficiaries, healthcare providers and the Medicare Program, HIDA urges this Subcommittee to repeal home health agency consolidated billing.

HOME CARE ASSOCIATION OF NEW YORK STATE, INC.
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A voluntary association to foster and strengthen home health and related support services.

AUG 21 1998

Written Statement of the Home Care Association of New York State, Inc.
Prepared for the

Subcommittee on Health
of the
House Ways and Means Committee

Hearing on Payment Systems for Medicare's Home Health Benefit

August 6, 1998

The Home Care Association of New York State, Inc. (HCA) is a statewide association representing 300 providers of home care services that advocates for home care and community-based services. HCA thanks Chairman Thomas for the opportunity to submit testimony on the current payment system for the Medicare home health benefit. We appreciate the serious interest in addressing the problems that have been created by the Interim Payment System and urge immediate action on a solution to the many problems raised in previous testimony and in this written statement.

Fixing the Interim Payment System

Congress today is dealing with the unintended consequences of the Interim Payment System (IPS), a payment method that rewards inefficient providers and penalizes those whose expenses and utilization were low in the base year of federal fiscal year 1994, which for almost all New York providers is calendar year 1993. There are several aspects of the payment provisions of the Balanced Budget Act of 1997 (BBA) that must be addressed in order to assure a reasonable transition to a Prospective Payment System (PPS). They are:

- **The per beneficiary limit** – the use of agency-specific data coupled with a base year that is too far removed from the needs of today's patients should be modified. HCA has always recommended using a national component for the blend, preferably at a blend of 75% national, 25% state or regional;

- **The per visit cost limits** – the reductions to the cost limits have also exacerbated the negative consequences of the IPS. HCA recommends raising the cost limits to 110% of the mean;
- **The 15% cut of October 1, 1999** – Providers able to sustain the initial cuts will certainly be compromised by the additional 15% cut scheduled for cost reporting periods beginning on or after October 1, 1999. Had providers been able to expect prospective payment with appropriate reimbursement for severity, the 15% reduction might have been somewhat mitigated; however, the inability of the Health Care Financing Administration (HCFA) to implement PPS requires that the cut be repealed.

Copayments

The Home Care Association opposes the imposition of beneficiary copayments for a variety of reasons:

- They fall disproportionately on the sick and frail low-income seniors;
- They are an added administrative cost to the system;
- They are difficult and often impossible to collect; and
- They would create a new tracking burden for the provider in the context of the split of home health service payment between Part A and Part B of Medicare.

Outlier Payment Policy

A number of outlier payment policies have been proposed. Unfortunately, many would create a payment for providers, rather than patients, who are outliers. Without a case mix adjuster, there is no adequate way from a health policy standpoint to examine the variation in utilization and length of stay. Therefore, HCA recommends the following approaches to the problem:

- Payment could be made for each unduplicated patient whose visits exceed a certain threshold over a specified period of time;
- A specified payment could be made for each unduplicated patient whose costs exceed a certain percentage of the per beneficiary cap; or
- A fixed monthly rate for specific diagnoses or patients with disease(s) that exacerbates the healing process (e.g., wound care, brittle diabetics, multiple sclerosis, COPD).

In all of these instances, payment amounts would be determined by the "pool" of monies set aside for outliers. That pool should probably be limited to no more than 5% of the total Medicare expenditures for home health care.

Regardless of the approach taken, it is important to recognize that true outlier policy should reflect **both** the acuity of the patient and the costs associated with care, which for chronic patients may require a longer length of stay.

Outcomes Assessment and Information Set (OASIS)

New York State has 24 home health providers participating in Phase I of the New York demonstration of the Outcomes Assessment and Information Set (OASIS), known as the Outcome-based Quality Improvement Demonstration (OBQI), and 3 more certified home health agencies that are participating in the national OASIS demonstration. An additional 45 providers in New York have recently been selected to participate in Phase II of the New York demonstration which will also test personal care indicators. HCA strongly recommends that a modification to the Interim Payment System include recognition for the costs associated with the ongoing activity of quantitative measurement of outcomes. The costs borne by providers are in no way captured in the FFY '94 base since OASIS will not be implemented until FY '99 at the earliest. HCA believes that continuing this effort will re-enforce and enhance the clinical competence of services in home health which serves the Medicare program overall.

The OASIS effort should be continued and provider costs should be recognized in a manner that will ensure the ongoing collection and transmission of outcomes data. One specific factor related to the success of the effort will be the ability of HCFA to give reports back to providers once they have the data. No outcome measurement activity can be sustained over time if health care professionals fail to receive feedback from their activities.

In addition, in order to further research and improvement on a concurrent basis, the severity adjuster used in the OASIS system should be placed in the public domain, especially since it was financed through public dollars under contract from HCFA.

Other Recommendations

Additionally, HCA recommends the modification of two other provisions of the BBA related to home care:

- The proration of payment among providers should only occur when there is a demonstrated attempt to game the system; and,
- The Periodic Interim Payment (PIP) system should be retained until after PPS is put in place.

Additional Concerns

In addition, Congress should ensure that providers are able to access PIP under reasonable criteria. Today this is not the case as FIs closed off access. Sequential billing coupled with increased audit activity (PPS audits, joint audits, compliance audits, focused medical review) has created severe cash flow problems that must be addressed if access to services is to be maintained.

Conclusion

Even with changes to the Interim Payment System, HCA thinks it is important that Congress recognize that there will continue to be problems in the system, largely due to the consequences of the A/B shift and policies developed for the purposes of halting fraud and abuse.

HCA believes that an expedited implementation of a prospective payment system, along with the measurement of outcomes, and compliance plans, are the best antidotes to fraud and abuse. Once the Interim Payment System is addressed and the other policies are implemented, great strides will have been made to ensure that those providing home health services meet appropriate standards and will continue to provide quality, cost-effective services to the most vulnerable of our frail and elderly population.

HCA thanks you for the opportunity to present our views on the Interim Payment System and looks forward to continuing its work with the Subcommittee on Health.

"The mission of the Coalition is to enhance consumer access to quality home care services, supplies, and equipment. The Coalition focuses on education and communications advocating the benefits of home care to policy makers and the public. The Coalition is a diverse group of organizations representing consumers/patients, family caregivers, health care professionals, providers, and manufacturers dedicated to serving people in their homes."

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Statement for the Record

Submitted by

Home Care Coalition

To the

Ways and Means Subcommittee on Health

On

Payment Systems for Medicare's Home Health Benefit

August 6, 1998

Contact:
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On behalf of the Home Care Coalition, thank you for the opportunity to provide comments on payment systems for the Medicare home health benefit. The Home Care Coalition was founded in 1991 to unite the efforts of home care providers, family caregivers, health care professionals, manufacturers, consumers, and consumer advocacy organizations. The Coalition has become a major voice in support of home health care, which is often patient-preferred and more cost-effective than institutional care. As the only national organization representing providers, consumers and manufacturers of home health services, we urge you to act quickly to address the crisis created by the interim payment system (IPS) for home health agencies (HHAs).

We understand that the Subcommittee included the IPS in the Balanced Budget Act of 1997 (P.L. 105-33) to address concerns regarding the rate of the growth of the Medicare Part A home health agency benefit, and to ease the transition into a full prospective payment system (PPS) for HHAs. Unfortunately, the IPS enacted by HCFA on October 1, 1997 is antithetical to these goals and threatens access to home care services by pushing a number of HHAs out of business, and depriving many of the most medically complex patients access to home health services.

Understanding the Home Health 'Explosion'

It is important to recognize that the increase in the use of the home health benefit is a natural result of advances in medical technologies and changes in Medicare's payment structure. As in every other aspect of modern medicine, home health care has benefited from an explosion of new and emerging technologies. 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 faction of the cost. Today, it is common for a Medicare beneficiary to undergo chemotherapy in the comfort of his or her own home, a fete 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.

Recent changes to Medicare's payment system have also spurred a growth in home health utilization. In the late 1980's, HCFA's rigid definition of the coverage criteria for home health services was struck down by a United States District court, making it possible for more beneficiaries to have access to home health services. At roughly the same time, Medicare instituted a prospective payment system for hospital inpatient care in which reimbursed hospitals according to the patient's diagnosis regardless of the number of days spent in the institution.

Together, these changes have resulted in a situation where more Medicare-eligible beneficiaries are arriving home "quicker and sicker" than ever before. In turn, these beneficiaries require more and more complex health services than ever before. All indicators show that as the 'baby-boomers' continue to age, this trend will continue. The Coalition understands that the increased utilization of home health care prompted by these changes should not necessarily be seen as a problem, but as a rational response to the changing needs of Medicare beneficiaries and the increased ability of home health providers to meet these needs.

Closer to PPS?

At the same time, the Coalition is sensitive to concerns that the cost-based reimbursement system for HHAs does not encourage the most efficient delivery of needed services. For this reason, the Home

Care Coalition also supports a quick enactment of a prospective payment system (PPS) for home health care that assures the appropriate provision of services, and equitably and predictably pays for services while minimizing administrative burdens of providers. Congress should ensure that the PPS avoids payment anomalies that make any class of patients undesirable to treat from an economic standpoint.

As a number of the national associations representing HHAs have testified, the IPS system actually penalizes the most cost-efficient HHAs and makes it impossible for providers to meet the needs of the sickest Medicare beneficiaries. In addition, a number of studies have concluded that the IPS system is actually an impediment to the development of the PPS for HHAs.[1]

Access

In addition, IPS is driving established efficient home health agencies out of business. Due to the vagaries of the IPS, the HHAs that have a history of efficient operations and treating medically complex patients have been hardest hit. It is estimated that at least 1,200 HHAs have already closed their doors due to the IPS. HCFA's office of the actuary estimates that home health expenditures in 1998 will be 2% lower than expenditures in 1997. Clearly, if the IPS is allowed to remain in place and the 15% payment reduction scheduled for October 1999 goes into effect, Congress will be confronted with a serious access problem.

Copayments

The Home Care Coalition is also concerned about recent indications that the Subcommittee is considering imposing a $5 to $8 copayment on home health visits. The Coalition has long opposed such copayments because:

- While individuals over age 75 account for about one-third of the total Medicare population, they account for two-thirds of all home health beneficiaries. Medicare beneficiaries who use home health services tend to be in poorer health than other Medicare beneficiaries. Two-thirds are women and one-third live alone. Forty-three percent have incomes under $10,000 per year.
- The elderly are already health-care poor without this new expense. Seniors spend nearly twice as much of their income on their health care now than before Medicare began (10.6% in 1961 as compared to 18% in 1994). Most home health patients on the average will have paid $1,900 or more in the preceding 12 months for Medicare premiums, deductibles, and copayment even before the first home health copay comes due.
- For disabled Medicare beneficiaries, out-of-pocket spending for home care can be an extremely heavy burden, as Medicare does not cover all their needs and many must purchase additional home care services. In fact, elderly home care patients pay more than one-third of their home care expenses out-of-pocket.
- Home care recipients have fewer financial resources than the general Medicare population. Nearly three-fourths of the poor elderly do not own Medigap to help cover the costs of copayments.

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[1] *Medicare Home Health Services: An Analysis of the Balanced Budget Act of 1997 for Access and Quality*, The Center for Health Policy Research, the George Washington University (March 1998).
The Balanced Budget Act of 1997: Effect on Medicare's Home Health Benefit and Beneficiaries Who Need Long-term Care, the Georgetown University Institute for Health Care and policy on behalf of the Commonwealth Fund (February, 1998).
Implications for the Medicare Home Health Interim Payment System of the Balanced Budget Act, The Lewin Group (March 1998).

- A $5 copament could cause Medicaid outlays to increase by nearly $2 billion over five years. Nearly 25% of all Medicare home care patients are dually eligible for both Medicare and Medicaid.
- A copament would create strong barriers for those in need of home care. Home health was exempted from the Part B coinsurance in 1972 to encourage use of less costly, noninstitutional services. Reimposing a coinsurance would dramatically undermine that effort.
- Home health copayments are inefficient. The collection of copayment amounts would create additional paperwork burdens and billing and tracking programs, increasing administrative costs.
- The Office of Technology Assessment (OTA) found that making patients responsible for copayments would keep them from seeking necessary care.

Conclusion

The IPS fails to meet the goals stated by Congress, imposes an undue hardship on efficient HHAs and HHAs that serve medically complex patients, and threatens to create serious access problems for Medicare beneficiaries. We are aware that the Subcommittee, HCFA, and others have been investigating adjustments to the IPS system. We urge you to make IPS reform a top priority and to implement these reforms this year. The Coalition also urges the Subcommittee to assure that this reform ensures access to home health services for the medically complex and long term home health patients. We sincerely hope that this reform measure will not to include a copayment for home health visits.

Thank you for the opportunity to provide our comments on Medicare's payment system for home health services. We look forward to working with the Subcommittee to solve the difficult issues facing this important benefit.

HOME HEALTH
CARE ASSOCIATION
OF MASSACHUSETTS, INC.

August 6, 1998

The Honorable William Thomas, Chair
Health Care Subcommittee, House Ways & Means
1100 Longworth House Office Building
Washington, DC 20515

Dear Chairman Thomas:

On behalf of the 150 Medicare/Medicaid certified agency members of the Home & Health Care Association of Massachusetts and the 125,000 elders and disabled citizens they cared for last year, I want to thank you for acknowledging the disastrous consequences of the Medicare Interim Payment System and for convening this hearing.

The Home & Health Care Association of Massachusetts has always supported efforts to reduce the inappropriate use of the Medicare home health benefit. We believe, however, these efforts must be targeted. As it is currently being implemented, the Interim Payment System penalizes agencies that have a history of providing cost-efficient services. Massachusetts has a long history of efficient community based service provision, much like its New England neighbors (see January 7, and February 11, 1998, *Wall Street Journal* articles). We estimate that the reductions in Medicare reimbursements to the state will be $111 million in 1998 alone. This equates to 1.8 million visits to patients. In what was a $750 million industry in Massachusetts, the economic impact is already being felt -- five home health agencies have announced that they are closing their doors, and over 800 employees have lost their jobs. The fact is that an aggregate payment cap based on cost and utilization data from five years ago is inadequate, given the increased numbers of medically complex, nursing home at-risk patients we now service and the increased administrative expenses imposed by the federal government on the industry.

IPS was drafted by Congress based on a perception that there is significant overutilization of the home health benefit. For the Commonwealth of Massachusetts, that is just not true. A 1997 federal Operation Restore Trust (ORT) audit of 10,000 visits in Massachusetts found *less than one percent* in which technical coverage requirements were not met, and *no instances of fraud or abuse*.. If IPS was truly designed only to cut out fraud and waste from the home health system, agencies in Massachusetts should have suffered only minor cuts. Instead, we are faced with a total payment cut of 15% or more this year alone. Agencies that last year passed ORT surveys with flying colors are this year scrambling to cut costs and services by as much as thirty and forty percent. The interim payment system and its per patient 'cap' force agencies to make an impossible choice: either reduce services that are clearly necessary, or provide services in excess of the cap and go bankrupt.

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A study by the George Washington University Center for Health Policy Research has found that IPS "fails both the tests of rewarding efficiency and assuring appropriate access to all." The consequences of such failure, according to the authors, are "potentially significant." We fear that the huge cuts in home health services required by IPS may save Medicare money in the short term, but will cost much more in the long term in re-hospitalizations and nursing home admissions. The real victims of IPS are those elders with complex care needs who will no longer be able to access the home health services they desperately need.

Congressman McGovern and the entire Massachusetts Delegation recognized early on the inequities of the Act, as well as the problems with its interpretation and implementation by HCFA. Thanks to their advocacy on our behalf, legislation was filed to mitigate the negative impact of IPS, and we have had numerous written and face to face communications with HCFA convened by Congressman McGovern. In fact, in early June, we had the opportunity to present our recommendations for administrative relief -- that HCFA could act on now -- to White House Policy Advisor Chris Jennings. To date, we have yet to see any movement by HCFA on any recommendation from either the industry or from Congress.

Congressman McGovern, along with a number of House colleagues, recently filed legislation that reflects many months of dialogue with and research of the home health industry. While we support the legislation, we believe that several additional measures must be implemented to alleviate further financial devastation on the industry until a reasonable PPS can be implemented.

As you know, the seriously flawed Interim Payment System has reduced Medicare home health payments far more than required by the BBA targets. In its notice establishing the IPS rates, HCFA stated that it expected to reduce Medicare home health expenditures by $1.4 billion during FY1998. In fact, HCFA's latest projections show that Medicare home health outlays will be reduced by *$3.8 billion* this year, and more than double the $16 billion BBA target between 1998 and 2002. The Home & Health Care Association urges you to restore funding to the original BBA targets in any IPS legislative remedy the Committee drafts. We recommend:

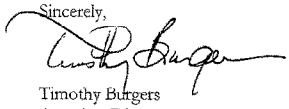
- Any revision to the formula for setting per-beneficiary caps must include the following two provisos:
    - Eliminate the application of the two-year freeze on inflation adjustments, allowing the formulas to be updated using the home health market basket index for all years (1994 through 1998, going forward until full PPS is implemented);
    - Use as the base for calculating the formula the 1995 HCFA published data (1997 statistical supplement) trended forward;
- Eliminate the additional 15% reduction scheduled to take place if PPS is not in place October 1, 1999 (We believe it is unfair to punish home health providers for HCFA's failure to implement PPS on schedule.);

- Extend the Prospective Payment Demonstration Project until full PPS is implemented (91 agencies nationwide -- including ten Massachusetts agencies -- are participating in the HCFA study);

- Extend Periodic Interim Payment (PIP) for one full year after PPS is in effect (agencies in the PPS Demonstration have encountered severe cash flow problems during the transition to PPS).

On behalf of the members of the Home & Health Care Association of Massachusetts, I thank you and the members of the committee for your serious consideration of these issues. If you desire additional information, do not hesitate to contact me directly.

Sincerely,



Timothy Burgers
Associate Director

Enclosures

cc: Massachusetts Congressional Delegation

HOME HEALTH
CARE ASSOCIATION
OF MASSACHUSETTS, INC.

Addendum to Health Care Subcommittee Letter

Percentage of New England agencies with costs above the published caps: *(Source: HCFA Final Rule, 03/31/98)*	84.5%
Cost per home health visit in Massachusetts in 1995: *(Source: HCFA Statistical Supplement, 1996)*	$50
Rank of Massachusetts in terms of home health cost per visit: *(Source: HCFA Statistical Supplement, 1996)*	5th lowest of 50 states
Percent of home health agencies classified as VNA's in Massachusetts:	65%
Percent of HHA classified as VNA's nationally:	25%
Estimated reduction in Medicare home health reimbursements in Massachusetts from 1997 to 1998 because of IPS: *(Source: Massachusetts Division of Health Care Finance & Policy)*	$111 Million
Number of visits which $111 Million reduction equals to:	1.8 Million

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

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HOME HEALTH SERVICES & STAFFING ASSOCIATION

Commemorating 20 Years of Leadership, Integrity and Vision

Subcommittee on Health
House Committee on Ways and Means

August 6, 1998 -- 10:00 am
1100 Longworth House Office Building

The Home Health Services and Staffing Association (HHSSA) is a national trade association with over 2,000 offices throughout the country in 48 states. HHSSA appreciates this opportunity to comment on provisions enacted in the Balanced Budget Act of 1997 (BBA 97). In particular, HHSSA believes that any legislative change to the Medicare interim payment system (IPS) should place the interests of Medicare beneficiaries first and restore access to the home health benefit for the sickest and frailest beneficiaries.

As documented in three reputable public policy studies,* the Medicare interim payment system has had a devastating impact on home health patients and providers. The Center for Health Policy Research of George Washington University concluded its study with the following findings:

- the home care population represents an increasingly sicker population requiring more acute management of chronic illness and higher intensity acute care;
- the BBA's reductions in Medicare home health coverage and financing have affected the sickest and highest cost patients and punish the very agencies that specialize in the provision of care to this population;
- the most severe effects of the interim payment system fall on the sickest patients living in states with the lowest historical utilization patterns;
- the BBA's interim payment system shifts costs to other payers (notably Medicaid) while rewarding inefficient agencies who care for relatively healthier patients; and
- the interim payment system makes it more difficult to design and implement the permanent prospective payment system scheduled to become effective in FY 2000.

According to the George Washington University study, "by creating strong disincentives for agencies to provide Medicare services to chronically ill beneficiaries, this payment system essentially severs a large portion of chronic illness care from the program, using providers as the severing mechanism." Under the interim payment system, the sickest Medicare patients no longer have access to the home health benefit. However, BBA 97 did not change or restrict Medicare coverage for the medically-complex patients.

HHSSA believes it is critical that any legislative relief, passed by Congress this year, restore payment for the medically-complex patients. The legislative proposal should include some form of supplemental payment or funding which ensures access for all long-stay patients -- and not only a small percentage. One of the recommendations from the George Washington University study would be to place a moratorium on the current interim payment system to ensure access for the long-stay patients. HHSSA supports a moratorium as one way to achieve that goal.

*Medicare Home Health Services: An Analysis of the Implications of the Balanced Budget Act of 1997 for Access and Quality, The Center for Health Policy Research, The George Washington University (March 1998)
The Balanced Budget Act of 1997:Effect on Medicare's Home Health Benefit and Beneficiaries Who Need Long-term Care, The Georgetown University Institute for Health Care Research and Policy on behalf of The Commonwealth Fund (February 1998)
Implications of the Medicare Home Health Interim Payment System of the Balanced Budget Act, The Lewin Group (March 1998)

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The BBA '97 imposes an additional 15% reduction in home health reimbursement by October, 1999. To date, over 1,015 home health agencies have returned their Medicare provider numbers to HCFA. The Congressional Budget Office (CBO) originally projected that the home health growth rate would be 13.7% in 1997. CBO recently provided new calculations which show the rate of growth to be 4.8% -- much lower than originally predicted. HCFA's Office of the Actuary estimates that home health expenditures for FY'97 were $17.6 billion and that expenditures in FY'98 will be $17.3 billion -- a growth rate of -2%. Due to the large savings recouped by HCFA and the number of home health agencies who no longer care for Medicare beneficiaries, there no longer seems to be a need for additional savings from the home health program. Therefore, HHSSA strongly supports an elimination of the 15% cut effective in October, 1999.

HHSSA strongly opposes any implementation of a copayment for home health services. In the past, there has been Congressional support for copayments as a way to decrease utilization of home health services. However, with the per beneficiary limit, there has been a decrease in the utilization rate for home health services. The per beneficiary limit has also negatively impacted the ability for home health services to care for the sickest Medicare beneficiaries. A new copayment requirement would exacerbate the current problems surrounding the interim payment system. The sickest Medicare beneficiaries would be further impacted by a copayment -- many of whom are below poverty level but require medical services. Once again, the sickest Medicare beneficiaries would be the patient population bearing the largest portion of this burden, and are the patients least capable of sustaining such a burden.

HHSSA also opposes a Medicare copayment for the following reasons: a further increase in the administrative costs of providing home health services while not improving the benefit; penalize the most cost-effective providers the most severely; deprive the poor, elderly, and disabled of access to health care services which have been determined by their physician to be medically necessary; shift costs to the patient, private insurer, or Medicaid programs; and create an incentive for patients to remain in the hospital because there is no Medicare copayment for the first 60 days of inpatient hospital care.

HHSSA supports a change from the 75% agency-specific component of the beneficiary limit to a 50/50 national/regional blend. This change would take a step towards ridding the industry of some of the competitive disparities between home health providers. However, to enact legislation which only addresses the change in percentages of the beneficiary limit would not be sufficient -- and in some cases may be worse than the current interim payment system. While there is no substantial data to explain patient-mix of particular home health agencies, there is some evidence to imply that southern areas of the country care for patients with overall lower health status, such as malnutrition. Likewise, these same states seem to be lacking strong state programs which would support care for certain home health patients. Therefore, any legislative proposal should be cautious to not drastically change the percentages for home health providers who are caring for the more medically complex patients.

As HCFA is facing the Y2K problems, home health agencies also need relief from the implementation of the OASIS project. The OASIS project is expected to begin in October of this year. The new outcomes measurement tool has not been formally announced by HCFA and home health agencies will have little lead time to prepare their computer systems as well as the staff to comply with the formidable new regulations. As the interim payment system has negatively impacted home health agencies financially, there is little room within the current budgets to prepare, train and comply with the requirements which have not yet been formally announced. Therefore, HHSSA would request that Congress provide a one-year delay in implementation of the OASIS project. This time will permit for clarification and training by HCFA to home health agencies, and the opportunity for home health agencies to prepare internally for the new requirement.

HHSSA supports the legislative proposals that would increase the current per-visit cost limit. Although the majority of HHSSA members have been well-below the cost limits, a combination of the reduction in the cost limit and the new beneficiary limit has made an increase in the cost limit a necessity for the home health industry. HHSSA supports an increase in the cost limits to 112% of the mean.

HHSSA also supports the continuation of the periodic interim payments (PIP). Studies have shown that the majority of home health services are provided to a home health patient within the first sixty days of care. Since these services are provided at the beginning, home health agencies experience a "cash flow" problem. Even when home health agencies move to a prospective payment system, there will still be a need for PIP to continue since the payments will not be paid prospectively.

HHSSA would urge that Congress eliminate the proration requirement of the beneficiary limit. A proration requirement might be necessary for home health agencies under common ownership or control. However, proration between home health agencies will be feasibly impossible for both HCFA and the home health agencies to implement.

In conclusion, HHSSA supports the following points:

- A supplemental payment for the long-stay patients;
- Elimination of the 15% cut effective on October, 1999;
- A new blend of the beneficiary limit at 50/50 national/regional;
- An increase in cost limit to 112% of the mean;
- A delay in implementation of OASIS which is scheduled to begin October, 1998;
- Continuation of PIP through PPS implementation; and,
- Elimination of proration between home health agencies except where there is common ownership or control.

The above changes would be instrumental in adequately changing the interim payment system for home health services. For the past several years, HHSSA has strongly supported the move to a prospective payment system. The changes above would be beneficial for a short-term reimbursement system. However, it is critical for the home health reimbursement system to be moved to a prospective payment system as soon as possible.

The association would be pleased to work with Members of Congress, the Administration and consumers to develop a legislative proposal that would be supported by all. However, HHSSA believes that any legislative proposal which is enacted this year must place the interests of Medicare beneficiaries first, and assure access to the Medicare home health benefit.

New York State Association of
Health Care Providers, Inc.
Representing home care and related services since 1974.

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Phyllis A. Wang, *President*

FOR THE RECORD

Hearing Testimony
prepared for the
Subcommittee on Health
House Committee on Ways and Means
Medicare Home Health Benefit Payment System August 6, 1998
1100 Longworth House Office Building

The New York State Association of Health Care Providers, Inc. (HCP) represents approximately 600 offices of licensed and certified home care providers across the State of New York. The Board of Directors of HCP thanks the Committee for the opportunity to provide testimony on this crucial topic for the industry.

Implementation of the Balanced Budget Act of 1997 (BBA) has precipitated serious consequences for Medicare beneficiaries and the home health care industry. Home health providers are concerned that the sickest, long-term medically complex and highest-cost patients will suffer as a result of several BBA provisions. Agencies and patients alike will feel the impact of the BBA's interim payment system, which punishes the most cost effective and efficient home health agencies and limits patient access to needed services.

The BBA subjects home health providers to arbitrarily low cost limits, a new and drastically low per beneficiary cap, further limitations on payments for patients receiving services from more than one agency in a calendar year, and the possibility of another automatic 15% cut in reimbursement in 1999. The potentially disastrous effect of these provisions was detailed earlier this year in three independent studies conducted by the Commonwealth Fund, George Washington University and the Lewin Group.

Already more than one thousand home health agencies across the country have closed their doors. New York State has seen significant agency retrenchment, with agencies laying off staff and limiting services to only those patients they can afford to admit. In addition, providers are reporting that their cash reserves are dangerously low, which can be attributed to three factors: the changes in reimbursement mandated by the BBA; the withholding of payments under focused medical reviews; and faulty claims processing resulting from the government fiscal intermediary's inability to program software to accommodate the BBA shift of some home health care from Medicare Part A to Part B.

As an industry representative, HCP appreciates Congress' recognition of the need to institute changes to the BBA to avoid a general collapse of the home care system. We are aware that legislation has been introduced recommending a number of changes to improve the current situation. HCP has carefully reviewed these proposals and would like to recommend specific changes we believe should be included in any legislation aimed at preserving the home care system.

First, coverage must be assured for the long-stay, medically complex patient. This assurance can only be provided through the creation of an adequate supplemental funding mechanism for these patients. Such a payment system could be developed by calculating limits for short stay and long stay patient categories separately, with a prior approval mechanism, if appropriate. A solution that provides only an incidental increase for a specific class of agency based on size or other criteria will not accomplish the objective of assuring coverage for the high cost, medically complex patient. **HCP strongly recommends a supplemental financing mechanism for management of long-stay, medically complex patients.**

Second, the per beneficiary limit must be calculated so as not to catastrophically disadvantage providers in states with historically low utilization. Suggested modifications include altering the mix from an agency specific/regional blend to a national/regional blend that could be 75% national/25% regional or 50% national/50% regional. Any combination that includes an agency specific component will create grossly unfair competitive advantages and disadvantages. Institutionalizing arbitrarily high or low agency limits will, in some cases, accelerate agency closures. **HCP therefore strongly recommends a 50/50 or 75/25 national/regional blend.** This would ameliorate the present competitive disparity which favors the historically less efficient over the more efficient.

Third, providers should not be required to "share" limits where patients receive services from more than one agency in a year. The BBA payment system's proration of limits for patients receiving services from multiple agencies impairs agencies' financial viability. Providers that admit a patient should be able to expect full cost reimbursement for services provided, up to approved limits. Patients will suffer if providers must consider whether to deliver service because they previously received services from other agencies. Because there is no adequate global system in place to track patients, an agency could begin to treat a patient who, unbeknownst to it, had earlier been treated by another agency. After providing services, the agency's reimbursement could later be reduced because it must "share" a limit with another agency. **HCP therefore recommends that the proration be eliminated in favor of another more appropriate control, if deemed necessary.**

Fourth, the automatic 15% cut in reimbursement in 1999 should be eliminated to ensure that an adequate supply of providers is available to meet the needs of Medicare patients. Simply put, the home health industry is in turmoil. The industry has already absorbed substantial and severe cuts. This is most clearly demonstrated by the savings already projected by HCFA to date, which are far greater than anticipated for a twelve month period, with only a few months of the year's experience tracked. HCFA's calculated savings projections made such deep cuts to reimbursement in anticipation of a high gaming factor. Now that the cuts are being

implemented, however, it is clear that the Congressional Budget Office's (CBO) high gaming assumptions were invalid. **HCP recommends that the 15% cut be eliminated in favor of a fail safe mechanism that could be used if designated savings are not achieved.**

Fifth, cost limits have been reduced by an average of 20 percent for New York home care providers. This, coupled with per beneficiary caps, further reduces reimbursement. **HCP recommends that cost limits be increased to at least 108% of the median.**

Sixth, the BBA eliminates the periodic interim payment (PIP) system in 1999. This will cause significant additional cash flow problems for home health agencies. **HCP recommends that PIP be extended until there is at least a full year's experience under a fully implemented prospective payment system (PPS).**

Finally, the Conditions of Participation (COP) requiring OASIS data collection, slated for release in August, will impose additional new costs on agencies in both dollars and human resources. The COP release, together with the BBA's catastrophic cuts in reimbursement, form a one-two punch that could knock additional organizations out of the industry. While it is anticipated that the OASIS will be part of the PPS requirements, PPS implementation is still several years away. The industry should be given an opportunity to regroup and focus on current management and survival issues, rather than being forced to undertake additional costs and changes during this crucial time. Therefore, **HCP recommends a delay in implementing the OASIS COP requirements.**

While co-pays were not included in the BBA, there is continuing discussion that they should be part of any home care revision package. HCP strongly believes that copayments are poor public policy for home care. They increase the administrative costs of providing home health services and penalize the most cost-effective providers. Co-pays will disadvantage those in greatest need: the medically complex, the poor and the disabled. They also shift costs to the patient, the provider, the Medicaid program and other insurers. Finally, home care copays would create a financial incentive for patients to remain in the hospital, where there is no copay for the first 60 days of care. **HCP recommends that copays not be added to the burdens already imposed on beneficiaries and providers.**

HCP has been working with state and national groups for at least six years to advance the agenda of reimbursement reform. The discussion and recommendations included here do not address the true objective, which is to see the industry move to a prospective payment system. The unfortunate circumstances that resulted in the interim changes to home care reimbursement have served to further delay what both Congress and the industry have worked toward since the 1980s -- the elimination of cost based reimbursement and the introduction of a fair and equitable prospective payment system.

HCP respectfully requests that the Subcommittee consider the suggestions set forth in this testimony in the course of developing legislation. We would be pleased to provide any assistance requested in meeting the twin goals of resolving the current crisis and developing a workable PPS for home care.

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August 4, 1998

Committee on Ways and Means
Subcommittee on Health
U.S. House of Representatives
1102 Longworth Building
Washington, D.C. 20515

RE: Testimony for Medicare's Home Health Benefit
Thursday, August 6, 1998

Dear Health Committee Members:

In lieu of my presence at the hearing on Medicare's Home Health Benefit, I respectfully submit the following testimony for inclusion in the Congressional Record. This written testimony is being submitted on behalf of my agency, PHC Home Health, our patients, and our employees.

As a physician and agency owner, I am acutely aware of the benefits of home health services. **Studies have proven that a multi-disciplinary approach to patient care including skilled nursing, physical therapy and other services helps to prevent future hospital admissions, and at the same time reduces medical costs.** Unfortunately, the availability of such care is being diminished as a result of legislation passed in the Balanced Budget Act of 1997. The Health Care Financing Administration (HCFA) alleged that the home health industry was inundated with fraud and abuse. **Despite facts to the contrary, HCFA persisted in it's reliance on this faulty information to impose punitive measures on home health agencies**. As a result, legislation was passed to implement an Interim Payment System (IPS) intended to curb over-utilization. Ironically, this formula often works to punish efficient agencies while rewarding inefficient ones.

The IPS is so devastating that many agencies have already closed. My agency will bear the same fate if IPS is not overturned. The following statistics apply to my agency and the state of South Carolina. Other agencies across the nation can show similar results.

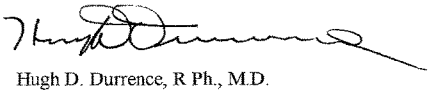
- Reimbursement for services is, on average, $14.28 less per visit than the wage alone paid to the nurse or therapist. Therefore, our agency will absorb this difference and all other expenses associated with patient care.
- In excess of 26% of our staff has been eliminated. Seventeen (17) full time employees have been dismissed. All contract workers have been dismissed.

- Our agency typically cares for patients with a primary diagnosis of congestive heart failure and stroke. Currently, 45% of our patients suffer from these diagnoses which are complex, long term illnesses. Due to their significant level of care, this group stands to suffer the most under IPS.
- 62% of our patients are between the ages of 66-85. As such, they are extremely vulnerable and are at great risk to exacerbate without home health, requiring hospitalization.
- In excess of 77,000 South Carolina residents are in need of and receive home health benefits annually.
- South Carolina registered nurses employed in the field of home health are in excess of 2,300 in number. Licensed practical nurses are in excess of 250. No specific count is available for all other disciplines, however, these numbers are well into the thousands. All these employees are at risk of losing their jobs.
- The state's Medicaid program will be terribly over-utilized because the patients will require nursing home care when home health is not available.

These statistics represent the repercussions of IPS now. The long term effects will be insurmountable. With our nation's aging population, if IPS is not overturned or significantly altered, our nation will face a crippling health care crisis. An immediate solution to resolve IPS is imperative. My agency and thousands more will crumble under this system. Any proposal that includes a ratio or blended percentage is poised to fail. These formulas tend to favor some agencies over others and will therefore face opposition. Proposals reflecting per beneficiary caps are also inappropriate because the medically complex patient falls through the cracks and will go without care.

Our industry and the patients we serve are looking to the members of the Subcommittee on Health for a solution. **In response to HCFA's delay of the Prospective Payment System (PPS), we urge you to put a moratorium on IPS retroactive to October 1, 1997.** Such action will allow Congress and the industry time to formulate a system which will maintain patient access as well as quality patient care.

Sincerely,



Hugh D. Durrence, R Ph., M.D.
President

The PPS Work Group

A Nonpartisan Coalition of National and State Associations Committed to Prompt Implementation of Medicare Prospective Payment for Home Care

Statement of the PPS Work Group
On
"Payment Systems for Medicare's Home Health Benefit"
Before The
House Ways and Means Health Subcommittee
August 6, 1998

The PPS Work Group is a coalition of national and state home health associations (see attachment) which have been working together to develop a consensus proposal for reforming the home health interim payment system ("IPS") which was enacted as part of the Balanced Budget Act of 1997 ("BBA '97").

The Adverse Impact of IPS

The Medicare home health benefit is in a state of crisis due to the interim payment system. To date, over 1,000 home health agencies have been forced out of the Medicare program, and that number is expected to increase significantly over the next several months. The Work Group is most concerned about the adverse impact these changes are having on the sickest Medicare beneficiaries. Three recent public policy studies independently found that:

- IPS will deprive the sickest, most frail Medicare beneficiaries of access to covered home health services;
- IPS will create competitive disparities among agencies by establishing radically different payment limits that do not reflect current patient mix or quality; and
- IPS does not move the reimbursement system toward a prospective payment system.[1]

Accordingly, we request that Congress act this year to correct the defects in IPS and restore access to covered home health services for those who need it most.

Structural Defects in IPS

These adverse consequences of IPS are caused principally by the following three structural flaws:

1. The per beneficiary limit is based on an average cost per beneficiary which encompasses two patient populations with widely divergent costs. The home health patient population consists of at least two distinct subgroups—lower cost, short stay patients and higher cost, longer stay patients. See George Washington University study, Executive Summary at ii. By establishing the limit at a percentage of the average costs for all patients, the limit has the effect of eliminating coverage for patients whose costs are at the upper end of the range.

   Data show, for example, that about 10% of the home health population requires more than 200 covered visits each year and that these services account for 43% of total costs. Access to care for these patients is essentially eliminated by the use of a

[1] Medicare Home Health Services: An Analysis of the Implications of the Balanced Budget Act of 1997 for Access and Quality, The Center for Health Policy Research, The George Washington University (March 1998).

The Balanced Budget Act of 1997: Effect on Medicare's Home Health Benefit and Beneficiaries Who Need Long-term Care, The Georgetown University Institute for Health Care Research and Policy on behalf of the Commonwealth Fund (February 1998).

Implications of the Medicare Home Health Interim Payment System of the Balanced Budget Act, The Lewin Group (March 13, 1998).

1875 Eye Street NW 12th Floor Washington DC 20006 P:202-466-6550 F:202-785-1756

limit based on a single average cost per patient. Thus, the savings achieved under IPS come almost entirely from the longest stay, sickest patients.

2. The 75% agency-specific element of the per beneficiary limit is designed to reflect differences in case mix but is too imprecise. This element is not entirely effective because it is impossible to know whether an agency's costs in the base year were high because it treated higher cost patients or because it was wasteful and inefficient.

   In addition, the per beneficiary limit for "new" agencies may result in either a windfall or a crippling economic hardship for an agency because it is unrelated to an agency's patient mix or efficiency.

3. The per beneficiary limits (for both "old" and "new" agencies) under IPS do not change to reflect changes in patient or case mix. This provides an incentive for agencies to discharge or avoid the sickest, most costly patients so that the agencies can gain room beneath the per beneficiary limit.

Objectives

The Work Group believes that any reform proposal should be designed to achieve the following objectives:

1. **The incentives in the current interim payment system to avoid treating the sicker, longer stay patients should be eliminated.**

In order to achieve this objective, limits or payments must vary, at least to some degree, based on the type of patients treated. Any single limit that does not change with patient mix creates an incentive to discriminate against the sickest, most costly patients.

While a supplemental payment for medically complex beneficiaries would help to prevent discrimination, agencies must know the level at which they will be reimbursed at the time the services are rendered.

2. **The interim payment system should not provide higher limits or payments to certain agencies for reasons unrelated to patient or service mix.**

In order to achieve this result, the 75% agency-specific element of IPS should be replaced with an element that better reflects the mix of patients currently served. This would eliminate the incentive to game the system by discharging or avoiding the sickest, most costly patients.

The per beneficiary limit for "new" agencies that is unrelated to an agency's patient mix or efficiency should be eliminated.

3. **The interim payment system should expedite and facilitate the transition to a prospective payment system.**

The Work Group was instrumental in getting a prospective payment system for home health included in the Balanced Budget Act of 1995, and we continue to believe that such a system would make the single most significant contribution to ensuring that medically necessary home health services are provided in an efficient manner.

4. **The interim payment system should make adequate funding available to ensure that covered services are provided.**

To date, over 1,000 home health agencies have been forced out of the Medicare program, and thousands of the sickest patients have been discharged to nursing homes, hospitals, assisted living facilities or left with no services.

HCFA actuaries have projected that Medicare home health spending will be at least $1 billion less than projected by CBO in fiscal year 1998 alone. More recent, preliminary data suggests that home health spending will decline this year by at least 25% to less than $14 billion.

That kind of dramatic and abrupt reduction is more disturbing given that it comes almost exclusively at the expense of the sickest patients. Further, a delay in implementation of the home health prospective payment system will exacerbate the situation.

Elements of Reform

In order to achieve these objectives, any reform proposal should include the following elements:

1. A variation in the per beneficiary limit to reflect patient mix, including medically-complex patients;

2. Elimination of the additional 15% reduction scheduled for October 1, 1998;

3. A per beneficiary limit based on a national/regional blend of average cost per beneficiary. (While a majority of the Work Group supports a 50/50 blend, a minority supports a three-way blend of national/regional/agency-specific).

4. An increase in the per visit limit to 112% of the mean;

5. A delay in implementation of OASIS;

6. Preservation of periodic interim payments (PIP) until twelve months after the implementation of PPS in order to maintain cash flow for agencies during the turbulent transition period; and

7. Elimination of the proration requirement for the per beneficiary limit except for agencies under common ownership or control.

The Work Group opposes copayments for home health services because they increase the administrative costs of providing home health services while not improving the benefit. More importantly, the imposition of copayments would reduce access to medically necessary home health services for those beneficiaries who need them most. Copayments disproportionately penalize poor, elderly and disabled beneficiaries, and are therefore in conflict with one of the fundamental objectives of health care reform.

In summary, any reform proposal must put the interests of the beneficiaries first by making access for the sickest patients the top priority. We look forward to working with Congress, HCFA, and consumer groups to restore access to home health care for those who need it most.

PPS Work Group Participants

National Organizations:

American Federation of Home Health Agencies
Home Health Services & Staffing Association
**Visiting Nurses Association of America

State Organizations:

Associated Home Health Industries of Florida, Inc.
California Association for Health Services at Home
Colorado Association of Home Health Agencies
Connecticut Association for Home Care, Inc.
Georgia Association of Home Health Industries, Inc.
Home Care Alliance of Maine
Home Care Association of Louisiana
Illinois Home Care Council
Indiana Association for Home Care, Inc.
Maryland National Capitol Homecare Association
Michigan Home Health Association
Mississippi Association for Home Care
New Mexico Association for Home Care
New York State Association of Health Care Providers
North Carolina Association for Home Care
Ohio Council for Home Care
Pennsylvania Association of Home Health Agencies
Texas Association for Home Care
Virginia Association for Home Care
Vermont Assembly of Home Health Agencies

** Although the Visiting Nurses Association of America is a member of the PPS Work Group, they support their own proposal which is embodied in H.R. 3567 and S. 1993.

The PPS Work Group

A Nonpartisan Coalition of National and State Associations Committed to Prompt Implementation of Medicare Prospective Payment for Home Care

August 20, 1998

The Honorable William M. Thomas
Chairman, Health Subcommittee
House Committee on Ways and Means

Re: Statement for the Record Regarding Home Health Payment Reform

Dear Chairman Thomas and Subcommittee Members;

On behalf of the Home Health PPS Work Group, we would like to supplement the record of the August 6 hearing on "Payment Systems for Medicare's Home Health Benefit".

At the hearing, you asked the home health representatives if they would prefer the additional 15% cut in the cost limits scheduled for October 1, 1999 or copayments. We would like for all members of the Subcommittee to understand clearly that **the Work Group does not support copayments**. We believe that either copayments or the additional 15% cut in limits would further eliminate access to covered services and discriminate against the sickest, most frail patients. Thus, copayments should not be considered as an alternative to the 15% cut.

By contrast, the Work Group supports an approach that encourages agencies to provide medically necessary covered services in a cost effective manner.

We are also aware of a proposal that the Subcommittee may have been considering which contains an outlier payment for some percentage of costs incurred that exceed 105% of an agency's limit. We do not believe that an outlier payment will effectively reduce or eliminate the incentives in IPS to discriminate against sicker patients unless the outlier payment is paid at or near the time the services are rendered and is at least the cost of efficiently providing the services.

Finally, the concern was raised that some in the home health industry had not come forward with constructive proposals for resolving the problems with IPS. The Work Group has repeatedly developed and presented constructive proposals to the Subcommittee that are designed to address the problems of the reimbursement system while treating all providers and beneficiaries fairly.

The Work Group was instrumental in developing the prospective payment provisions which passed Congress in the Balanced Budget Act of 1995. We and others revised and improved that proposal in 1997 only to have it rejected in favor of the Administration's proposal which is now unanimously viewed as bad public policy. The Work Group has worked with Congress to develop an IPS reform proposal which cures the most serious defect of IPS and is based on data which has already been collected by HCFA. That bill has been introduced as H.R. 4495.

Work Group members also worked closely with the Office of the Inspector General to develop the recently issued model corporate compliance guidelines. Accordingly, the Work Group has offered constructive solutions designed to improve the quality and integrity of the home health benefit. We look forward to the opportunity to work with Congress further in preserving one of the most valuable and popular services covered by Medicare.

Sincerely,

James C. Pyles

James C. Pyles

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David T. Hannan
President

Written Testimony Submitted For the Record
to Committee on Ways and Means, Subcommittee on Health, US House of Representatives
on the Interim Payment System of the Balanced Budget Act of 1997

for the South Shore Visiting Nurse Association
Submitted by: Bonnie Matthews
Vice President, Home and Post-Acute Services
South Shore Hospital, South Weymouth, MA

My name is Bonnie Matthews. I am the vice president of the South Shore Visiting Nurse Association, a division of South Shore Hospital which is located south of the city of Boston. It is an honor to be able to provide testimony regarding the negative impact of the 1997 Balanced Budget Act Interim Payment System and its implementation regulations on small home care providers.

The South Shore Visiting Nurse Association has been providing home health care to 41 communities in Southeastern Massachusetts since 1911. Our agency's programs include a not-for-profit, Medicare certified visiting nurse service; a licensed, certified hospice; and a fee-for-service private duty program. We employ 550 people. We service 5,000 clients per year. On any given day, we care for two to three times more people in our community than does our affiliated hospital.

The implementation of the Interim Payment System has dealt a devastating blow to the home health industry, to our agency, and to our patients.

Let me first acknowledge that I am not an expert on the Small Business Administration's (SBA) criticism of HCFA's technical compliance with notice and comment requirements. I can say that I believe that the SBA is absolutely correct in saying that the implementation of the Interim Payment System (IPS) -- and to a slightly lesser degree the surety bond -- has been both "punitive" and "unfair" to "legitimate law abiding home health agencies."

Given that this Committee's interest is in protecting small business, I would like to present to you a picture of how "unfair" the current situation is by posing two questions:

1) How long can a small business survive that is required today to provide an *unlimited* amount of services with a *funding cap* that is less than the cost of care in 1993?

2) What business do you know that could or would continue to provide a product or service for seven months after a reimbursement reform -- *without knowing what they'll be paid?*

That is precisely what home health providers have been asked to do.

As soon as we at South Shore VNA saw the legislative language of the Balanced Budget Act (BBA) of 1997, we began to prepare for dramatic losses. HCFA's regulatory interpretations of the BBA, published on March 31, 1998, only exacerbated our problems.

South Shore Hospital is a not-for-profit, tax exempt affiliate of South Shore Health and Educational Corporation.

As a result of a change in corporate structure that occurred in mid-1994, South Shore VNA is being considered a "new provider" under HCFA's interpretation of the provisions of the BBA. Keep in mind, as I testified earlier, that we have been providing care continuously since 1911. The effects of this arbitrary designation are a loss, which we project will be $4.5 million this year alone. We are in the very situation that SBA cited in suggesting that HCFA far exceeded Congressional intent and in so doing "ensnared HHAs that would not otherwise have been deemed new providers under the BBA." (SBA Office of Chief Counsel for Advocacy Letter to N.A. Min Deparle, June 15, 1998)

As a result of these actions, South Shore VNA is struggling with a reimbursement cap that is 40 percent below our current cost of caring for a patient. We are also struggling to compete in an environment in which there is as much as 25-30 percent difference in the per-beneficiary limits assigned to home care agencies operating in the same geographic area. In fact, a competitor within 17 miles of our agency has a cap that is almost double what ours is estimated to be at the national median for new providers.

As a result, we have had to lay off 50 staff members and close two satellite offices. Essentially, even with these changes we are facing an irreconcilable dilemma: we must cut needed services to get below the cap or bankrupt our agency by continuing to provide them.

As it is currently drafted, IPS will effectively cripple the ability of the home health industry to afford to care for all patients, particularly those who are frail, elderly, disabled or have multiple diseases of a chronic nature and need what we term "illness management" at home.

Clearly, as the SBA points out in the same June 15, 1998 letter, lost in all of this has been the impact on the beneficiary. While HCFA has projected that certain unspecified "offsets" will reduce the degree of cuts, it is in fact our experience that the reductions needed to get under the caps have been underestimated.

To demonstrate the impact in human terms, I will close with a true story of a patient of ours who fits the profile of someone who can fall into this new "no care zone" with no safety net and in extreme jeopardy under the restrictive new reimbursement system for home care.

But before I do, let me add that problems that I present to you on behalf of South Shore VNA are not unique to us. HCFA's own March 31, 1998 rule indicates that New England is taking a disproportionate hit in terms of percentage of agencies with costs over the caps. This is a direct result of our being dominated by community-based providers that have been traditionally more efficient in terms of keeping costs per patient and per visit low.

As at least three reports have documented, this reimbursement reform actually punishes efficient agencies. As the *Wall Street Journal* reported on January 7, 1998:

> "If New England's home health providers had been a little greedier,
> it's home health industry would be a lot better off now."

Now let me tell you our patient story:

This is a patient who is quite elderly, frail, chronically ill, with multiple diagnoses. This patient may not be consistently "sick" enough to meet the requirements of ongoing Medicare home health care, but cannot afford private help. Without skilled monitoring, there is an increased risk for serious medical deterioration, hospitalization or nursing home placement.

Mr. M is 90 years old. His wife is 89. Both have multiple health problems. For the past two years they have managed to live alone in their apartment with some assistance from South Shore VNA.

Mr. M has heart disease, lung disease seizure disorder, thrombosis of the veins in his legs, asthma, hypertension and short-term memory loss. He is not independent in his activities of daily living (bathing, dressing, feeding himself). He uses a walker and is at risk for falls.

He takes 16 different medications -- with a daily medication schedule that is complex and confusing. He wants to age in place at home with his wife.

Mrs. M is 89 years old and in failing health, with hypertension and coronary disease. It is too exhausting for her to regularly bathe and dress Mr. M, as well as to handle his complex medication regime. She takes 12 medications herself a day.

South Shore VNA has been providing this couple a complement of both skilled and non-skilled care. A home health aide has visited three times a week to assist with personal care and medication checking. A nurse visits every two weeks to check his vital signs and prefill his medications for the next two weeks.

Medicare does not reimburse for medication prefilling. Medicare does not reimburse for monitoring a chronic illness. Mr. M. is considered stable, with no acute needs according to coverage standards. He is generally in a "no care" or at least "no reimbursement" zone. When one of his conditions exacerbates sufficiently, he may, in fact, become Medicare home health covered. Of course, without the ongoing monitoring, such an exacerbation may happen very quickly meaning a likely hospitalization or nursing home admission.

South Shore VNA does -- to the extent we can -- continue to treat the Mr. Ms of our community under our free care program. Facing a $4.5 million loss on the business we can bill to Medicare severely jeopardizes our ability to continue to do so.

For our patients, our employees, and our industry of caring providers with long community histories, I thank you for calling this hearing and I respectively request that you act and act soon.

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WRITTEN STATEMENT

My name is James C. Fling and I am Executive Director of TLC Home Health Services in Shamrock, Wheeler County, Texas ("TLC"). TLC serves approximately 30-35 elderly patients who are Medicare beneficiaries with home health services in the Shamrock, Texas area (approximately five counties are served by this agency). At this time, 100% of our patient census are Medicare beneficiaries. Effective October 1, 1997, Congress enacted the Balanced Budget Act of 1997 ("BBA") mandating the implementation of a prospective payment system ("PPS") by October 1, 1999, and an interim payment system for the period from October 1, 1997, until PPS could be in place. Additionally, the BBA mandated a 15% reduction in all Medicare payments for home health agencies effective October 1, 1997. Supposedly, pursuant to these mandates, the Health Care Financing Administration ("HCFA") published a rulemaking effective April 1, 1998, establishing per beneficiary limits for all home health agencies under IPS, the per beneficiary limits being irrationally and substantially different for home health agencies which had settled cost reports for 1994 and those agencies who had cost reports after 1994. I will refer to these agencies as "old" versus "new" agencies. Nowhere in the BBA did Congress mandate that home health agencies ("HHA") were to be treated significantly different as to payments for medically necessary home health services. IPS per beneficiary caps formulas create various classes of HHAs, each treated differently in the amount per patient it is to receive.

For old HHAs, these include:

1. Old HHAs with high costs (which may be the result of inefficient care or inflated claims) are rewarded since the higher the FY 94 costs were, the higher the 1998 IPS per beneficiary caps will be;

2. Old HHAs with low FY 94 costs (e.g. if the result of high efficiency) are penalized because their lower FY 1994 costs will be perpetuated in IPS 1998 per beneficiary caps;

3. Old HHAs with base years that are not representative of their current costs or patient mix are saddled with these unrepresentative costs and patient mixes in IPS 1998 per beneficiary caps;

4. Old HHAs with more current low-cost patients that have altered their patient mix from 1994 from high-cost to low-cost patients are rewarded with a higher 1998 IPS beneficiary cap than their current patient mix and operating costs otherwise justify;

5. Old HHAs with high-cost patients that have altered their patient mix from 1994 from low-cost to high-cost patients are penalized with a lower 1998 IPS beneficiary cap than their current patient mix and operating costs otherwise justify;

For new HHAs receiving the National Median these include:

1. New HHAs involved in only screening patients to treat routine, short-term needs instead of intensive medical needs are rewarded since such substantial patient care costs below the median cap benefit the HHA on its aggregate cap;

2. New HHAs involved in providing care-intensive, high-cost medical needs are punished since patient care costs substantially over the median cap eliminates the opportunity of the HHAs to meet its aggregate cap;

3. New HHAs that have experienced significant growth (especially into rural areas or specialty treatment niches) or significant changes in patient mix toward care-intensive, high-cost medical needs are punished since operating costs or patient care cost substantially over the median cap eliminates the opportunity of the HHA to meet its aggregate cap;

4. Old HHAs that have been reclassified as new HHAs because of a change of ownership or status (e.g. free-standing/provider/based, branch/sub-unit, etc.) resulting in a significant reduction in per beneficiary aggregate caps.

Additionally, the BBA's provision providing for a phasing in rather than an immediate imposition of the per benficiary cap creates an additional two classes of all HHAs--both old and new.

HHAs with shorter FY's will benefit from escaping the retroactive effect of the caps--a HHA with an October 1, 1997 FY will have their prior 8 months' operations recalculated and the "overpayment" recaptured by HCFA.

The impact of these different per beneficiary caps for old and new agencies have, in effect, allowed older agencies to have a much higher per beneficiary cap ($6,000 to $17,000 per patient) than new agencies ($1,500 to $3,300 per patient) and has given older agencies a tremendous competitive advantage and is not related to health care services being provided to the patients. It is interesting to note that these per beneficiary caps as developed by HCFA appear to be inconsistent with the intent of Congress in issuing these mandates. The fraud and abuse statistics provided to Congress and relied upon by Congress in mandating these changes in the BBA would have primarily included the old home health agencies and they are the HHAs who will profit from these changes. Basically, these per beneficiary caps allow the HHAs involved in the fraud and abuse statistics to profit from their actions. The new agencies are not able to deliver home health services with the per beneficiary caps assigned to them and are closing all over the country. In many rural areas, the elderly patients of these new agencies are being discharged and have no place to go and will die as a result of these new per beneficiary rates for new agencies. This is not what Congress intended nor is it consistent with the intent and purpose of the Medicare Act. In fact, the mandates of the BBA conflict with other provisions of the Medicare Act relating to home health services and interference by the government in the medical treatment of Medicare patients by their doctors. 42 U.S.C. Section 1395x(m) provides that once a person is determined to meet the basic criteria for eligibility under Part A, the beneficiary may receive home health services for an unlimited number of visits provided the services are medically reasonable and necessary. The BBA provision now shifts the costs after 100 visits after

discharge from a hospital to Part B which is funded in part by the States in conflict with the above provisions. The mandates of the BBA effectively limit the number of visits that a beneficiary may receive. The rulemaking implementing these proposed reductions in the Medicare benefit to Medicare recipients was done without legal and proper notice to the people affected by it in violation of constitutional due process. In fact, HCFA attempted to prevent beneficiaries from learning that their benefits were being cut substantially.

The retroactive effect of the implementation of these new per beneficiary limits and the 15% reduction in reimbursement for actual medical costs incurred has resulted in most home health agencies having a substantial purported over-payment for the period from October 1, 1997, until the effective date of these new acts on April 1, 1998. No agency could protect itself from this artificially created over-payment since an agency should be getting reimbursed for its actual costs in providing home health services and nothing more. Thus, HCFA has provided HHAs with an enigma--you can't have an over-payment, but, because of their laxness in promulgating these new rules, you do have a substantial over-payment. At the same time, HCFA also attempted to require HHAs to put up surety bonds to cover these purported over-payments. Due to the fact that HHAs supplying Medicare services are not allowed to make a profit, the only way a surety bond company would write such a bond would be if they also had personal guarantees and other personal collateral. This was just another way of driving HHAs out of the home health market. Fortunately, HCFA, after pressure from Congress, has delayed the surety bond requirement, but the impact of IPS and its retroactive application has already caused many HHAs to close and to discharge their patients.

In the Shamrock, Texas area, already several HHAs have closed their doors due to these onerous and unfair rules. As additional HHAs are forced to close, the home health beneficiaries are being left without care that they need and deserve such as medication teaching by skilled nurses, insulin injections for patients unable to administer their own insulin (life-threatening if not given properly in the right dosages and frequency), wound care, and personal care by home health aids for patients with severe incontinence problems who have no other caregiver available to provide such care. This agency's location is in rural America, sparsely populated, with the nearest major medical facility being 93 miles away from Shamrock (i.e. Amarillo, Texas). Home health is an integral part of these patients' daily lives as each patient's home health nurse serves as both liason and advocate for the patient in communicating vital medical information to the patient's doctors, specialists, etc., and carrying out the doctor's orders for care of the patient via long-distance communications that are vital to the patient's well-being and welfare. Our elderly citizens deserve to live independent lifestyles in their homes if that is what they choose to do, and home health helps our mothers, father, grandmothers, and grandfathers to live with dignity and quality of life. If these patients lose these services in the rural locations, some will surely die as a result of these rules, being forced to go without medical services due to distance and travel time to each patient's physician with dire consequences a certainty. Even one death is not acceptable. The government promised the elderly when Medicare was first passed in 1964 that no citizen in the United States would be without proper medical care, especially the oldest and sickest of our society, this is an entitlement under the Medicare program. The BBA has changed this concept. Shame on HCFA for not following Congressional intent when promulgating these rules.

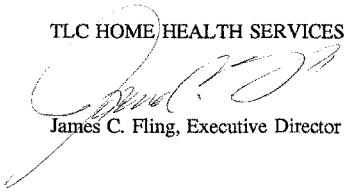
Since IPS was intended to merely bridge the gap until a prospective payment system could be implemented, I would submit that a moratorium be immediately implemented on IPS and the 15% reduction in reimbursement rates contained in the current rules and that all reimbursement rates be frozen at the 1996 level until a complete study of the effects of IPS on Medicare beneficiaries in all geographic locations can be conducted. This will stop the bloodbath that is currently going on in the home health industry and will insure that vital home health services are provided to those elderly in need of such services. Keep in mind that HCFA has now publicly stated that PPS cannot be implemented by October 1, 1999, as originally stated to Congress. It boggles the mind that HCFA could implement IPS after several months, yet PPS cannot be implemented after several years. IPS was ill-conceived and not studied before implementation. The effect has been disastrous on many home health agencies and the patients and must be remedied. IPS, as currently configured, prevents an agency from admitting a patient with long-term medical needs and encourages only the admission of patients with acute short-term care needs in violation of 42 U.S.C. Section 1395x(m) and in violation of provider agreements. HHAs have been advised by letter from HCFA that long-term Medicare patients cannot be refused home health services because of IPS. Someone has their head up in the clouds. No HHA will admit patients if they cannot afford to provide the type of home health care needed, each patient's medical situation being unique with each patient requiring different types and levels of skilled care and home health aid needs. The moratorium proposed by Senator Christopher Bond seems to be a sensible and practical solution to this problem (S 2354). For the good of the country, I urge all to support this bill and hope that it passes immediately.

As an alternative to HR 4339/S2354, I understand that at the hearing of August 6, 1998, Representative Thomas proposed a $5 co-pay on home health care to be administered with the agency given the option to "collect $5 from each beneficiary (per-visit) or to simply accept lower Medicare payments." This would certainly be a viable and feasible alternative for this agency, the agency operates and is staffed in a very efficient manner, and I would certainly support some type of legislation in this regard as opposed to the IPS legislation that would put a cap or limit on the amount of services a patient can receive. This would insure that home health agencies could continue to deliver medically and reasonably necessary care to qualified patients without the worry of IPS limits and over-payment situations "hanging" over each agency and preserve what remains of the home health industry in providing vital in-home care to hundreds of thousands of deserving and qualified Medicare beneficiaries throughout this country.

Thank you for your time in reading this statement, and if I can be of further assistance or clarify points as contained in this statement, please do not hesitate to contact me or other agency staff members. We would be happy to discuss this situation with our representatives and senators.

Sincerely,

TLC HOME HEALTH SERVICES



James C. Fling, Executive Director

AUG 2 0 1998

Written Testimony

Texas Association for Home Care

for the August 6, 1998 home health care hearing before

the Health Subcommittee
Ways and Means Committee

Texas Association for Home Care
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Priorities for IPS Change

1. Delay implementation of IPS until FY 1999

Agencies were expected to operate for many months without knowing what their per beneficiary limits would be, or what their interim visit rates would be under the per beneficiary limits. The per beneficiary rates turned out to be 25 % to 40% lower in Texas than the best estimates, which has created a retroactive crisis. An alternative to IPS must be a known factor by agencies before implementation.

2. Ensure that payments to agencies are sufficient to care for high-cost and/or long-term patients

IPS's greatest defect is that it has too little money in it to care for anyone other than short-term, low need patients. Either the payment system must have additional funding to recognize the needs of different beneficiaries, or new coverage limits must be imposed.

3. Eliminate discrimination in payments between 'old' and 'new' agencies

There is no relationship between what agencies were spending in FY 94 and their patients' needs today. All agencies in a community should receive the same reimbursement for the same types of patients.

4. Restore the per-visit cost limits to at least 1996 levels

As utilization drops, cost per visit increases; therefore, the reduction of both per beneficiary and per visit limits is a double whammy which makes it next to impossible to operate.

5. Eliminate the additional 15% reduction in payments scheduled for FY 2000

This reduction is scheduled regardless of savings achieved through IPS implementation. The amount of cut should be determined and triggered only if specified spending levels are exceeded.

6. Eliminate proration provision of the BBA except in cases where there is obvious intent to circumvent the limit

The proration provision discriminates against the beneficiary who happens to get sick more than once in a year. Apply proration only in circumstances where agencies actively attempt to circumvent reimbursement limits.

7. Establish payment system prospectively

8. Maintain periodic interim payments (PIP) until 12 months after the implementation of a prospective payment system.

Texas Association for Home Care
Testimony

With this submission, Texas Association for Home Care (TAHC) would like to both (1) respond to issues raised during the August 6, 1998 hearing of the Health Subcommittee of the Ways and Means Committee, and (2) recommend appropriate actions for Congress to take in order to mitigate the imminent and severe crippling of the Medicare home health benefit as a result of the Interim Payment System (IPS).

During the hearing, subcommittee Chairman Bill Thomas accused home health provider Mary Ann Brock of Houston of using "scare tactics" by speculating that 75 percent of the agencies in Texas would close as a result of IPS and the way it is being implemented. Ms. Brock's testimony was based on the prediction of several knowledgeable financial consultants working with home health agencies across Texas. In addition, knowledgeable employees of the primary fiscal intermediary in Texas have also predicted that 75 percent of Texas agencies are likely to close. So her testimony was based on the best estimates of experts, and not intended to be alarmist. Based on the best information we can put together, TAHC believes that if there is not significant alteration to IPS, at least half of the agencies in Texas will close over the next year. However, the number of agencies left open today, or several months from now, is not the issue; TAHC's concern is whether beneficiaries will have access to needed care, and whether those agencies remaining will be financially stable enough to secure bonds and provide the quality of care expected and required under the Medicare Conditions of Participation. We do not believe HCFA is doing anything to identify access problems, and by the time HCFA is aware of such a problem, it will have reached destructive proportions. It is in the best interest of the nation that the provider base for home health be financially stable, and avoid both unnecessary service delivery disruptions and expenses associated with closing and opening operations.

Chairman Thomas also accused Ms. Brock of "misrepresenting the facts" in her written, detailed testimony concerning the confusing and seemingly contradictory letters she has received from her fiscal intermediary, PGBA. In fact, Ms. Brock's statements were totally accurate. Before her testimony was sent to the committee, it was checked for accuracy by her CPA who has many years of experience working with various Medicare programs, including home health. Also, Ms. Brock's experience is not an isolated incident. TAHC has received copies of these letters written to other agencies which are causing great confusion. In one letter, the government owes the agency money, and a new per visit rate is set. Then in the next letter the agency owes the government money and a lower per visit rate is set. Then in yet another letter the visit rate is dropped significantly again with the per beneficiary cap. The swing can be $1 million or more over a matter of weeks, creating major financial crises for agencies. TAHC also reviewed Ms. Brock's testimony for accuracy. Perhaps Chairman Thomas or his staff misread or misinterpreted the testimony.

We were also disappointed to hear Chairman Thomas's claim that providers and their trade associations had done nothing to bring viable solutions to the table, and that we only seem to want to return to a cost-reimbursed system of the past. For the past 13 years, we have been on record supporting a move to a prospective payment system (PPS). This organization has never recommended returning permanently to an open-ended cost-reimbursed system. Our support for a moratorium on the IPS is only as a temporary "fix" until we can reach PPS, or until Congress can approve an alternative to the IPS. During the BBA 97 debate, the industry proposed a very workable interim plan. Unfortunately HCFA convinced Congress to go with it's IPS. In hindsight, it appears clear that Congress needs to involve the expertise of the industry to accomplish workable goals. As to the alternatives to the IPS, we have sent several suggestions to Congressman Archer's office over the last several months, and we have maintained a continual dialogue with Chairman Archer's staff on possible avenues that might be pursued. Unfortunately, there are no solutions that will stabilize the benefit without restoring some of the cuts from IPS. Perhaps this is why Chairman Thomas does not believe we have constructively contributed to the dialogue. Now with the new restrictions imposed by HCFA's Y2K problems, and the position of the President on no restored cuts to home health, the industry and Congress are together in a very difficult "box". We believe that the industry and Congress must work together to make needed reform possible. We agree with Chairman Thomas and other committee members that it would serve no purpose to simply rearrange the "winners and losers". However, without restoration of some of the cuts caused by IPS, there can be no viable alternative that accomplishes anything other than rearrangement of winners and losers.

Several members of the subcommittee raised the issue during the hearing of why utilization in Texas is so high. We believe there are several reasons. Poor and middle class Texans have very limited access to program to meet their chronic medical needs other than nursing homes. Accordingly, they and their physicians have aggressively used Medicare home health, and the home health agencies welcomed the business. Texas has the highest number of elderly persons living below the poverty level in the nation, so the State of Texas has been aggressive in directing medically needy—including those with long term disabilities--into Medicare home health. Meanwhile, our fiscal intermediary, PGBA, has led agencies and physicians here to believe that the higher utilization was appropriate because they always approved the visits and paid the claims. Coverage guidelines are so broad that it is difficult to determine which services are not covered. To fix these problems, HCFA should clarify the coverage, implement normative standards, and concentrate focused medical reviews on agencies whose utilization is out-of-line.

Co-pays

Co-pays, or the so-called "agency optional pass-through," are inappropriate to a capitated, non-profit reimbursement system, which is what we have under IPS and all alternatives under discussion. Co-pays might work as an incentive for patients to hold down cost when providers have incentives to increase spending and have some means for

covering the cost of unpaid co-pays. Under IPS and every alternative on the table, agencies have heavy incentives to limit the number of visits and cost as much as possible, so co-pays are unnecessary. As long as providers are operating under strict capitated rates, and cannot retain assets through which to cover losses from unpaid co-pays, then these unpaid co-pays force every agency to operate at a guaranteed loss, which will put them all out of business sooner or later. Co-pays or an "optional agency pass-through" only make sense when the uncollectible co-pays can be covered by retained assets, thus only affecting the level of profit, not the available operating revenue. In addition, co-pays discriminate against the poor and middle class elderly, as well as the sicker patients. It would make more sense to revise Medicare into a financially means-tested benefit. Co-pays were proposed by Chairman Thomas as an alternative to the October, 1999 additional 15% cuts. With the excess savings already achieved in excess of CBO expectations, and with the extension of an interim payment system for at least a year longer than originally intended, that 15% cut should be unnecessary to achieve the expenditure goals outlined in BBA.

Solutions

For any alternatives to address the crisis, the unanticipated cuts—cuts over the CBO estimates—in home health must be restored. The issue is not saving every home health agency, or condoning wasteful spending. The issue is to stabilize enough agencies to keep the benefit in existence and to be able to meet the needs of all entitled patients.

Option I.

Implement the provisions of H.R. 4404.

Rationale: Simple to implement. Sets global limits to prevent unleashed spending, yet allows agencies needed flexibility to handle their case-mix. We believe agencies will continue to control spending in order to prepare for PPS, and to avoid unnecessary additional costs in the future, such as increased unemployment taxes if employees are later laid off.

Option II.

Abandon IPS for FY 98 and implement an alternative beginning with FY 99.

Rationale: Spending is sufficiently down for FY 98 to cover the intended savings for this year anyway. Would eliminate the need to implement yet another new system retroactively, but would mitigate the damage of IPS.

Option III.

1. Leave the base year at FY94 and get rid of the extra 2% reduction. Update the inflation factors for both the cost limits and per beneficiary limits for 1994-96

2. For FY 98, agencies may choose one of the following:
   (1) national average
   (2) regional average
   (3) Their current per beneficiary calculation under IPS

Rationale: Eases the immediate crisis. Gives more time for agencies in high cost regions to adjust to the lower amounts, and helps low-cost regions and agencies make the transition. For irresponsible agencies that have not already significantly cut cost, they are out of business anyway. Does no harm to agencies that in good faith have been operating under the new limits. Still makes it impossible for Medicare home health to be the de facto long term care program, which is clearly what all this is intended to accomplish (at least in Texas).

3. For FY 99, all agencies choose between:
   (1) national average
   (2) 25% national and 75% regional blend

Rationale: Levels the playing the field among all agencies in a community. Begins the process of moving toward national standardization. Helpful to all regions. Maintains other advantages listed above.

4. For FY 2000, retain FY 99, or give agencies a choice of:
   (1) 50% national and 50% regional blend
   (2) national average

Rationale: Continues above. This would be similar to the 5-year process by which HCFA implemented hospital Drags, and is a natural progression toward PPS. Does it favor states like those in the south with high regional cost? Not really, if wage adjustments continue to be applied as they are under IPS. Those wage adjustments have nearly killed rural and South Texas (especially since they do not consider travel time/costs), while boosting organized labor states of the East and Midwest.

5. Eliminate the blanket requirement for proration among agencies in the event a beneficiary needs home health more than once a year. Instead, require proration only when the agencies involved have worked to circumvent the limits.

Rationale: The blanket proration discriminates against beneficiaries who happen to get sick more than once a year. In no other Medicare benefit is such rationing applied.

6. Eliminate the 15% reduction at October, 1999.

Rationale: It will not be necessary in order to reach spending targets under BBA '97. Additional cuts on top of those proposed for each year above is too severe.

7. To deal with outliners, implement one of the following:
   (1) A prior approval system through an independent case manager for any services delivered after two certification periods.
   (2) A split cap approach similar to the one in H.R. 4495.

Rationale: These are the only two approaches we know of that responsibly deal with those longer term patients, and those short term patients who unexpectedly turn into long term care patients. The reality of dealing with the "old-old" is that many of their medical needs become chronic. If Congress refuses to limit the coverage to exclude chronic conditions, and refuses to limit an agency's liability, then it must realistically reimburse for cost of care.

8. Offer incentives to states to cost-effectively transition into Medicaid community based LTC programs those poor patients who can be cared for cheaper than under Medicare home health. In addition, make it clear that Medicaid is required to take LTC patients into community based Medicaid waiver programs (as well as into nursing homes) even though the Medicare benefit has not technically been exhausted. Consider expanding NF waiver programs to allow a sliding-scale co-pay for those of modest means but above Medicaid NF financial eligibility.

Rationale: Politically it would ease the transition from Medicare home health. Medicare COPs for home health are too cumbersome and expensive in many cases, increasing cost unnecessarily. Many states, including Texas, have and continue to refine policies for LTC home care under Medicaid waivers that are more innovative and streamlined. Elderly and disability advocacy groups have and will continue to support these efforts, because it means more people can be served at home rather than in nursing facilities. In addition, census data claims Texas has the largest number (not percentage) of elderly living below the poverty level of any state in the nation, so the transition of responsibility is enormous--we calculate some $226 million a year to Medicaid in Texas alone. Without a limit on the benefit for home health services, Medicare puts poor elderly in jeopardy of not being able to access community-based Medicaid LTC benefits. Most states, including Texas, require that Medicare be the payer of first choice, and that Medicare benefits be exhausted before Medicaid will pay. Under current criteria for homebound patients requiring on-going skilled nursing and ADL support services, the Medicare "benefits" are never exhausted; thus, a patient can and will be denied Medicaid LTC services under a Medicaid NF waiver program. This has already happened in two North Eastern states, and it will happen elsewhere. If agencies try to transition their poor LTC patients from Medicare home health into their agency's state Medicaid waiver programs, their claims will be denied and the agency will be accused of Medicaid fraud, as was the

case in those states. However, there is insufficient funding in the IPS per beneficiary limits to meet the long term needs of these patients.

Option IV.

Require HCFA to sit down with knowledgeable computer experts to consider what really might be possible under an outside contract without interfering with the Y2K programming.

Rationale: HCFA already has contracts with outside firms who handle computer programming for Medicare home health. There are conflicting versions about what could be possible under an outside contract. HCFA seems to take the position that if it cannot be accomplished internally, it cannot be done at all. Congress and the industry might have considerably more options to consider if outside computer capability were available. For example, one option might be to implement the current PPS demonstration project in lieu of IPS. Preliminary reports are that it has been successful. The primary opposition has been that the case mix adjuster is not yet adequate; however, it is better than no case mix adjuster in IPS, and it recognizes the needs of each patient.

Option V.

Consider H.R. 4495, except change the blend to allow for a more gradual transition toward a national average per beneficiary limit.

Option VI.

If Congress is unable to agree on a means by which to stabilize home health agencies and the benefit, then it must implement a moratorium on IPS until the next Congress can appropriately resolve the issue. Otherwise, too few agencies will be able to survive and be financially stable enough to secure a bond, and the benefit will dissolve.