

**THE BALANCED BUDGET ACT OF 1997: A LOOK
AT THE CURRENT IMPACT ON PROVIDERS
AND PATIENTS**

HEARING
BEFORE THE
SUBCOMMITTEE ON
HEALTH AND ENVIRONMENT
OF THE
COMMITTEE ON COMMERCE
HOUSE OF REPRESENTATIVES
ONE HUNDRED SIXTH CONGRESS
SECOND SESSION

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THE BALANCED BUDGET ACT OF 1997: A LOOK AT THE CURRENT IMPACT ON PRO- VIDERS AND PATIENTS

WEDNESDAY, JULY 19, 2000

HOUSE OF REPRESENTATIVES,
COMMITTEE ON COMMERCE,
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:04 a.m., in room 2123, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Upton, Greenwood, Deal, Burr, Bilbray, Whitfield, Ganske, Coburn, Shadegg, Bryant, Bliley (ex officio), Brown, Pallone, Stupak, Green, Strickland, DeGette, Barrett, Capps, Towns, and Eshoo.

Also present: Representative Fossella.

Staff present: Tom Giles, majority counsel; Carrie Gavora, majority counsel; Robert Simison, legislative clerk; Amy Drowskoski, minority professional staff; Karen Folk, Presidential Management Intern; and Bridgett Taylor, minority professional staff.

Mr. BILIRAKIS. If we can have order, please, we will get started. I am pleased to convene this hearing to review the impact of the Balanced Budget Act of 1997, or as we fondly refer to it, BBA. Last September, we held a similar hearing to examine the effect of this law on the quality of care for patients across the country. Congress subsequently passed legislation to rectify some of the unintended consequences of the Balanced Budget Act and restored roughly \$16 billion in funding over 5 years. This was a necessary first step to stabilize affected health care programs while we continue our efforts to ensure their future viability.

This week, the Congressional Budget Office released its mid-session numbers, which project a significant budget surplus for fiscal year 2001. We should all be very pleased that our belt-tightening has paid off and we are no longer increasing the national debt. However, the savings from the BBA have been far greater than Congress anticipated when the law was enacted. For that reason, it is important that we hold this hearing today. It is time for us to step back and to review the continued impact of the BBA on providers and the patients they serve.

Just over 2 years ago, we enacted landmark changes to the Medicare program. Many of these changes were designed to provide for more beneficiary choice and to help guarantee the solvency of the Medicare program well into the 21st century. Those objectives have

been met. But as we know, and as often is the case, some unintended consequences ensued.

Today, we will hear from both the Medicare Payment Advisory Commission and the General Accounting Office about challenges facing the Medicare program, and I would like to welcome Dr. Gail Wilensky and Dr. Bill Scanlon. Their objective testimony will help us target areas of greatest need.

Other witnesses will focus on a multitude of areas affected by the BBA. As we begin crafting legislation to correct some of these unintended consequences, the testimony from this hearing will help us make informed decisions about the scope of any legislation. Each witness can provide valuable insight into the effects of the BBA on providers and on patients' access to health care services.

For example, the Nation's hospitals, including public, non-profit, for-profit, teaching, and children's hospitals, have waged a very public campaign to remind Congress that the BBA is continuing to have very real consequences for patients every day. Data from the Florida Hospital Association shows that Shands Jacksonville Hospital in Florida will lose almost \$32 million, in total, because of changes under the BBA. Last year's relief measure diminished those losses, but only by roughly \$1.3 million. The hospital will soon be bankrupt unless the necessary assistance is received. I think that these effects are being felt by hospitals around the country and certainly not just in Florida.

I would caution, however, that the days of runaway Federal spending are over. While we work to ensure patients' access to necessary services, we must remain vigilant guardians of taxpayers' dollars. And as we draft legislation to further refine the BBA, we certainly will not be reopening every provision. Relief must go to those areas of demonstrated and compelling need.

This hearing will focus on issues within the jurisdiction of the Commerce Committee and this subcommittee in particular. However, any legislation that ultimately moves forward will address the issues of all relevant providers and patient advocates, and to that end, we do welcome comments on any and all of the unintended consequences of the BBA.

I want to again thank all of our witnesses who have taken the time to testify today. I know we all look forward to productive dialog. I would, before yielding to the ranking member, ask unanimous consent that the opening statements of all members of the subcommittee may be made a part of the record. Without objection, that will be the case.

Now I will yield to Mr. Brown of Ohio.

Mr. BROWN. Mr. Chairman, thank you, and thank you very much for holding this hearing and getting us back in the middle of this very, very important issue.

I would like to thank our witnesses for joining us this morning and extend a special welcome to Dave Williams from Amherst, Ohio. Dave is the Director of Government Relations for Invacare, the Nation's leading provider of durable medical equipment for post-acute care. He is a nationally respected expert in health and disability issues. Closer to home, he is a member of the Amherst, Ohio, City Council.

In anticipation of this hearing, I spoke with administrators in several health care systems in and around my district in Northeast Ohio. Two themes emerged from this discussion. First, BBA cuts are not only too deep, they are also too steep. No provider can be expected to absorb cuts of this magnitude in this kind of timeframe that is laid out in the BBA.

Second, the Medicare and Medicaid cuts obviously do not exist in a vacuum. Health care providers are not contending with one cut to one service one time. They are contending with multiple cuts to multiple services over multiple years. They are not contending with Medicare cuts only. They are contending with Medicare cuts, with Medicaid cuts, with private sector managed care cuts. Unlike Medicaid and Medicare, managed care plans can negotiate bare-bones payments by shifting blocks of patients from one provider to another, something we are seeing all too often. Some providers have virtually no leverage. That is just the way it is.

Providers are not contending with flat costs, they are contending with growing costs, tight labor markets, skyrocketing prescription drug prices, the imperative to embrace new technology, new treatments. These costs are not exactly discretionary.

Finally, providers are not contending with lower reimbursement, they are contending with both lower reimbursement and often no reimbursement. The Nation's uninsured population is 44 million strong and is growing. The uncompensated care burden is not spread evenly over health care providers, but many of the BBA cuts are. In its March report, MedPAC asserted that Medicare is not required to cover the shortfalls created by inadequate private sector payments, understandably. But I also understand where Ms. Wilensky and the MedPAC Commission are coming from. But if the public sector does not acknowledge the collective threat to health care providers and to their patients, who will? What about our safety net providers, especially our big inner-city hospitals? Where is their safety net?

Congress may not be required to look at the larger picture when we consider Medicare payments, but we cannot ignore the larger picture and then still claim that Medicare is fulfilling its mission. If a provider has to cut service or close its doors, it does not matter where the payment shortfall came from. All patients suffer.

If we were to privatize Medicare, it would be a different story. Congress would pass the buck. Let the HMOs deal with provider payments. Let HMOs deal with beneficiary quality and beneficiary access. Then providers could compete with shareholders for adequate payments, beneficiaries could call HMO customer service lines when they have access problems or quality problems, and Congress could get out from under all this pressure.

Fortunately, Medicare is still a public program. Its mission is still to serve the public good and we are still directly accountable, and this subcommittee especially and in this Congress for that mission. In that context, I hope we will take action this year to restore needed funding to Medicare providers, paying particular attention to the Nation's safety net providers. In the absence of universal coverage, in a wealthy Nation riddled with medically underserved areas, we simply must ensure adequate payment to public hospitals, especially, community health centers and other safety net

providers. Realistically, Medicare and Medicaid payments must reflect that fundamental goal.

Mr. Chairman, thank you.

Mr. BILIRAKIS. I thank the gentleman.

I would ask that other opening statements be held as close to 3 minutes as possible, and I now recognize Mr. Whitfield of Kentucky.

Mr. WHITFIELD. Mr. Chairman, I cannot think of a more timely or important subject for us to be discussing today than what we are discussing. The focus of this hearing is to consider the programs which have been disproportionately affected as a result of changes made in reimbursement under the BBA Act of 1997 and whether Congress should restore monies to the Medicare and Medicaid programs.

I think each Member of Congress will be focusing on different areas, but I, for one, want to focus on the DSH proportionate payment problem. For the first time, the BBA Act of 1997 imposed an annual cap on the Federal Medicaid DSH dollars a State could receive. Many of these caps deserve a decrease over the fiscal year 1998-2002 window, and today, almost 33 percent of all hospitals will operate at a loss this year, the highest number ever.

In Kentucky, the fiscal year runs from July 1 through June 30. This year, 6 months into the fiscal year, all DSH monies had been exhausted to pay indigent care that hospitals had to render through June of 2000. This last year, Kentucky's hospitals provided indigent care at a cost of \$231 million and received only \$159 million in DSH payments, a payment of 69 cents for every dollar of indigent costs incurred. This left a \$72 million shortfall of unreimbursed indigent care that hospitals were required to absorb.

At a time when the number of people without insurance continues to rise and hospitals are losing billions of dollars caring for low-income patients, further reductions in DSH payments are ill-advised, at best. For that reason, Ms. DeGette of Colorado, Brian Bilbray of California, and I have introduced legislation to freeze any further reduction in DSH payments to hospitals. This legislation must be passed before the most severe BBA cuts in DSH take effect and strangle hospitals even more than they are today.

We all know that BBA has reduced payments to hospitals at a far greater degree than was ever anticipated by Congress, and all of us are committed to take steps necessary to restore some of this funding, certainly to reduce any further reductions, and I look forward to working with this committee and other Members of the Congress as we make efforts to address these problems.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Pallone, for as close to 3 minutes as you possibly can do.

Mr. PALLONE. Thank you, Mr. Chairman. I have already shortened it. I want to focus on my home State of New Jersey, but obviously I think that this needs to be addressed on a national level and that the problems with the BBA cuts are having a national impact.

The Balanced Budget Act of 1997 had a severe impact on New Jersey's hospitals. The cuts the BBA imposed have turned out to be far greater than Congress intended and hospitals throughout New Jersey and the patients they serve are suffering as a result.

Although last year's Balanced Budget Refinement Act helped, it was not nearly enough. Overall, the BBRA restored less than 10 percent of the cuts imposed by the BBA. The \$123 million New Jersey hospitals actually received under the BBRA is just 6 percent of the total Medicare reductions imposed by the Balanced Budget Agreement.

These reductions have helped bring New Jersey's hospitals to the worst financial state in decades. Their average margin of profitability is negative 1.6 percent and Medicare margins are below the national average. With the majority of BBA mandated cuts still to come, New Jersey's hospitals need Congress to take advantage of the larger-than-expected budget surplus and pass a comprehensive and significant refinement act this year.

Mr. Chairman, I just wanted to point out that the President and the Democrats have put forward a, over 10 years, a \$50 billion give-back plan which so far has met with total resistance from the Republicans. We tried to include this plan with the Medicare prescription drug plan before the Rules Committee when the Republican prescription drug proposal came to the floor and it was blocked in the Rules Committee. We tried again to include this last week, attach it as a motion to recommit to the marriage penalty bill that the Republicans proposed, and again, that was rejected by the Republicans. So we are out there trying to bring this to the floor and we are getting resistance from the other party.

Let me just mention a few issues that directly impact New Jersey. The inpatient payment reduction scheduled for fiscal year 2001 and 2002 should be repealed. Over the last 3 years, hospital inflation has been around 7 percent, yet the increase in payment has been below 2 percent. The BBRA provided no inpatient payment relief to New Jersey hospitals.

The funding levels for indirect medical education should be maintained at 6.5 percent. If Congress wants to ensure we have adequate teaching facilities for health professionals, Congress must provide an adequate level of funding. The reductions in IME funding scheduled for fiscal years 2001 and 2002 will place a heavy and unnecessary burden on the teaching hospitals in my State and should be scrapped.

The transfer provisions in the BBA should be repealed. Currently, hospitals actually receive a lower reimbursement when some patients are moved more quickly to more appropriate, less expensive settings. The expanded transfer definition is especially harmful to the delivery system in New Jersey, where 24 percent of seniors seek additional care after they leave the hospital.

I also support, Mr. Chairman, repealing the 15 percent cut in home health payments. This has had a major impact in New Jersey. And I also support inclusion of the safety net provisions in H.R. 2341 our colleagues Mr. Burr and Mr. Towns have introduced to strengthen community health centers.

But last, Mr. Chairman, I want to stress again that the Democrats have been out there. The President and the Democratic leadership have talked about this \$50 billion plan over 10 years. We should be allowed to bring this up. We have been trying to address it and we are getting nowhere. This needs to be addressed in a bipartisan manner.

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. PALLONE. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Mr. Bryant?

Mr. BRYANT. Thank you, Mr. Chairman. Thank you for holding this hearing. I wake up every morning and come in here bright and cheery-eyed and then consistently I hear from my good friend from New Jersey how evil the Republicans are, and I do not like them either. It makes me mad, those Republicans that do not like clean air and clean water and want to throw senior citizens out on the street and want to close all the hospitals out there so that nobody can get medical care to help our rich friends. Everything up here seems to boil down to that type of sentiment.

As a lot of us continue to try to preach up here, there is a way to go about doing things and I think our chairman has set the right course for us here. We are at a time now when all of us agree, we have agreed almost since day one that, as the numbers began to come in, that the cuts were too deep. There is no question about that. We have been trying to, since, I know the 6 years I have been in Congress, we have been trying to practice some discipline and balance the budget and get a surplus going, things that everybody now is claiming credit for, but it did not happen until about 1995, when the change of Congress took place, if you want to get partisan about it.

We are trying to do all that in that environment of keeping a balanced budget and being fiscally responsible on all these other issues. We have got a surplus now, and because of these good practices we have put into play, we have got anticipated projected even a bigger surplus than we thought.

So we are here today to talk about where and how do we address those needs of restoring money back to the health care providers to try to bring this more into line, and I think consistent with a resolution that was passed that was sponsored, I think, by Representatives Wilson and Bilbray, overwhelmingly that we need to find ways to capture parts of this money, not all of it because we have got other responsibilities, too, but to again lessen some of these cuts and to restore money.

This is not a Republican issue. It is not a Democratic issue. It is not an Independent issue. We all agree that we want to do it, but we have to do it in a fair, balanced, disciplined way as we are trying to learn to do in Washington, something that has not gone on for a number of years before we came up here and took control of the Congress. So it is a hard lesson to learn, but we are trying to stay that course and be responsible, yes, to the medical providers, but also to the senior citizens and to the young people out there and to education and to the environment and anything else you can name out there. It is not an easy task, but if we can continue to work together and not practice a politics of division that so often happens up here, I think we have a better chance of doing it.

With that, I will yield back my time.

Mr. BILIRAKIS. I thank the gentleman.

Ms. DeGette for her opening statement.

Ms. DEGETTE. Thank you, Mr. Chairman. I will add my thanks for holding this hearing.

I want to emphasize that Medicaid and the CHIP program were also included in the Balanced Budget Act of 1997 and I want to do that because so often we forget that they are the forgotten sister health programs to Medicare. But we need to remember these programs are both solely in our jurisdiction and I hope that we will address issues that have arisen in them as well as Medicare in this hearing and as we move forward.

I have sort of a smorgasbord of issues this morning, so I will try to move as quickly as I can through them. The first one, I understand, has been mentioned, is this issue of the disproportionate share program which is causing our Nation's safety net hospitals to absorb \$10.4 billion in reductions. Safety net hospitals like Denver Health, Virginia Commonwealth, Los Angeles Children's Hospitals, and even for-profit hospitals are suffering tremendously under these cuts.

As you have heard, Representative Whitfield, Representative Bilbray, and I have been working assiduously on this issue for the last number of months. Between our two bills, we now have 60 percent of the Commerce Committee as cosponsors and over 215 total cosponsors in the House. I think this is an issue with significant grassroots and bipartisan support and I believe we need to address it with passage of legislation this year.

Second, I think the Commerce Committee needs to address some issues on the children's health insurance program. We talked about this in full committee markup last week, and I would also like to note a majority of the members of this committee are cosponsors of bipartisan legislation that would grant States the option of providing coverage to pregnant women through the CHIP program, as well as my bill, H.R. 827. Similar language is included in bills by Representatives Emerson, Ganske, and Hyde, and Senator Bond has introduced identical language that has been cosponsored by Majority Leader Trent Lott and Senator McCain.

I am listening to my colleague across the aisle. I am really trying to be bipartisan here, because I think these are bipartisan issues that we need to address. There are a lot of other issues with the CHIP program that I think can be fixed, as well.

A couple of other issues that I want to talk about, with regard to Medicare, the Balanced Budget Act established a self-management education benefit for diabetics, for Medicare beneficiaries. However, HCFA has failed to issue a final rule on this provision, and what is more, it allowed the interim guidance to expire. As a result, the availability of diabetes self-management education is not increasing as intended by the BBA. As co-chair of the Diabetes Caucus, with over 280 members, I think HCFA needs to act quickly to revise the interim guidelines and complete its rulemaking. If we can have adequate diabetes health management, we will avoid many of the side effects that this disease can bear upon people.

Mr. BILIRAKIS. Will the gentlelady please finish up?

Ms. DEGETTE. Yes. I would just like to highlight one more concern I do not think we will hear about from anybody else, and that is access to ambulance services. The BBA required HCFA to place ambulance service providers on a Medicare fee schedule through a negotiating rulemaking process. The problem is the BBA requires the process to be conducted in a budget-neutral fashion, so HCFA

cannot actually talk about the costs. Unfortunately, there is a recent study that shows ambulance service providers may face a profound shortfall, so I hope we will address this, too, Mr. Chairman.

Once again, thanks for your consideration.

Mr. BILIRAKIS. I thank the gentlelady.

Now, in the interest of time here, we have a lot of hearing ahead of us. I have asked members to keep their remarks to within 3 minutes. We have that prerogative. Dr. Ganske?

Mr. GANSKE. Thanks, Mr. Chairman. I will stay within 3 minutes.

I chose to sit in this spot because this is where I sat 5 years ago, in 1995, and I very well remember one hearing that we had in which I had the temerity to suggest that a tourniquet could staunch hemorrhage, but applied too tightly could cause gangrene, in more or less those words. Well, so here we are today and we are looking again at some adjustment.

I would say the No. 1 problem in my district is the issue of rural hospital reimbursement, and I think we need an across-the-board inflationary adjustment for those hospitals because they have cost increases that are beyond their control, for instance, their pharmacy and their drug costs, which we have debated a lot on that issue in the last several weeks. Basically, we need to increase the DRGs for those hospitals. I mean, it will not do my senior citizens any good to have a prescription drug benefit if they do not have a hospital to go to any more in their town.

So I look forward to this hearing and the testimony that we are going to have from the panels and I hope we have enough chairs for the second panel. Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman.

Ms. Capps?

Ms. CAPPS. Thank you, Mr. Chairman, for holding this important hearing. It could not be more timely.

As we know, the Balanced Budget Act of 1997 enacted some far-reaching changes in the way Medicare pays health care providers. These changes were intended to modernize and save money, some \$115 billion. Today, we know that the actual savings are much larger than Congress had anticipated and that those changes are affecting services. Providers say that delivery of care could be compromised. Many say that it already has become such.

The Balanced Budget Refinement Act, which passed last year and restored \$16 billion, was certainly a step in the right direction. I was glad to strongly support that effort, but there is still so much more to be done to bring relief to the hardest-hit providers. Like many members, I hear again and again in my district regarding these cuts in the BBA and how they are affecting quality health care. I take these concerns very seriously. We are going to hear more personal stories today, I know, and I want to give one of my own, if I may.

Just recently, I met with the Santa Barbara Rehabilitation Institute, where my husband, Walter, received multi-disciplinary treatment after a serious car accident in 1996. This is the only free-standing non-profit rehabilitation center between Los Angeles and San Francisco. Approximately 70 percent of their patient care is

paid by Medicare or Medicaid. They have been devastated by the 1997 BBA cuts.

If these cuts continue, the Santa Barbara Rehabilitation Institute estimates that they will have to shut their doors in 2 years, this in the face of a huge public outpouring of support to the tune of raising money to build a new facility. This institution saved my husband's life. The accident happened a few short months before his election, to which he was elected to Congress. He would never have been elected if it were not for this wonderful facility, non-profit facility in my community. Soberly, they told me a month ago that they have cut to the point where they know in 2 years, despite public outpouring for a new facility, they will close their doors because they cannot provide service.

The other large hospital in our community is Cottage Hospital, a medical staff of more than 500, including a wide range of adult and pediatric services. My constituents rely on it. They will experience a \$23 million reduction in Medicare reimbursement from fiscal year 1998 to 2002. The largest losses have occurred in graduate medical education, with almost half of their GME costs not being reimbursed. In addition, the reimbursement for Medicare patients to Cottage has dropped significantly since 1997, is continuing to drop. They know that the most severe drops are in the next 2 years. I am very deeply concerned that the ultimate quality of care is being affected now and that unless something pretty dramatic happens, that the worst is yet to come because many of these institutions have already pared as much as they can.

So I am looking forward to hearing from our witnesses today on these and other critical issues. Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentlelady.

The chairman of the full committee, Mr. Bliley. Chairman Bliley?

Chairman BLILEY. Thank you, Mr. Chairman. I am please that the Health and Environment Subcommittee is holding this important and timely hearing today. This committee made important changes to the Medicare-Medicaid programs 2½ years ago. In addition, we created the State Children's Health Insurance Program. It is good to continuously monitor thee programs and the impact policy decisions have on the health care system. In particular, the committee should know of any unintended consequences that may have an adverse effect on access to care.

In the Balanced Budget Act of 1997, this committee made some difficult decisions on how best to address the financial concern of the Medicare program. Changes needed to be made and we made them. The committee made tough choices. Moving to a prospective payment system for hospital outpatient department services, skilled nursing facility services, and home health services were just some of the revisions. These were to achieve savings of \$103 billion over 5 years.

CBO continues to revise their estimates of spending in the Medicare program. It seems every revision they have released since passage of BBA 1997 shows that spending is less than originally anticipated. In addition, spending in 1999 was actually less than it was in 1998. Just yesterday, the CBO released its mid-session review of its budget estimates, which showed that Medicare spending

is again lower than projected. At the same time, we are enjoying a greater-than-expected budget surplus.

A resolution was offered by two members of this committee late last month, Mr. Bilbray and Ms. Wilson, which declared it was the sense of Congress that if CBO's estimates showed a greater-than-expected non-Social Security surplus, then we should consider further refinements to the changes enacted in BBA 1997. CBO now estimates that this fiscal year 2000, non-Social Security surplus is \$84 billion, compared with an estimate of \$26 billion just 3 months ago, for an increase of \$58 billion.

It is very timely that this hearing today considers how best to refine even further the policies we enacted 2½ years ago in BBA 1997. In doing so, however, we must be mindful that last November, Congress responded to problems some providers were facing in the Medicare program due to changes made in BBA 1997 by restoring nearly \$16 billion over 5 years to the Medicare, Medicaid, and SCHIP programs. We worked on a bipartisan, bicameral basis with the White House in refining the policies established in BBA 1997.

As further refinements are considered, it is important to recognize that it is hard to calculate the true impact of those recent changes. We must not rush to spend money or change policy too quickly.

I look forward to the testimony from our first panel of expert witnesses, Dr. Wilensky from MedPAC and Dr. Scanlon from the General Accounting Office. I also want to thank our witnesses on today's second panel. I particularly want to welcome before the committee a constituent whom I consider a good friend, Ms. Marilyn Tavenner. Marilyn is a registered nurse and the CEO of the Johnson-Willis and Chippenham Medical Center in Richmond, where she also runs the Henrico Doctors' Hospital, the John Randolph Medical Center, and the Retreat Hospital.

Again, Mr. Chairman, thank you for convening this hearing, and I yield back the balance of my time.

Mr. BILIRAKIS. I thank you, Mr. Chairman.

Mr. Stupak for an opening statement.

Mr. STUPAK. Thank you, Mr. Chairman. I will try to be brief.

I am especially concerned about the effects of BBA on rural areas, especially like Northern Michigan, and let me just quote the Director of the Center for Health Plans and Providers of HCFA when he said, "About one in four Medicare beneficiaries live in rural America and rural hospitals serve a critical role in areas where the next nearest hospital may be hours away. Yet rural hospitals face special challenges. They have a higher per unit cost, difficulty maintaining enough patients to break even, and difficulty recruiting physicians. Medicare has made exceptions and special arrangements to address the unique needs in rural areas and strengthen these vital facilities. Even before the BBA, Medicare provided special payment support to more than half of all rural hospitals." These special challenges and concerns are why the BBA has had a disproportionate effect in rural areas. The administration understands these concerns and has proposed a number of steps, including \$1 billion over the next 10 years to address those concerns.

But I know that my providers and I believe that the outpatient department and the cuts made there have really been detrimental to rural hospitals. We need to change the flawed Medicaid payment policy for community health centers, and that is why I strongly support the enactment of H.R. 2341, the Safety Net Preservation Act, and I join with a number of bipartisan members and urge the committee to include that in any BBA relief.

With that, Mr. Chairman, I will yield back the balance of my time because I look forward to hearing from our witnesses.

Mr. BILIRAKIS. I thank the gentlemen.

Mr. Burr for an opening statement.

Mr. BURR. Thank you, Mr. Chairman. Mr. Chairman, for the entire time that I have been in Congress, I have gone home and suggested to my constituents that they not judge us on what we do but judge us on what we get wrong and how quickly we go back and fix it, because I think, clearly, 5½ years ago, we had a challenge in Washington, a fiscal challenge, a policy challenge, one that doing nothing was not an answer. We had to do something.

You do not get 100 percent of the things right when you have got as big a task as we had, and with this, we did not get 100 percent of the things right. Our target for health plans was intended cuts of \$22 billion over 5 years. The actual is \$30 billion. Hospitals, \$53 billion was the target over 5 years. Seventy-five is the actual. Home health was \$16 billion over five and the actual is \$69 billion. Nursing homes, \$9.5 billion and the actual is \$16.6 billion.

In my district, Baptist Hospital lost \$90 million in inpatient and outpatient payments and \$40 million in IME payments as a result of BBA. The BBRA only gave back \$4 million to the Baptist Hospital.

Last fall, this House passed the BBRA. Included in that was H.R. 2341, a bill sponsored by Mr. Towns and myself. It had overwhelming support in the House and I think it is safe to say that there was overwhelming support on the Hill. Unfortunately, in the conference with the Senate, it was not included in BBRA, but we did get some temporary relief. H.R. 2341 currently has 226 cosponsors in the House. Seventy percent of the Commerce Committee cosponsors this bill. Seventy-seven percent of the Health and Environment Subcommittee are cosponsors of H.R. 2341. The Senate companion bill has 54 cosponsors. This is the year to enact this legislation, yet even with this much support, there are still people that oppose this bill. For the life of me, I cannot understand why.

Community health centers have two major sources of money. One pot of money is for Medicaid. The other pot of money is from the Federal Government for the uninsured. When we tighten one too much, the other has to pay out and there are losers, and in this case it is the uninsured throughout this country.

Mr. Chairman, if we do not include H.R. 2341 in a final BBA refinement bill, community health centers and rural health clinics will lose \$1.1 billion in the next 5 years. That will be 1.3 million uninsured that potentially go without coverage.

Now is the time for us to do this. I thank the chairman for his holding this hearing and I look forward to this committee's work on a refinement bill.

Mr. BILIRAKIS. Thank you, sir.

Mr. Green for an opening statement.

Mr. GREEN. Thank you, Mr. Chairman, and again, like my colleagues, I appreciate you calling this important hearing. I appreciate the opportunity to focus on the status of our health care providers, the impact of the BBA in 1997. I am disappointed that we do not have a representative from the public hospitals on our panel today. Public hospitals serve the poorest of the poor, particularly in Houston and other cities across the country. I know in Houston, our public hospitals are in a crisis due to the funding reductions. All hospitals have been devastated by the payment cuts in the Balanced Budget Act. Public as well as private hospitals need relief. Like my North Carolina colleague, I agree, and I supported the Balanced Budget Act of 1997, but also realize that it went much too far and hopefully this Congress will correct it.

The Institute of Medicine, a nonpartisan advisory board, recently completed its study of "America's Health Care Safety Net: Intact, Endangered." In this report, the IOM concluded that the urban safety net providers are in crisis. The increased number of uninsured, the growth of Medicaid, managed care, and reductions in Federal funding have hurt not only public hospitals but all providers. IOM concluded that the safety net providers in our country comprise a unique health care delivery system. They deserve stronger Federal tracking and targeted direct support, and I agree and I am hopeful that we will consider putting money back into our Medicare system and keep in mind those living and providing care in our urban areas.

One of the most important things we can do this year is examine the impact of the BBA's freeze on the disproportionate share, or the DSH, funding. The Medicaid program is our Nation's primary source for the safety net hospitals that serve the most vulnerable Medicaid, uninsured, and under-insured patients. The Balanced Budget Act was supposed to cut \$10.4 billion from DSH expenditures to States over 5 years with the impact coming this year and next year. State DSH programs will receive a 30 percent reduction in fiscal year 2001 and a 37 percent reduction in fiscal year 2002. While the legislation we passed last year provided some relief for hospitals, that relief was targeted primarily to the Medicare program. Fifteen percent of the BBA savings came from Medicaid, but less than 3 percent of the funding we restored last year went to Medicaid. I commend my colleague, Diane DeGette, for her efforts on this issue, and her legislation to restore DSH funding should be part of any Medicare give-back legislation.

Thank you, Mr. Chairman. I yield back my time.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Greenwood?

Mr. GREENWOOD. Thank you, Mr. Chairman, for holding the hearing. I am one who believes that managed care Medicare is a great idea. Done properly and funded appropriately, managed care as an option within Medicare stabilizes Medicare because it gives us a predictable cost per beneficiary per year. It saves the taxpayers money by providing Medicare benefits at less than the average cost. And for the beneficiary, it has offered the opportunity to have quality care without the cost of a medigap policy and with enhanced benefits, like prescription drugs.

But we have not been handling and funding managed care and Medicare properly. We have been trying to buy it on the cheap, and additionally, HCFA has not been much help in the regulatory sphere. Last year, 41 plans terminated services to Medicare beneficiaries in 58 service areas and forced 327,000 seniors to choose a new plan or move back into fee-for-service and 79,000 of them could not get back because there was not a managed plan option where they lived. Next year, 711,000 Medicare beneficiaries will lose access to health benefits and choices next year as a result of this underpayment.

Today, I am introducing the Medicare Beneficiaries Choice Stabilization Act, which will be a bipartisan plan to put Medicare Plus Choice programs back on solid, stable financial ground. I hope, Mr. Chairman, that that legislation can be included in our BBA fixes.

I also yesterday introduced a Hospital Indigent Care Relief Act of 2000 with Ms. DeGette which will help in that area. And finally, on Thursday of this week, I will introduce with Mr. Deutsch a bill to increase Medicare reimbursement for mental health services for low-income seniors.

Mr. Chairman, I hope that each of these critical areas can be addressed in the legislation that we ultimately adopt and thank the chairman for the comments.

Mr. BILIRAKIS. I thank the gentleman. I think that completes our opening statements.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. Chairman, thank you for calling today's hearing to examine the impact that the Medicare and Medicaid provisions of the Balanced Budget Act of 1997 are having on patients and providers. The Balanced Budget Act made the most sweeping changes in the Medicare program since its inception. It is vital that we in Congress closely monitor the implementation of those changes and their impact on beneficiaries' access to care and quality of care.

I meet very regularly with my health care community, and I can tell you that they are very concerned about the future of the health care delivery system in my district and state and across the nation. If Medicare payments fail to reflect the real costs of delivering quality health care and hospitals, home health agencies, nursing homes, emergency ambulance services, and rehabilitation practices close, not only Medicare beneficiaries but entire communities will suffer a loss of access to care. This is particularly true in our rural areas. When rural hospitals close, physicians and other health care providers may also be forced to leave the community as well.

I'd like to highlight some specific areas of concern that my health care community has shared with me. First, there is a good deal of uncertainty and angst about the implementation of the hospital outpatient prospective payment system. I want us to take this opportunity today to determine whether the Health Care Financing Administration, hospitals across the nation, and the intermediaries are ready to implement the system in a way that will ensure fair and adequate payments reflecting the intensity of care that is needed in each case.

Second, I hope we can revisit the issue of the caps on physical, occupational, and speech and language therapy. I know we have postponed the effective date for the caps, but I want us to focus on developing a more sensitive way than imposing arbitrary caps of ensuring that the care Medicare is paying for is necessary and appropriate.

Similarly, I want to revisit the 15 percent across the board cut in home health care reimbursement. We have postponed the effective date of this cut, but I hope that we can eliminate this cut and instead continue work out a more refined reimbursement system for ensuring that Medicare payments reasonably reflect the true cost of providing necessary and appropriate care.

Fourth, I am very concerned about the implementation of the BBA requirement of a fee schedule for ambulance services. It is my understanding from talking with

my ambulance service providers that the system that HCFA may promulgate will not come close to reflecting the actual cost of providing these services. I want to encourage HCFA to continue to work with the ambulance community to get the system right before it is implemented.

Fifth, I hope that we can revisit the community health center provisions of the Balanced Budget Act. I am concerned that the current provisions phasing down the percent of costs for which state Medicaid programs must reimburse the centers would, if further implemented, seriously undermine the survival of these safety net health care providers for the poor and the uninsured. I'd like us to look instead to implementing a prospective payment system that has incentives for efficiency but that will permit community health centers to continue to meet the needs of the poor and the uninsured with high-quality care and services.

I look forward to working with you, Mr. Chairman, my colleagues on the Subcommittee, and providers and beneficiaries to ensure that we are strengthening, not threatening, access to care and quality of care.

PREPARED STATEMENT OF HON. ANNA G. ESHOO, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF CALIFORNIA

Like so many of my colleagues, I hear every week from health care providers in my district that the cuts in the 1997 Balanced Budget Act are crippling them.

Hospitals, home health agencies, and nursing homes across the country say they simply can't provide quality medical care within the budget cuts we enacted just three short years ago.

Mr. Chairman, as a New Democrat, I know the importance of fiscal responsibility and budgetary constraint. However, I'm concerned that we may have gone too far.

A Lewin Group study found that payments to health care providers are already \$40 billion lower than we anticipated when we passed the BBA.

While some of the savings may be the result of outside forces, particularly an aggressive crackdown on fraud and abuse, it's clear that the BBA cut deeper than Congress expected or intended.

Before coming to Congress, I served as chair of the county hospital board in San Mateo County, California. I know that a hospital can't continue to offer services on a negative margin. Something has got to give.

And I fear that the thing that will give is patient care. Without relief, hospitals, home health agencies and nursing homes are faced with two options: cut back services or withdraw from the Medicare program altogether.

It's already happening.

In the first year following enactment of the BBA, nearly 25% of home health agencies in the U.S. closed their doors, leaving over 500,000 seniors without services.

By the end of 1998, 400,000 beneficiaries were thrown out of their Medicare HMOs when their insurance company terminated their contracts with Medicare.

We remedied some of these problems with last year's Refinement bill.

The 15% across-the-board cut in home health services was delayed.

A two-year moratorium was placed on implementation of the therapy caps.

But there is much left to do. This is the second hearing we've held on this issue, Mr. Chairman. I hope that the next action that this Committee takes is to write a bill that takes care of these problems.

And I hope that this year's bill includes Medicaid.

Last year's BBRA did not include any money for Medicaid, leaving a large gap for the public hospitals in my congressional district who serve a disproportionate share of indigent clients.

BBA reductions in Medicaid DSH spending have been particularly dramatic in California, where payments have declined more than \$116 million in the past two years.

Without relief, California DSH hospitals stand to lose another \$164 million by 2002.

I'm a cosponsor of Rep. DeGette's bill to eliminate any further cuts to Medicaid DSH hospitals. I urge this Committee to include the DSH freeze, and other fixes for Medicaid, in any givebacks bill we write this year.

CBO has given us the good news—we now have a \$2.2 TRILLION non-Social Security surplus. The President has expressed his support for dedicating a large portion of this to BBA givebacks.

Now is the time to shore up the Medicare and Medicaid systems and ensure that seniors continue to have access to good, quality healthcare.

I look forward to a bill that provides needed relief while still remaining true to the BBA's goal of fiscal responsibility.

PREPARED STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF MICHIGAN

Medicare is a good, solid program. For 35 years the program has ensured that America's seniors and disabled have dependable, affordable health care. Congress should take care to ensure that the program remains strong and that beneficiaries continue to have access to high quality health care.

The Balanced Budget Act of 1997 (BBA) was an attempt to reduce costs in the Medicare program where there was evidence that the program was overpaying. Investigations by the Inspector General and the General Accounting Office and others indicated areas where the program could do better. But some other changes may have inflicted more harm than good.

I agree that there are some areas where Congress should revisit some of the changes made in the Balanced Budget Act. I know that in my own district, hospitals have struggled, and some, like Mercy Hospital, a provider of care to many low-income and uninsured patients, have even closed their doors. Other hospital closures will follow. Community Health Centers, which are beginning to feel the effects of the phase-out of cost-based reimbursement and the state Medicaid program's transition to managed care, are struggling as well. These are matters that concern me greatly.

However, we must keep in mind that changes as sweeping as those enacted in the BBA take time to digest, and we must not act with haste. We should carefully explore the issues and the merits of the claims. We want to act judiciously.

When contemplating program changes, we must keep our focus on the beneficiaries. There are a number of modifications that Congress could make that would improve the program for beneficiaries. The first step is adding a solid prescription drug benefit in the Medicare program that is meaningful and affordable. But, we should also consider adding preventive benefits, buying down the hospital outpatient department co-payments, increasing enrollment of low-income beneficiaries in assistance programs and other options to improve the program for seniors and the disabled.

In conclusion, I welcome this hearing as a first step in exploring the need for further modifications to the changes made in the Balanced Budget Act of 1997. I hope that our Committee will thoughtfully deliberate—and act—on this matter. I also ask my colleagues not to forget those who depend on the program for their care—the seniors and disabled. I hope that we will find it in our hearts to ensure they benefit directly, as well as indirectly, from additional Medicare spending this year.

Mr. BILIRAKIS. I would now ask the distinguished panelists making up panel one to come forward. Dr. Gail Wilensky is the chair of the Medicare Payment Advisory Council. Bill Scanlon is the Director of Health Financing and Public Health of the General Accounting Office. Both have appeared before this committee countless times in the past and I expect countless times in the future.

We will set the clock at 5 minutes, but by all means, if you have got to go over it, it will not be any problem in that regard. Dr. Wilensky, please proceed, ma'am.

STATEMENTS OF GAIL R. WILENSKY, CHAIR, MEDICARE PAYMENT ADVISORY COMMISSION; AND WILLIAM J. SCANLON, DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, U.S. GENERAL ACCOUNTING OFFICE

Ms. WILENSKY. Thank you, Mr. Chairman and members of the subcommittee. I am pleased to be here representing the Medicare Payment Advisory Commission as its chair.

As you have indicated, MedPAC appeared before you in the fall of 1999 indicating at that time, while we had some areas of concern, there was not clear evidence that wholesale changes needed to be made to the Balanced Budget Act. There were some specific areas of concern and Congress correctly took those up in the Balanced Budget Refinement Act. There are still issues that remain and we would like to indicate some areas where we as a commis-

sion have some concern, although we would again like to caution that this does not mean that you ought to undertake wholesale changes to the Balanced Budget Act.

Its purpose, of course, was to moderate spending and also to introduce more choice, as we have just heard, and it is obvious that spending on Medicare has been moderated substantially. It was estimated that spending would increase at about 5.5 percent per year in the first fiscal year. It increased 1.5 percent. It declined slightly in the last fiscal year. It appears, as best we can tell through the first 8 months, that Medicare spending is up about 3.5 percent over last year, still under the spending that was projected by the Balanced Budget Act, but it does appear that spending is increasing in this Medicare program.

However, in looking at potential changes, we ought not just to look at spending patterns. They are important. They are important by specific services. But we ought to ultimately look at what we can tell in terms of what is happening to access. Ultimately, that is what the Medicare program is supposed to be about, making sure that our seniors get access to high-quality care.

There is not very much, if any, systematic evidence that seniors are having difficulty receiving care under Medicare as a result of the Balanced Budget Act, but there are some areas, either because of what we can see going on in the spending patterns that have raised concerns in the minds of the MedPAC commissioners or because of some principles in terms of how the payment structures are laid out, that we think are appropriate for some further adjustment, and I would like to talk about the major areas of hospitals, home care physicians, and the Medicare Plus Choice.

First, let me say once again that we continue to be plagued by data problems. We have difficulty getting timely data. MedPAC joined with HCFA to try to get an indicator survey going so we would get a little bit more timely hospital data. We are continuing to try to work on this. We are frustrated, we are sure you are frustrated, because it makes it difficult to make the best decisions.

Let me talk first about the hospital payments. As you know, MedPAC in this year has recommended a substantially higher increase than is part of current law. We are recommending an increase that is about .5 to 1 percent above the market basket, and there were three reasons why we came to that conclusion.

The first is that while we have gone to suggest take-back from site of care substitution, that is, hospitals having some of the care that used to be done inpatient being done more often in home care or in nursing homes over the last decade, that attempting to recoup for past movements did not seem prudent when we were observing the sharp declines in total margins that hospitals were reporting.

Second of all, for the first time, there appears to be some down-coding. That is, in a systematic review of actual medical records, it appears that hospitals are billing for lower rather than higher or the right diagnoses for the patients that they have seen.

And finally, we are a little concerned about what has been happening with some of the scientific and advancement areas and also the inpatient pharmaceutical costs that hospitals have to face. So, therefore, we have suggested that there be a consideration given to a higher update than is currently part of law.

We do recognize that the BBRA did look to help the hospitals in a variety of ways last year, particularly in terms of softening the transition to the outpatient PPS, to putting a hold on continued downward payments in disproportionate share, and on the IME part of the medical education payment. Nonetheless, the sense of the commissioners was that for at least this one year, consideration be given to this increased payments for hospitals.

With regard to home care, while we feel we know the least about what is going on, particularly to the patients who are receiving care, we are troubled by the very dramatic decline in spending that has occurred in the last 2 years, a decline of 45 percent from spending in 1997. This is an area where we had seen very rapid growth in the 1990's, both in terms of the number of services and in terms of the number of people receiving services and in the number of agencies, but those numbers have declined sharply, closer to 1994 levels, and as I have indicated, a rather substantial decline in absolute spending.

We believe that moving to the prospective payment system will help. We think that there are some issues that need to be monitored in terms of making sure that access continues to occur for people in home health. It is the sense of commissioners, although we have not made this a formal recommendation because of the timing, that the Congress would be wise to postpone the 15 percent reduction in payments that has been part of current legislation because of these very substantial declines in spending that we have seen. We think we will know more and the Congress will know more when data becomes available and we have a better sense about the clinical services provided to seniors as part of home care and what it may mean if they do not continue to have these services.

With regard to physician care, there were a number of areas where we have raised some questions, some of which were addressed in BBRA. We had some concern about the oscillations, the swings in the sustainable growth rate, and the BBRA has moved to reduce those and also to take care of some of the errors in terms of the estimations that would occur, although they will be only in the future.

And finally, we have encouraged further review about how HCFA makes its estimates for the number of people who will be served in the traditional fee-for-service program because that impacts the sustainable growth rate.

And finally, let me say a word about the Medicare Plus Choice program. As I indicated, that was supposed to be, that is, giving more choices to seniors was supposed to be one of the objectives of the Balanced Budget Act. We clearly are seeing a troubled program. In part, we think it is because there is some inherent conflict with some of the goals that Congress has enunciated about what they want from that program, saving money and also providing either more benefits or more choices.

We think regulatory burdens have been a problem. There has been some attempt in the BBRA to address some of them and I believe HCFA is now sounding as though they also agree that regulatory burdens may have had some negative effect. And I believe that the uncertainty about future payments has been a problem.

I continue to believe that the idea of having Medicare replacements is an important strength of the Medicare program and hope that this committee and other committees of the Congress will look to find ways to produce a stable set of Medicare replacement programs in addition to strengthening the traditional Medicare program.

Thank you, Mr. Chairman.

[The prepared statement of Gail R. Wilensky follows:]

PREPARED STATEMENT OF GAIL WILENSKY, CHAIR, MEDICARE PAYMENT ADVISORY COMMISSION

Good morning Chairman Bilirakis, Congressman Brown, members of the Subcommittee. I am Gail Wilensky, chair of the Medicare Payment Advisory Commission (MedPAC). I am pleased to participate in this hearing on the Balanced Budget Act (BBA) of 1997 and its impact on patients and providers.

When MedPAC last appeared before this subcommittee in September 1999, we testified that although there was no evidence in support of wholesale changes to the BBA, there were several areas in which specific steps could be taken to preserve access to high-quality care for Medicare beneficiaries. The Congress addressed—or began to address—some of the issues we raised when it enacted the Balanced Budget Refinement Act (BBRA) of 1999. Other issues remain unresolved and may warrant action. My testimony today discusses these unresolved issues and possible courses of action. It concludes that in considering alternatives, the Congress should take care not to oversolve problems. Changes as sweeping as those enacted in the BBA necessarily take time to digest, and the uncertainty caused by frequent changes in payment rates and systems may do more harm than good.

Introduction

The BBA was enacted to control the growth of Medicare spending and to provide Medicare beneficiaries with additional choices for care through private health plans. To control spending on services already paid prospectively, such as the services provided by hospital inpatient departments, the Act reduced payment updates in relation to what they would have been. To control spending on services that had been reimbursed largely on the basis of costs or charges, such as those provided by hospital outpatient departments, skilled nursing facilities, and home health agencies, the Act established new prospective payment systems. To control spending and to expand beneficiaries' choices of private health plans, the law also created the Medicare+Choice program, which allows new types of plans to participate, and established new payment rules that raised payments to plans in some areas, lowered them in others, and capped the growth in payments at less than the growth in fee-for-service spending.

Since enactment of the BBA in 1997, Medicare outlays have increased at a rate well below what was projected at the time. After flat or declining spending in fiscal years 1998 and 1999, outlays for Medicare are now growing slowly. Through the first eight months of fiscal 2000, spending has increased at only 3.5 percent, well below the 5.5 percent rate projected when the BBA was enacted. This continued slow growth in Medicare spending has raised concerns about whether the BBA may have compromised beneficiaries' access to high quality care. Much of this concern has come from health care providers and plans. Over the past two years, providers have asserted that the impact of the BBA has been harsher than was intended by Congress, that the law's intended effects have imposed undue burdens on them, and that there have been specific problems with the Health Care Financing Administration's (HCFA) implementation of the law.

Measuring beneficiaries' access to care in traditional Medicare is a difficult exercise in the best of times. Because we cannot directly observe access on a timely basis, we must often rely on indirect measures that we believe indicate providers' ability and willingness to provide services. These indirect measures include trends in spending for specific services and in providers' financial performance. We also make analytical judgments to help us determine where problems are likely to arise. For example, we know payment systems that do not adequately account for variations in patients' resource needs are likely to be problematic for beneficiaries with the greatest need.

Last fall, before this Subcommittee, MedPAC testified on the implications of the BBA for Medicare's fee-for-service sector. We noted then that our efforts to assess changes in access resulting from the BBA had been hampered by a paucity of data

and by the difficulty of sorting out the effects of changes in Medicare payment policy from other policy changes and from developments in the broader health care market. In the case of hospital services, for example, we lacked systematic data on financial performance in the post-BBA period; the limited evidence we did have did not allow us to attribute observed changes to Medicare. In the case of home health care, we knew that spending and use had fallen, but we had no way to disentangle the effects of payment changes enacted in the BBA from concurrent policy changes intended to reduce fraud and abuse.

We also indicated in our testimony areas in which we had reason to believe that technical aspects of Medicare's payment systems could lead to problems. For example, we noted that the absence of an adjustment for case mix in the interim payment system (IPS) for home health services could raise problems for patients with high resource needs. We noted a similar concern with respect to the newly implemented prospective payment system for skilled nursing facilities, which did not appear to account adequately for the needs of high-acuity patients. Finally, we noted technical difficulties with the sustainable growth rate (SGR) system used to update payments to physicians.

A number of developments affecting fee-for-service Medicare have occurred since we testified last September. In some areas—such as hospitals' financial status—we now have data that allow us to make a better assessment of the BBA's implications. In other areas, changes enacted by the Congress in the BBRA have addressed the issues we raised.

Gauging the success of the Medicare+Choice program is different than measuring access to specific services in traditional Medicare. Here, the appropriate measure is whether the program is meeting the Congress's goals of controlling program spending and increasing beneficiaries' choices of plan options. In our March 1999 report to the Congress, MedPAC noted specific changes in regulatory policy—such as how HCFA defined service areas and when the agency required submission of premium data—that could encourage plans to participate without compromising the objectives of the program. The BBRA codified these policies and made other changes intended to put the Medicare+Choice program on a more solid footing.

The following sections provide more detail on what we know about the impact of the BBA and BBRA for hospital services, home health care, physicians' services and the Medicare+Choice program. They also suggest possible courses of action.

Hospital services

Hospitals have been among the most vocal providers in seeking relief from the BBA, in part because so many of their operations were affected by provisions of the law. For inpatient services covered by the prospective payment system, the BBA froze base payments in fiscal year 1998 and reduced updates in subsequent years, instituted a new policy for transfer cases, lowered the adjustment for indirect medical education (IME) to teaching hospitals, lowered the adjustment received by hospitals that treat a disproportionate share (DSH) of low-income patients, and reduced capital payment rates. For outpatient services, the BBA eliminated the so-called formula driven overpayment, extended reductions in payments for capital and services paid on a cost basis, and directed the Secretary to implement a prospective payment system for services still being paid at least partially on the basis of costs. Collectively, these provisions were intended to slow Medicare spending growth, bring inpatient payments in line with costs, and move payments for outpatient services from a cost-based system to a prospective one.

In response to hospitals' concerns that the BBA had been too harsh, the BBRA increased IME and DSH payments for inpatient services and eased the transition to the outpatient prospective payment system. The law raised the payment base for outpatient services, provided partial protection against financial loss through 2003, added an outlier policy to compensate for extremely high-cost cases, and allowed additional payments for certain drugs, biologicals, and medical devices for three years.

Hospitals' financial status deteriorated significantly in 1998 and 1999. MedPAC estimates that on hospitals' largest lines of Medicare business—acute inpatient, outpatient, skilled nursing facility, home health, and inpatient rehabilitation and psychiatric—Medicare margins dropped from 9.8 percent in 1997 to 6.5 percent in 1998. Considering acute inpatient services alone—which account for three-quarters of hospitals' payments—hospitals' Medicare margin fell from an historic high of 17.0 percent in 1997 to 14.4 percent in 1998. Excluding payments for graduate medical education, the fraction of hospitals with negative inpatient margins rose from 23 percent in 1997 to 29 percent in 1998.

To obtain more timely data, MedPAC is co-sponsoring with HCFA a new survey of hospitals. Although data from this survey cover fewer hospitals and do not allow us to break out margins on Medicare services, they are more current than the infor-

mation on Medicare margins we obtain from cost reports. Based on this new survey, we estimate the aggregate total margin for hospitals covered by Medicare's inpatient prospective payment system to have been 2.7 percent in 1999, less than half its 1997 level.

The drop in total and Medicare margins provides information we did not previously have, but two issues cloud interpretation of this information. First, while reduced Medicare payments played a role, lower private payments (relative to the cost of care) accounted for about three-quarters of the decline in total margin between 1997 and 1998. Second, changes in margins do not translate directly into changes in access or quality; instead, they indicate the pressure that hospitals face.

In assessing hospital inpatient payments, MedPAC relies on margin data for context, but we base our recommendations on updates to payments on a framework that examines factors influencing providers' costs or payments. Using this framework last year, we concluded that the update set in law for fiscal year 2000 was appropriate. This year, however, we recommended an update of 3.5 to 4.0 percent (0.6 to 1.1 percentage points above market basket). Three factors guided our reasoning. First, in view of the financial stress that hospitals are experiencing, we elected to delay the phase-in of a downward adjustment for unbundling of services—shifting the latter days of inpatient stays to a post-acute setting—that we have previously recommended until we can revisit the issue next year. Second, a first-ever drop in the case-mix index—possibly reflecting more cautious coding by hospitals in response to federal antifraud efforts—led us to recommend an upward adjustment to offset the decline. And third, we recommended an increase for the costs of scientific and technological advances, primarily in response to the impact of new drugs.

With respect to outpatient services, some transitional problems are inevitable as Medicare moves from cost-based reimbursement to prospective payment; hospitals that cannot control costs adequately will face financial risk. However, the protections enacted in the BBRA make it unlikely that payment amounts will be too low; changes in payment rates are probably not warranted. In view of the significant change in payment policy that is being implemented, however, we do recommend monitoring implementation of the outpatient prospective payment system to ensure that it does not have unintended, adverse consequences on beneficiaries' access to care and that the quality of care delivered is not compromised.

Another important issue with respect to outpatient services is the coinsurance paid by beneficiaries, which now averages almost 50 percent. Although coinsurance amounts will remain fixed at their current dollar level until they are reduced to 20 percent of Medicare-approved payment amounts, the process will take decades. MedPAC has twice recommended that the Congress enact legislation to accelerate the reduction to achieve a 20 percent coinsurance rate in a more reasonable time frame. By comparison, the most gradual phase-in Medicare has used to date for any payment system change is 10 years.

Home health care

In response to extraordinarily rapid growth in spending for home care during the early to mid-1990s, the Congress enacted major changes in the BBA as to how home care agencies are paid. Prior to the BBA, agencies were paid on the basis of their costs, subject to agency-specific limits based on per visit costs. The BBA imposed new agency-specific limits based on average payments per beneficiary and average payments per visit. This interim payment system was intended to achieve savings until a prospective payment system could be put in place. The prospective payment system is now scheduled for implementation in October.

Changes in home care have been the most pronounced of any sector of Medicare. Even with the increase in payment limits that was enacted in 1998, Medicare spending for home health services fell 45 percent between 1997 and 1999 and the number of agencies has dropped from more than 10,500 to less than 8,000. By 1998, the number of home health users per fee-for-service beneficiary had returned to its 1994 level, and the average number of visits per user was below the 1994 level.

Although these changes are dramatic, they cannot be completely attributed to the payment changes enacted in the BBA. Concurrent policy changes, including anti-fraud initiatives targeting home care agencies, eliminating venipuncture as a qualifying service for home health eligibility, and imposing sequential billing (since discontinued) have all been important. Moreover, dramatic as the changes in spending and use have been, interpreting what they mean for Medicare beneficiaries is not easy. Without clear coverage and eligibility guidelines that reflect the clinical characteristics of beneficiaries—which MedPAC has previously recommended be developed—it is difficult to know how much of the decline reflects less inappropriate care and how much reflects less appropriate care.

In MedPAC's March report, we indicated our support of the prospective payment system for home health care that HCFA intends to put in place in October. Although the proposed system will need refinement over the longer run, it represents a substantial improvement over the IPS because it takes into account variation in resource needs among home care patients. The proposed system will also incorporate an outlier policy for beneficiaries with extraordinary costs.

With a new payment system pending, MedPAC did not make formal recommendations in our reports to the Congress earlier this year with respect to payment rates for home health services. However, given the dramatic changes in use that have already occurred, and the changes yet to come with introduction of the PPS, the general sense of the Commission is that reducing payment rates by an additional 15 percent, as currently scheduled in law for next year, would not be prudent without additional evidence to justify such a reduction.

Physicians' services

For physicians' services, the BBA required a phase-in of resource-based payments for physicians' practice expenses. The law also created a sustainable growth rate system for annually updating payments to physicians.

The transition to new payments for practice expenses started in 1999 and will continue through 2002, as required by the BBA. During this transition, payments for some high-volume surgical services will fall sharply. For example, the payment rate for single coronary artery bypass graft will drop 19 percent and the payment rate for total knee replacement will fall 23 percent. Questions have been raised about the data and methods HCFA has used to determine changes in practice expense payments. The agency is working through these issues during a refinement process that includes contractor support and the involvement of the physician community.

With respect to the SGR system, one issue that MedPAC identified last year—the potential for oscillation in updates—was resolved by the BBRA. The BBRA also directed the Secretary to correct estimates in previously issued SGRs to avoid by locking estimation errors into future spending targets. This happened in 1998 and in 1999, when underestimates of fee-for-service enrollment led to lower target levels of spending.

MedPAC also recommended in March 1999 that the sustainable growth rate be revised to include measures of change in the composition of fee-for-service enrollment—much like demographic adjusters for payments to Medicare+Choice plans—and to include an allowance for cost increases due to improvements in medical capabilities and advances in scientific technology. The BBRA required the Secretary to study these issues and their effects on the use of physician services, and the Agency for Healthcare Research and Quality has begun this work.

We have no evidence that beneficiaries are experiencing problems with access to physicians' services. As we testified last year, a survey undertaken in early 1999 by Project HOPE for MedPAC showed that among physicians accepting all or some new patients, more than 95 percent were accepting new Medicare fee-for-service patients both in 1997 before the BBA payment changes were introduced and in early 1999. Given that updates to the conversion factor were equal to or greater than increases in input costs in 1999 and in 2000, we would not expect to find different results today.

Medicare+Choice

A key component of the BBA was the creation of the Medicare+Choice program, which the Congress intended to provide Medicare beneficiaries with choices of plan options and to help control the growth of Medicare spending. Some policymakers saw Medicare+Choice as a vehicle to provide Medicare beneficiaries with richer benefits—lower cost sharing and prescription drug coverage—than those available in the traditional fee-for-service program. And some policymakers wanted to see rapid growth in the Medicare+Choice program to help set the stage for future changes in the structure of Medicare.

Progress toward these goals has been minimal. On the one hand, spending per enrollee in private plans has been controlled, primarily because of the slow growth in fee-for-service spending which is used to determine updates. (Compared with the previous payment rules, however, the Medicare+Choice program has probably increased spending, because the new rules have prevented the effects of the slow growth in fee-for-service spending from being passed through fully.) On the other hand, the goals of increasing choice and expanding access to plans with richer benefits remain elusive. The range of plan options has not increased, most beneficiaries in rural areas still cannot enroll in Medicare+Choice plans, benefit packages have become less generous, and enrollment growth has been stagnant.

Perhaps the most visible indicator of how the Medicare+Choice program is faring has been announcements by health plans of contract terminations and service area cutbacks. In January 1999, more than 400,000 enrollees were affected by such changes; 50,000 lived in counties where no other plan was available. In January 2000, about 330,000 enrollees' plans withdrew; 80,000 had no other plan available. Plan withdrawals are likely to have an even greater impact in January 2001. In the past several weeks, plans have announced contract terminations and service area cutbacks indicating that nearly one million Medicare+Choice enrollees will be unable to remain in their current plans, and more than 150,000 enrollees will have no Medicare+Choice alternative in their county. About 70 percent of Medicare beneficiaries lived in counties that had a Medicare+Choice plan in 1999 and 2000. That fraction is unlikely to change next year, with fewer beneficiaries having access to health maintenance organizations (HMOs), and some beneficiaries newly having access to a private fee-for-service plan.

Data on the availability of richer benefits tell the same story. The share of Medicare beneficiaries with access to a Medicare+Choice plan that did not charge a premium fell from 61 percent in 1999 to 53 percent in 2000. The share of Medicare beneficiaries with access to a Medicare+Choice plan that offered prescription drug coverage and did not charge a premium fell from 54 percent in 1999 to 45 percent in 2000. These declines occurred in both urban and rural counties, but were most pronounced in counties where the base payment was between \$400 and \$550 per month.

Finally, there is the lack of new products. The BBA expanded Medicare's risk contracting program, which previously had been open only to HMOs, to allow participation by preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service plans, and high-deductible plans offered in conjunction with a medical savings account (MSA). To date, no PPOs, no MSAs, and only one private FFS plan have joined. The one PSO plan that joined is withdrawing.

Three issues help explain why the Medicare+Choice program is not meeting expectations. First, the Congress's goals for the program are partially at odds with one another. For example, there is a basic conflict between controlling Medicare spending and providing richer benefits. The Congress wants to take advantage of the efficiencies associated with managed care, but it is still wrestling with how to do so in a way that both attracts beneficiaries to plans and allows Medicare to share the savings.

Second, both regulatory and market barriers may have made plans reluctant to participate. An example of the former is the lack of participation by PPOs, which are a popular option for people with employer-sponsored insurance. Plans that offer a PPO option have argued that collecting the data and implementing the quality improvement programs required by HCFA would be prohibitively costly given their loose networks. An example of market barriers may be the case of rural areas, which are often characterized by low population density and few or monopoly providers. Under such conditions, plans find it difficult to establish networks.

Finally, uncertainty about future payment streams may have made plans reluctant to participate. Under the old risk contracting program, plans could count on regular increases in premiums because updates were based on fee-for-service spending, which grew rapidly from the late 1980s through the mid-1990s. Under the new rules, updates are dependent on a spending changes in a sector that has been undergoing significant changes. The new rules have also held down updates to plans in high-payment areas to fund higher payments in the so-called blend counties. Finally, plans have had to face the prospect of lower payment growth as a new system of risk adjustment is phased in, with another new system scheduled to be implemented in 2004. The BBRA contained a number of provisions intended to push the Medicare+Choice program forward. It increased payment rates directly by further backloading the phase-in of risk adjustment, and indirectly by the pass-through effect of higher payments to fee-for-service providers. It provided for bonus payments—5 percent the first year and 3 percent the second year—to plans entering areas with no existing Medicare+Choice plans. The law also changed requirements regarding the definition of service areas and the timing of premium submissions, which should make participation in the program more attractive.

In our March 2000 report, we supported the BBRA provisions intended to provide Medicare beneficiaries with more coverage choices. Although the Commission made no specific recommendations, we continue to be concerned about the stability of the M+C program. For MedPAC to provide useful guidance on what to do next, Congress must make its priorities for the program clear. Maintaining access to richer benefit packages will likely entail increasing spending. Expanding access to rural areas may entail considering alternatives to requiring plans to assume full risk as they now must, such as some form of split capitation.

Mr. BILIRAKIS. Thank you, Dr. Wilensky.
Mr. Scanlon?

STATEMENT OF WILLIAM J. SCANLON

Mr. SCANLON. Thank you very much, Mr. Chairman and members of the subcommittee. I am pleased to be here today to discuss the effects of the Medicare payment reforms that were in the BBA and potential modifications to them.

These reforms were intended to institute strong financial incentives to providers to operate efficiently and to provide only needed services. Not surprisingly, the effects have been significant and you are hearing much about the need for modification. Much of that attention has been focused on the fact that Medicare spending growth has been much less than what CBO had predicted in 1997 that would occur with BBA changes. I think two points about that difference are notable.

First of all, CBO's director has indicated in testimony that CBO does not believe its projections of the BBA impacts, with the exception of home health care, were understated. Rather, it believes that lower inflation and increased efforts to reduce fraud and abuse have contributed significantly to the lower growth.

Second, I think as many of you indicated in your opening statements and as Dr. Wilensky indicated, our concern should not be focused only on spending less than the estimated baseline. Our litmus test should be whether or not payments are too low to provide necessary services to Medicare beneficiaries.

I would like to comment on three areas where we have ongoing work with respect to BBA impacts that overlap somewhat with the areas that Dr. Wilensky has talked about. They are home health, skilled nursing facility care, and Medicare Plus Choice.

First of all, with respect to home health, there is no question about the substantial drop in utilization in the last few years. Here, even CBO indicates that the decline exceeded what it expected. It also exceeded what would have been required to stay within the limits created by the interim payment system. Agencies could have provided more services, served more beneficiaries, and still be paid by Medicare. It is hard to determine to what extent beneficiaries did not receive needed services due to agencies' reaction to the interim payment system.

Our ongoing work shows that the recent contractions in home health use are more concentrated in agencies and areas that had substantially higher use and growth in the years preceding the Balanced Budget Act. Significant concerns exist that all of that utilization might not have been justified.

While this has been the experience under the interim payment system, the new home health prospective payment system to be implemented in October will fundamentally change the ways agencies are paid and provide a cushion to deliver necessary services. The episode rates in the PPS are based on prior, higher utilization levels rather than today's significantly lower levels. Agencies will be paid for all episodes of care provided, and as before, clear criteria to review the appropriateness of claims will not exist. We are concerned that we could easily be facing again a large and inexplicable growth in home health spending.

Nursing homes are a second area where the BBA's impact on service seems profound. On the one hand, five large nursing home chains have entered bankruptcy since the PPS was implemented. On the other, when we look at the facts underlying these bankruptcies and beneficiaries' access to care, we do not see fundamental problems with the PPS. The financial woes of some nursing home chains stem from the incompatibility of some of their pre-BBA business strategies and the SNF PPS, which created strong incentives for efficiency. Prior to the Balanced Budget Act, these corporations invested heavily in both nursing homes and ancillary service businesses. The new PPS rates do not support disproportionate shares of nursing home revenue going to debt service and make other nursing homes who are buying these companies' ancillary services much more sensitive to the prices being charged.

There also do not appear to be significant problems with access. Last year, we surveyed hospital discharge planners, who reported that problems placing patients were not different than before. Since that time, the use of skilled nursing facility care under Medicare has increased.

We have noted, however, that the PPS system needed improvement. However, these improvements involve more appropriate targeting of the dollars to match patient needs. Given that the rate of increases in SNF spending prior to the Balanced Budget Act mirrored the inappropriate incentives of the old cost-based system, it would seem that the total dollars in the pool for SNF care are very likely sufficient to support that care.

Finally, let me comment on our work on the Medicare Plus Choice program, another area of profound change, and our conclusions are very similar to those of Dr. Wilensky. Medicare Managed Care appears to be at a crossroads. Since the BBA's enactment, 168 plans have either left the program or reduced the geographic areas they serve and more plans are scheduled to follow in the year 2001. Plans have stated clearly that they are not being paid enough to stay in the Medicare program. However, our ongoing work shows clearly also that Medicare Plus Choice plans are continuing to get paid more than if their enrollees had remained in the fee-for-service Medicare program. Medicare loses money, on average, when each beneficiary joins a managed care plan.

This paradox can be deciphered. Plans are paid too much for what was originally intended, funding a more efficient means of providing the package of Medicare coverage services. Plans are saying, however, that they are paid too little to do what they have been doing, competing for beneficiaries by offering additional uncovered benefits for little or no additional premiums. The paradox thus leaves you with a fundamental choice. Do you want to ensure that Medicare Plus Choice plans are widely available so that beneficiaries have a choice of who organizes the delivery of their care? If so, this may entail increasing the rates to those plans.

This choice, while seemingly affordable today, may prove problematic for the future. The demographics of the baby boom generation already make the projections of Medicare spending foreboding. Preserving the program and its benefits will depend heavily on our finding the most efficient ways to deliver services for the long term.

We have considerable work in progress on these and other issues related to the Balanced Budget Act and will be sharing some of the results of that work with your staff during the month of August so that you have as much information as possible as you consider changes to the BBA.

Thanks very much, Mr. Chairman. This concludes my statement. I would be happy to answer any questions you or the members of the committee may have.

[The statement of William J. Scanlon follows:]

PREPARED STATEMENT OF WILLIAM J. SCANLON, DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, GAO

Mr. Chairman and Members of the Subcommittee: I am pleased to be here today as you discuss the effects of recent Medicare payment reforms and the potential need for additional refinements. The Medicare payment provisions in the Balanced Budget Act of 1997 (BBA) were enacted to control rapid spending growth in the traditional fee-for-service program that was neither sustainable nor readily linked to demonstrated changes in beneficiary needs. Essentially, these reforms changed the financial incentives inherent in pre-BBA payment methods to more appropriately reward providers for delivering care efficiently. The BBA also created Medicare+Choice to expand beneficiaries' managed care options under Medicare and bring payments more in line with the costs of providing covered benefits in the traditional program.

Since the BBA's enactment, the Congress has faced pressure from providers to undo the act's payment reforms. With changes so sweeping, achieving perfection in all the details at the outset is unrealistic. Accordingly, the Congress has monitored experience with these changes and made certain modifications. To date, some of the act's provisions have taken effect, some have been modified by the Balanced Budget Refinement Act of 1999 (BBRA), and others have just recently begun to be phased in.

Calls for additional changes come at a time when federal budget surpluses and lower Medicare outlays could make it easier to consider accommodating enhanced Medicare payments. At the same time, however, the Congress is considering the addition of an expensive prescription drug benefit to the current program. In view of the coming upsurge in the Medicare-eligible population, the Comptroller General has cautioned repeatedly that, even before expanding benefits, projected Medicare spending threatens to absorb ever-increasing shares of the nation's budgetary and economic resources. Thus, without meaningful reform, demographic and cost trends will drive Medicare spending to levels that will prove unsustainable for future generations of taxpayers.¹

My comments today focus on the BBA's payment reforms affecting home health agencies, skilled nursing facilities (SNF), and the health plans in Medicare's managed care program, known as Medicare+Choice. My remarks are based on our extensive published and ongoing work in each of these areas.

In brief, the reactions by providers serving Medicare beneficiaries to BBA and BBRA payment reforms share a similar scenario. Tightened payment policies have required many providers to adjust their operations. The adjustments have been particularly disruptive for providers that took advantage of Medicare's previous payment policies to finance inefficient and unnecessary care delivery. Industry representatives are advocating the partial restoration of payment cuts. Following are the recent developments that have ensued since the BBA's implementation in the areas of home health services, SNF services, and the Medicare+Choice program:

- Home health services: Home health utilization has dropped substantially, well below what would have been required to remain within the BBA-imposed payment limits. We expect the new Medicare payment system for home health services, scheduled for implementation in October, to generally provide agencies a comfortable cushion to deliver necessary services.
- SNF services: Some corporate chains have declared bankruptcy. The new Medicare payment system for SNF services adequately covers the cost of beneficiaries' services but no longer supports the extensive capital expansions or the ancillary service business that corporate chains relied on to boost revenues.

¹ *Medicare Reform: Leading Proposals Lay Groundwork, While Design Decisions Lie Ahead* (GAO/T-HEHS/AIMD-00-103, Feb. 24, 2000).

- Medicare+Choice program: Many plans are withdrawing from Medicare. The withdrawals are tied to a combination of Medicare program changes and plans' business decisions. In addition, our ongoing work shows that payments to plans for their Medicare enrollees continue to exceed the expected fee-for-service costs of these individuals. The significance of this finding is that Medicare managed care, although originally expected to achieve program savings, continues instead to add to program cost.

In our view, the basis for potential changes to BBA reforms should be how they affect beneficiaries' access to necessary services and the long-term outlook for this program. Therefore, progress needs to continue to better align provider payments with the expected costs of the beneficiaries served and to bring about the fiscal discipline needed to contain Medicare spending in these areas over the longer term. We will continue to monitor the payment reforms' effects to help the Congress ensure that beneficiary access is protected, providers are fairly compensated, and taxpayers do not shoulder the burden of excessive program spending.

BACKGROUND

Medicare's home health care benefit enables beneficiaries with post-acute-care needs and chronic conditions to receive certain skilled nursing, therapy, and aide services in their homes rather than in other settings. To qualify for Medicare's home health benefit, a beneficiary must be confined to his or her residence ("homebound") and must require intermittent skilled nursing, physical therapy, or speech therapy. A beneficiary who needs only custodial or personal care does not qualify. Beneficiaries are not liable for any coinsurance or deductibles for these services and may receive an unlimited number of visits, provided the coverage criteria are met. Historically, Medicare has reimbursed home health agencies their costs, subject to limits, for services they provide to the program's beneficiaries. A prospective payment system (PPS) for home health services will go into effect October 1, 2000.

The Medicare SNF benefit provides up to 100 days of post-acute care per spell of illness. To qualify for SNF services, a Medicare beneficiary must need daily skilled nursing or rehabilitative therapy services, or both, generally within 30 days of a hospital stay of at least 3 days in length, and must be admitted to a Medicare-certified SNF for a condition related to the hospitalization. When the beneficiary meets these conditions, Medicare covers all necessary services, including room and board; nursing care; and ancillary services such as drugs, laboratory tests, and physical therapy. Beginning on the 21st day of care, the beneficiary is responsible for a daily coinsurance payment, which equals \$97 in 2000. Until 1998, Medicare reimbursed skilled nursing facilities on a cost basis. Payments for routine costs, such as room and board, were subject to cost limits, but payments for capital and ancillary costs were virtually unlimited. Medicare is phasing in a PPS for SNF services over a 3-year period that began in July 1998.

Medicare managed care plans have provided beneficiaries an attractive alternative to the traditional fee-for-service program. In return for giving up the freedom to seek care from any provider, beneficiaries who enroll in plans typically receive coverage for benefits not offered by the traditional program (such as routine physical examinations and prescription drugs) and enjoy lower out-of-pocket expenses. Medicare pays the plans a fixed monthly amount for each beneficiary, regardless of the actual costs of providing care to that individual. Previously, plan payment rates were tightly linked to average local spending in the traditional fee-for-service program and only adjusted for certain beneficiary characteristics such as age and sex. The BBA changed how plan payments were calculated beginning in 1998 by weakening the linkage to fee-for-service spending and required that, beginning in 2000, payment rates reflect differences in beneficiary health status.

PENDING HOME HEALTH PPS RATES LIKELY TO BE ADEQUATE, BUT ARE UNTESTED TO DATE

To curb rampant spending growth, BBA overhauled the program's method of paying for home health services. Between 1990 and 1997, Medicare expenditures for home health services went up three times faster than spending for the program as a whole. This rapid rise has been attributed to many factors, including a loosened interpretation of the home health benefit criteria and few controls to protect the program from abusive billing practices at a time when Medicare paid for every home health visit with almost no scrutiny. In combination, these factors made conditions ripe for providers to deliver more services to more beneficiaries in order to increase their revenues.

In response to these problems, the BBA required, by October 1, 1999, the implementation of a new home health PPS, and until then, the implementation of an in-

terim payment system (IPS) to slow spending growth.² The IPS made the existing per visit cost limits more stringent and added an annual agency revenue cap to control the number of services provided to beneficiaries.

Between 1997 and 1998, Medicare home health spending fell by nearly 15 percent, while total home health visits dropped an unprecedented 40 percent. The Congressional Budget Office (CBO) attributes the decline to agencies' tighter compliance with benefit eligibility criteria and their cautious interpretation of IPS limits.³ Our ongoing work on home health spending shows that these declines continued in 1999 and that the drop in utilization was most pronounced in areas where, pre-BBA, use had grown the most and beneficiary utilization was the highest.

These findings suggest that part of the contraction in service delivery since the BBA may be a correction of the excessive use when Medicare did little to control home health spending. However, it may also reflect an inappropriate response to the IPS by home health agencies. While remaining within IPS payment limits, all agencies could have served more beneficiaries and many agencies could have increased the services provided each beneficiary. Yet the number of beneficiaries receiving home health services declined 14 percent between 1997 and 1998 and is continuing to fall. Because the payment limits under the IPS are not adjusted to reflect the needs of individual patients, agencies must maintain a balance high-cost and low-cost patients in order to keep their costs below the IPS revenue caps. Agencies that do not fully understand how these caps are applied may restrict their admissions or reduce care to current patients further than necessary.

The home health PPS, which replaces the IPS on October 1 of this year, is a more appropriate payment tool than the IPS because it is designed to align payments with patient needs. Medicare will pay agencies a per-episode rate based on historical, national average utilization for each 60-day period during which a patient receives services. PPS rates are scheduled to be tightened a year later by 15 percent. The per-episode payments are designed to control service provision during the episode, while giving home health agencies the flexibility to vary the intensity or mix of services delivered. Home health industry advocates generally support the PPS, but argue that the 15-percent payment reduction is unnecessary.

In our view, the new home health PPS rates overall are likely to provide agencies a comfortable cushion to deliver necessary services. These rates are based on pre-BBA beneficiary use levels, which are widely regarded as excessive. PPS rates will provide sufficient resources to restore a considerable portion of the service reductions of the past 3 years. They will not support, however, widely divergent levels of utilization where some agencies supplied many more services than others for comparable patients.

Unfortunately, the new PPS has the potential to be advantageous to agencies at the expense of beneficiaries and taxpayers. Under the per-episode method of payment, agencies can increase profits by skimping on the number of visits provided within the episode. Agencies can also inappropriately expand the number of episodes provided by protracting the delivery of care over a longer period. No standards exist for what the right amount of care is for specific types of patients, particularly the right amount of home health aide care, which composed almost half of all visits in 1997. Implementing safeguards to ensure Medicare payments are used to deliver services to meet beneficiaries' needs is a difficult task.

The home health PPS, while having a design superior to the IPS, is largely untested. It is built on the concept of paying for episodes of care, yet there is no consensus on what an episode should entail. In addition, similar to other new PPSs, which vary payments according to patients' expected needs, the potential exists for payments to be too low for some episodes involving very sick patients and too high for others. To minimize the potential for adverse effects for the program and individual agencies, we recommended in April this year that HCFA implement a risk-sharing provision whereby the government shares in any home health agency's losses under the PPS but also protects the program from any agency's excessive gains.⁴

²The Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999, P.L. 105-277, delayed the implementation of the home health PPS until October 1, 2000.

³*Impact of the Balanced Budget Act on the Medicare Fee-for-Service Program*, Statement of Dan L. Crippen, Director, Congressional Budget Office, before the House Committee on Commerce Sept. 15, 1999.

⁴A risk-sharing arrangement that limits the amount a home health agency can lose or gain would involve a year-end settlement that compares an agency's actual Medicare-allowed costs with its total Medicare payments. Payments above the costs would be constrained to a specific percentage, as would agency losses. For further detail, see *Medicare Home Health: Prospective*

SNF PPS RATES COVER MEDICARE-RELATED COSTS

Under Medicare's SNF PPS, facilities receive a payment for each day of covered care provided to a Medicare-eligible beneficiary. Previously, SNFs were paid the reasonable costs they incurred in providing Medicare-covered services. Although there were limits on the payments for the routine portion of care (that is, general nursing, room and board, and administrative overhead), payments for ancillary services, such as rehabilitative therapy, were virtually unlimited. Because higher ancillary service costs triggered higher payments, facilities had no incentive to provide these services efficiently or only when necessary.

By establishing fixed per diem payments for all services provided to beneficiaries, the PPS attempts to provide incentives for SNFs to deliver care more efficiently. SNFs that previously boosted their Medicare revenue—by using more or higher-priced ancillary services—will need to modify their practices more than others.

Recent accounts of nursing home chain bankruptcies raise questions about the adequacy of Medicare's SNF payments under the PPS. Our published and ongoing work identifies several factors that contributed to the poor financial performance of these corporations.⁵ Some corporations invested heavily in the nursing home and ancillary service businesses in the years immediately before the enactment of the PPS, both expanding their acquisitions and upgrading facilities to provide higher-intensity services. Under tighter payment constraints, these debt-laden enterprises are particularly challenged. The PPS not only puts a premium on operating their SNFs efficiently, it changes the market for their ancillary services business as well. It makes other SNF operators sensitive to the costs of ancillary services, so they are no longer willing to purchase them at high prices. Thus, while SNFs have to adapt to the PPS constraints, these large post-acute care providers may have greater adjustments to make as a result of the strategic decisions they made during a period when Medicare was exercising too little control over its payments.

There are indications that SNF payment rates under the BBA are likely to provide sufficient—or, in some cases, even generous—compensation for services provided to a facility's Medicare beneficiaries. Medicare's average daily rate under the SNF PPS in fiscal year 1999 was higher than the average daily SNF payment in fiscal year 1997. The significance of this comparison is that 1997 payments were thought to be excessive because they reflected 7 years of cost increases of more than 14 percent per year. In fact, some providers have been eager to adopt the PPS rates well ahead of schedule. Currently, PPS rates are being phased in over a 3-year period, which began in July 1998. This transition period was designed to allow facilities time to adapt to the new payment system by continuing to tie a facility's payment rates to its historical costs. The BBRA gives SNFs the option of forgoing this transition period. Although a current tally is not available, HCFA estimates that about half of Medicare-certified SNFs will opt to forgo the transition period to receive fully prospective rates as soon as possible.

Beneficiary access to SNFs, moreover, does not appear compromised under the new PPS. Utilization levels in 1999 were higher than those in 1997. Hospital lengths of stay for admissions likely to lead to a SNF stay have continued to decline, suggesting that hospitalized patients continue to find SNF care.

Nevertheless, the SNF PPS initially proposed by HCFA was not flawless. Last year, we testified before the full Committee about PPS design problems.⁶ A primary concern was the possibility that facilities treating a disproportionate number of high-cost cases might not receive adequate payments. HCFA is in the process of refining its method to account for patient needs in its payments. The goal is to redistribute payments across types of cases so that they more appropriately reflect each patient's expected costs. HCFA recently proposed such refinements to the case-mix adjustment system, which are scheduled to be implemented on October 1 of this year.⁷

In the meantime, BBRA included a provision that temporarily boosts payments for certain cases by 20 percent,⁸ which will add an estimated \$200 million to Medicare SNF spending in fiscal year 2000. The provision is scheduled to expire on October 1, 2000, or when HCFA implements a refined case-mix adjustment system,

Payment System Will Need Refinement As Data Become Available (GAO/HEHS-00-9, Apr. 7, 2000).

⁵*Skilled Nursing Facilities: Medicare Payment Changes Require Provider Adjustments But Maintain Access* (GAO/HEHS-00-23, Dec. 14, 1999).

⁶*Medicare Post-Acute Care: Better Information Needed Before Modifying BBA Reforms* (GAO/T-HEHS-99-192, Sept. 15, 1999).

⁷The proposed rule is contained in 65 *Fed. Reg.* 19188-19291 (Apr. 10, 2000) (to be codified at 42 C.F.R. pts. 411 and 489).

⁸We could not determine what criteria were used to select these cases.

whichever comes later. Industry advocates favor prolonging the life of the BBRA provision and delaying the implementation of HCFA's proposed payment modifications, which they assert are not sufficiently refined. CBO estimates that if the 20 percent payment increase remained in effect for 5 years, spending would increase by \$1.4 billion. In our view, the BBRA increase was helpful as a stopgap measure, but fiscal prudence argues for implementing research-based improvements to the rates as soon as practicable. Such improvements aim to distribute existing payments more appropriately and thereby address the problem originally identified, while avoiding the unwarranted expenditure of an additional hundreds of millions of dollars each year.

MEDICARE+CHOICE PAYMENTS REMAIN PROBLEMATIC

Although Medicare managed care plans have provided beneficiaries an attractive alternative to the traditional program, they have never been a bargain for taxpayers. Prior to the BBA, studies by us, other government agencies, and private researchers concluded that, instead of producing expected savings, Medicare's managed care option substantially increased program spending. Plans tended to attract relatively healthy, low-cost beneficiaries, while Medicare's payment rates reflected the expected costs of a beneficiary in average health with average health expenses. Consequently, plans received payments for their Medicare enrollees that well exceeded what Medicare would have paid had these individuals remained in the traditional fee-for-service program. Our study of Medicare plans in California showed that aggregate plan payments exceeded plan enrollees' estimated fee-for-service costs by more than an estimated \$1 billion in 1995. This finding suggests that many of the additional benefits enjoyed by plan enrollees were the direct result of Medicare's overly generous payment rates, not of efficiencies achieved under managed care.⁹

The BBA sought to improve Medicare's financial posture by changing the methodology used to establish managed care payment rates. Accordingly, the BBA slowed the growth in payment rates relative to the growth in per capita fee-for-service spending for 5 years and required HCFA to improve its risk adjustment of plan payments so that they more closely matched beneficiaries' expected health care costs. The BBA also included payment changes and other provisions to achieve a second goal: increase the availability of plans and allow new types of plans to participate in Medicare.

The declining participation of health plans in the Medicare+Choice program suggests that the BBA's cost containment and expansion goals may be irreconcilable. Since the BBA's enactment, 168 plans have either left the program or reduced the geographic areas they served. Recently, more plans announced that they will terminate their contracts or reduce their service areas effective January 1, 2001. Industry representatives have largely attributed the withdrawals to the BBA's payment rate changes. The representatives contend that Medicare is no longer a sufficiently profitable line of business for some plans and that other plans have had to reduce the benefits they offer and raise beneficiary premiums. They warn that the Medicare+Choice program will continue to flounder unless payments are increased.

Our published and ongoing work suggests that several factors influenced plans' decisions about whether to participate in Medicare+Choice or to participate only in certain areas. As we reported last year, the 1999 withdrawals represented plans that were recent market entrants, had enrolled few beneficiaries, or faced competitors that had substantially larger market shares, suggesting that plans made business decisions or used business strategies that could be sustained only in an era of more generous Medicare payments.¹⁰ We will issue a report soon on the withdrawals in 2000 and 2001. While information on the 2001 withdrawals has only been available for a few weeks, our analysis of the withdrawals in 2000 indicate a pattern similar to that found for 1999.

Some health plans may find the payment rates established by the BBA to be too low to warrant their future participation in Medicare+Choice. However, in our ongoing work, when we compared plan payments for enrolled beneficiaries in 1998 with the estimated Medicare fee-for-service costs for these individuals, we found that plans received payments that substantially exceeded what Medicare would have paid for the plans' enrollees had they been covered under the fee-for-service program. This paradox stems from differences in the intent of Medicare+Choice and its

⁹*Medicare HMOs: HCFA Can Promptly Eliminate Millions in Excess Payments* (GAO/HEHS-97-16, Apr. 25, 1997).

¹⁰*Medicare Managed Care Plans: Many Factors Contribute to Recent Withdrawals; Plan Interest Continues* (GAO/HEHS-99-91, Apr. 27, 1999).

evolution. On the one hand, Medicare+Choice plans are paid too much relative to the original intent of Medicare managed care—to provide beneficiaries the package of Medicare-covered services at less cost than the traditional fee-for-service program. On the other, the plans may be paid too little for what they have been offering to attract beneficiaries—a more comprehensive benefit package beyond that authorized for fee-for-service beneficiaries for only modest or no premiums.

Efforts to expand the Medicare+Choice program, particularly one in which plans cover prescription drugs, have been important, because the traditional Medicare program has not provided such coverage, and this program alternative has provided an avenue for some beneficiaries to obtain drug coverage. However, if the Congress adopts a prescription drug benefit for the entire Medicare program, there may be less reason to have Medicare+Choice payments exceed the costs of providing services in the traditional program. The problem of excess payments can be addressed in part by better adjusting payments for the actual health status of enrollees. Such a step would also protect those plans that attract sicker-than-average enrollees.

CONCLUSIONS

As anticipated, the BBA reforms have had significant effects on the delivery, cost, and use of Medicare services. Changes in providers' incomes and services to beneficiaries are becoming a reality. We have seen a rapid fall-off in home health use, the bankruptcies of several large SNF chains, and continued health plan withdrawals from the Medicare+Choice program. Although providers have been quick to attribute these changes to inadequate Medicare payments and call for extra federal dollars, careful analysis indicates that these responses are adaptations to appropriately tightened payments following a period of unchecked growth.

Needed refinements to the BBA's new payment policies for home health, SNF, and managed care services are under development or are soon to be implemented. In assessing the merit of these refinements, prudence suggests that beneficiary needs and the program's prospects for long-term sustainability, not provider profitability, should be paramount. We have several studies under way to inform these decisions and we will continue to work with you to provide this important information.

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

GAO CONTACTS AND ACKNOWLEDGMENTS

For future contacts regarding this testimony, please call William J. Scanlon at (202) 512-7114 or Laura A. Dummit at (202) 512-7118. Individuals making key contributions to this testimony included James C. Cosgrove, Hannah F. Fein, Dana K. Kelley, Erin M. Kuhls, and James E. Mathews.

Mr. BILIRAKIS. Thank you very much, Mr. Scanlon.

Dr. Wilensky, the last statement Dr. Scanlon made regarding the Medicare managed care plans, do you agree with his assessment?

Ms. WILENSKY. I agree in general. There is one small addition I would like to raise, and that is part of the problem has been inappropriate expectations on the part of seniors about how much they could get in the way of additional benefits for free in a managed care plan, that they could get some or that managed care plans could provide care somewhat more efficiently, I think was the correct assessment.

What happened in the early years is that the amount that was being spent in traditional Medicare was so high in some areas, in the places where managed care plans were most likely to grow, that seniors got used to having an enormous amount of benefits provided for free. That expectation, even for those of us who believe that managed care can provide care more efficiently and frequently more effectively, is just out of whack with the reality, and it is that painful contraction of having some additional benefits but not what you have expected in the past.

There also may be a question of whether or not, as Medicare spending gets back to a more normal level of growth, such as was envisioned in BBA, that will put a little less pressure. The fact that

there has been such low growth has hit the managed care plans very hard. Not only have they got the impact of that low growth, but the high-care areas were under constraints, as well, and so they really have been operating in the last 2 years under a lot of constraints.

Mr. BILIRAKIS. You, in your remarks, mentioned the reducing of regulatory burdens or the lack of reducing the regulatory burdens.

Ms. WILENSKY. Right.

Mr. BILIRAKIS. When we held our hearings regarding these concerns that so many of these HMOs were dropping out of Medicare, we heard complaints that inadequate funding, particularly in some areas of the country, and the regulatory burdens, the paperwork, was also a very large part in forcing them out of the picture. That is happening all over. That is certainly happening in our area of Florida and it is just difficult to know exactly how to take care of that.

Ms. WILENSKY. We have heard that is especially a problem in some of the rural areas. We had some of the companies that provide in rural areas under the Federal Employees Health Care Plan talk to several of us at MedPAC about why they were able to do it there and not under Medicare and one of the responses was that if they stayed in traditional Medicare, the hospital had far fewer regulatory burdens than if that same hospital joined part of a Plus Choice program, that the regulatory burdens were substantially greater and that that was a major disincentive for both the physicians and the hospitals in some of the rural areas, along with other issues.

Mr. BILIRAKIS. So even if we were to increase the reimbursements, if you will, the payments—

Ms. WILENSKY. These other problems need to be fixed.

Mr. BILIRAKIS. [continuing] it may not solve the problem?

Ms. WILENSKY. Right. I believe that. I believe it is not just a payment issue.

Mr. BILIRAKIS. That is an area that we have got to spend more time on, but let me get into the home health benefits with you. In your study of the impact of BBA 1997 on Medicare home health benefits, could you identify any type of patients that were being denied or had a hard time securing home health services?

Ms. WILENSKY. We did a study where we looked at—we went to survey some of the discharge planners and some of the advocates for home health to try to see whether we could discern a problem. We could not at that point document any particular access problem. What we were hearing anecdotally is that people with special needs, both for skilled nursing facilities prior to BBRA and also in home care that had high acuity, were having trouble getting the services or being accepted by home care. But we have not been able to document that in a systematic way. We are now sitting down to plan some additional surveys to see whether we can try to provide some information, although we will not have any of that available prior to August.

Mr. BILIRAKIS. Is it just too early to tell?

Ms. WILENSKY. There is nothing we can see that provides any systematic evidence in the work that we have done thus far.

Mr. BILIRAKIS. Mr. Scanlon?

Mr. SCANLON. Mr. Chairman, I would note that in our survey of discharge planners, we found a very similar result, in fact, that the problems of some of these patients with more skilled needs, those problems predated the BBA and the problem, in part, relates to the lack of resources in communities to provide those skilled services.

But what we are finding right now in terms of the latest changes in terms of utilization is a much sharper drop in terms of home health aide services than we are finding it in terms of skilled services, which would suggest that, in some respects, we are reverting to the type of home health benefit that we had more experience with in the more distant past, where it was a skilled benefit aimed at recuperation and rehabilitation following hospital stays and less the long-term custodial benefit that we experienced in the mid-1990's.

Mr. BILIRAKIS. In your minds, and my time has expired so maybe I will ask the question but not expect an answer, is there a dollar figure that you feel would be necessary to give back to the providers to sort of get things back on the even keel? That is a question that I would ask you, and I do not know whether you have a quick answer to that or not.

Mr. SCANLON. My quick response would be that the prospective payment system is already going to put dollars back into the system and that we actually will see an increase and should see a potentially significant increase in utilization because of the incentives.

Mr. BILIRAKIS. So over a short period of time, you expect that this would take place—

Mr. SCANLON. We do.

Mr. BILIRAKIS. [continuing] without any necessarily additional dollars. Do you have an opinion, Ms. Wilensky?

Ms. WILENSKY. The biggest problem was we have so little idea about whether what we were doing before was anything like the right amount, but we would be glad to work with the committee and the committee staff in the next month or 2.

Mr. BILIRAKIS. Thank you.

Mr. Brown?

Mr. BROWN. Mr. Chairman, thank you. Mr. Scanlon, I appreciate your comments and want to pursue them on overpaying of managed care plans. The GAO has written a number of reports over the past few years about Medicare's payments to plans and Medicare Plus Choice and its predecessors. These reports have concluded that Medicare has consistently been overpaying managed care plans. Talk a little, if you would, about Medicare's historic overpayments to managed care plans, why are we overpaying, how much. Give us some of that.

Mr. SCANLON. In the past, we had identified and other researchers had identified that Medicare was overpaying plans, principally because the payments to plans were adjusted for differences in beneficiaries' or enrollees' demographic status but not for differences in their health status, and that plans, on average, were attracting enrollees that were healthier than the average sort of Medicare beneficiary, not a surprise given that people with more significant illnesses may already have relationships with providers

who are not part of plans' networks and, therefore, were reluctant to join with a managed care plan.

That continues today. I mean, we are on the verge of improving our risk adjustment process but we are not there yet. While there were some people that hypothesized that as managed care grew, which it was doing before the BBA, that these overpayments would disappear because the population the managed care would sort of average out to be the same as the population in fee-for-service. What we found is that that is not the case. We will be issuing a report within about a month that has looked at much more recent data, looked at mature markets across the country, and found out that this factor of favorable selection with healthier enrollees entering managed care persists.

Ms. WILENSKY. I would like to point out, though, that the studies have focused on the entrants or those very small numbers of people who exit. One of the big questions that has been very difficult to look at is what happens as people stay in managed care plans for substantial periods of time, and because some managed care plans are made up of 70 percent of enrollees who have been there for 3 or more years and others are primarily new plans dominated by new enrollees, this information on self-selection either into or out of the plans really does not address, or has not in the past, the large numbers of people who may be in these plans over a substantial period of time.

Mr. SCANLON. If I could add, we recognize that shortcoming of other studies and have attempted to take into account the distribution of enrollees in plans by the length of time they have been there. We recognize that people when going into plans have much lower utilization of services than other beneficiaries. That is on the average of about 35 percent lower. But we also have identified that there is likely to be an immediate increase in their utilization of services and that those increases will continue over time and we have incorporated those into our estimate.

We have also tried to be very conservative about thinking about costs of dealing with people that die and costs of people that are leaving plans to make sure that if we are biasing results, we are biasing them in favor of the plans, not sort of an over-finding that there are excessive costs to the Medicare program.

Mr. BROWN. A couple of studies I have seen show how much costs increase when people leave plans later in life, when taxpayers are paying for their health care instead of managed care.

Let me pursue one other part of that, Mr. Scanlon. You said people just sort of naturally, more healthy people more naturally gravitate toward managed care plans instead of traditional fee-for-service. What actions do the managed care companies take to encourage, to cream-skim, to encourage the healthiest people to go into managed care? I understand there is sort of that natural proclivity to do that. I also understand, I believe, that managed care companies try to encourage and increase that. What kinds of things do you see there?

Mr. SCANLON. Mr. Brown, we have not looked at that in any systematic way. I think we probably have heard some of the same anecdotes that you have in terms of maybe structuring the benefits in a way that might attract healthier enrollees or in terms of where

one markets. But again, we have not looked at that systematically. We know over time there has been probably much less of that that has gone on than occurred very early in the history of the program.

Mr. BROWN. But for a for-profit insurance company, is it not natural and expected and understandable and justifiable from the bottom-line standpoint behavior to try to recruit into managed care plans the lowest-cost beneficiaries?

Mr. SCANLON. If you are lucky enough to get the lowest-cost beneficiaries, it certainly is good for the bottom line.

Mr. BROWN. I guess my time is about up. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Mr. Whitfield?

Mr. WHITFIELD. Thank you. Ms. Wilensky, in the BBRA of last year, I believe a provision was put in establishing what they call a critical care access provision where certain rural hospitals of so many beds and below would be able to have a cost-plus basis for reimbursement. How significant do you think that will be in addressing some of the financial problems of the smaller rural hospitals?

Ms. WILENSKY. I think the critical care access program is potentially a very good program. I do not know that we have been able to see very much the results yet, just because it is so soon, but in principle, I believe it was a very good proposal.

A number of you mentioned concerns about rural areas. Let me make two points. The first is, our June report for next year for MedPAC will entirely be focused on rural issues, much more than just BBA but providing health care in rural America and the interaction of Medicare and other issues. So we will be able to say much more.

The second point is you have to be careful when you talk about rural hospitals. Our look in terms of the work we have done already suggests that rural hospitals are faring very differently depending on who they are. Rural referral centers and sole community hospitals have substantial margins. They have both substantial Medicare margins, but they actually have pretty reasonable overall margins, as well. Small Medicare-dependent hospitals, some of which may become critical access hospitals depending on what happens or some of the under-50-bed other rural may become these, are having more difficulty. So we really—you have to be careful when you talk about rural as to not sweep too many different types. Some of the programs that we have had in effect already have done a good job.

Mr. WHITFIELD. You had mentioned the report. When will this report be available?

Ms. WILENSKY. This is each year MedPAC has two reports, a March report and a June report. This will be our June report for next year, and this is as a result of the BBRA. Among the many requests that the Congress made was to have a major look at rural issues and we have decided to devote our June 2001 report to health care in rural America.

Mr. WHITFIELD. Okay. Mr. Chairman, I yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentleman.

Ms. DeGette to inquire.

Ms. DEGETTE. Thank you, Mr. Chairman.

Mr. Scanlon, the GAO has issued reports for a number of years about the importance of health coverage for children and pregnant women, particularly in the Medicaid program. For example, I have an outstanding 1997 report here called "Health Insurance Coverage Leads to Increased Health Care Access for Children," where the GAO found that health insurance coverage increases children's access to preventative, primary, and acute care. This improves a child's health and saves lives. The same report says that there are a number of studies that show access to care for pregnant women decreases infant and child mortality.

I am wondering if you know whether anything has changed with respect to the importance of coverage for children and pregnant women since that report was issued in 1997.

Mr. SCANLON. I have seen nothing that would suggest that changed. In fact, most of the studies continue to indicate that the uninsured use less care than the insured and there has been nothing to contradict the positive effect that preventive and primary care has for individuals, both children and pregnant women.

Ms. DEGETTE. From a policy perspective, then, do you think that it would make sense to allow pregnant women to be covered by Medicaid if the goal of CHIP is to improve children's health care coverage, including infants?

Mr. SCANLON. I think that represents a fundamental choice on your part in terms of expanding the program. Given that it has limited resources and even though we have not seen those resources being exhausted to this point, you have made a decision to provide them for children and you would be expanding sort of the pool that is going to be covered. Pregnant women are going to be expensive, and at some point, there could be a crowd-out effect for children given the limits on funding.

Ms. DEGETTE. But as I look at this 1997 study, for example, of the top ten conditions that are treated in hospitals that have the highest hospital charges, four of them are infants. Respiratory distress syndrome is the most expensive of all of the ten conditions, even more expensive than spinal cord injury, heart valve disorders, leukemias, and so on. Prematurity, which is in many studies I have seen directly linked to lack of prenatal care, is the third highest, and low birthweight is included in there. So in some ways, if you gave coverage to pregnant women to have prenatal care, I would think that that would actually save some money on the other end for hospital costs for infants.

Mr. SCANLON. I cannot at this point say that it would save money in the aggregate because while it would save money with respect to some individuals, whether or not the expansion of coverage would cost more, but maybe also produce many positive other benefits besides saving money. But at this point, we have not done any work to identify whether the net savings would exist.

Ms. DEGETTE. Is that something that might be on your radar screen to do some analysis on?

Mr. SCANLON. It will be on our radar screen.

Ms. DEGETTE. I think that that is a good idea. Let me ask you about some other issues on Medicaid and, in particular, CHIP, on other related issues. You have also done some studies to the point

that barriers that States impose that limit the access to coverage in the Children's Health Insurance Program. There was a 1996 report called "Health Insurance for Children: State and Private Programs Create New Strategies to Ensure Children," which said, "Simplified enrollment procedures and flexible eligibility documentation requirements minimized enrollment barriers and thus encouraged program participation." But then in 2000, GAO found in its April 2000 report that some States are imposing significant barriers to coverage despite the fact that "there is some flexibility under Federal law."

So, I mean, we have now had 4½ years of knowledge about what does and does not work with CHIP in the States. I am wondering if you have any views on what can be done by Congress to improve this program that many of us think is really important but is also a little bit flawed in its working.

Mr. SCANLON. As we have looked at the CHIP program, we have found incredible variability across the States in terms of how they are approaching the outreach process and the enrollment process, and exactly as you have cited from our work, there are States in which there are more barriers to becoming a CHIP enrollee, or even if you have applied for CHIP and it is discovered that you are eligible for Medicaid, to then become Medicaid-enrolled.

Efforts to reduce some of those barriers, or actions to reduce some of those barriers would certainly facilitate enrollment. We have not seen the kind of enrollment that we thought we might sort of in the program yet. Whether the impetus should come from the Congress or from individual States, I think that again is your choice.

Ms. DEGETTE. Thank you. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Mr. Bryant to inquire.

Mr. BRYANT. Thank you, Mr. Chairman, and I want to thank the outstanding members of this panel and I know the second panel, also, for your patience in sitting through our opening statements and going through the questioning. We appreciate you being here.

Mr. Scanlon, let me ask you about a concern that has been raised by members of this committee, including myself, about dollars that we have allocated to the States in the BBA 1997 to be used to ensure children under the SCHIP program. The States that did not spend all of their 1998 allotments are about to be forced to turn over to HCFA these unspent funds to be redistributed to the States who have spent their allocations. It is my understanding that only 12 States have spent all of their 1998 allotted amounts.

These States would argue, including my State—well, the other 12 States would argue that they should be rewarded for moving quickly to implement the programs, knowing that unspent dollars would be lost. Conversely, the other side, which includes my State of Tennessee, will argue that, for whatever reason, it was difficult getting started. In Tennessee, we are enmeshed in this TENNCare. But the other States that did not are like us. They are facing this situation. But most, I think all, of their programs are now up and running, and since an overwhelming majority of the States have not spent their 1998 allotments, they would like to have more time to be able to spend these dollars.

Two quick questions. Do you think the States would spend down their allotments if given more time, and second, why were so many States unable to spend all their allotments?

Mr. SCANLON. We do think that States would spend down their allotments if given more time, given that the spending more recently has been at a faster rate than it was in the early period of the program. However, having said that, I mean, to spend their 1998 allotments, about half the States that have not done that yet would only spend them in a year and the other half would probably take 2 years before they have fully expended their 1998 allotments.

We think that the delays here are attributable to two things. One is the difficult in some States in getting the program sort of up and running, the combination of planning, the State's effort, and getting HCFA's approval of what a State was going to do. Some States were much better positioned to do that. They had ideas in terms of how they were going to cover children, and when the program passed, they were ready to make proposals.

Other States, in order to get started, put into place what we call placeholder programs in which they did a Medicaid expansion because it was the easiest thing to do, but then they have come back subsequently and have set up a stand-alone program, which was their original intent, but they did not want to wait until they could put all of that into place. So I think that is one of the factors.

The other factor, I think, why money has not been spent is the fact that we are in a good economy and, therefore, the pool of potential individuals, while large enough to absorb these funds if we could reach them, is not so big that we have enough people choosing to apply for the program and, therefore, using up some of the funds.

Mr. BRYANT. Does GAO have a position on whether these 38 States, such as Tennessee, should be allowed some additional time or granted some mercy on this?

Mr. SCANLON. We do not see a downside to granting them additional time in the sense that the money, if it was to be reallocated to the remaining States, that currently no State has actually spent its 1999 allocation and here we are almost at the end of fiscal year 2000. So it seems that the money in the SCHIP program at this point is adequate to allow the States that have not spent their money additional time to spend it.

Mr. BRYANT. On behalf of our Governor and the citizens of Tennessee, we appreciate your kind words.

I would yield the balance of my time to Dr. Coburn.

Mr. COBURN. Thank you. I just had a couple questions on rural hospitals and home care. Dr. Wilensky, do you have any data to say that if you exclude paybacks, which a lot of the home health firms have had to come up with, if you exclude those and those that remain, do you have any data to say that the profitability or capital structure of the home health agencies that are serving people in need in this country are in less good financial position than they were before?

Ms. WILENSKY. We do not have information that is at that level of detail.

Mr. COBURN. Mr. Scanlon?

Mr. SCANLON. No, Dr. Coburn, I think the only thing we can say is we have seen the loss of a significant number of home health agencies. But beyond that, the capacity of the remaining ones cannot be determined easily.

Ms. WILENSKY. One thing that we have noted in our discussions, and as I mentioned earlier, the commissioners are concerned about the substantial decline in absolute spending and the impact in terms of the number of services provided, is home health by its nature tends to be able to be expanded more rapidly and, therefore, some of the infrastructure concerns that may be raised with regard to hospitals or skilled nursing facilities, we believe, are less critical for home care. The question of whether they can get the adequate labor, particularly aides, or whether the prospective payment system will be at the right level are, of course, very important. But we are not quite as concerned about the actual infrastructure or capital structure because of the fact that it appears services can be expanded much more rapidly than in some areas.

Mr. BILIRAKIS. The gentleman's time has expired.

Ms. Capps?

Ms. CAPPS. Thank you to our expert witnesses who have given us good testimony. I would like to ask Mr. Scanlon about safety in nursing homes. In the statement by Mr. Richtman, who is on the next panel, he expresses the senior community concerns about abuse and safety in nursing homes, patient safety, and I know that the GAO has done work looking into these conditions for residents in nursing homes and would love to hear briefly from you. I have two other questions, also.

Mr. SCANLON. We have looked at the question of nursing home quality and what we have found is that there unfortunately is a significant number, about 15 percent, of homes in which residents have suffered actual harm, or it has been identified that residents have suffered actual harm when the homes were surveyed the last two times and a considerable number of these are due to issues of abuse.

We have real concerns about sort of the system that we have in place to try and prevent this in terms of encouraging homes to remain of high quality and deficiency-free and we think that the Congress has provided HCFA the right tools in terms of statutory provisions to potentially influence the quality of care. We think that it is also important that HCFA have the resources to be able to implement that system. But at the same time, we think we have not yet given the system a chance to see whether or not it can improve quality of care.

Ms. CAPPS. There is also a fear within the communities, my community particularly, that the problem of inadequate staffing may grow worse with the implementation of the Medicare prospective payment system, PPS, for nursing homes. We have a shortage of workers at this time and to face this looming issue, it seems to compound the concerns that people have. I am wanting to hear from you about what your recommendations are in terms of addressing this with the PPS.

Mr. SCANLON. We also have heard many concerns about the issue of staffing in nursing homes and are looking at this from a broader perspective, in part because Medicare is a relatively small payer of

nursing home care, on average constituting about 10 percent. So it is very important what is happening in terms of the other payers, Medicaid and private patient.

One of the problems with respect to staffing today is the fact that we have a good economy—

Ms. CAPPS. Yes.

Mr. SCANLON. [continuing] and traditionally, when we have had good economies, nursing homes have had more difficulty in attracting workers as well as retaining workers. The turnover rate is extremely high. We know that a number of States have put pass-throughs in their Medicaid reimbursement systems which target money directly on staffing and we think that is a positive thing to do when you find that you have a staffing problem.

With respect to the Medicare PPS, we do not think there should be a profound impact or even a significant impact on the ability of a home to staff, both given the small share of dollars that come from Medicare as well as sort of the potential, I will call it cushion, that has been built into those rates by the fact that we saw such dramatic increases before the PPS was implemented.

Ms. CAPPS. I know my time is up, but if I could just pose another concern that I have and it may be addressed now or later, is anyone looking at home health care declining services, the reasons for it, and the surprise number of additional dollars saved in the BBA cuts and what the reasons for some of this might be?

Mr. SCANLON. We definitely are looking at the pattern of declines and trying to glean from the patterns of decline something about sort of the why and the consequences of those declines. I mean, one of the unfortunate things is that we do not have an expectation as to what home health care should be doing and do not have the kind of information that would allow us to develop a reasonable set of expectations for home health care and then to know whether we are meeting them or not.

Ms. WILENSKY. MedPAC will also be doing some further work in terms of these issues for home care. We will be glad to make it available when we have something.

Ms. CAPPS. Excellent. Thank you very much.

Mr. BILIRAKIS. I thank the gentlelady.

Dr. Ganske?

Mr. GANSKE. I am concerned about kind of a yo-yo effect on home health care. The 1997 BBA basically addressed home health care's explosive growth. We have seen decrease in that. I am concerned that if we loosen up the PPS too much, then we will see a big up-swing again, which leads me to my question.

Dr. Wilensky, I thought a much better way of handling the home health care was to basically do what we do in other parts of Medicare, which was to have a copayment in terms of the utilization of services in home health care, and I believe that MedPAC in the past has thought that a copayment system would be a better way to go.

Ms. WILENSKY. Yes.

Mr. GANSKE. I mean, you could means-test that to help low-income senior citizens. Can you comment on that?

Ms. WILENSKY. In our last report, we did recommend for the second year report in a row for MedPAC that a coinsurance, copay-

ment system be devised. We suggested that people who are on the low-income support programs of QMB or SLMB be exempted from that, that it be a relatively small payment, about \$5 a visit, and that there be a stop-loss provision. That is, that after some 60 visits, that there would be a reassessment about the need for home care as a clinical visit and that if there was further need, that the care be provided, of course, but there be no further copayments because we did not want to have it be a financial burden, and we thought that would be a way to balance making sure there was access and also to put in some cost restraints on the usage.

The Congress obviously chose to go in a different direction as part of the Balanced Budget Act. We will have to wait to see what we can see after the implementation of the prospective payment. There was widespread belief that the interim payment system that was adopted was not a good system and so a sense that going the next step now will be better than where we just were, whether or not it will be as good or better than where you could have gone is a harder question.

Mr. GANSKE. Well, I will make a prediction. We will be dealing with this for some time.

Dr. Wilensky, on the next panel we are going to hear from Dr. Zetterman on HCFA's site of service differential payment methodology. Basically, I have heard from different medical specialties—gastroenterologists, urologists, and others—about how HCFA is basically saying that if you do not do this type of procedure in your office, you are going to get paid less.

Now, I have looked at some of those CPT codes, and as a surgeon, I think we are getting into an area where doing some of those procedures in an office could be dangerous to the patient. Would you care to comment on that?

Ms. WILENSKY. This is an issue, particularly looking at gastroenterology, that is part of our March report where we look at some of the differentials in payment per site and they clearly are substantial, sometimes half of what you would get in your office if you do it in a facility. The justification, at least initially, was that some of the physicians' direct costs or indirect costs that would have been absorbed in the office are being absorbed by the facility and therefore the actual payment to the physician should be less if that is the case.

We have recommended that HCFA meet with the specialty groups to try to decide if there is a clinical preference area. It may well be that in areas, particularly some of the endoscopy differentials or other areas, that there ought to not be a higher payment in the physician's office because you do not want to encourage what is regarded as clinically inappropriate behavior. So we have basically recommended that in these areas where the site of care is substantially different, that there be more clinical dialog going on.

MedPAC has also been concerned that the groupings are sometimes too aggregative in the new prospective payment system and that may also influence behavior. We do not actually believe that physicians will choose their site according to these payments, but we think it is not a good idea to put financial incentives to either underpay or overpay depending on whether you do a procedure in

the outpatient or do a procedure in your office. So we are concerned.

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. GANSKE. Mr. Chairman, I will provide you with some examples of the types of procedures that I do not think you would want to have done in a physician's office.

Mr. BILIRAKIS. Great. That is what this is all about.

Mr. Stupak?

Mr. STUPAK. Thank you, Mr. Chairman.

Ms. Wilensky, in your testimony, you indicated that there has been a decline of 45 percent in home health reimbursements, is that correct?

Ms. WILENSKY. That is correct.

Mr. STUPAK. And I believe it is October 1 we are going to put in a prospective payment system for home health?

Ms. WILENSKY. October 1, the system is supposed to move to prospective payment instead of the interim payment system.

Mr. STUPAK. Do you believe that will happen, prospective payments starting October 1?

Ms. WILENSKY. It is looking better. I was less certain that it would, but HCFA has put out a rule that now has indicated the base payment, and although we had some concerns at MedPAC about the prospective payment system, our MedPAC commissioner who comes out of home care who heads the New York Voluntary Nursing Association had indicated that the sense was the interim payment system was so bad in terms of its actual implementation that an imperfect prospective payment system would be preferable.

Mr. STUPAK. It would still be preferable?

Ms. WILENSKY. It would still be preferable. That is now—because we did have some concerns about the particulars of the prospective payment system. The rest of the commissioners were impressed by the pleas to go forward, because where we were right now was really not a good place.

Mr. STUPAK. Mr. Scanlon, do you care to comment on that at all, on prospective payment, any kind of a baseline we can expect coming out of that October 1?

Mr. SCANLON. We do believe it will be in place on October 1, given that HCFA has not issued the final rule on this, and I agree with Dr. Wilensky and her MedPAC commissioner from the VNS of New York that it is a major improvement over the interim payment system. The interim payment system just was not targeted enough to be able to support appropriate care.

Mr. STUPAK. Will venepuncture be back in for home health as a payment reimbursable?

Ms. WILENSKY. It as an event, my understanding, was reimbursable. It did not entitle the senior to the rest of home care services and I do not believe there is a change there, but I do not know.

Mr. SCANLON. No, there will be no change. It cannot be the sole basis for qualifying for home health care. If you need another skilled service besides venepuncture—

Mr. STUPAK. But in rural areas where you have to travel so far just to get your blood checked, and that may be the only service you need, and that is ridiculous not to have it part of the system. To put it mildly, I mean, we would go 30, 40 miles to have a reg-

istered nurse do it or have the registered nurse come to our house, but if that does not happen, then we have to go to the emergency room or a physician's office and you will pay for it then. I think it would be much more efficient if we would allow it under home health.

Mr. SCANLON. It would be more efficient in terms of the covering of that skilled service. The issue that I think was raised—

Mr. STUPAK. And also cost.

Mr. SCANLON. Well, the issue that I think that was raised, though, that covering that one skilled service then entitled you to all the other services that home health provided meant that many people would receive a significant amount of aide care, as well.

Mr. STUPAK. So you can craft the rule that says venepuncture should be allowed and that is the only service granted? Any other services—

Mr. SCANLON. You could treat it as a separate service.

Ms. WILENSKY. Right.

Mr. SCANLON. It would be independent of the—it could be provided by home health agencies, but it would be independent of the home health benefit as we know it today.

Ms. WILENSKY. And it could be paid as it is currently paid.

Mr. STUPAK. For a couple of years, we have always had that trouble. You always cut us out, and in the rural areas, we have nowhere to go and it costs a heck of a lot more to have people go to emergency rooms every time to have it done.

Ms. WILENSKY. My sense is there has not been a question that that specific service should be paid. It is only a question of whether, if that is the only reason, that other services should be provided.

Mr. STUPAK. Then I cannot understand why we cannot draft a rule that says that service only is paid under home health and let the home health agencies do it, as opposed to make these patients travel.

Let me go a little further. Dr. Wilensky, you mentioned hospitals and the PPS and increase the IMEs and things like that. One of the things I am hearing a lot from my hospitals is the cost of prescription drugs, especially in cancer-treating drugs. It has just gone outrageous, 35, 40 percent increase in the last year or 2 per year, and they just cannot pass all that cost on to the patient. Any thoughts on that?

Ms. WILENSKY. Well, in an inpatient setting, the increase of prescription drugs will get fed into the DRGs but there will be a delay of a couple of years because of how the data feeds in. It was one of the reasons we suggested that the Congress consider a higher than usual update this year because we know the last year or 2, before these have been fed in, there have been substantial increases in cancer drugs and other inpatient drugs.

With regard to cancer drugs that are outside, some of the times they are covered through special provisions—

Mr. STUPAK. But most of the times, they are not.

Ms. WILENSKY. That is obviously then relating to the broader issue of prescription drugs and how you do it and when you do it.

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. STUPAK. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Mr. Burr to inquire.

Mr. BURR. Thank you, Mr. Chairman.

Let me also deviate from the fixes for a second just to get a response from both of you. Would you agree that the cost of health care today is no longer separated rural and urban? Would you agree that the equipment costs the same?

Ms. WILENSKY. The equipment cost—

Mr. BURR. If you buy an x-ray machine, it costs the same in New York City that it does in rural North Carolina?

Mr. SCANLON. The machine itself costs the same. The issue is when we compute it on a per patient basis or per use basis, we may not have enough people in North Carolina. That, I think, is—

Mr. BURR. I am talking about the raw cost of the machinery.

Mr. SCANLON. The machine itself is the same price.

Mr. BURR. And lab work, probably the same. I mean, there may be some variation, but in rural cases, they probably send it to an urban facility to be read and the fact is that the cost is the same. Would you agree that, really, the only difference is the real estate?

Ms. WILENSKY. Well, labor costs in some of the services can be different, including in lab services.

Mr. BURR. But is MedPAC not seeing the same thing that I am, and that is that the urban centers are now recruiting in the rural areas, offering nurses and PAs unbelievable increases because they have a shortage in the urban areas, and this has caused not only a migration of the workforce, it has also caused the rural areas to raise their rates to a point that is not reflective in a lot of the data that we are picking up.

Ms. WILENSKY. Well, getting the right wage rate data is very important. Looking at labor costs is legitimate. You can certainly make arguments that in some cases, the labor costs may be greater because there is less competition in rural areas.

Mr. BURR. I had a rural hospital that had to make a mid-year adjustment in their nursing staff's pay because 30 miles away was Greensboro, North Carolina, and that \$1 increase in their nursing staff was an unplanned adjustment to their annual budget of \$260,000. There is no formula that we have got that will pick that up now. It may pick it up in the future, if it does, but the reality is that they are going to come up with a shortfall. That is inherent to the system, is it not?

Ms. WILENSKY. Yes.

Mr. BURR. It is.

Ms. WILENSKY. Yes.

Mr. BURR. Ms. Wilensky, let us go to home health for just a second, if we could. You mentioned that the board would propose a delay in the 15 percent—

Ms. WILENSKY. That is now current law.

Mr. BURR. It is a temporary delay.

Ms. WILENSKY. Right.

Mr. BURR. Do you perceive a permanent elimination of the proposed 15 percent?

Ms. WILENSKY. It is hard to tell because of the dramatic swings in spending that we have seen. It is certainly possible that we would say there is no further need to moderate spending if the

slowdown persists. I think we are not sure what will happen when we go from one system, interim payment, where you have been doing a per visit for a daily charge to an episode payment, so we think it is prudent to say we ought to wait and see. I would not be surprised if that happened.

Mr. BURR. What were the policy reasons for a 15 percent reduction in payment?

Ms. WILENSKY. It was not our policy. I do not know.

Mr. BURR. It was not a policy. Do you know of any policy reasons, Mr. Scanlon?

Mr. SCANLON. I do not think there was a reason in terms of the care being provided because we do not understand the home health benefit. I think it was more an issue of, we have had such excessive growth that we set a new target in terms of what we wanted to spend and it involved a 15 percent cut.

Mr. BURR. Which is traditionally the way we do health care. We work within the framework of the dollars and not necessarily concentrate as much on the policy, which is the No. 1 mistake, I think, that this institution makes.

I think Bruce Vladek, then-administrator of HCFA, put it best. When pressed, he said it makes the budget balance. That is how they came up with 15 percent. That is why it was not five, it was not ten. My only fear is that we fell into the same trap and adopted the same philosophy and proposed legislation that also had an arbitrary, pull it out of the sky, 15 percent cut because it made the numbers work and I think—

Mr. SCANLON. Mr. Burr, if I could add, at the same time, though, there was such variation across the country in terms of the use of home health care, if you took 15 percent off the areas that were at the extreme high end, you might find no impact on the care being provided and you would not disturb the areas that were providing much more modest levels of care.

Mr. BURR. And in some cases, the reimbursements with the proposed 15 percent cut forced the capital that was financing those vital businesses in rural America to pull back, reduce services, or go out of business, which puts me into nursing homes just real quick. You mentioned them earlier. You said five firms had gone into bankruptcy. Do you know how much of the marketplace those five firms represented?

Mr. SCANLON. They were about 15 percent of the market.

Mr. BURR. Fifteen percent of the market? Did you look at the market capital of the industry sector itself, in other words, the stock price of the industry sector?

Mr. SCANLON. We did and we know that there has been a substantial sort of drop in those, in part because the expectations that were built into the stock prices initially were expectations built upon significant growth over time and as that growth evaporated, so did the stock valuation.

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. BURR. Let me just add, Mr. Chairman—

Mr. BILIRAKIS. Well, very quickly.

Mr. BURR. [continuing] the stock devaluation of that industry sector was 75 percent of the entire sector after BBA 1997 and I think that though we might not see short-term shortfalls, I would

tell you that when we sit here and know that the senior population in America will double over the next 20 years, the lack of investment in that single area of nursing home facilities is going to be a tremendous challenge for this country to address in the future.

I thank the chairman.

Mr. BILIRAKIS. Ms. Eshoo to inquire.

Ms. ESHOO. Thank you, Mr. Chairman, for having this hearing, and welcome to our witnesses.

I have a couple of questions that I would like to ask of you, Mr. Scanlon, and I will state my questions first and then you can answer them. I do not want to run out of time on the questions. I have not gotten this down pat yet, after all these years.

Dr. Wilensky testified that managed care plans have cited Medicare's regulatory burden as a reason for leaving the Medicare Plus Choice program. It is my understanding that many of the regulations serve an important purpose. Regulation, of course, can be a blessing to some and a burden to others, a dirty word, or whatever. But I would like to think that there are regulations in this that serve the very important purpose of protecting seniors and their access to quality care.

I know that the GAO issued a report last year about how greater Federal oversight is needed to protect seniors' rights in Medicare and its managed care. Could you just speak to HCFA's regulations and how they play an important role in protecting seniors' rights?

My other question has to do with the attention that has been given to the effects of BBA cuts on hospitals, especially teaching hospitals and disproportionate share hospitals. I was very disappointed that we did not include anything in last year's refinement bill to restore cuts to Medicaid DSH hospitals. I have experienced that. I know something about it. I chaired a hospital board of directors of my county hospital before I came to the Congress, so I saw firsthand the faces of people that came in to that facility, shaping the kinds of services that they most needed, and how we filled that role as a disproportionate share hospital. Would you comment on the cuts endured by DSH hospitals under BBA and what you would suggest we do to alleviate them?

So those are my two questions, and I thank you both for being here.

Mr. SCANLON. With respect to the first question, in terms of HCFA's regulation of Medicare Plus Choice plans, we are very much in agreement with Dr. Wilensky that there needs to be a balance in those regulations. I mean, I also think you might want to—if you do not like the word “regulation,” you can think of them as purchasing specifications. We really want to sort of know what we are buying from these plans and make sure that we are getting what we paid for for the beneficiaries that are enrolling.

At the same time, we want to make sure that the burden of those regulations on plans is minimized, and as Dr. Wilensky indicated, some of the smaller plans in rural areas may find the current regulations too burdensome and that may be a significant factor in their withdrawals.

In the case of many other plans, what we are finding is that they are deciding to change service areas, meaning that they are complying with the regulations in some areas because they find the

market attractive enough and pulling out of other areas where the market is not attractive enough.

While we are certainly in favor of this, we also think that HCFA needs to be very efficient in terms of the burden they place on plans in applying the regulations, and in addition to finding that HCFA does not do a good job sometimes in applying the regulations—

Ms. ESHOO. Can you give me an example of that, what you just mentioned?

Mr. SCANLON. Well, the example I think that we had in the report you referred to is the issue of marketing to beneficiaries and telling beneficiaries what the plans are going to provide them, and what we discovered is that, one, poor information was being provided to beneficiaries in terms of not describing the benefits fully, and second, plans were encountering the difficult issue of having to deal with one regional office after another to get marketing materials approved and finding inconsistent application of the rules in those different regions. HCFA has taken some steps to improve that and we think that is very positive.

With respect to the DSH hospitals and the changes in BBA with respect, and with BBRA with respect to the DSH payments, I mean, I think we need to recognize some of the concerns and problems we have had with DSH over the past, the fact that DSH dollars were not always targeted in the best way in all States. Therefore, as you look at the changes in BBA, you see a very great difference across States in terms of the amount of reductions.

We have been looking at some of the States that are more significantly affected and trying to discover what is happening to the safety net hospitals in those States as opposed to other uses of the DSH dollars. At this point, while we recognize that it is preliminary, the impacts on many safety net hospitals are modest. The question is, what is modest for me may not be modest for those hospitals or in your eyes.

Ms. ESHOO. If there is a misuse of DSH dollars, then I think that that needs to be identified. I do not think any one of us are going to defend something that is not defensible. But DSH entirely is another story. I mean, we have set up a policy in this country that recognizes those hospitals that take care of the poorest of the poor. To dance on the backs of the people that need this the most is just plain wrong.

Mr. BILIRAKIS. The gentlelady's time has expired.

Ms. ESHOO. I do not think we can afford to have it cloaked in one thing when it is another.

Mr. BILIRAKIS. The gentlelady's time has expired.

Ms. ESHOO. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Dr. Coburn will inquire.

Mr. COBURN. Thank you, Mr. Chairman.

I want to raise the level that Mr. Stupak raised on phlebotomy. All HCFA has to do is to pay an increased fee for phlebotomy and you will have the labs around this country coordinating rural phlebotomy. Make it where it is cost efficient for somebody to plan that and it can happen, and we do not have to pay \$65 every time somebody goes out and draws somebody's blood. We can pay \$20 or \$25 and it can all be scheduled and be done and the labs would be more

than happy to do it because they would get to run and bill Medicare for the lab.

The second thing I wanted to address is we do have a problem in prenatal care in this country, but providing a mechanism for that does not necessarily solve it. In my hospital alone, we have 20 people a month drop in, no prenatal care. Ninety percent of them meet all the requirements for Medicaid or Title 19 and they know about it. They refuse to get it. So part of it is education, and we can throw all the money at that we want. Until we educate people about the need for prenatal care, we do not need to add another dollar for it. We need to utilize the services that are out there.

I want to ask a question. Mr. Burr asked you about the 15 percent. Is it your consensus—I think it is certainly the members of this committee—that that ought to go into oblivion as far as home health care? There is no need to have that number there now and we ought to eliminate that threat hanging over home health care so that we can plan for the future. Would you all agree with that?

Ms. WILENSKY. MedPAC has recently had a sense of the commission that we would at least not like to see it go into effect now. We did not take the position on “ever.” We just felt comfortable saying “not now.” I do understand the issue you are raising in terms of planning for the future and that is really a question for the Congress. But we do believe that given the sharp reduction in spending, it is inappropriate at the present time to go forward with yet another reduction.

Mr. COBURN. Mr. Scanlon?

Mr. SCANLON. I think we would not agree that it should be put off completely because of the fact that we expect the situation under the prospective payment to be so much different than under the IPS, that we really need to witness that experience and then make a decision about that.

Mr. COBURN. What do you mean when you say that? Do you expect a significant increase in payments for home health care under the prospective payment versus the IPS?

Mr. SCANLON. That is what we are anticipating today. For one thing—

Mr. COBURN. What do you estimate?

Mr. SCANLON. I beg your pardon?

Mr. COBURN. What do you estimate the increase to be?

Mr. SCANLON. We do not have an estimate of the increase because we have never had experience with a change that is this significant. One of the things that we are moving from is a per-visit to a per-episode payment. We are moving to a system where it is very hard to determine what is the appropriate number of episodes for an individual and we do not have very good criteria by which to review episodes to decide whether they should be paid for.

Mr. COBURN. Has HCFA in their final ruling allowed for outliers on the prospective payment system?

Mr. SCANLON. Yes, they have. Yes.

Mr. COBURN. And will that not take care of—I do not understand why you cannot know that. You know the diagnosis codes on all these people that are under home health care now. Why can we not apply the data based on new rule to look at what is happening right now and look at what the costs are going to be?

Mr. SCANLON. We do not know what the volume of beneficiaries are that are going to be using services.

Mr. COBURN. What about the volume right today? What would be the comparison under the IPS versus the PPS for right now? Has nobody looked at that?

Mr. SCANLON. They have, and there would be a likely increase in terms of—

Mr. COBURN. How much?

Mr. SCANLON. I can get you those data, but I do not have them here today.

Mr. COBURN. Would you be so kind as to bring—

Mr. SCANLON. I would be happy to do that.

Ms. WILENSKY. There is also the problem that you are now going to go to a system where having the right coding, having coding is going to make a big difference. One of the problems we have had in the past is that we have not required and we do not really have a good sense of what the diagnoses are that are requiring home care services, nor the services that are actually being provided. It is that dramatic a change that leads us not to know whether both the kinds of diagnoses that will be coded and the volume—

Mr. COBURN. I want to get this next question in. I am very concerned about rural hospitals in this country. We have in my district alone, and even with the changes last year, we still have five rural hospitals that will probably not make it this year through the year and I want to know what you all see coming down the road in terms of the marked reduction in payments to the rural hospital, especially in Oklahoma. What needs to be done to revitalize and stabilize those hospitals so they are not bleeding?

Ms. WILENSKY. I indicated that MedPAC is going to focus its entire June report on health care in rural America. Our looking at the margins suggests that there are substantial differences in the financial well-being between the sole community rural referral centers being pretty financially robust and the small Medicare-dependent and under-50-bed hospitals that are not sole community hospitals which are more fragile.

Mr. COBURN. Mr. Scanlon?

Mr. SCANLON. We have left the work on hospitals largely to MedPAC, but I think that we are in total agreement in terms of the issue of targeting. I mean, in our mind, it is not necessary an issue of not having enough resources overall that Medicare is providing but in making sure that they go to the right places, and the issue of rural hospitals, as I am reminded on many occasions, the differences within rural communities, the fact that there is very rural and then there is rural, it is important to target sort of on each of those to make sure that there is adequate service—

Mr. BILIRAKIS. The gentleman's time is long expired, but when would that report be available?

Ms. WILENSKY. Our report will be available next June. There may be some—

Mr. BILIRAKIS. Next June? It will not do us very much good when it comes to—

Ms. WILENSKY. Not for your August decisions, but for your next year's decisions.

Mr. BILIRAKIS. Mr. Strickland to inquire.

Ms. WILENSKY. Mr. Chairman, we can, however, provide you with the information we have to date in terms of what is going on in rural America.

Mr. BILIRAKIS. Well, if you would, I am sure that would be very helpful.

Ms. WILENSKY. Yes.

Mr. STRICKLAND. Thank you, Mr. Chairman. I have two questions I would like to direct to Mr. Scanlon.

Mr. Scanlon, as you know, before BBA, community health centers and rural health clinics received cost-based reimbursement from Medicare. The BBA instituted a phase-out of this cost-based reimbursement system so that eventually the States could determine their own payment systems for these services. Now, we passed a provision in the BBRA that would slow down this phase-out from occurring and would give these essential safety net providers more time to adjust, and this is my question. Based on your experience with community health centers and rural health clinics, what potential problems will these providers face if this cost-based reimbursement system continues to be phased out?

Mr. SCANLON. As also part of the BBRA, there was a study that we were required to do in terms of looking at this question and we have a report that we will be providing you in, unfortunately, November of this year, which is also beyond your August decision point. But in doing prior work on community and migrant health centers, what we have found is that there is about half that the HRSA has found to be sort of suffering from either financial or management difficulties and another 10 percent which they find to be highly vulnerable, potentially sort of going out of business.

Mr. STRICKLAND. We are talking about 60 percent?

Mr. SCANLON. We are taking about 60 percent. Now, this is in a world in which most of them are still being paid full-cost reimbursement, because except for States, and there are about a dozen of those that have got 1115 waivers in their Medicare program to introduce some other form of reimbursement, and for six States that went to the 95 percent level. All the other States have stayed at 100 percent cost reimbursement.

But what we have found is it is not only just an issue of revenues that puts the community health centers sort of in trouble. It is also an issue of management. As you move to different reimbursement systems in States with 1115 waivers, where some managed care plans are paying capitated amounts to the centers as opposed to full-cost fee-for-service reimbursement, centers can do well if they are well managed and they have enough other resources. We do not have at this point enough information to give you on the proportions of centers that are in different situations and how they would fare, but that is what we are trying to gather for you for November.

In the interim, there is an issue of you have slowed this down and it is protective of the centers. This may be an area that you want to think about in terms of slowing down some more because of the role that these centers play. About 40 percent of their patients are the uninsured, and even though we have this good economy, we are seeing increases in the uninsured.

Mr. STRICKLAND. I guess it makes sense to me that if we do not have the data and we will not have it for several months and these

are essential safety net providers, that we should, if possible, stop this process until we do know what we are facing, because, as you say, these centers do provide services to those who are least able to help themselves.

Mr. SCANLON. I agree that it is important to have the information to understand this more fully. At the same time, though, I think we need to, for the longer term, be thinking hard about the appropriateness of full-cost reimbursement. We have moved away from cost reimbursement for virtually every other provider type because of the poor incentives that we know it creates, and so we need to think about how we can make these centers fully functioning without necessarily dependent upon cost reimbursement.

Mr. STRICKLAND. And I would agree with you, but I would reiterate my point, that until we have the essential information, we ought to protect these centers, it seems to me. If we have the information and it validates a conclusion that we can move to a different payment system without hurting people, then I would fully support that. But it seems as if we are moving forward without having the kind of information we need to make a rational judgment. That seems reasonable to me. I do not know if it seems reasonable to you or not, sir.

Mr. SCANLON. It does seem reasonable and I wish we could provide you the information much sooner.

Mr. STRICKLAND. Could I have additional time, Mr. Chairman?

Mr. BILIRAKIS. You have another few seconds.

Mr. STRICKLAND. I will yield back the balance of my time.

Mr. BILIRAKIS. I appreciate that.

I just want to announce for the benefit of the panelists and the second panel and the audience, we expect, in just a few minutes, a series of votes. There will be one vote, then there will be a 10-minute debate and a recommittal, and then another vote on the recommittal, and then a vote on final passage. We are probably talking 45 minutes to an hour. Right after we finish up with this panel, we will break. That way, people can have an opportunity to go get some lunch or whatever the case may be and then come back approximately in an hour's time, depending, of course, when the final passage takes place.

Having said that, the Chair would now yield to Mr. Deal.

Mr. DEAL. Thank you, Mr. Chairman.

I would like to follow up with Mr. Strickland's last questions about community health centers. As I understand it, you do not have any statistics for those States that have already begun to phase out the cost-based reimbursement as to what effect that phase-out might be having on their delivery of services to their patients, is that what I understand?

Mr. SCANLON. We do not at this point, no, sir.

Mr. DEAL. And that is what your November report—

Mr. SCANLON. That is what our November report will deal with.

Mr. DEAL. As you are probably aware, we are receiving the same kind of complaints that I am sure you are receiving about the practice expense component and moving in that direction for reimbursement to physicians and specialties, in particular, and we are continuing to hear the complaints about the process whereby information is being gathered and the difficulty in arriving at a conclusion

as to how this transition of reimbursement should be made. Would either of you care to enlighten us as to where this process is? As you know, there are some groups urging us to abandon it and go to a 50-50 formula and forget about completing the process. Please bring us up to date, if you would.

Ms. WILENSKY. We are in the process of a transition as part of the BBA. Rather than go to a full adoption of the practice expense, the Congress put in a transition period. The transition and the practice expense relative value was an attempt to try to align on a relative basis practice costs across the different specialties and the different procedures that they do. The complaint has been raised as to whether or not that will mean that they cover absolute expenses in terms of practice costs and the answer is there is nothing in the provisions to assure they will cover absolute costs, but rather the allocation among the different specialties and the different procedures will make more sense. That is the relative issue.

The problem you get into of simply abandoning the relative practice expense is that there is a belief that some procedures and specialties were being heavily overpaid or disproportionately paid and some procedures and specialties underpaid with regard to their practice expenses and that staying with historical values really builds in those inappropriate payments.

HCFA has been urged to have more conversations with specialists. That was something MedPAC and others have urged. My sense is that is going on. But this question about absolute payments is one that I think needs to be clearly understood by the Congress. This is one of the many areas, as Mr. Scanlon just referenced, where there is movement away from cost-based reimbursement to try to move to a different type of reimbursement system and the main focus here is on the relative values, not the absolute costs.

Mr. DEAL. Thank you. I would yield back, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Barrett to inquire.

Mr. BARRETT. Thank you very much, Mr. Chairman. Thank you for holding this hearing.

I have two questions. One relates to DSH, the other relates to occupational therapy. I would like to start with you, Mr. Scanlon, on DSH. I think a number of the speakers have talked about the DSH problems in their States and I know that Mr. Whitfield and Ms. DeGette have legislation to deal with the problems that have been created by BBA in their States.

I represent Wisconsin, where the situation is a little different. We get so little DSH money that the fixes that have been proposed do not even touch us because they basically restore some of the cuts that were made to some of the other States. But when you have a State like Wisconsin that gets \$7 million, which is much lower than many of the States that are of comparable size, we are looking for a way in a State that has a below-average income but a significantly higher-than-average taxation on State taxpayers to deal with this problem.

In your analysis, or has there been anything done to sort of demonstrate the rhyme and reason for how States get money under the DSH formula?

Mr. SCANLON. Mr. Barrett, I can say that there is, in terms of looking at the overall distribution. The focus really has been sort of on what the consequences of the changes in DSH levels are for sort of the hospitals in given States. We know that the changes are more pronounced for States that had high levels of DSH in the past and for States that had more of their DSH dollars going to institutions for mental disease. But that is the principal focus, is what those reductions have meant.

I know your situation is very different in the sense that you are talking about a small amount of DSH money to begin with. The question for you would be sort of the adequacy of those dollars relative to the problem that you have.

Mr. BARRETT. Is there an analysis in existence that shows how different States got the money they are getting now? I am trying to decipher the code.

Mr. SCANLON. In terms of the historical growth?

Mr. BARRETT. Yes.

Mr. SCANLON. I think there are a number of analyses that address that issue. DSH was an uncontrolled expense until 1992, I think, at which point there were some restrictions placed on DSH expenditures by the Congress. At that point, it meant that some States' DSH dollars were frozen, could not increase over time, and other States had some room to grow but chose not to grow. The determinants of why States chose not to grow, that, I do not think, has been investigated.

Mr. BARRETT. From your standpoint, is there a policy correlation between the amounts States get and their need?

Mr. SCANLON. There is more of a correlation after the changes that are in BBA sort of will have been implemented than there was before, because before, one of the concerns that we had about DSH dollars was that they were not solely being used to meet their original purpose but they were being used to fund other things and that was why the Congress initially acted in the early 1990's to put restrictions on that, in 1991.

Mr. BARRETT. Dr. Wilensky, occupational therapy, my understanding is that it is treated differently for home health than it is for Medicare, for SNF facilities. Would MedPAC support including occupational therapy in the eligibility criteria for home health?

Ms. WILENSKY. That is not an issue we have taken up. We can try to get back to you if we have any thinking on that subject.

Mr. BARRETT. What they are telling me is that the definition of what is included for rehabilitation services is different for home health than it is for some of the other services and that they are not included in home health. Obviously, home health has taken a huge beating since BBA and so it is maybe trying to, I do not want to say board the Titanic, but I think that those are two areas that need some further exploration.

Ms. WILENSKY. We will be glad to get back to you.

Mr. BARRETT. I would yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Towns, and my apologies to the gentleman. I did not realize that he had come in before at least Mr. Barrett.

Mr. TOWNS. And also Mr. Strickland.

Mr. BILIRAKIS. And also Mr. Strickland?

Mr. TOWNS. Yes.

Mr. BILIRAKIS. A double apology.

Mr. TOWNS. Thank you very much, Mr. Chairman. I appreciate that because now I am sure you are going to give me 10 minutes.

Mr. Chairman, one thing before I start my questioning, though, could you set a definite time for us to return?

Mr. BILIRAKIS. No, I cannot because we do not know exactly when the vote on the final passage will be. We have the first vote at approximately 12:30 and then there will be a 10-minute debate on recommittal, then a vote on recommittal, and then a vote on final passage.

Mr. TOWNS. Could we say 10 minutes after the final vote? I think we need a number.

Mr. BILIRAKIS. We will say 10 minutes after the final vote.

Mr. TOWNS. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Boy, you are really picking on me today.

Mr. TOWNS. Thank you, Mr. Chairman.

Let me begin by saying, first of all, thank you very much for the hearing and we thank the witnesses for being here. Of course, some of our teaching hospitals are having great difficulty. I noticed in the Balanced Budget Restoration Act we took the first step toward restoring the BBA cuts of teaching hospitals. Do you feel or do you agree that we need to restore even more of the cuts that we enacted in 1997 if our teaching hospitals are to remain vibrant?

Ms. WILENSKY. No, I do not, and I would like to explain why. We think that a number of steps were done to help teaching hospitals in BBA and others that we have recommended will also help teaching hospitals because of the kinds of work they do. The assistance with regard to the transition to the outpatient PPS and the corridors that were put around so that there would not be too disruptive a change, and the fact that there is no longer savings to be had from moving to an outpatient PPS was very important to the teaching hospitals. They do a large amount of outpatient work as part of their mission. There was a hold put on the reduction in IME and disproportionate share and there were also some small assistance to home care and skilled nursing facilities to the extent that they are involved.

We are advocating an increase in the update factor for hospitals this year, substantially larger than we have in our history, but we think that in terms of the IME and DME change per se, that that is an amount that is above the empirical level of support still and that the specific way to deal with the higher costs of teaching hospitals could be better dealt with. We issued a report to Congress last year and we have some further updates, so while we think there are things that should be done to help hospitals to better differentiate their payments, to specifically go in and stop the reduction in IME payments that are now scheduled would not be a part of the recommendations, at least that MedPAC has made to the Congress.

Mr. TOWNS. So I think we will have another Balanced Budget Restoration Act this year. So you would not support more permanent solutions to the plight facing the Nation's teaching hospital?

Ms. WILENSKY. We would support an increase in payments to hospitals this year which will obviously help the teaching hospitals

and we think the Congress needs to relook at how payments to teaching hospitals are being made. We have issued now a separate report and separate chapters in this report about how best to help pay teaching hospitals. We think it is far more than just the level at which the IME payment is made, and we would be glad to work with you and your staffer about these issues. This is an area that MedPAC has devoted a lot of study to.

Mr. TOWNS. Well, I sure would like to work with you on it, because let me just say right up front, the hospitals in New York City are having great difficulty, I mean, serious difficulty, and I would like to work with you in terms of seeing what we can do in terms of finding some way to bring about some relief.

Thank you very much, Mr. Chairman. On that note, I yield back.

Mr. BILIRAKIS. I thank the gentleman.

Then we will go ahead and break until—

Mr. BROWN. Mr. Chairman, can I make an observation?

Mr. BILIRAKIS. The gentleman is recognized for an observation.

Mr. BROWN. Taking the time of Mr. Towns.

Mr. BILIRAKIS. Taking the time of Mr. Towns.

Mr. BROWN. Thank you, Mr. Chairman. Just a point of clarification. I hear our friend, Dr. Wilensky, refer to Medicare Plus Choice as Medicare replacement plans, and she mentioned that in her testimony. I do not know if that is focus-grouped or poll-tested, but I do not think it is the intent of anybody that I know in this Congress, certainly on this side of the aisle, and I do not know of anybody that really saw Medicare Plus Choice as a replacement for Medicare. It is listed under Medicare Part C.

I bring that up only because I know there are efforts in this Congress to sort of back-door privatize Medicare, and to call that a Medicare replacement plan goes a bit beyond what I think there is any Congressional intent to do. Thank you.

Mr. BILIRAKIS. I do not know of any efforts to back-door privatize Medicare, and I suppose I would probably know about it if there were.

Mr. BROWN. Mr. Chairman, they are so far in the back door that you may not have seen them.

Mr. BILIRAKIS. Yes, they may be that far back.

Ms. WILENSKY. And that is my term and I do not know if anybody else is using it. It is a way that I have found for myself to distinguish between the traditional Medicare program and the other, and I regard these as traditional Medicare alternatives.

Mr. BILIRAKIS. All right.

Ms. WILENSKY. So it is a way for me, but if you just use Medicare Plus Choice outside of Washington, it does not convey a sense of what you are talking about—

Mr. BROWN. And that, Mr. Chairman, is exactly the point. If you are outside Washington and talking about Medicare replacement plans, that sends a real message that privatization is around the corner and it is not around the corner. It is a long way off and a whole lot of us in this Congress do not want it privatized and a whole lot of people in this country, an overwhelming majority, do not want it privatized.

Mr. BILIRAKIS. The gentleman has made his observation. That being the case, we will break for approximately an hour to an hour and 15 minutes. Thanks so much.

[Brief recess.]

Mr. BILIRAKIS. Let us get started. Again, we apologize, but those of you who have done this before know what it is like.

This second panel consists of Ms. Marilyn Tavenner, Richmond Market President, HCA-The Healthcare Company, Richmond, Virginia. She has already been introduced by Mr. Bliley.

We also have with us Ms. Karen Coughlin, Chief Executive Officer of Physicians Health Services out of Shelton, Connecticut; Dr. Rowen K. Zetterman, President Elect of the American College of Gastroenterology from Arlington, Virginia, on behalf of the American College of Physicians and the American Society of Internal Medicine; Mr. Max Richtman, Executive Vice President of the National Committee to Preserve Social Security and Medicare, except that I do not see him right here; Ms. Juliet Hancock, Program Consultant for the RehabCare Group out of Saint Louis, Missouri, on behalf of the National Association for the Support of Long Term Care; Mr. Daniel R. Hawkins, Junior, Vice President of Federal and State Affairs, National Association of Community Health Centers from here in Washington; Ms. Mary Lou Connolly, RN, MSN, Administrator of UCSD Home Care, San Diego, California, on behalf of the National Association of Home Care; and Mr. David T. Williams, Director of Government Relations at Invacare from Elyria, Ohio, the district of our ranking member.

Max, you are now here, so we are missing Mr. Hawkins. I assume we can get started. Ms. Tavenner, why do we not kick it off with you. Your written statements, as per usual, are part of the record. We will set the clock at 5 minutes. Hopefully, you can confine your remarks in that category, and hopefully you will complement and supplement your remarks verbally rather than redo what is already in writing. Ms. Tavenner, please proceed.

STATEMENTS OF MARILYN TAVENNER, CHIEF EXECUTIVE OFFICER, RICHMOND MARKET PRESIDENT, HCA-THE HEALTHCARE COMPANY, JOHNSTON-WILLIS AND CHIPPENHAM MEDICAL CENTERS, ON BEHALF OF THE FEDERATION OF AMERICAN HEALTH SYSTEMS; KAREN COUGHLIN, CHIEF EXECUTIVE OFFICER, PHYSICIANS HEALTH SERVICES HEALTH PLANS, ON BEHALF OF THE AMERICAN ASSOCIATION OF HEALTH PLANS; ROWEN K. ZETTERMAN, PRESIDENT ELECT, AMERICAN COLLEGE OF GASTROENTEROLOGY, ALSO ON BEHALF OF THE AMERICAN COLLEGE OF PHYSICIANS-AMERICAN SOCIETY OF INTERNAL MEDICINE; MAX RICHTMAN, EXECUTIVE VICE PRESIDENT, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE; JULIET HANCOCK, PROGRAM CONSULTANT, REHABCARE GROUP, INCORPORATED, ON BEHALF OF THE NATIONAL ASSOCIATION FOR THE SUPPORT OF LONG TERM CARE; DANIEL R. HAWKINS, JR., VICE PRESIDENT, FEDERAL AND STATE AFFAIRS, NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS; MARY LOU CONNOLLY, ADMINISTRATOR, UCSD HOME CARE, ON BEHALF OF THE NATIONAL ASSOCIATION OF HOME CARE; AND DAVID T. WILLIAMS, DIRECTOR OF GOVERNMENT RELATIONS, INVACARE CORPORATION, ON BEHALF OF THE AMERICAN ASSOCIATION FOR HOMECARE AND THE HOME MEDICAL EQUIPMENT SERVICES INDUSTRY

Ms. TAVENNER. Thank you, Mr. Chairman. My name is Marilyn Tavenner, and as discussed before, I am CEO of Johnston-Willis and Chippenham Medical Centers, which are located in Richmond, Virginia. I also happen to be a registered nurse as well as a fellow with the American College of Healthcare Executives and I serve on the Board of Governors and the Legislative Committee for the Federation. In addition to Chippenham and Johnston-Willis, I also am responsible for managing Henrico Doctors' Hospital, John Randolph Medical Center, and Retreat Hospital, all of which are located in Richmond, Virginia.

Our doctors and our nurses are tireless advocates and committed advocates for health care. We have over 30 parish nurses who have created health ministries in their own congregations. We have a physician who has created Noah's Children, which is the only pediatric hospice program in the area, and we have many caregivers who are committed to the residents of Virginia. Many of these caregivers have expressed concerns to me about their ability to continue to provide the care that they feel their patients deserve in our current financially stressed environment.

All hospitals, both urban and rural, have been seriously and negatively impacted by the BBA, which has had a far greater impact than anyone imagined when it was passed 2½ years ago. In 1997, Congress and the administration agreed to reduce Medicare spending by \$103 billion. However, we now know today that these cuts may be more than \$225 billion. Last November, the BBRA restored \$1 billion in program spending for this year and \$15.8 billion over a 5-year period and we are very thankful for that, and yet, still almost one-third of the Nation's hospitals will operate in the red this year, the highest number ever.

Overall, hospitals are losing money on every Medicare beneficiary that walks through their door. Hospital margins are expected to drop by 55 percent in 2002. Congress cannot expect hospitals to operate with negligible margins, or in the red, and be able to maintain the quality of service.

In my home State of Virginia, the BBA payment cuts are unprecedented. They are estimated at nearly \$1.6 billion over a 5-year period. Just the four hospitals that I am responsible for will see \$70 million in cuts because of BBA. This has a potentially devastating effect on our ability to provide services and comes at a time when we find our costs to be soaring, particularly prescription costs and labor costs. Indeed, the number of uninsured even in our environment has increased by 13 percent from 1996 to 1998. It is clear that Virginia hospitals, which are already among the most efficient in the Nation, will be hard-pressed to achieve additional economies to weather the BBA storm.

Congress must address this issue before it adjourns in the fall. Our recommendations include giving all hospitals a full market basket update, which is the hospital equivalent of the CPI. United States has recommended that Congress increase the inpatient update between 3.5 and 4 percent in 2001. The administration in its proposal released last month called for a full market basket update. The Hospital Preservation and Equity Act that would give hospitals a full market basket update currently has 291 cosponsors, including nearly 60 percent of the House Commerce Committee.

Second, freeze the Medicaid DSH reduction at 2000 levels to help ensure quality, access to quality care for the vulnerable uninsured. We commend the leadership of Congressman Bilbray, Congresswoman DeGette, and Congressman Whitfield, who have introduced legislation that would accomplish this goal.

The BBA slashed hospital reimbursement for bad debt. Hospitals incur bad debt when Medicare beneficiaries do not pay their share of the costs associated with hospital stays. These cuts in bad debt negatively impact hospitals that provide needed hospital care to these low-income seniors. That is why we are pleased that Congressman Greenwood and Congresswoman DeGette have recognized this problem and introduced legislation to restore hospitals' bad debt reimbursement.

Third, the BBA reduced Medicare DSH payments by 5 percent, phased in over 5 years. The 1999 BBRA reversed a portion of this cut. Restoring this funding will help hospitals that provide care to low-income seniors remain viable. We understand that key committees, both in the House and Senate, including this committee, are also moving toward a comprehensive BBA relief package. The Nation's 39 million seniors who depend on America's hospitals to meet their daily health care needs desperately need this attention.

Mr. Chairman, thank you again for inviting the Federation to testify, and as one of Chairman Bliley's constituents, I would also like to thank him for his long period of dedication to the people of Richmond and we will sorely miss him.

[The prepared statement of Marilyn Tavenner follows:]

PREPARED STATEMENT OF MARILYN TAVENNER, CEO, JOHNSTON-WILLIS HOSPITAL & CHIPPENHAM MEDICAL CENTER, ON BEHALF OF THE FEDERATION OF AMERICAN HEALTH SYSTEMS

Mr. Chairman, hello, I am Marilyn Tavenner, CEO of the Johnston-Willis and Chippenham Medical Centers in Richmond, Virginia. I am a registered nurse, as well as a fellow of the American College of Healthcare Executives, and I serve on the Board of Governors and the Legislative Committee of the Federation of American Health Systems. The Federation represents nearly 1,700 privately owned and managed community hospitals across the United States. As I am sure you will hear from almost all of the witnesses today, the last few years have not been pleasant—or easy—for anyone involved in delivering healthcare to patients.

In addition to Chippenham Medical Center and Johnston-Willis Medical Center, I am also responsible for managing Henrico Doctors' Hospital, John Randolph Medical Center, and Retreat Hospital, all in the Richmond, Virginia market. Together, these hospitals annually treat 646,000 patients, 33% of which are Medicare and 19% of which are Medicaid. We provide care to 57,500 uninsured patients each year. Our doctors and nurses are tireless and committed advocates for their patients and their communities. From the 30 parish nurses who have established health ministries in their congregations, to the physician who created Noah's Hope—our area's only pediatric hospice, to the employees who serve as big buddies for Camp Comfort—a youth bereavement program, or who packed and delivered 3,000 emergency meals for the 'Meals on Wheels' program, our caregivers are on the front line in caring for the residents of Virginia. Many of these caregivers have expressed concerns to me about their ability to continue to provide the care their patients deserve with the ongoing financial stress our hospitals are under.

The Problem: The 1997 BBA

All hospitals, urban and rural, have been seriously and negatively impacted by the Balanced Budget Act of 1997 (BBA), which has had a far greater impact than anyone could have imagined when it passed two-and-a-half years ago. In 1997, Congress and the Administration agreed to reduce Medicare spending by \$103 billion ('98-'02). However, we now know based on current projections that these cuts will be more than \$225 billion. And, over \$125 billion of this unexpected windfall is forever "gone" to the Medicare program towards the surplus and other discretionary spending.

Last November, the Balanced Budget Refinement Act (BBRA), a.k.a. the BBA "add back" bill, restored \$1 billion in program spending for FY '00, and \$15.8 billion over 5 years. We were, *and are*, very grateful for Congress' thoughtful bipartisan response. This Committee's leadership was particularly helpful. However, between November 1999 and January 2000, Medicare spending estimates fell by \$8 billion for FY '00 alone, and by \$73 billion over 5 years, wiping out—many times over—the intended impact of the restoration package.

Both Houses of Congress have considered Medicare "lock box" proposals that would ensure that any future unexpected savings would be reserved for Medicare. Plus, the Administration has suggested taking Medicare 'off budget'. These would be enormous positive steps in strengthening the program.

The Impact of BBA on Hospitals

Almost one-third of all hospitals will operate in the red this year—the highest number ever. No matter where you look, whether it is government reports or independent studies, hospital margins are sharply lower. The evidence is overwhelming:

- "The financial crisis in health care has shifted from the solvency of the Medicare Trust Fund, which now appears to be intact until 2025, to the financial condition of the nation's hospitals." [*HCIA Sachs/Ernst & Young LLP, March 2000*]
- "The BBA's impact has shaken the confidence of the financial markets in the health care industry. Moody's reported that the credit deterioration for U.S. not-for-profit hospitals continued throughout 1999. Therefore, as the need for capital increases, hospitals may find it difficult to access financial markets in order to maintain adequate capital levels, e.g., new technologies." [*HCIA Sachs/Ernst & Young LLP, March 2001*]
- The Ernst and Young study also found that "hospitals with less than 100 beds are hardest hit by the BBA: their margins significantly decrease from positive 4.2 percent in FY 1998 to negative 5.6 percent in FY 2002, a drop of 233 percent."
- According to the Lewin Group, total hospital Medicare margins are projected to be negative 2.5 in 2002, and stay negative through 2004 despite passage of the BBRA.

Overall, hospitals lose money on every Medicare beneficiary that walks through their door. Total hospital margins are projected to fall by 55% in 2002. Clearly, Congress cannot expect hospitals to operate with negligible margins, or in the red, and still maintain current services.

The Effect of BBA on Virginia's Hospitals

In my home state of Virginia, the BBA payment cuts are unprecedented. According to the Lewin Group, these cuts will total nearly \$1.6 billion over five years and will have had potentially devastating impact on all major services—inpatient, outpatient, and home health care. This comes at a time when hospital costs are skyrocketing—especially prescription drug costs and labor costs—and when the number of uninsured patients has increased dramatically—by 13% from 1996 to 1998. So, while it is clear that Virginia hospitals—which are already among the most efficient in the nation as measured by length-of-stay and case/mix data—will be hard pressed to achieve additional economies to weather the BBA storm.

The Best Remedy for Hospitals

Congress must address this issue before it adjourns in the fall. To do so, Congress should:

- Give all hospitals a full market basket (MB) update, which is the hospital equivalent of the Consumer Price Index (CPI). This full inflation update should apply to both inpatient and outpatient services. For the last three years, hospital cost inflation rose a total of 8.2%. The inflation adjustment policy from the BBA for the last three years has been a freeze (FY '98); MB -1.8 (FY '99) and MB -1.8 (FY '00), substantially below our costs increases. Labor costs, which account for 60% of a hospital's budget, also continue to increase. Drug inflation continues to rise at double-digit rates, and access to new technology continues to drive up a hospital's costs. The cumulative impact has been devastating.

Even Congress' own Medicare Payment Advisory Committee (MedPac) recently recommended that Congress increase the inpatient update between 3.5 and 4.0% for FY '01. The Administration, in its proposal released last month, also called for a full Market Basket update. H.R. 3580, "The Hospital Preservation and Equity Act" that would give hospitals a full Market Basket update currently has nearly 300 co-sponsors, including close to 60% of the House Commerce Committee.
- Freeze the Medicaid DSH reduction at FY '00 levels to help ensure access to quality care for the vulnerable uninsured. We commend the leadership of Congressman Bilbray, Congresswoman DeGette and Congressman Whitfield who have introduced legislation that would accomplish this goal—H.R. 3710 and H.R. 3698. Between the two bills, this issue has attracted the support of more than 200 Members of Congress, including nearly 60% of the House Commerce Committee. For instance in California, absent Congressional action this year, the state will see a devastating \$164 million reduction in Medicaid funding over the final two years of BBA '97.
- Restore Medicare Bad Debt/Indigent Care reimbursement. The BBA reduced hospitals' reimbursement for bad debt/indigent care from its pre-BBA level of 100% to 55%. This occurred at the same time as the number of U.S. uninsured rose from 39 million to better than 45 million. Hospitals incur bad debt when Medicare beneficiaries do not pay their share of the costs associated with hospital stays. While most seniors have "Medigap" coverage for deductibles and co-pays, there remain about 10% of "near poor seniors" who do not have Medigap and do not qualify for Medicaid. Hospitals make every effort to collect this money directly from the patient, but these are seniors who just cannot afford to pay their portion of these costs. So, this cut in bad debt directly negatively impacts hospitals that provide needed hospital care to these low-income seniors. This is why we are pleased that Congressman Greenwood has recognized this problem, and introduced bipartisan legislation to restore hospitals' bad debts reimbursement rate to 100 %.
- Restore Medicare Disproportionate Share (DSH) payments. The BBA reduced Medicare DSH payments by 5%, phased-in over five years. The 1999 BBRA reversed a portion of this cut, but it is still 3% in 2001 and 4% in 2002. DSH hospitals provide the majority of care to Medicare beneficiaries, accounting for over 58% of Medicare PPS payment for services in FY '97. Additionally, these hospitals are often the only source of medical care for the poor. Rural facilities have been particularly hard-hit by this cut. Restoring this funding, with new money, will help hospitals that provide care to low-income seniors to remain viable.

- Allow rehabilitation and long-term acute care (LTACs) hospitals to move to PPS immediately. These facilities are a class of specialty hospitals and units that were excluded from the Medicare hospital inpatient prospective payment system (PPS) when it was enacted in 1983. The BBRA requires a case-mix adjusted, per discharge, inpatient PPS for LTACs by October 1, 2002. The issue at hand is that LTACs have been expecting a prospective payment system with its own DRGs as an alternative to the flawed cost-based TEFRA system since the middle of the 1980's when HCFA promised one, PROPAC recommended one, and Congress mandated one. Instead, public policy has tended to focus on treating the latest program aberration caused by TEFRA, i.e., high target rates, inequitable target rates between "old" and "new" hospitals, hospitals within hospitals, transfer policies, etc. These tinkering have inflicted severe damage on long-term hospitals, which according to the June 2000 MedPAC report, now have negative margins. The hospital industry would like LTACs to go immediately to the PPS, preferably through a bill introduced by Sen. Cochran (R-MS) and supported by virtually every one of the 150 long-term acute care hospitals in the United States. For rehabilitation hospitals, BBA'97 required the establishment of a case-mix adjusted PPS effective FY2001, with full implementation by October 1, 2002. Implementation has been delayed, and many hospitals are anxious to move to the 100% PPS rates immediately.

The Process for Relief

The President recently offered a proposal, totaling more than \$21 billion in relief over the next five years. We understand that key Committees, in both the House and Senate—including this Committee, are also moving toward a comprehensive BBA relief package. The Federation hopes that these efforts move forward, and that these will serve as the basis for a serious, bipartisan and bicameral BBA restoration discussion.

We certainly hope that this hearing will encourage the House to place BBA restoration on the "must do" list for the House before Congress adjourns. The nation's 39 million seniors, who depend on America's hospitals to meet their daily healthcare needs, desperately need this attention.

Mr. Chairman, thank you again for inviting the Federation to testify. As one of Chairman Bliley's constituents, I would also like to take this opportunity to thank the Chairman for his years of dedication to the people of Richmond. Like all Virginians, we will certainly miss his leadership in the coming Congress.

At this time, I look forward to answering any questions you may have for me.

Mr. BILIRAKIS. Thank you, Ms. Tavenner. We will pass that along to him.

Ms. Coughlin?

STATEMENT OF KAREN COUGHLIN

Ms. COUGHLIN. Mr. Chairman and members of the committee, thank you for this opportunity to testify today. I am Karen Coughlin, the CEO of PHS Health Plans. I am testifying today on behalf of the American Association of Health Plans.

Like Ms. Tavenner, I am also an RN and practiced at the bedside for 10 years, taking care of sick children and babies in intensive care units. I also ran nursing departments and hospitals over the years, and for the past several years have been running managed care plans. My focus when I get up and go to work every day is trying to keep high-quality health care affordable for people.

The Medicare Plus Choice program offers important advantages to both the government and to Medicare beneficiaries. Fifteen years ago, the government made a compact with beneficiaries. By delivering care in a more efficient way, Medicare HMOs achieved cost savings that were then passed on to beneficiaries in the form of increased benefits and reduced out-of-pocket expenses.

The success of the Medicare HMO program inspired Congress to establish the Medicare Plus Choice program in 1997. Three years later, however, the Medicare Plus Choice program has not fulfilled

its progress of expanding health care choices for Medicare beneficiaries. Two major problems are responsible for this outcome. First, the Medicare Plus Choice program is significantly underfunded, and second, the Health Care Financing Administration has imposed excessive regulatory burdens on health plans participating in the program. The funding program has been caused by the unintended consequences of the Medicare Plus Choice payment formula.

To illustrate this problem, please consider the following example. Total premiums collected by health plans from OPM and from enrollees participating in the Federal Employees Health Benefits Program, the FEHBP, have increased for the average beneficiary by a total of 29.1 percent between January 1997 and December of this year. During this same period, however, government payments to Medicare Plus Choice plans have increased for the average beneficiary by a total of only 8.6 percent.

In January 2001, at least 750,000 beneficiaries will be forced to change health plans or return to the Medicare fee-for-service system. This number is more than the number who were similarly affected in the previous 2 years combined. Additionally, many other beneficiaries have lost important benefits and are paying higher out-of-pocket costs even though they are able to keep their health plan.

To understand why beneficiaries are losing choices and benefits, please consider that in 1998, in Foundation's Eastern Region, for which I am responsible, we paid \$1.10 in benefits for every \$1 in premium we received. Even if we had incurred no administrative expenses, we could not survive while paying more in benefits than we received in payments.

These disruptions have been particularly painful for low-income Medicare beneficiaries, whose health security will be severely compromised if this program is not saved. Our plans have worked very hard to prevent this situation from happening.

Despite our disappointment, this program has provided unprecedented value to Medicare beneficiaries and we are committed to working with all of you to save the Medicare Plus Choice program. We believe that \$15 billion is needed over the next 5 years to stabilize this program on a long-term basis. A commitment of this magnitude is needed to assure that the Medicare Plus Choice program fulfills its promise of preserving and expanding health care choices for all Medicare beneficiaries.

We also urge you to combine this additional funding with meaningful regulatory reforms so beneficiaries are receiving quality and value in their Medicare Plus Choice plans. It is critically important to ensure that the benefits of regulations outweigh their costs. Currently, while the figure of 2 percent is often used to describe administrative costs under Medicare, that figure reflects only HCFA's cost and does not reflect any of the cost of complying with the Medicare programs.

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

[The prepared statement of Karen Coughlin follows:]

PREPARED STATEMENT OF KAREN COUGHLIN, PRESIDENT AND CEO, FOUNDATION
HEALTH SYSTEMS' EASTERN DIVISION

Mr. Chairman and members of the subcommittee, thank you for the opportunity to testify on the impact the Balanced Budget Act of 1997 (BBA) has had on Medicare+Choice organizations and the beneficiaries they serve. I am Karen A. Coughlin, CEO of PHS Health Plans, an open-access HMO serving 1.1 million members in New York, Connecticut, New Jersey and Pennsylvania. I also serve as the President and CEO of Foundation Health Systems' Eastern Division, responsible for the above named markets, as well as our operations in South Florida (Broward and Dade Counties). My undergraduate degree is in Nursing and I practiced as an RN at the bedside for the first ten years of my career, caring for infants and children in neonatal and pediatric intensive care units. I served several years as the Head Nurse of the Pediatric ICU at Loma Linda University Medical Center in California.

Foundation is the sixth largest Medicare+Choice plan in the nation. When I started at PHS Health Plans in 1998, Foundation covered 290,000 Medicare members in 12 states. By January 2001, due to the problems I will discuss in my testimony, we will have completely withdrawn from six states and terminated coverage for 57,000 Medicare members. Moreover, all of our remaining Medicare members have suffered either a loss of benefits or an increase in premiums since 1998.

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

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

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

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

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

Beneficiaries valued this important health care choice under the original Medicare HMO program—and still value it today—because Medicare HMOs, when adequately funded, are able to provide a more comprehensive package of benefits and lower out-of-pocket costs than the old Medicare fee-for-service system. This is particularly important to low-income beneficiaries. For many seniors and persons with disabilities who live on fixed incomes, having access to a Medicare HMO means that they can spend their limited resources on groceries and other daily essentials—instead of “going without.” Beneficiaries also like Medicare HMOs because they provide coordinated care and place a strong emphasis on preventive services that help them to stay healthy and avoid preventable diseases. According to a survey conducted by

HCFA, when Medicare managed care enrollees were asked to rate their plans on a scale of 1 to 10 (with 10 being the highest score), 50 percent assigned a “10” rating to their plan and another 34 percent assigned an “8” or a “9” rating to their plan.

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

Two major problems are responsible for this outcome: (1) the Medicare+Choice program is significantly underfunded; and (2) the Health Care Financing Administration (HCFA) has imposed excessive regulatory burdens on health plans participating in the program. The funding problem has been caused by the unintended consequences of the Medicare+Choice payment formula that was established by the BBA, as well as the Administration’s decision to implement risk adjustment of Medicare+Choice payments on a non-budget neutral basis. Under this formula, the vast majority of health plans have been receiving annual payment updates of only 2 percent in recent years—while the cost of caring for Medicare beneficiaries has been increasing at a much higher rate.

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

1. Total premiums collected by health plans (from OPM and from enrollees) participating in the Federal Employees Health Benefits Program (FEHBP) have increased, for the average beneficiary, by a total of **29.1 percent** between January 1997 and December 2000. During this same time period, government payments to Medicare+Choice plans have increased, for the average beneficiary, by a total of only **8.6 percent**. In 2001, government payments to Medicare+Choice plans will again generally increase by just 2 percent—making this the third time in four years that the annual update was 2 percent. In the Northeast (Connecticut, New York and New Jersey), medical costs per beneficiary have risen 12.5% since 1998, while Medicare reimbursement has only risen by 4.1%. Our only options for keeping up with these costs have been to limit benefits or charge premiums to beneficiaries.
2. In many geographic areas where large numbers of Medicare beneficiaries are enrolled in Medicare+Choice plans, government payments for Medicare fee-for-service beneficiaries will exceed government payments to plans on behalf of Medicare+Choice beneficiaries by **\$1,000 or more per beneficiary in 2004**. These areas include—to name just a few—Los Angeles (which currently has 314,000 Medicare+Choice enrollees); New York (174,000 Medicare+Choice enrollees); Miami (134,000 Medicare+Choice enrollees); and Philadelphia (78,000 Medicare+Choice enrollees). This payment differential has challenged the ability of health plans to offer beneficiaries the quality coverage they deserve and, additionally, to maintain provider networks and expand into new geographic areas.
3. By establishing a blend of local and national rates, the BBA intended to reduce the variation in Medicare+Choice payments among counties. As noted above, however, the blend has been funded in only one year and government payments to Medicare+Choice plans continue to vary among geographic areas, including neighboring geographic areas. For example, the monthly payment from the government in 2000 is \$485.76 in Fairfield County, Connecticut and \$679.10 in Richmond County, New York—a difference of \$193.34 even though these areas are only 40 miles apart.

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

In January 1999, 407,000 beneficiaries were forced to change health plans or return to the Medicare fee-for-service system because many health plans—faced with inadequate government payments and excessively burdensome regulatory requirements—were forced to curtail their participation in the Medicare+Choice program. In January 2000, 327,000 experienced similar disruptions in their health coverage. Additionally, many other beneficiaries have lost important benefits and are paying higher out-of-pocket costs even though they have been able to keep their Medicare+Choice plans. To understand why beneficiaries are losing choices and benefits, please consider that, in 1998, in Foundation’s Eastern Region, the ratio of medical costs to total reimbursements was 110% for our Medicare+Choice members.

Even if we had incurred no administrative expenses, we could not survive while paying more in benefits than we receive in revenues.

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

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

In an effort to address the crisis in the Medicare+Choice program, Congress enacted the Balanced Budget Refinement Act of 1999 (BBRA). While this legislation was a step in the right direction, it provided only a small fraction of the resources that are needed to fully stabilize the program on a long-term basis. As a result, the Medicare+Choice program will experience further disruptions in January 2001.

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

A survey recently commissioned by AAHP indicates that at least 711,000 Medicare beneficiaries will suffer the loss of their current health coverage in January 2001 because Medicare+Choice organizations are being forced to exit the program. This survey was based on information provided by health plans covering 85 percent of beneficiaries currently enrolled in the Medicare+Choice program. When the decisions of the remaining Medicare+Choice organizations are known, it is likely that the total number of affected beneficiaries will be greater than the number who were similarly affected in the previous two years combined.

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

Despite our disappointment, we remain committed to the success of the Medicare+Choice program and we will continue to work with you to advance the changes that are clearly needed to put the program on sound footing. We are encouraged that there is bipartisan movement within Congress to enact such changes. We also appreciate Congressman Bilbray’s resolution—approved by the House on June 29 by a strong bipartisan vote of 404 to 8—which acknowledged that “inadequate reimbursement rates” are a problem in the Medicare+Choice program and that action must be taken this year to address this critical issue. We thank the 28 members of this subcommittee who voted for this resolution.

We now urge you to take action this year on specific legislation that follows through on the serious concerns you expressed when you voted for Congressman Bilbray’s resolution. We believe Congress must provide \$15 billion directly to Medicare+Choice plans over the next five years to stabilize the Medicare+Choice program on a long-term basis. A commitment of this magnitude is needed to assure that the Medicare+Choice program fulfills its promise of preserving and expanding health care choices for all Medicare beneficiaries. As you consider options for devoting more funds to the program, we urge you to assure that resources are allocated in such a way as to assure that the Medicare+Choice program is viable in areas

where beneficiaries have already selected health plan options and that the program can expand in areas where such options are not yet widely available.

We also urge you to combine this additional funding with meaningful regulatory reforms so beneficiaries are receiving quality and value in their Medicare+Choice plans. It is critically important to assure that the benefits of regulations outweigh their costs. Currently, Medicare+Choice plans are being forced to devote substantial human and financial resources toward compliance activities, thus leaving fewer resources available for providing health care services to beneficiaries. One example of a set of unnecessarily onerous requirements that merit immediate attention can be found in the physician encounter data requirements under the Medicare+Choice risk adjustment initiative. Preparations for their implementation are requiring an enormous commitment of resources by Medicare+Choice organizations, and this burden will spill over to require similar efforts by their network providers. However, less costly options are available that would meet HCFA's need for data for risk adjustment purposes. We believe beneficiaries will be better served by a regulatory environment that assures quality of care and, at the same time, assures that the costs associated with regulations do not unnecessarily divert resources away from patient care and benefits.

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

Mr. BILIRAKIS. I guess you all know what the bell means, but we do have a few minutes yet. Dr. Zetterman, please proceed, sir.

STATEMENT OF ROWEN K. ZETTERMAN

Mr. ZETTERMAN. Thank you, Mr. Chairman. Thank you for the opportunity to testify. I am Dr. Rowen Zetterman and I appear here today in my capacities as the President Elect of the American College of Gastroenterology and as the Chair of the Board of Regents of the American College of Physicians-American Society of Internal Medicine.

My oral testimony today will focus on three policies that have resulted from the Balanced Budget Act of 1997 and that are of particular concern to the specialty of internal medicine and to gastroenterologists. The first is HCFA's application of a site of service differential for certain endoscopic procedures that are provided less than 10 percent of the time in the office. The second is the reduction of overall Medicare payments to physicians. And the third is the reduction in payments to teaching institutions.

Prior to 1997, Medicare applied a site of service differential that reduced the practice expense component of the physician's professional fee when an office procedure was performed in the hospital or in the ambulatory surgical center. Office procedures were defined as those services provided more than 50 percent of the time in the office. HCFA's 1997 proposal changed the site of service rule markedly and introduced two distinct fee structures for the same professional service. Typically, a physician is paid a lower fee for services provided in the hospital or ASC and a significantly higher fee where those services are provided in the office setting.

ACG and other GI organizations immediately objected to this policy change. Nevertheless, in January 1998, HCFA implemented this bifurcated fee structure. This impact of the rule is particularly felt with respect to GI procedures. Many of these procedures require sedation of patients, and while very safe, especially for our older patients, it is still essential to ensure access to resuscitation equipment, facilities, and personnel for those rare events in which

complications occur. Well over 90 percent of these services are being performed in the non-office setting. GI services make up a relatively major portion of the small number of HCFA procedures that are performed in the office less than 10 percent of the time, but are still subject to the bifurcated fee schedule based onsite of service.

There are two key problems with HCFA's site of service policy. The first and larger problem is that the new policy creates incentives to treat patients in the office instead of a Medicare-certified hospital or ASC. Take, for example, colonoscopies. This is a major diagnostic tool in the fight against colorectal cancer. By fiscal year 2002, Medicare will pay physicians 39 percent more for performing diagnostic colonoscopy in the unregulated office environment than for performing the same service in a hospital or an ASC which is Medicare certified and meets criteria for quality and good training.

Because HCFA has established the bifurcated fee structure for some but not all diagnostic and surgical procedures, there is a more immediate and narrower problem relating to the standard HCFA uses that identify those services appropriate for bifurcated fees. There must be a standard, but HCFA has not articulated the standard.

The absence of any standard for the bifurcated fee structure is the issue which we today propose is appropriate for a modest legislative fix. Last year, the Commerce Committee's mark in the BBRA package included a provision which would have established a 10-percent threshold before HCFA could establish a bifurcated fee and would have remedied current and past economic inequities. At that time, concerns were expressed by other organizations and the specific legislative language that might inadvertently apply to a larger universe of services and so it was dropped.

Such concerns have been addressed in the current legislative proposal, which has the endorsement of all three GI organizations and ACP/ASIM has determined that it has no objection. ACG asks that the committee favorably consider incorporating this proposed legislative fix in legislation to restore inappropriate cuts mandated by BBA 1997.

BBA also made a number of other significant changes in the way physicians were paid. This included replacing the volume performance standard with a sustainable growth rate system. However, HCFA's original method for estimating SGR was flawed, resulting in a \$3 billion shortfall in physician payments during 1998 and 1999. This financial burden has strained physicians' abilities to adequately serve Medicare beneficiaries and led to a joint lawsuit against HCFA by the American Medical Association, ACPSIM, and other medical organizations. In addition, this distortion of the SGR will result in only a 1.8 percent net update. After inflation, this will be less than what we would have been reimbursed in 2000.

Finally, we need to provide safety relief to the safety net of teaching hospitals and we would encourage you to look critically at disproportionate share payments.

So in summary, ACG and ACP/ASIM recognize that at the time Congress enacted BBA 1997, it was doing so in an effort to control large Federal deficits. It has become evident, however, that some of these cuts, particularly relating to physicians' services and

teaching institutions, went too far. We hope you will take the opportunity to restore some of these cuts. Thank you very much.

[The prepared statement of Rowen K. Zetterman follows:]

PREPARED STATEMENT OF ROWEN K. ZETTERMAN, ON BEHALF OF THE AMERICAN COLLEGE OF GASTROENTEROLOGY AND THE AMERICAN COLLEGE OF PHYSICIANS-AMERICAN SOCIETY OF INTERNAL MEDICINE

I am Dr. Rowen K. Zetterman, and I appear here today in my capacities as President-Elect of the American College of Gastroenterology (ACG), and as the Chair of the Board of Regents of the American College of Physicians-American Society of Internal Medicine. I am also one of the ACP-ASIM's representatives in the House of Delegates of the American Medical Association, but my testimony today is not on behalf of the AMA.

In 1997, Congress enacted major reductions in Medicare spending as part of the Balanced Budget Act of 1997 (BBA 97). As a result of these reductions and inappropriate payment policies from the Health Care Financing Administration (HCFA), quality and access to care for millions of beneficiaries is being placed at risk. Today, my testimony will focus on three specific BBA-mandated reductions that are of particular concern to the specialty of internal medicine and to gastroenterologists:

- HCFA's inappropriate application of a site of service differential for certain procedures done by gastroenterologists that are provided less than 10 percent of the time in the office.
- Reductions in overall Medicare payments to physicians.
- Reduction in payments to teaching institutions.

Site of Service Differential for Certain Procedures Done By Gastroenterologists

HCFA's application of a site of service differential to endoscopic procedures done less than 10 percent of the time in the office is of great concern to gastroenterologists. My testimony on this issue reflects the particular concerns of the gastroenterology community, including ACG, about the site of service differential. As an umbrella organization representing all internists, subspecialists as well as generalists, ACP-ASIM is addressing broader issues relating to the impact of the BBA 97 cuts and HCFA's policies, rather than more narrowly focused issues like the site of service differential for certain GI procedures. However, as explained later, ACP-ASIM has no objections to the legislative remedy that the ACG has developed for the site of service problem for gastroenterology.

HCFA has applied a "site of service" differential to physician payments for a number of years. Prior to HCFA's 1997 proposal, Medicare reduced the practice expense component of the physician's professional fee when an office procedure was performed in a hospital or in the ambulatory surgery center. "Office procedures" were those services provided more than 50 percent of the time in the office. This rule meant that diagnostic flexible sigmoidoscopy, which is performed more than 70 percent of the time in the office because no anesthesia is required, was subject to the site of service differential. Diagnostic colonoscopy, which does require anesthesia, is seldom performed in the office so the HCFA rule did not apply. HCFA's 1997 proposal changed the site of service rule markedly, and introduced two distinct fee structures for the same professional service. Typically, a lower fee is paid to the physician if a service is provided in the hospital or ASC, and a significantly higher reimbursement applies if the same procedure is provided in the office setting. This policy is not applied consistently across the family of GI endoscopy. ACG and other GI organizations immediately objected to this change in policy.

Nevertheless, in January, 1998 HCFA implemented this bifurcated fee schedule and through a four-year phase-in, the spread between the higher (office) fee and the lower (hospital/ASC) fee has grown markedly with each successive year. (See Table I)

Identified Codes Include Major Colorectal Cancer Screening Procedures—This Fix Would Help Remedy Underutilization of Medicare Colorectal Cancer Screening Benefit; HCFA's Site-of-Service Rule Has a Disproportionately Heavy Adverse Impact on Gastrointestinal Procedures

The impact of this rule is particularly felt with respect to gastrointestinal procedures. These procedures require sedation of patients and, while very safe, particularly in older patients, it is essential to ensure access to resuscitation equipment, facilities and personnel for those rare events in which complications occur. Similarly, it is essential that there be some credentialing and review of adequacy of training. In all of these services, well over 90% are being done in non-office setting, i.e. hospitals or ASCs:GI services are the major portion of the small number of

Medicare procedures which have fewer than 10% currently being performed in the office, but to which HCFA still has applied the bifurcated fee schedule of the site-of-service rule. Included among these procedures are colonoscopies—the major diagnostic and treatment tool in the fight against colorectal cancer. The GAO recently reported to the Senate Aging Committee that despite the new Medicare colorectal cancer screening benefit, only 1% of Medicare beneficiaries are availing themselves of screening.

When the phase-in is complete in 2002, Medicare will pay physicians 39 percent more if he/she performs the diagnostic colonoscopy in the completely unregulated office environment, than provided for the same service performed in a hospital or ASC which is Medicare-certified and meets criteria for quality and minimal equipment, as well as the training/credentialing requirements that these facilities impose.

The anomaly whereby HCFA maintains a mechanism and standards which must be met to qualify as a Medicare-certified ASC, and then implements a reimbursement system which pays physicians more if they perform cases in the office environment where none of the training, mandatory capacities to handle complications or other ASC-required standards apply is inexplicable. As much as HCFA articulates that the rationale for the higher physician payment for office-based services lies in the higher practice expenses, it would be naive not to consider that a substantial motivation is elimination of the Part A facility fee paid to those facilities that meet the requirements for Medicare certification.

There are two key problems with HCFA's site-of-service policy. The first and larger problem is that the new policy creates incentives which can result in patients receiving treatment in the office instead of the Medicare-certified hospital or ASC. While some procedures can safely be performed in the right office setting—one with some of the same criteria that are mandated for Medicare certified facilities—the ultimate decision should not be based upon reasons other than what is best for the patient. We are very concerned about how minimal quality of patient care can be assured in the largely unregulated environment of the typical private physician's office.

We are not here today to propose a solution to larger issues relating to site of service or practice expenses. Keeping in mind that HCFA has set up this bifurcated fee structure for some, but not all diagnostic and surgical procedures, there is a more immediate narrower, problem relating to the standard HCFA uses to identify those services appropriate for dual fees. There must be a standard, but HCFA has not articulated it. We assume that such a standard would be tied to the percentage of cases already being performed in the office, and also would take into account the safety of the office setting. For example, coronary artery bypass graft surgery retains a single fee, presumably because HCFA believes it is not and ought not be done in the office.

At one point HCFA directed its clinical practice panels to use the 10% threshold as a benchmark, meaning that if a procedure is done less than 10% of the time in office, then it would not be considered for the bifurcated fee. However, in response to ACG's comments and in meetings with ACG, HCFA has denied that this is their standard (See Secretary Shalala's Letter). This narrower problem—the absence of any articulated standard for the bifurcated fee structure, as well as the unfair results from HCFA's having reduced payments by 39 percent over the four-year phase in to the 90-95% of GI physicians who, despite the HCFA disincentives, still have declined to do these procedures in the unregulated office setting, but choose to take their patients to Medicare-certified facilities—is the issue which we today propose is appropriate for a modest legislative fix.

Last year, the Commerce Committee's Mark in the Balanced Budget Relief Act (BBRA) package included a provision, then-labeled as section 204(v), which would have established a 10% threshold before HCFA could establish a bifurcated fee, and would have remedied current and past economic inequities by instructing HCFA to revert to a single fee structure (i.e., number of relative value units, or RVUs, then proposed as the 1997 level that pre-dated HCFA's change). At that point, the ACP-ASIM criticized the specific language, expressing concern that it might inadvertently apply to a much larger universe of services than the ACG intended. In the interim, we have held frequent discussions among the ACP-ASIM and three major GI organizations, namely, the American Gastroenterological Association (AGA), American Society For Gastrointestinal Endoscopy (ASGE) and ACG. The current proposed legislative language has the endorsement of all three GI organizations; these changes also have prompted ACP-ASIM to withdraw its objections to this proposal.

Attached to my written testimony is an addendum that refers to comments, meetings and discussions with HCFA officials about this problem. Several members of Congress from both parties have communicated their concerns about this policy to

the Secretary of HHS as well as to the HCFA Administrator. In a recent response to one of these inquiries, Secretary Shalala addressed this issue in terms which demonstrate: (1) the current absence of any agency standard; (2) the prospects for creation of unintended financial incentives potentially steering where care is delivered; and (3) HCFA's economic objective of avoiding payment of the facility fee to those hospitals and ASCs that meet Medicare certification requirements. Her response, and ACG's comments on her response, are summarized in the addendum.

A recent GAO report to the Senate Special Committee on Aging underscored that the colorectal cancer screening benefit has not been utilized very widely by Medicare beneficiaries—numbers were in the range of 1% uptake in 1998. While there are many reasons for this, the reimbursement inequities of the inappropriate site-of-service treatment, despite less than 10% office volume level must be considered as a contributing factor.

Certainly, there is little logic in creating a national priority for colorectal cancer screening and then whittling the payment rates to such low levels as to make them a losing proposition for physicians. So, in the narrow fix to this site of service problem, Congress also would be making an important investment in favor of colorectal cancer screening.

It is essential to recognize the proposed section 204(v) provision is not directed to resolving concerns about the larger site-of-service differential issue. It addresses solely an antecedent problem, the much smaller subset of services where the volume of services performed in the office setting have never reached the 10% threshold. This issue needs to be resolved distinctly from, and in advance of, any effort that may evolve to address broader concerns about the site of service differential.

While we do not seek to address or solve the broader site-of-service differential issue, we strongly oppose the solution to that issue which has been proposed by the Medicare Payment Advisory Commission (MEDPAC), which will only compound the problem, and further strip reimbursement rates.

We ask that the Committee favorably consider incorporating this proposed legislative fix for this narrow problem by articulating the 10% threshold, and requiring HCFA to revert to a single fee structure—the fee currently being paid only for services provided in the office to be set at either the 2000 office fee, or the 2001 office fee, whichever is higher, as to a limited number of specific services where office volume falls well below the 10%.

Reversing Overall Cuts in Payments to Physicians

The BBA made a number of significant changes in the way physicians were paid under Medicare fee-for-service. This included replacing the volume performance standard with the sustainable growth rate system (SGR) and phasing-in a new method of calculating practice expenses for physicians. The SGR establishes a target growth rate for Medicare spending on physician services, then annually adjusts payments up or down, depending upon whether actual spending is below or above the target.

However, HCFA's original method of estimating the SGR was flawed and resulted in a \$3 billion shortfall in payments to physicians during 1998 and 1999. This financial burden has strained physicians' ability to adequately serve Medicare beneficiaries, and led to a joint lawsuit against HCFA by ACPASIM and 16 other medical organizations, which is still pending. Fortunately, the Balanced Budget Relief Act of 1998 (BBRA) has corrected this technical flaw for the years 2000 and beyond.

The BBA's new methods for establishing Medicare payment rates for physicians still present significant technical concerns for physician organizations, especially their potential for producing wide fluctuations in reimbursement rates from one year to the next. To ensure physicians are fairly compensated for their services, and in a manner that does not allow for precipitous fluctuations in income, MEDPAC, in its March 1999 Report to Congress, recommended the following SGR improvements:

- Revise the sustainable growth rate to include measures of changes in the composition of Medicare fee-for-service enrollment.
- Revise the sustainable growth rate to include a factor of growth in real gross domestic product per capita plus an allowance for cost increases due to improvements in medical capabilities and advancements in scientific technology.
- Amend a provision of the Balanced Budget Act of 1997 to require the Secretary to publish an estimate of conversion factor updates by March 31 of the year before their implementation.
- Reduce time lags between sustainable growth rate measurement periods by allowing calculation of the sustainable growth rate and update adjustment factors on a calendar year basis.

- Require the Secretary to correct estimates used in sustainable growth rate system calculations every year.

The BBRA did produce some significant refinements to the SGR, primarily limiting oscillations in the annual update to the conversion factor, and requiring that the SGR be calculated on a calendar year basis. The BBRA did fail, however, to reinstate the \$3 billion shortfall in 1998 and 1999 physician payments, and to “increase the SGR to account for rising physician costs due to technological advances and an aging population,” as noted in the November 22/29, 1999 issue of *American Medical News*.

Though the SGR will be 5.8% for 2000, according to the April 24, 2000 issue of *American Medical News*, the preliminary SGR estimate for 2001 of 2.8% is considered “too low” according to the MedPAC, in its June 2000 Report to Congress. The MedPAC report explains that HCFA has underestimated the SGR by underestimating one of its key components, growth in traditional Medicare enrollment, by overestimating the number of beneficiaries who will join Medicare+Choice plans. This distortion of the SGR results in only a 1.8% net update to the Medicare physicians’ conversion factor, meaning the pool of Medicare funds available to pay physicians in 2001 will be substantially less than in 2000. This has led the MedPAC to recommend that, “When preparing the final 2001 update to the physician fee schedule’s conversion factor, the Secretary (of the Department of Health and Human Services) should review the data and methods used to project growth in enrollment in traditional Medicare and explain the methods used to project that growth.”

In its March 2000 “Report to the Congress: Medicare Payment Policy,” the MedPAC shows that physicians display a serious erosion of their confidence in the ability of Medicare and managed care plans to pay them fairly for their services, as shown in survey findings:

- About 45% said that reimbursement levels for Medicare FFS patients are a very serious problem, compared with 25% for private FFS patients.
- A higher percentage of physicians—59%—reported that reimbursement levels for FFS Medicaid patients are a very serious problem.
- Physicians expressed the highest level of concern with the reimbursement levels of health maintenance organizations and other capitated plans—about 66% of the total surveyed.

The underfunding of physician services is contributing to concerns that the medical community has about other Medicare payment issues. Although there are different views within the medical profession on specific Medicare reimbursement/payment policies, there is widespread agreement that Congress should address the underfunding of Medicare physician payments that was caused by the SGR and other budget cuts.

Cuts in Payments to Teaching Institutions

The heart of the safety net are the nation’s academic medical centers and large inner city hospitals. ACPASIM, in a October 1, 1999 letter to the House of Representatives’ Ways and Means Subcommittee on Health, was very vocal in expressing its concern about the BBA’s impact on these vital institutions, seeking restoration and/or relief from BBA cuts—especially those related to indirect medical education and DSH payments. The letter noted that the cuts would be particularly harmful to teaching hospitals, which “often serve as providers of health care for inner city populations that otherwise are underserved. They provide substantial amounts of uncompensated care for poor and indigent patients. Graduate medical education is the linchpin for these inner city safety net hospitals, and they cannot survive if their educational programs are not adequately funded.” In the same letter, ACPASIM also warned Congress that “The BBA cuts also jeopardize our nation’s medical research enterprise . . . medical schools and teaching hospitals serve as the crucible for much of the nation’s medical research . . . the Medicare BBA cuts undermine the ability of teaching hospitals to perform this vital mission.”

The March 2000 MedPAC Report to Congress displayed great concern for the BBA’s impact on access to hospital care, especially that obtained in public hospitals and academic medical centers: “With the passage of the BBA, the Congress made several changes in hospital payments that have the potential to affect beneficiary access or reduce the quality of hospital care. These provisions included: no updates to inpatient operating payments for hospitals under the Medicare Prospective Payment System (PPS) in fiscal year 1998 and limited updates from 1999 to 2002; phased reductions in the per-case adjustments for the indirect costs of medical education (IME); temporary reductions for hospitals serving a disproportionate share (DSH) of low income patients; and a new transfer policy for 10 high volume diagnosis related groups (DRGs) that reduces payment rates when hospitals discharge patients in these DRGs to post-acute care facilities following unusually short stays.”

A November 1999 study by the Commonwealth Fund showed just how vital Medicare and Medicaid DSH payments are to the survival of safety net hospitals: In 1996, the year before the BBA was passed, “costs for uncompensated care at a sample of urban, safety net hospitals totaled \$4 billion and represented 26 percent of total costs. These costs were financed through state and local government subsidies (59 percent), Medicaid DSH payments (29 percent), Medicare DSH payments (9 percent), and cost-shifting from privately insured patients (3 percent)... In 1996, without DSH payments, these hospitals would have experienced an alarming negative 7 percent margin... BBA cuts in DSH payments will reduce by half the surpluses derived from Medicare and Medicaid payments (without accounting for the impact of any other BBA reductions). Coupled with declining local government appropriations and market forces that include managed care and an eroding Medicaid patient base, these cuts will severely undermine the ability of these hospitals to remain financially viable.”

The most thorough analysis of the combined impact of the BBA and BBRA on academic medical centers is offered by the American Association of Medical Colleges, which concluded in its April 21, 2000 Issue Brief: “America’s Teaching Hospitals Still Hurt from the BBA.” The brief is quite critical of the BBA cuts, indicating that “the BBA’s significant Medicare and Medicaid payment reductions—along with a highly competitive marketplace that is reducing private payer reimbursements to teaching hospitals—will undermine the ability of teaching hospitals to support their education, patient care and research missions.” The specific BBA cuts include \$17 billion in reduced inflation updates for Medicare patient service payments and \$10 billion in Medicaid DSH payment reductions from 1998 to 2002. Also, teaching hospitals’ additional payment from Medicare for indirect medical education costs was being reduced from 7.7 percent in 1997 down to 5.5 percent in 2001, a \$5.6 billion reduction.

The AAMC Issue Brief also notes that the BBRA restored only about 6 percent of the BBA cuts to teaching hospitals, giving back about \$7 billion of the BBA’s reductions. This includes a one year delay in the schedule of reducing the IME to 5.5 percent, with the IME reduction “still representing the second largest inpatient payment cut for teaching hospitals after the reduction in inflation updates to patient service updates.” Even with enactment of the BBRA, “total hospital profit margins will continue to decline by over half from 4 percent in 1998 to 1.6 percent in 2002.”

AAMC President Jordan J. Cohen, M.D. called IME payments “absolutely critical for teaching hospitals to be able to appropriately care for the sickest patients, provide an environment in which clinical research can flourish, and train new physicians.” These points are underscored by the following AAMC statistics: Though U.S. teaching hospitals represent 6% of all hospitals, that is where 44% of all indigent care in the country is provided (10), and where 75% of all residents are trained and a vast majority of the clinical research is performed.”

The central, indispensable role academic medical centers play in medical research and serving the indigent is also the theme of a May 10, 2000 article in the *Journal of the American Medical Association* entitled “The Perilous State of Academic Medicine.” The article warns... “academic medicine is in serious danger... Without prompt action, the results could be devastating... The vitality of teaching hospitals and medical schools should be a primary concern of the president and congressional leadership... Reversals should be made of the BBA cuts for hospitals.”

CONCLUSION

The ACG and ACP-ASIM recognize that at the time Congress enacted the BBA 97, it was doing so in an effort to control large federal budget deficits and restore solvency to the Medicare program. It has become apparent, however, that some of the cuts—particularly those relating to physician services and teaching institutions—went too far, and that access and quality are being placed at risk as a result. Now that the federal government is enjoying a large federal budget surplus, it is time for Congress to re-examine the BBA 97 cuts and related HCFA policies, including the site of service differential for endoscopic procedures performed less than 10 percent of the time in the hospital. Our organizations are committed to working with the Congress to restore adequate financing for all parts of the Medicare program and to correct HCFA policies that may endanger quality and access to care for millions of beneficiaries.

TABLE 1

CPT CODE	PROCEDURE/ SRVC	Percentage PERFORMED IN OFFICE (based on 1996 Medicare data)	1997 MFS SECT. 204(v) WOULD HAVE REINSTATED THIS RVU/FEE LEVEL** (using 2000 conversion factor)	2002 MFS Office Rates (At full implementation using 2000 conversion factor)	2002 MFS Outpatient Rates (At full implementation using 2000 conversion factor)	% DIFFERENTIAL 1997 to 2002 Outpatient Rates
43200	Esophag.	5.35%	3.89/ \$142.43	6.50/ \$237.99	2.49/ 91.17	-36%
43234	Upper GI	7.50%	4.88/ \$178.67	5.56/ \$203.57	2.86/ \$104.71	-41%
*43235	EGD	4.76%	5.75/ \$210.53	7.00/ \$256.30	3.37/ \$123.39	-41%
*43239	Upper GI/biop.	5.62%	6.46/ \$236.52	6.74/ \$246.78	3.79/ \$138.77	-41%
*43246	Place Gas'tmy. tube	These codes were never assigned an office fee	U A P E C T E S	N/A	6.14/ \$224.81	
*43255	Operative Upper GI			N/A	6.18/ \$226.27	
*43260	ERCP			N/A	8.36/ \$306.09	
*43262	Sphinct.			N/A	10.40/ \$380.78	
*45330	Sigmoid.	71.93%		2.38/ \$87.14	1.35/ \$49.43	
45331	Sigmoid/biop.	43.99%		3.35/ \$123.02	1.78/ \$65.17	
*45378	Diag. Col.	7.05%	8.22/ \$300.96	9.95/ \$364.30	5.25/ \$192.22	-36%
*45380	Col./biop.	5.07%	9.20/ \$336.85	10.48/ \$383.71	5.66/ \$207.23	-38%
*45385	Col./polyp.	5.91%	12.54/ \$459.14	12.62/ \$462.06	7.51/ \$274.97	-40%
The Section 204(v) site-of-service provision would not apply to the six boxed codes, and would not modify fee payments on these codes in any way (i.e., there would be no reversion to 1997 RVU values).						
*Amounts are calculated simply by published total RVUs x \$34.7315 (1999 conversion factor) and \$36.6137 (2000 conversion factor); total dollar amounts vary slightly from HCFA tables and text, which were computed differently.						
**Section 204(v) would have reinstated fees in this column, which have been computed by multiplying the 1997 RVU levels x 1999 conversion factor.						

ADDENDUM TO ACG TESTIMONY ON SITE OF SERVICE POLICY ON CERTAIN ENDOSCOPIC PROCEDURES

excerpts from hhs' secretary's letter to house member on site-of-service

States 10% Not the Formal Standard, but No Standard Articulated

"Your letter states that HCFA has a national policy exempting procedures performed less frequently than 10 percent of the time in a particular setting from having a site-of-service payment differential for that setting. There is no such Medicare payment policy. Rather, in view of the volume of codes for which we had to develop resource-based practice expense RVUs, we did not generally ask our expert clinical panels to review practice expense inputs for services in a particular setting if our data showed the services were infrequently performed in that setting. Ten percent was used as a general guideline for establishing priorities for expert panel review. However, for services such as diagnostic colonoscopies, which while performed only about 5 percent of the time in an office setting still represent over 40,000 allowed services in the office, we believe it is consistent with the statute to establish a payment amount that reflects the resources utilized in the office."

Site-Of-Service Policy May Implicitly Create Incentives, Even if Unintended

"The relative values in our November 2, 1999, final rule are intended to reflect relative resource-cost differences that physicians incur for services they provide in different settings as required by law. These relative values are not intended to provide an incentive to furnish a service in a particular setting over another setting."

HCFA Has Desire to Spare the Facility Fee Paid to Medicare-Certified Facilities

"However, the total Medicare payment—physician professional fee and facility fee combined—is substantially higher when these procedures are performed in an ASC or in a hospital than when performed in a physician's office. For example, when the new practice expense RVUs are fully effective in 2002, physician payment will be about \$160 higher for a colonoscopy performed in an office than in an ASC. However, this is more than offset by the ASC facility fee payment of about \$400, which is paid in addition to the physician fee."

Patient Quality of Care Issues

"I assure you we are concerned about quality of care and patient safety. We are not aware of any studies showing adverse outcomes from endoscopies performed in the office setting. HCFA staff met with representatives of national physician gastroenterological organizations on this matter. We informed them that we would be happy to examine any data they might have concerning adverse outcomes from endoscopies performed in the office setting. To date, no such data has been provided."

AMERICAN COLLEGE OF GASTROENTEROLOGY COMMENTS

We agree that the application of the site-of-service policy to services with volume under 10% in the office is, and always has been, improper. In this regard, there are several ethical considerations and principles which the ACG believes must underlie any resolution of this issue.

1. Any steering of patients, or decisions on how or where patients are treated that is based on economics rather than what is best for the patient, is wrong.

2. There are certain services which are not appropriate or safe to be performed in the office setting. There must be an objective standard to identify those procedures, rather than permitting HCFA to apply a purely subjective standard. We believe that the best objective standard is the percentage of services performed in the office, before HCFA considered utilizing different office-based and facility fees. A 10% threshold, i.e. where at least 10% of cases are being done in the office before a bifurcated fee would be considered, is probably as low as you reasonably could go with any vestige of safety. It also is essential to recognize the implication of certificate of need issues; there are many facilities which would qualify for Medicare-certified ASC status (and would merit a Medicare Part A facility fee), except for the state-level CON limitations—At present the profile of volume of services provided in the office includes all of these cases, despite the fact that these facilities often meet standards identical to the ASC. This tends to skew upward the number of services which appear to be rendered in a pure "office" setting. A 20% threshold would be wiser than 10%, but there is already some precedent from HCFA at the 10% threshold. If a service was not already being performed at least 10% of the time in the office before HCFA sought to institute the site-of-service policy, that service should never have been considered for a bifurcated fee.

3. The Medicare program must have a standard. HCFA initially referenced a 10% standard, but did not observe that standard in practice. At this point, either there is a 10% standard, and HCFA has violated it, or there is no objective standard whatsoever. An objective standard is required, not a subjective target that is very prone to inconsistent, or even arbitrary, application.

The services with fewer than 10% office volume through 1996 (the last year before HCFA mandated its policy), have been compensated at inappropriate levels due to application of HCFA's site of service differential over the course of three years' fee schedules. To remedy this problem, the ACG's legislative proposal would establish payments for these procedures at the CY 2000 or 2001 levels, whichever is greater. GI procedures have seen fee reductions of over 65% since 1987, with still further reductions slated in 2000-02. At this point, these services are significantly under-compensated (See *Annals of Internal Medicine* 1999; 130-525-530, an article on "Barriers to Office-Based Screening Sigmoidoscopy: Does Reimbursement Cover Costs?" by James Lewis, MD and David Asch, MD), so any remedy to the site of service problem must be linked to establishing an adequate level of compensation.

Mr. BILIRAKIS. Max and the rest of you, I guess we really ought to run and cast this vote. It is only one vote, so hopefully Mr. Brown and I can get right back and we can continue. Again, forgive us, but we will recess for a few minutes.

[Brief recess.]

Mr. BILIRAKIS. We will get right back into it, and again, our apologies.

Max, please proceed, sir.

STATEMENT OF MAX RICHTMAN

Mr. RICHTMAN. Mr. Chairman, Ranking Member Brown, good afternoon. On behalf of the millions of members and supporters of the National Committee to Preserve Social Security and Medicare, I would like to thank you for the opportunity to discuss how we can strengthen the Medicare program for beneficiaries as well as providers.

One of the most pressing issues facing Medicare beneficiaries today is the lack of affordable prescription drug coverage. The National Committee strongly supports the creation of a universal, voluntary, and affordable prescription drug benefit as part of the Medicare program.

Second, Congress should expand Medicare to cover new preventive services based on the expert recommendations of the U.S. Preventive Services Task Force. Adding to the list of preventive services covered by Medicare will improve life expectancy, decrease disability, and enhance Medicare's financial stability. Waiving the co-insurance and deductible for all Medicare preventive services would encourage greater utilization.

The National Committee, therefore, supports H.R. 3887, the Medicare Wellness Act of 2000. This bipartisan bill expands Medicare to cover screening and counseling for some of the most common conditions among seniors, including hypertension, glaucoma, osteoporosis, and high cholesterol. This legislation offers a cost-effective approach to disease management and injury prevention that also looks back at some of the lessons learned from the BBA.

Third, the National Committee is concerned about the growing out-of-pocket costs that seniors must absorb. The average Medicare beneficiary spends nearly 20 percent of his or her income on health care expenses. Along with services not covered by Medicare, there are significant cost-sharing obligations, including a 20 percent coinsurance for hospital outpatient services. The creation of a prospec-

tive payment system for hospital outpatient services in the BBA addressed this issue by limiting beneficiary copayments to 20 percent of the Medicare allowable charge. To reduce the fiscal impact of these provisions, however, the Congress mandated a phase-in period of 40 years. We believe that Congress should reduce the phase-in period for Part B copayment to 10 years.

Fourth, we support legislation to increase access to adult day care, which allows seniors to be in a community-based setting that promotes rehabilitation by providing social interaction, meals, and therapeutic services. Unfortunately, existing Medicare regulations require that seniors be homebound to receive home health care. This means that attending a privately funded adult day care program for medical treatment could result in a loss of eligibility for Medicare home health care. There are several bills that allow beneficiaries to use adult day care without losing their eligibility for home health care, including H.R. 4028, sponsored by Representatives Chris Smith and Ed Markey, and H.R. 745, sponsored by Representative Pete Stark.

Finally, we are concerned about the growing problem of patient neglect at nursing homes. Studies and testimony show that increased staffing provides improved care. Yet many nursing homes fail to provide adequate staffing. Patient advocates fear that the problem of inadequate staffing may grow worse under the PPS, which has no safeguards to ensure that facilities provide the amount of nursing services that they are supposed to. We are concerned that nursing homes may be dangerous places for seniors and that taxpayers may not be getting their money's worth when it comes to nursing home care.

To address this serious concern, we urge this subcommittee to include in any BBA revision the provisions of H.R. 4614, the Nurse Staff Accountability and Training Improvement Act of 2000. This bill requires nursing facilities to report the aggregate amount of nursing hours provided and allows the Secretary to make a proportional reduction in future payments to a facility if it falls short. The legislation would also require nursing facilities reimbursed by Medicare and Medicaid to post the current number and ratio of licensed and unlicensed nurse staffing positions responsible for patient care.

I would like to thank the chairman and the ranking member for asking for our views on these important issues and we would be pleased to assist the subcommittee with any additional information it may need to act on these recommendations, and Mr. Chairman, I still have 5 minutes, it seems.

Mr. BILIRAKIS. You were not supposed to notice that.

Mr. RICHTMAN. Thank you very much.

Mr. BILIRAKIS. Thank you.

[The prepared statement of Max Richtman follows:]

PREPARED STATEMENT OF MAX RICHTMAN, EXECUTIVE VICE PRESIDENT, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Good morning. I am Max Richtman, Executive Vice President of the National Committee to Preserve Social Security and Medicare, a grassroots education and advocacy organization with millions of members and supporters around the country. Mr. Chairman, ranking member, thank you for this opportunity to share our views with the Subcommittee.

With an expected non-Social Security budget surplus of \$1.9 trillion over the next ten years, this Congress has an historic opportunity to assist beneficiaries by expanding the current benefit package and reducing some of the cost-sharing features of the program.

One of the most pressing issues facing seniors today is the lack of affordable prescription drug coverage. Prescription drugs have become as important today as hospital coverage was in 1965 when Medicare was created. So long as prescription drugs are available to some, but not all seniors, there will be a substantial barrier to necessary care for seniors. The National Committee strongly supports the creation of a universal, voluntary and affordable prescription drug benefit as part of the Medicare program.

Second, Congress should expand Medicare to cover new preventive services, based on the expert recommendations of the U.S. Preventive Services Task Force. New developments in science have shown that a decline in health status is not an inevitable part of the aging process. A healthier lifestyle, even one adopted later in life, can increase active life expectancy and decrease disability.

Adding to the list of preventive services covered by Medicare would improve the quality of life for seniors and enhance Medicare's financial stability. Waiving the coinsurance and deductible for all Medicare preventive services would encourage greater utilization.

The National Committee supports H.R. 3887, the Medicare Wellness Act of 2000. This bipartisan bill requires Medicare to pay for eight new services, including some of the most common conditions among seniors hypertension; glaucoma; vision and hearing loss; osteoporosis; and high cholesterol. The legislation offers a cost-effective approach to disease management and injury prevention that also looks back at some of the lessons learned from the BBA and addresses the underutilization of preventive services.

The National Committee believes that changes in Medicare financing and benefits should protect all beneficiaries from burdensome out-of-pocket costs. The average Medicare beneficiary spends nearly 20 percent of his or her income on out-of-pocket for health care expenses, excluding the costs of long-term care. In addition to items and services not covered by Medicare, beneficiaries have significant Medicare cost-sharing obligations, including 20 percent coinsurance for most Part B services and a substantially higher coinsurance for hospital outpatient services.

This was partially addressed in the BBA. In creating the Prospective Payment System for hospital outpatient services, Congress limited beneficiary copayments to 20 percent of what Medicare would pay for the services in another setting. To reduce the cost of the PPS, however, Congress agreed to a lengthy phase-in period. For some services, the phase-in is forty years. We urge Congress to shorten that phase-in to a ten year period for the Part B deductible. It is our understanding that this would cost approximately \$3-4 billion.

Fourth, we support passage of legislation that would amend the definition of "home bound" so that Medicare beneficiaries can receive home health benefits and still attend adult day care programs. Home health services are essential for enabling Alzheimer's patients and other cognitively impaired adults who at great risk for institutionalized care to stay in their own homes.

Unfortunately, existing Medicare regulations require beneficiaries to be home-bound to receive such services. Attending a privately funded adult day care program for medical treatment can result in a loss of eligibility for home health care and more costly institutionalization of beneficiary. This legislation ends that threat and allows beneficiaries to receive home health care in a setting that promotes rehabilitation by providing social interaction, meals and therapeutic services beyond what is required by the home health. This legislation is a winner, for Medicare and for the beneficiary because it allows seniors to stay in a less costly and less restrictive setting.

There are several bills that accomplish these needed reforms in home health care. Reps. Chris Smith (R-NJ) and Edward Markey (D-MA) have introduced H.R. 4028 that would lessen the definition of "home bound" for patients with Alzheimer's Disease, while H.R. 745 sponsored by Rep. Pete Stark (D-CA) would allow Medicare beneficiaries and their families to choose adult day care centers as alternative settings for the provision of home health care.

Fourth, we are concerned about the growing problem of patient abuse and neglect in nursing homes. Most nursing home residents have impaired physical or mental function. Many are vulnerable to malnutrition, dehydration, injury, infection and other complications and therefore need competent professional care and observation. Studies and expert testimony show that increased staffing improves care. Yet, many nursing homes fail to provide adequate staffing.

Patient advocates fear that the problem of inadequate staffing may grow worse with the implementation of the Medicare of a Prospective Payment System (PPS) for nursing facilities. The PPS provides homes with a capitated payment based on the average cost of caring for someone with a particular diagnosis. In the aggregate, the reimbursement a home receives may be adequate, but for the individual ward, there will be an incentive to reduce staffing levels and save money where possible. There are no safeguards to ensure that facilities provide the amount of nursing services that are attributed to the payment category for which they are reimbursed. We are concerned that taxpayers may not be getting their money's worth when it comes to nursing home care.

We urge this committee to include in any BBA revision the provisions of H.R. 4614, the Nurse Staff Accountability and Training Improvement Act of 2000. This bill requires that Medicare-reimbursed skilled nursing facilities report the aggregate amount of nursing staffing hours provided for the care of nursing home residents every 32 days or in a time period corresponding to the facility's regular billing cycle, whichever is less. In cases where the Secretary determines that staffing is inadequate, he or she shall have the authority to make a proportional reduction in future payments to the facility.

This legislation would also provide the public with more information on staffing at nursing facilities. The legislation would require nursing facilities reimbursed by Medicare and Medicaid to post the current number and ratio of licensed and unlicensed nursing staff responsible for patient care. This information must be displayed in a uniform manner and in a place that is clearly visible to the public. Nursing facilities must also report average daily staffing ratios for the last cost reporting period in a place that is clearly visible to the public. The bill also requires the Secretary to disclose facility specific nurse staffing information on the Internet.

I want thank the Chairman and the ranking member for soliciting our testimony. We stand ready to assist the Subcommittee with any additional information it may need to act on our recommendations.

Mr. BILIRAKIS. Ms. Hancock?

STATEMENT OF JULIET HANCOCK

Ms. HANCOCK. Good afternoon, Chairman Bilirakis and members of the committee. I appreciate the opportunity to address you today to discuss the Balanced Budget Act of 1997 and its current impact on providers, patients, and the Medicare program.

My name is Julie Hancock and I am a program consultant for the RehabCare Group. I currently provide clinical oversight and therapist training in over 80 rehab programs in the nursing home setting across the country. I am here today on behalf of the National Association for the Support of Long Term Care, which is a trade association which represents over 150 companies that provide products and supplies to skilled nursing home and home health care patients. I am also a member of the American Physical Therapy Association. I am a PT by background.

We appreciate the opportunity to participate in today's hearing. We recognized that the Balanced Budget Act was passed with the goal of slowing the rate of growth in Medicare. However, there have been some unintended consequences. We are asking for your relief in three specific areas.

First of all, the \$1,500 cap on therapy services under Part B should be delayed for an additional 3 years.

Second, the consolidated billing requirement that nursing homes bill for Part B services should, at a minimum, be delayed or repealed until further studies are conducted to understand the impact on the beneficiaries.

Third, a separate transportation fee for portable EKG and ultrasound services should be established so that these services can be provided for nursing home residents onsite.

First of all, on behalf of my sick and frail elderly patients that I see all over the country, thank you, Mr. Chairman and your colleagues, for providing a 2-year delay of the arbitrary \$1,500 caps. These financial limitations cut back on benefits for seniors and harm those most in need of these services. The oldest and sickest patients were the most affected. Congress enacted a 2-year moratorium. This moratorium is due to expire at the end of next year.

Mr. Chairman, I have attached to the handout a letter signed by 11 organizations urging your support for an additional 3-year extension, a 3-year extension to the moratorium on therapy caps which we believe will provide HCFA, Congress, and the providers necessary time to work cooperatively with consumers to effectively find some alternatives.

The second issue is consolidated billing. This is a requirement that nursing facilities bill for all Part B services. NASL asks Congress to repeal or, at a minimum, delay this requirement. There are many rules that were passed by Congress to ensure the integrity of the program, but the nursing facilities do not have billing professionals who can manage these billing requirements. They are struggling now.

Nursing facilities have improved accountability. HCFA can implement changes to eliminate errors and duplicate billing. Program integrity requirements enacted by Congress on rules for durable medical equipment products and supplies have reduced the ordering of unnecessary services. And even the Inspector General in a report has acknowledged DMERC success in addressing and correcting billing problems.

We are concerned that consolidated billing requirements will cost nursing facilities money. Nursing homes will have to increase their accounting and billing staff to handle patient bills, certificates of medical necessity, and other requirements for appropriate billing. Given the limited resources of nursing homes today, coupled with the new PPS rules for Part A services just about to be implemented in October, consolidated billing for Part B will limit the resources available for patient care. It will hurt the patients. It is too much, too soon.

The third point I want to discuss is Part B payment to ancillary providers who provide services to patients in nursing facilities. The benefit of bringing these services to the patients are twofold. The first, it avoids the cost of ambulance transport to the hospital. And second and most importantly, it eliminates the health risks of putting the frail elderly patients in ambulances.

We believe that a transportation fee needs to be added to the basic fee. The OIG has estimated that over \$100 million is spent each year on unnecessary ambulance trips due in large part to transporting SNF patients to diagnostic testing sites. Since HCFA lacks the statutory authority to pay a separate fee for transporting EKG and ultrasound equipment to the patient's bedside, we ask Congress to allow a separate fee for transportation.

In summary, the \$1,500 cap on therapy services should be delayed for an additional 3 years. The consolidated billing requirement that nursing homes bill for Part B services should be delayed or repealed. And third, a separate transportation fee for portable

EKG and ultrasound services should be established so that these services can be provided for nursing home residents onsite.

Mr. Chairman, this concludes my testimony. I will be glad to answer any questions or provide additional information. Thank you. [The prepared statement of Juliet Hancock follows:]

PREPARED STATEMENT OF JULIET HANCOCK, PROGRAM CONSULTANT, REHABCARE GROUP, INC.

Good morning Chairman Bilirakis and Members of the Committee. I appreciate the opportunity to address you today to discuss the Balanced Budget Act of 1997 (BBA) and its current impact on providers, patients, and the Medicare program.

My name is Julie Hancock, and I am Program Consultant to RehabCare Group, Inc. I currently provide clinical oversight and therapist training in over eighty rehabilitation programs in the nursing home setting. Rehabilitation includes physical therapy, occupational therapy, and speech-language pathology services. I am here today on behalf of the National Association for the Support of Long Term Care (NASL), a trade association representing over 150 companies involved in the provision of ancillary services, products and supplies to skilled nursing home and home health care patients. I am also a member of the American Physical Therapy Association (APTA).

We appreciate the opportunity to participate in today's hearing and your Committee's continuing efforts to monitor the impact of the comprehensive provisions of the BBA—particularly the impact on Medicare beneficiaries.

We recognize that the BBA was passed with goals of slowing the rate of growth. However, there have been some unintended consequences. We are asking for your relief in three areas:

- First, the \$1,500 cap on therapy services under Part B should be delayed for an additional three years.
- Second, the requirement that nursing homes bill for Part B services should at a minimum be delayed, or outright repealed, until further studies are conducted to better assess its impact on beneficiaries.
- Third, a separate transportation fee for portable EKG and ultrasound services should be established so that these services can be provided for nursing home residents on site.

We will provide you some sound solutions to help ensure that Medicare beneficiaries continue to have access to quality services, and that program integrity is maintained. Last year, under your leadership, some modifications were made to these programs. Again, we are seeking your assistance.

Outpatient Therapy Caps

First, on behalf of the sick and frail elderly patients I work with on a daily basis, thank you, Mr. Chairman and your colleagues, for providing a two-year delay in implementing the arbitrary \$1,500 therapy caps imposed by the Balanced Budget Act. These financial limitations, intended as a cost savings measure, cut back on benefits for seniors and harmed those most in need of services. In recognition of the negative impact these caps had on the most vulnerable patients, Congress enacted a two-year moratorium in the Balanced Budget Refinement Act of 1999 (BBRA) effectively suspending the therapy caps for the years 2000 and 2001. This moratorium is due to expire at the end of next year.

The BBRA provision also requires the Secretary of Health and Human Services to recommend to Congress, by January 1, 2001, a revised policy on payment for therapy services. Rather than using arbitrary dollar caps, this alternative payment methodology is to be based on the classification of patients by diagnostic category and use of services.

Mr. Chairman, we have with us today a letter signed by eleven organizations respectfully urging your strong support for an additional three-year extension of the moratorium. It is our understanding that the Health Care Financing Administration (HCFA) is making every attempt to meet the statutory deadline to make recommendations. While we have met with HCFA and intend to provide them data, therapy services vary by patient. It is important to recognize that this is the first year that all Part B therapy services are under a fee schedule without the arbitrary therapy caps. Since the most current data available from HCFA is from 1998, we believe that an additional three-year moratorium is necessary to ensure that proper time and consideration is given to the establishment of a new payment methodology for Part B physical therapy, occupational therapy, and speech-language pathology services under the Medicare program. These provisions affect patients receiving

services in nursing homes, outpatient clinics, comprehensive outpatient rehabilitation facilities (CORFs), and by independent practitioners.

In addition, we believe that the types of savings sought under the BBA may have already been realized by the shift in 1998 from a cost based reimbursement system for outpatient therapy services to one based on a fee schedule. Extending the moratorium through 2004 will help determine whether the rehabilitation therapy payments under the fee schedule have been successful in providing the requisite savings sought under the BBA. Finally, therapy professionals and HCFA will need this period of time to devise a new methodology to assess utilization of therapy services.

We respectfully ask for your support of a three-year extension to the moratorium on therapy caps, which we believe will provide HCFA the necessary time to work cooperatively with consumers and providers of care to effectively address this critical area of the Medicare program.

Consolidated Billing

The second issue that I wish to discuss with you this morning is the requirement that skilled nursing facilities bill for all Part B services. Under the previous law, nursing homes have accountability for all services provided to residents; however, they could contract with providers to offer and bill the services. NASL thinks it is very important for the Congress to take a second look at the requirement for billing by skilled nursing facilities (SNFs) for Medicare Part B products and services that are provided to skilled nursing facility residents. There are many services with varying requirements. Many nursing homes do not know these rules—many of which were passed by Congress to ensure the integrity of the program—or have billing professionals who can manage these billing requirements. We recommend that you repeal or delay this requirement in order to conduct a study of the optimal degree of oversight necessary in order to ensure patients are receiving covered services that are medically necessary.

Administrative action on this has improved accountability. For example, it is our understanding that HCFA has just begun implementing a number of internal standards that will eliminate errors and/or duplicate billing. Also, program integrity requirements enacted by Congress on rules governing durable medical equipment (DME) products and supplies have reduced unnecessary billing that has been perceived in ordering Part B products. Even the Inspector General has acknowledged DMERC success in addressing and correcting billing problems.

However, our most serious objection to consolidated billing is the unreimbursed costs for the SNFs in implementing this requirement. Nursing homes will have to increase their staffs for accountants, bookkeepers, software, and financial systems in order to fully implement an accounting system that deals with patient records, certificates of medical necessity and other requirements for appropriate billing. Given the limited resources of nursing homes today, this new obligation will limit the resources available for patient care.

Finally, skilled nursing facilities have had major challenges simply implementing the basic BBA requirements due to HCFA's inconsistent implementation of the new SNF payment system. This is compounded by a lack of intermediary preparedness. Additionally, on October 1, 2000 skilled nursing facilities must manage a five-fold increase in the number of patient classification categories for SNF patient care reimbursement. Almost simultaneously, the consolidated billing requirement is scheduled to go into effect on January 1, 2001—this is simply too much, too soon! Accordingly, it is our recommendation that MedPAC conduct a thorough analysis of the appropriate level of accountability and oversight which should be required of SNFs for the products and services that they purchase under Medicare Part B for beneficiaries. We need much more precision in the type of standards and accountability to assure patient quality care and access to services. Simply stated, implementation of the consolidated billing requirements will hurt patient care.

The following organizations concur with this position: The American Health Care Association (AHCA); The American Association of Homes and Services for the Aging (AAHSA); The Health Industry Distributors' Association (HIDA); and The National Alliance for Infusion Therapy (NAIT).

Transportation Fee for EKG and Ultrasound Services

The third point that I want to discuss is Part B payment to ancillary providers who transport services to skilled nursing facilities so that medically necessary procedures can be conducted at the patient's bedside. The benefits of bringing the services to the patient are two-fold: it avoids the cost of ambulance transport to the hospital and, more importantly, it eliminates the health risk of transporting frail elderly patients whose condition could be compromised. The OIG has estimated that over \$100 million is spent each year on unnecessary ambulance trips, due in large part

to transporting SNF patients to diagnostic testing sites. Starting in 1996, Medicare began bundling the cost of the transport fee for the provision of portable EKG and ultrasound procedures. This has the effect of spreading the costs associated with one or two percent of the procedures over one hundred percent of the procedures. In other words, HCFA is paying ninety-eight percent of the providers for a service they are not providing. Since HCFA claims they lack the statutory authority to pay a separate fee for transporting EKG and ultrasound equipment to SNF bedsides, we are recommending that your Committee initiate legislation to allow for a separate fee for transportation. Since Medicare is already paying for the cost of transportation, this proposal is budget neutral. In fact, this proposal may actually save money since it eliminates unnecessary ambulance transportation, and will only pay the providers that actually incur the costs of transporting equipment and technicians.

In summary:

- The \$1,500 cap on therapy services under Part B should be delayed for an additional three years.
- The requirement that nursing homes bill for Part B services should at a minimum be delayed, or outright repealed, until further studies are conducted to better assess its impact on beneficiaries.
- A separate transportation fee for portable EKG and ultrasound services should be established so that these services can be provided for nursing home residents on site.

Mr. Chairman, this concludes my testimony. I would be glad to answer any questions or provide additional information. Thank you.

Mr. BILIRAKIS. Thank you very much, Ms. Hancock.
Mr. Hawkins?

STATEMENT OF DANIEL R. HAWKINS, JR.

Mr. HAWKINS. Thank you, Mr. Chairman. It is good to see you again. Mr. Chairman, Mr. Brown, and members of the subcommittee, on behalf of the National Association of Community Health Centers, the more than 1,000 federally qualified community migrant and homeless health centers nationwide and the 11 million people who rely on them for care, thank you for this opportunity to express our support for H.R. 2341, the Safety Net Preservation Act, and to advocates for its inclusion in any BBA relief legislation considered by the Congress this year.

Before I begin, let me express my sincere gratitude to you, Mr. Chairman, and to Mr. Brown for your support for increased funding for health centers to allow them to serve yet additional numbers of uninsured, and to Mr. Burr and his colleague Mr. Towns for their stalwart leadership and support in seeking to protect health centers from the devastating impact of the BBA.

H.R. 2341, introduced by Mr. Burr and Mr. Towns and cosponsored by 24 of the 29 members of this subcommittee and 224 of your House colleagues, is a common sense, fair, and long-term solution to the threat that a provision in the BBA poses to health centers and especially to the 4.5 million uninsured people that they serve.

For 35 years, health centers have formed the backbone of America's preventive and primary health care safety net for millions of Americans who have difficulty accessing the traditional health care system. Under the jurisdiction of this subcommittee and as required under the Public Health Service Act, health centers are required to make their care available to everyone who walks through their doors, regardless of their health status, insurance coverage, or ability to pay. Because of this, health centers serve an over-

whelmingly poor, uninsured, and medically underserved population.

This patient mix makes health centers unique among all health care providers, but it also creates some unique problems for health centers. In particular because almost 40 percent of health center patients are on Medicaid, health centers are more vulnerable to Medicaid revenue losses than other providers. Because health centers do not have the option of withdrawing from Medicare or Medicaid, nor would they want to, if Medicaid payments do not at least cover the cost of serving Medicaid patients, health centers must cover those revenue losses from the only other major source of revenue they have, the Federal PHS Act grants they receive to cover the cost of caring for the uninsured.

Some 10 years ago, this subcommittee recognized the threat and required health centers to be reimbursed on a reasonable cost basis by Medicaid agencies for the care they provide to Medicaid patients. Since that time, health centers have increased the capacity by over 4 million individuals nationally, including over 1.5 million people, or more than 50 percent, who are uninsured, at a time when the nation's uninsured population grew by about half that rate, and despite the fact that the appropriated dollars for health centers remained stagnant over that period.

However, in 1997, the BBA ordered the phase-out and eventual elimination of their Medicaid payment system. Under the BBA, the real losers will be the millions of uninsured families who today rely on health centers as their only source of locally available and affordable health care, people like the three families whose personal details are provided in attachments to my written testimony.

While Congress eased the BBA's phase-out rates in last year's Balanced Budget Refinements Act, the BBRA necessarily, nevertheless, allowed the elimination of cost-based reimbursement to continue and did not establish a long-term solution. Under the current phase-out formula, health centers face an aggregate loss of \$45 million this year alone, or equivalent to the cost of serving over 130,000 uninsured individuals. Based on our projections, in 2005 when the system is repealed, health centers Medicaid losses could cause nearly 1.5 million uninsured people, one out of every three uninsured served by health centers today, to lose access to health center services. This would come at a time when the number of uninsured is growing by a million a year and studies are documenting that other providers of necessity are having to cut back on the charity care they provide.

In order to avoid the devastating impact of this elimination of the payment system, a coalition of public officials, safety net providers, and health care advocates have endorsed the Safety Net Preservation Act to establish a minimum Medicaid payment floor with a prospective payment system for health centers and rural health clinics. This payment system is common sense and widely supported and will stave off the elimination of cost-based reimbursement. That is why a bipartisan majority in this body and in the Senate have cosponsored the bill.

Some will argue there is no need for Congress to protect health centers from BBA cuts. I respectfully disagree with that statement. To date, only eight States have established a secure, long-term

Medicaid payment system. We believe that Congress must safeguard the PHS Act dollars and establish a minimum Medicaid payment floor to protect those valuable resources and ensure access to care for the people who rely on them.

That is why I am here to urge you, to plead with you on behalf of the Resnicks, the Owens, the Fernihoughs, and the millions of other Americans who rely on health centers today to include the common sense Safety Net Preservation Act's bipartisan and permanent payment system in any BBA relief legislation considered this year.

Thank you, and I would be happy to answer any questions the committee may have.

[The prepared statement of Daniel R. Hawkins, Jr. follows:]

PREPARED STATEMENT OF DANIEL R. HAWKINS, JR., VICE PRESIDENT, FEDERAL AND STATE AFFAIRS, NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS

INTRODUCTION

Chairman Bilirakis, Representative Brown, and members of the Subcommittee: on behalf of the National Association of Community Health Centers and the over 1000 community, migrant, homeless, and public housing health centers nationwide, thank you for this opportunity to express our support for Balanced Budget Act (BBA) relief for health centers. Members of this Subcommittee have repeatedly reaffirmed their support for the crucial role that health centers have in providing a safety net to those who, for whatever reason, are unable to obtain health insurance but still need access to affordable primary and preventive health care services. Without question, this Subcommittee is comprised of members with the strongest commitment to the mission of health centers and a keen understanding of their need to remain viable sources of affordable health care services for everyone, regardless of their ability to pay for services.

Let me begin by expressing my sincerest gratitude to Chairman Bilirakis, Representative Brown, Representative Burr, and Representative Towns for your leadership to ensure that the more than 1000 health centers, which currently serve the 11 million people in over 3,000 communities across the country, remain viable as they struggle to meet the needs of medically underserved communities. Chairman Bilirakis and Representative Brown, thank you for leading the effort in the House to secure additional funding for health centers, allowing them to meet the ever-increasing needs of uninsured Americans that are relying on them for care. Representatives Burr and Towns, thank you for your leadership in introducing legislation to secure a permanent, fair, common-sense Medicaid payment system for health centers that will protect the grant funds invested by this Subcommittee in care for the uninsured. I hope that my testimony today will further strengthen the already strong support demonstrated by a significant majority of this Subcommittee, as well as of the full Commerce Committee, for BBA relief for health centers and provide a better understanding of the vital need to protect America's primary and preventive care safety net.

COMMUNITY HEALTH CENTERS: GUARANTEEING ACCESS TO AFFORDABLE HEALTH CARE SERVICES

For thirty-five years, health centers, alongside public hospitals, public health departments and free clinics, have formed the backbone of America's health care safety net for millions of Americans who have difficulty accessing the traditional health care system. A simple examination of their patient population demonstrates the importance of health centers to those that rely on them for care. Of the 11 million health center patients:

- Every patient (a) lives in medically underserved rural, frontier, or inner city community or (b) belongs to a medically underserved population, including migrant farm workers, the homeless, and those with linguistic or cultural barriers to care;
- 40% lack health insurance coverage;
- 34% rely on Medicaid for coverage; and
- 85% are at or below 200% of the Federal poverty level (FPL).

Under the jurisdiction of this Subcommittee and as required by the Public Health Service Act (PHSA), health centers are mandated to provide access to care for every-

one that walks through our doors, regardless of their health status, insurance coverage, or ability to pay for services. Health centers proudly accept this responsibility in return for the investment made by the American taxpayers in the form of PHSA grants. However, this overwhelmingly poor, uninsured, and medically underserved patient mix creates unique difficulties for health centers that are not necessarily confronted by other health care providers.

Hurdles to Accessing Care

Health center patients typically confront significant hurdles when accessing health care services, be they geographic, financial, linguistic, or cultural. Many of these patients have had a history of poor health and suffer from health and social problems that are seen much less frequently in insured, middle-class, or suburban populations. These problems include greater incidence of chronic disease, a poor history of health maintenance, and a significant lack of understanding of proper nutrition and health. Generally, health center patients have more health care problems and require greater chronic disease management and health education than the rest of the patient population in America.

Inability to Pay for Health Care Services

Millions of health center patients have difficulty paying for health insurance or health care services. More than 1 of every 3 health center patients lacks the financial resources to pay for the full cost of the care provided to them or their families. To ensure access to care, health centers base their charges on a sliding fee scale that takes into account the financial resources of the patient. Patients with incomes over 200% of the FPL pay full price for services delivered. Everyone pays according to his or her means. In return for guaranteeing this access to care, Congress provides health centers with grants through the PHSA that help defray the costs of health care services provided to uninsured patients.

Underpayments by Public Programs Threaten Health Care Delivery to the Uninsured

Because of where they are located and whom they serve, 86% of health center patients are uninsured (40%) or covered by Medicaid (34%), Medicare (8%), or other public assistance (4%). As a result, health center patients do not have a payer mix that easily allows them to subsidize underpayments from public payers. In other words, if Medicaid is not reimbursing health centers for the cost of providing care to Medicaid patients, health centers are forced to look elsewhere to make up for the shortfall.

The next portion of my testimony will examine in greater detail this crucial third issue and how Congress addressed these underpayments by public payers a decade ago.

UNDERSTANDING THE IMPACT OF LOW MEDICAID PAYMENTS TO SAFETY NET PROVIDERS:
THE HISTORY OF REASONABLE COST PAYMENTS TO HEALTH CENTERS

Threats to Care for the Uninsured

Community health centers are not the only providers to feel the pressure of reduced payments by public and commercial payers. The rise of managed care in Medicare and Medicaid, and the reduced payment rates that follow, have forced all providers to reevaluate their participation in these programs. Indeed, we have just witnessed another massive withdrawal of managed care plans from the Medicare+Choice program, citing insufficient payments. In Tennessee, the State legislature recently passed a massive bailout subsidy for managed care organizations to keep them from completely withdrawing from the State's Medicaid managed care program, TennCare.

I ask the members of the Subcommittee: if inadequate reimbursements are forcing insurance companies and managed care organizations to withdraw from Medicare and Medicaid managed care, what kind of strain must low payments be placing on not-for-profit community health centers?

All health care providers must seek to cross-subsidize when payments from a third party source are insufficient. However, unlike most physician practices that have paid for indigent care services by cross-subsidies from their commercial payers, health centers do not have a substantial commercially insured patient base from which to draw (see Appendix 1). Evidence abounds that the traditional response of physicians and other providers to reduced Medicaid or Medicare payments has been to (1) reduce their levels of indigent care and/or (2) reduce services provided to publicly insured patients.

Because of the shortage of commercial payments, health centers have three options if Medicaid, their largest third party payer, does not cover the cost of providing care to its beneficiaries. They can (1) reduce health care services or reduce the num-

ber of health care access points, (2) close their doors entirely, leaving whole communities with little or no access to primary health care services, or (3) cover Medicaid shortfalls with PHSA grants intended to defray the cost of caring for the uninsured.

The Committee must understand that health centers do not have the option of withdrawing from Medicare or Medicaid—health centers are statutorily required to provide access to care to everyone who walks through their door. This makes health centers unique among all health care providers.

The Enactment of Medicaid Cost-Based Reimbursement for Health Centers

If health centers are to fulfill their unique statutory role as core safety net providers, it is crucial that Congress recognizes and protects the PHSA-dictated mission of providing care to the uninsured. To do this, a “budgetary firewall” must be in place to protect the financial integrity of PHSA grants and ensure that Medicaid does not underpay health centers for services provided to Medicaid patients.

Over ten years ago, this Subcommittee recognized the threat that low Medicaid payments pose to health centers’ ability to care for uninsured patients, and included language in the *Omnibus Budget Reconciliation Act of 1989* requiring Medicaid to reimburse health centers on a reasonable-cost basis for services provided to Medicaid beneficiaries. In its report on this provision, the Committee wrote . . .

“The Subcommittee on Health and the Environment heard testimony that, on average, Medicaid payments to Federally-qualified health centers cover less than 70 percent of the costs incurred by the centers in serving Medicaid patients. The role of the programs funded under sections 329, 330, and 340 of the PHS Act is to deliver comprehensive primary care services to underserved populations or areas without regard to ability to pay. To the extent that the Medicaid program is not covering the cost of treating its own beneficiaries, it is compromising the ability of the centers to meet the primary care needs of those without any public or private coverage whatsoever.” *House Report 101-247, September 20, 1989*

So in the ten years since its enactment, has cost-based reimbursement met its goal of ensuring “that PHS grant funds are not used to subsidize health center or program services to Medicaid beneficiaries”?

The answer to that question is an unequivocal, undeniable YES!!

In the ten years since the enactment of cost-based reimbursement, health centers have been able to increase their capacity for uninsured care by 1.1 million people—more than 40%. And this increase occurred at a time when the appropriated dollars for the health center program were stagnant!

In other words, Congress received a higher rate of return on its annual appropriations investment in health centers because Medicaid cost-based reimbursement was in place. Medicaid no longer underpaid for the care provided to Medicaid patients, and as a result, PHSA grants were able to be used for their intended purpose—care for the uninsured. One can only conclude that the phase-out and elimination of cost-based reimbursement under the BBA will again reduce the effectiveness of the PHSA grants, thereby reducing care for the uninsured at a time when their number and needs have never been greater. If this occurs, millions of families who use health centers—like those from Indiana profiled in Appendix II—will lose their access to care.

The Balanced Budget Act of 1997 and the Elimination of Cost-Based Reimbursement

The BBA phased-out and ultimately eliminated the Medicaid reasonable cost reimbursement system for health centers and rural health clinics. We recognize the difficult choices that Congress had to make to balance the Federal budget in 1997. But we also believe that the elimination of Medicaid cost-based reimbursement did not take a holistic view of the interaction between Medicaid and other public health programs. Recognizing this, Congress provided some relief last year for health centers by slowing the BBA’s phase-out rate. Unfortunately, the Balanced Budget Refinements Act (BBRA) did not establish a long-term payment system for health centers in the Medicaid program.

Let me describe the BBA’s phase-out methodology in this way. Imagine a grocery store buys a gallon of milk from their wholesaler for \$4.00, but the law allows the purchaser to buy that same gallon of milk for \$3.00. Does anyone believe that the purchaser won’t buy the milk for \$3.00? How long would that store sell milk? If they did decide to sell milk, how long would they stay in business?

By eliminating the Medicaid cost-based reimbursement system and not replacing it with an alternative payment mechanism to protect the grant funds, the BBA threatens health centers’ fundamental ability to continue to make health care affordable and accessible to millions of low-income, uninsured, and medically under-

served Americans. Indeed, a recent report by the Institute of Medicine entitled, *America's Safety Net: Intact but Endangered* states...

"Failure to support these essential [safety net] providers could have a devastating impact not only on the populations who depend on them for care but also on other providers that rely on the safety net to care for patients whom they are unable or unwilling to serve..."

Over the years, Medicaid (and to a lesser extent Medicare) has become the financial underpinning of the safety net. Historically, Medicaid has provided the majority of insured patients for most safety net providers and has subsidized a substantial portion of care for the uninsured through such programs as disproportionate share hospital (DSH) payments and cost-based reimbursement for FQHCs [Federally qualified health centers]...

A major cause for concern is the [Institute of Medicine's] committee's finding that Medicaid as well as other revenues and subsidies that in the past have helped support care for the uninsured and other vulnerable populations are becoming more restricted at a time that the demand on the safety net is rising."

In addition, in a special report issued in February 2000, the Kaiser Family Foundation's Commission on Medicaid and the Uninsured stated...

"Unless alternative support mechanisms [to the BBA's elimination of cost-based reimbursement] are put in place, the reductions and eventual loss of the FQHC payment system will raise major issues for health centers. The FQHC system has ensured that health centers can recover the reasonable cost of covered services furnished to Medicaid patients..."

As a result, deep downward shifts in Medicaid financing have significant implications for the ability of health centers to sustain a level of care for the uninsured that they were able to achieve over the last decade."

Despite the evidence, some remain skeptical that the BBA's phase-out will have this dramatic impact on health centers. We respectfully disagree with that assessment. The best example of what happens when cost-based reimbursement is eliminated can be seen in those States that have already taken that step as part of a Section 1115 Medicaid waiver. In 1998, the certified public accounting firm of Goldstein, Golub, Kessler and Company (GGK) examined the impact of low-Medicaid payments on health centers in Tennessee under the TennCare program. In GGK's study they found that, while the number of TennCare visits to health centers increased, the gap between revenues and costs per TennCare visit widened, resulting in significant revenue losses for health centers.

By 1996, Tennessee's health centers were losing almost \$28 per TennCare patient visit. This created an unfunded gap in reimbursement that forced health centers to cover these losses out of PHSA grants. The result has been a reduction in the number of uninsured persons received care at Tennessee's health centers, and the virtual elimination of all "supplemental" services, including health and nutrition education, parenting classes and community outreach—all of which have been proven highly effective in improving the overall health of patients.

Be assured that this is not an isolated incident—it has happened to health centers in several States across the country. *In short, where the elimination of cost-based reimbursement has occurred, health centers are forced to eliminate health care services or close delivery sites for their patients. There is no reason to believe that this will not occur nationwide if BBA relief is not provided to health centers.*

THE SAFETY NET PRESERVATION ACT: STABILIZING AMERICA'S PRIMARY CARE SAFETY NET

The payment system included in H.R.2341, the *Safety Net Preservation Act*, is a common-sense approach to protecting the significant Federal financial investment in health centers from the elimination of reasonable cost based reimbursement under the BBA. That is why the *Safety Net Preservation Act* is cosponsored by bipartisan majorities of the Commerce Committee (37 of 53 members) and the House of Representatives (224 Representatives). Its companion legislation in the Senate, S.1277, has garnered the bipartisan support of a majority of the Finance Committee (11 of 20) and the full Senate (54 Senators).

This legislation accomplishes three fundamental goals:

- (1) It ensures that health centers are not forced to eliminate health care for their uninsured patients because Medicaid does not adequately reimburse them.
- (2) It addresses concerns about cost-based systems by creating incentives for efficiency and cost-containment.
- (3) It preserves State flexibility by establishing a minimum Medicaid payment floor, not mandating a particular payment methodology, and it also gives States the

ability to continue reimbursing health centers at 100% of their reasonable costs if they choose.

The next portion of my testimony will describe how the *Safety Net Preservation Act's* payment system works and address some outstanding concerns about this bill.

Stabilizing Payments and Establishing Incentives for Efficiency

Over the last several years, Congress has enacted prospective payment reimbursement systems (PPSs) for hospitals, nursing homes, and home health agencies in the Medicare program. Through prospective payment methodologies, governments can predict and control the budgets of public insurance programs. Likewise, providers can predict their reimbursement rates for services provided and can plan their budgets accordingly.

In short, the *Safety Net Preservation Act* brings health centers into parity with other providers participating in public insurance programs. In the initial year, health centers payments would be frozen at their previous year's per-visit payment. Every year thereafter, the per-visit rate would be increased by the rate of inflation calculated by the Medicare Economic Index (MEI) for primary care.¹

This methodology creates significant incentives for health centers to control costs and become more efficient. For example, if the per visit payment rate under the PPS is \$80 and a health center has a per visit cost of \$83, the health center can either (1) find ways to cut their costs and become more efficient or (2) lose revenues. Likewise, if a health center can reduce its cost per visit to \$77 dollars, it would receive \$3 that it could reinvest into expanding services or delivery sites. By creating a methodology in which health centers can be assured that Medicaid will cover the cost of care for its patients, the *Safety Net Preservation Act* ensures that PHSA grants can be used for their intended purpose—caring for the uninsured.

Protecting the Safety Net for the Long-Term

The *Safety Net Preservation Act* would reimburse health centers at a rate that prevents the elimination of care for their uninsured patients. By filling this gap, Congress ensures that its significant annual investment under the PHSA goes to its intended purpose—providing access to affordable health care services for uninsured people living in medically underserved areas.

Some argue that the BBA currently allows States to continue to reimburse health centers at 100% of their reasonable cost based rates, thereby negating the need for the *Safety Net Preservation Act*. Unfortunately, there is little evidence that States will use this flexibility to establish long-term payment mechanisms to protect Federal PHSA grant dollars. For example:

—Of the 15 Section 1115 Medicaid waiver States, *only two States*

(Massachusetts and Vermont) have continually paid health centers on a cost-based reimbursement methodology. The other 13 Section 1115 Medicaid waiver States did not establish mechanisms at the outset to protect health centers from inadequate Medicaid payments and have forced health centers to dip into their PHSA grants to cover their Medicaid losses. Recognizing this, Maryland and Oklahoma have taken steps to reestablish sufficient Medicaid payments to these safety net providers, but only after the health centers suffered from years of Medicaid losses under the waiver.

—*Only four non-1115 waiver States* have enacted legislation to continue adequate reimbursements to health centers permanently. Other States have made only a one-year administrative commitment to adequately reimburse health centers for Medicaid patients, which can be changed or eliminated at any time. This creates instability for health centers because they cannot develop plans for expanding service delivery sites, hiring new clinicians, or expanding health services, like pharmacy or mental health services, to their patients (insured or uninsured).

—In South Carolina, the State made a commitment to the health centers to continue Medicaid cost-based payments. However, several months later, South Carolina reversed its decision and began to implement the cuts according to the BBA/BBRA phase-out schedule. Health centers' patients in South Carolina are now feeling the effects of that broken commitment through service reductions.

In short, only 8 States have established a long-term Medicaid payment system for health centers. We believe that this demonstrates the need for Congress to establish a minimum Medicaid payment floor to protect PHSA grant dollars.

Thirty-five years ago, Congress established the health center program to ensure that a nationwide network of safety net providers would be there for everyone, re-

¹The MEI is also used to calculate annual payment changes in the physician fee schedule for the Medicare program.

ardless of where they lived. The Federal government wholly pays these PHSA grant dollars to health centers that in turn benefit people in every State in the country. *We do not believe that the States should be allowed to take advantage of the significant Federal investment in health centers by reimbursing health centers at a rate that does not cover the cost of providing care to Medicaid patients.* Rather, Federal and State governments should be partners in ensuring that people have access to health center services. The *Safety Net Preservation Act* would allow that partnership to flourish.

CONCLUSION: NOW IS THE TIME FOR CONGRESS TO ACT

Congress is again considering providing BBA relief to providers. The President has supported a package of \$21 billion in relief for providers and members of the House and Senate have signaled their support for additional BBA relief.

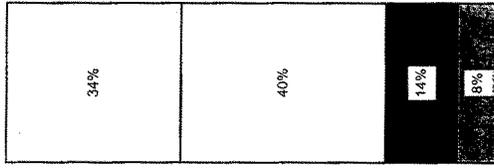
The *Safety Net Preservation Act* has wide, bipartisan support in both houses of Congress. In addition, the National Association of Mayors, the National Association of Counties, the National Rural Health Association, the National Association of Rural Health Clinics, the Health Care for the Homeless Coalition, and the National Center for Farm Worker Health have endorsed this legislation. It also has the support of the House and Senate Rural Health Care Caucuses.

Last year, the *Safety Net Preservation Act* was included in H.R.3075, the House's version of the Balanced Budget Relief Act, which passed the House with 388 votes. Unfortunately, the Conference agreement did not adopt the House position. In the end, the Conference agreement reduced the BBA's phase-out rate but retained the elimination of the permanent Medicaid payment system.

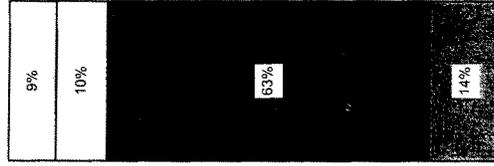
Given that this may be the last opportunity to revisit the policies of the BBA, health centers are calling on Congress to protect the struggling health care safety net in America. That is why I am here to urge this Subcommittee, the full Commerce Committee, this House, and this Congress to include the common sense, bipartisan, and permanent payment system included in the *Safety Net Preservation Act* in any BBRA legislation considered by Congress and to see that it becomes the law of the land before Congress adjourns this year.

Thank you and I look forward to answering any questions the Committee may have.

Appendix I: Health Center and Physician Office Patients by Payer Source



Health Centers



Physician Offices

- Medicaid
- Self-Pay (Uninsured)
- Commercial
- Medicare

Mr. BILIRAKIS. Thank you so much, Mr. Hawkins.
Ms. Connolly?

STATEMENT OF MARY LOU CONNOLLY

Ms. CONNOLLY. Thank you, Mr. Chairman and members of the subcommittee, for giving me the opportunity to testify on the impact of the BBA on the Medicare home health benefit. I am Mary Lou Connolly and I am Administrator of the Home Care Program at UCSD Health Care in San Diego. My remarks today are presented on behalf of the National Association of Home Care, NAHC. NAHC is the nation's largest home care organization, representing nearly 6,000 Medicare-participating home care providers, including nonprofit providers such as Visiting Nurse Association, for-profit chains, hospital-based and free-standing providers, and government-run agencies.

While we are greatly appreciative of efforts taken by you and your colleagues in 1998 and again in 1999 to mitigate some of the unintended damage to home care caused by the BBA, it is essential that further decisive action be taken this year to return the Medicare home care program to sound footing.

The reductions in Medicare's home health benefit since enactment of BBA 1997 have been startling and unprecedented. Home care outlays have decreased from \$18.3 billion in fiscal year 1997 to \$9.5 billion in fiscal year 1999. From calendar year 1997 to 1999, the number of beneficiaries served dropped nearly 1 million, from 3.5 million to 2.6 million. Home health claims dropped almost 50 percent and the average payment per patient dropped by 38.5 percent. The Medicare home health benefit as a percent of the total Medicare program has decreased from 9 percent in fiscal year 1997 to just 4 percent in fiscal year 2000.

The number of home health agencies has also taken a major hit, with over 3,000 net closures since 1997 nationwide. In California, my home State, there have been over 200 home health agency closures, and in San Diego, the city where my organization is, at least 15 agencies have closed or discontinued their Medicare businesses.

Various studies have concluded that for certain groups of homebound beneficiaries, especially those with medically complex or longer-term care needs, access to the home health benefit has decreased. No further studies are necessary. Many agencies readily admit that they have instituted more rigorous screening measures upon intake to ensure that high-cost complex care admissions are controlled. Surviving agencies feel they must limit the number of such cases as they are certain to exhaust their already depleted human and financial resources.

In addressing human resources, it should be recognized that home care agencies are also faced with decreased staffing due to cost reductions following BBA 1997. Staff who survived the BBA reductions are now voluntarily leaving home care, citing the impossibility of meeting increased regulatory mandates, such as OASIS, while being asked by administrators such as myself and nurse supervisors to care for more patients and to please do so more efficiently.

Transitioning from IPS to an underfunded PPS program is simply not enough to restore and preserve the Medicare home health

benefit. The five national home health associations have reached a consensus on the reforms necessary to protect the home health program and the beneficiaries it serves. The associations agree that Congress must take the following actions in this legislative session.

First, eliminate the 15 percent cut scheduled to take effect October 1, 2001. I take issue with the statement made by GAO that there is a cushion perhaps in PPS payments. If this 15 percent cost cut does go through on October 1, 2001, we will see more agency closures because agencies that have eliminated staff, reduced utilization, and cut costs to the bone to cope with IPS and whose PPS payments are based on the IPS budget simply are not likely to respond to a payment system that pays them 15 percent below the previous year's amount by increasing service and access to care.

Second, restore access to care for high-need and vulnerable patients as follows. Allow an additional expenditure of \$500 million in each of the next 5 years to be used as outlier payments for services to the most medically complex and costly patients. Increase payments for home health services in rural areas by 10 percent, and remove medical supplies from the per episode payment under PPS.

The five associations also ask that HCFA confine OASIS data collection and reporting requirements to only Medicare and Medicaid patients, and limit the items to the 20 elements which are actually needed to implement PPS and to provide for an emergency payment mechanism during at least the first 6 months of PPS to ensure there is no interruption in payments for services.

In addition, though not related to this hearing, NAHC and the other associations encourage you to reject any efforts to impose a copay on the home health benefit, as that issue has recently surfaced in the context of the prescription drug benefit.

Mr. Chairman and members, thank you for this opportunity. I will be happy to answer questions later.

[The prepared statement of Mary Lou Connolly follows:]

PREPARED STATEMENT OF MARY LOU CONNOLLY, ADMINISTRATOR, UNIVERSITY OF CALIFORNIA AT SAN DIEGO HOME CARE ON BEHALF OF THE NATIONAL ASSOCIATION FOR HOME CARE

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to testify on the impact of the Balanced Budget Act of 1997 (BBA97) on the Medicare home health benefit. My name is Mary Lou Connolly, and I am Administrator of the home health division of the University of California at San Diego's health care system. My remarks today are presented on behalf of the National Association for Home Care (NAHC). NAHC is the nation's largest home care organization, representing nearly 6000 Medicare-participating home care providers, including non-profit providers like the visiting nurse associations, for-profit chains, hospital-based providers, government-run agencies, and freestanding providers.

While we are greatly appreciative of efforts taken by you and your colleagues in 1998 and again in 1999 to mitigate some of the unintended damage to home care caused by BBA97, it is essential that further, decisive action be taken this year to return the Medicare home care program to a sound footing. Data recently provided by the Health Care Financing Administration (HCFA) provide a disturbing picture of the current state of the Medicare home health program. From calendar year 1997 to 1999, the number of beneficiaries served dropped by nearly one million, from 3.5 million to 2.6 million, or by close to 25 percent. Total outlays for the same period dropped from \$16.7 billion to \$7.7 billion, or nearly 54 percent. In those two years, home health claims dropped by almost 50 percent, and the average payment per patient dropped by 38.5 percent (source: preliminary 1999 HCFA/HICS data).

Home health will transition to a prospective payment system (PPS) under Medicare on October 1 of this year. This new payment system is expected to be much

more appropriate in design than the existing system that was imposed by the BBA97; however, because the global budget set for the PPS restricts outlays to what would have been spent if the current system were to continue, episode payment rates are expected to be inadequate and may perpetuate many of the access problems certain classes of patients (such as wound care patients) are experiencing today. The change in the home health payment system will not correct all of the problems in home health that have resulted from the BBA97.

Recently, NAHC, along with the four other national home health associations, developed a unified legislative agenda designed to restore and preserve the Medicare home health benefit in light of the devastation wrought by the BBA97. The national associations are agreed that true relief for the home care program cannot be achieved without legislative action that encompasses both restoration of services to patients who have lost care, and the elimination of further threats to the stability of the Medicare home health program and our national home care infrastructure. I will elaborate on the national associations' unified position later in my testimony.

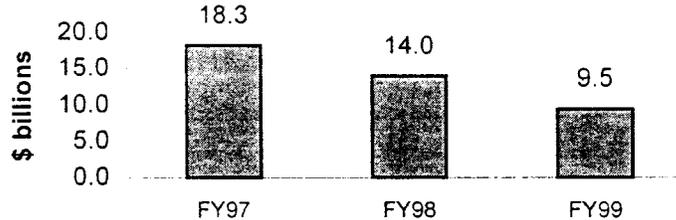
IMPACT OF BBA97 ON HOME HEALTH BENEFICIARIES AND PROVIDERS

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

The reductions in Medicare's home health benefit since enactment of the BBA97 are startling and unprecedented. Since fiscal year 1997 program expenditures decreased 48 percent, from \$18.3 billion in FY97 to \$9.5 billion in FY99 (Fig. 1).

Fig. 1

**Medicare Home Health Outlays
FY97-FY99**



Source: HCFA Office of the Actuary, Feb 2000, Home Health Outlays

While other Medicare programs have seen reductions due to the BBA97, no other decrease has been close to what the home health benefit has experienced (Table 1). In fact, FY99 was the first year in the history of the home health benefit in which Medicare outlays for skilled nursing facility care exceeded those of home health. Less was spent on Medicare home health services in FY99 than was spent in FY94.

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

Benefit Type	Amount (\$billions)		
	FY97	FY98	FY99
Managed care	25.0	31.9	37.4
Inpatient hospitals	88.3	87.0	85.3
Skilled nursing facilities	12.6	13.6	12.4
Home health	18.3	14.0	9.5
Hospice	2.1	2.1	2.5
Physicians	32.0	32.3	33.5
Outpatient hospitals	10.7	10.5	9.7
Durable medical equipment	4.1	4.1	4.2
Other	14.0	14.6	13.8
TOTAL MEDICARE	207.1	210.1	208.3
Percentage Change by Benefit Type	FY97-98	FY98-99	FY97-99
Managed care	+27.6%	+17.2%	+49.6%
Inpatient hospitals	-1.5	-2.0	-3.4

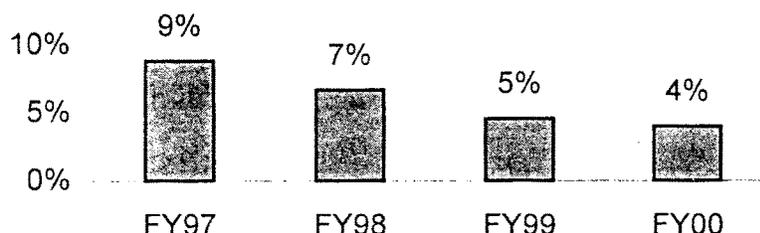
Table 1. Medicare Program Benefits, Fiscal Years 1997,1998,1999—Continued

Benefit Type	Amount (\$billions)		
	FY97	FY98	FY99
Skilled nursing facilities	+7.9	-8.8	-1.6
Home health	-23.9	-32.1	-48.1
Hospice	0.0	+19.0	+19.0
Physicians	+1.1	+3.7	+4.8
Outpatient hospitals	-1.9	-7.6	-9.3
Durable medical equipment	0.0	+2.4	+2.4
Other	+4.0	-5.5	-1.7
TOTAL MEDICARE	+1.4	-0.9	+0.6

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

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

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



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

The Congressional Budget Office (CBO) originally anticipated a \$16.1 billion reduction in projected home health spending over five years following enactment of BBA97. The most current CBO estimates and projections for home health show that spending was reduced by a total of \$19.7 billion in just two years (FY98 and FY99) (Table 2). Based on the latest CBO projections, home care spending will be reduced by a total of \$69 billion over five years (FY98-FY2002)—or, more than four times the intended reduction.

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

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

Network of Agencies Severely Diminished

Given the level of reductions, it is not surprising that home health agencies have been closing at a rate of more than 90 per month since October 1997, leading to a recorded net loss of over 3,000 agencies nationwide as of July 2000. HCFA data,

from which these figures are drawn, generally lags behind actual closures. These losses are particularly problematic in states with large portions of their elderly population living in rural areas. There are now fewer agencies serving Medicare patients than there were in 1994.

Agencies Less Able to Provide Needed Care

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

The employment reductions in Medicare are in sharp contrast to forecasts of continued growth in demand for home care personnel resulting from strong underlying demographic trends which include an aging population, increased availability of in-home medical technology, and consumer preference for avoiding institutionalization or delaying entrance to nursing homes. The Bureau of Labor Statistics forecasts an 82 percent increase in the demand for key home health personnel for the period 1998 to 2008. Due to the severity of the payment reductions under the BBA97, agencies increasingly are unable to offer competitive wages and benefits to attract qualified staff, and labor shortages are developing across the country.

Agencies Must Subsidize Medicare to Provide Services

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

Further, agencies throughout the nation have reported using funds other than Medicare to help pay for the care they provide to Medicare patients. An informal survey conducted during 1999 by NAHC revealed that 93 percent of responding agencies must find other funding sources in order to maintain home health access for Medicare beneficiaries. The median subsidy was \$165,000. Agencies are tapping funding sources such as state and local government monies, local community charitable funding, profits from other businesses or programs, personal lines of credit, bank loans, bequests, hospital systems, and financial reserves in order to continue providing care to needy and eligible Medicare beneficiaries. This continuing subsidization of the Medicare program means that agencies are less able to provide indigent care and other services that had been previously funded from some of these same sources, and is threatening the financial viability of many agencies.

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

Studies that have examined access to the home health benefit since 1997 agree on one central point: for certain groups of beneficiaries, access to the home health benefit has decreased. For example, a study of the effects of the BBA97 on home health agencies conducted by The George Washington University (GWU) reported that agencies were finding it increasingly difficult to meet the needs of high-cost patients, particularly complex diabetics. Among hospital discharge planners surveyed as part of the GWU study, 68 percent reported it was increasingly difficult to obtain home health services for Medicare beneficiaries.

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

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

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

The General Accounting Office (GAO) found that access generally has not been impaired, despite the closure of approximately 14 percent of home health

agencies since 1997 (GAO 1999). *But interviews with key stakeholders in areas with higher frequencies of closures suggest that home health agencies are asking more detailed information about potential patients, and that patients who require costlier services are facing difficulty in finding an agency willing to provide visits. [emphasis added]*

The controversy over the impact on access to home health is focused on how much access has been compromised, not whether it has decreased. Several research institutes, including the Robert Wood Johnson Foundation, have funded studies to look at the impact of the BBA97 on home health beneficiaries.

Media reports have also identified access problems due to the BBA97. An editorial in the April 25 edition of *The New York Times* notes that spending on home care services has dropped by over 45 percent since 1997. The *Times* editorial concludes by calling for the restoration of the Medicare home health benefit stating that, "Congress had reason to rein in ballooning Medicare costs in 1997. But the nation's oldest and most fragile citizens should not have to suffer for good intentions gone awry."

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

In the midst of the chaos that the BBA97 created, home health faces a major change in the Medicare payment system that is scheduled to take effect October 1, 2000. The IPS that began in October 1997 will be replaced by a PPS. The concept behind the new system is to encourage efficient provision of home health services by paying an amount based on the average national cost of treating a home health client for 60 days. Final payments to agencies are based on the average base payment, and adjusted to take into account patient characteristics (case-mix) and labor market differences (wage index). An outlier payment is provided for cases that exceed the expected costs.

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

NAHC has reviewed, digested and analyzed the final PPS rule as published by HCFA on June 28. The final rule addresses many of the concerns voiced by NAHC and the home care community. There are notable "improvements" in such areas as increases in low utilization payment adjustments (LUPA), per visit payment rates, billing and payment processes that enhance cash flow, and refinements to the case-mix adjuster. These changes, however, do not make up for the inadequacy of the overall funding of the home health benefit, which results in significant weaknesses in even the best PPS.

In addition, the final rule leaves unresolved some of the conflicts and concerns expressed with the proposed PPS. Of particular concern is HCFA's position on medical supplies, which may mean a dramatically expanded responsibility for home health agencies. It is NAHC's position that an agency is only responsible for those medical supplies used to treat illness or injury that occasioned the need for services.

RECOMMENDATIONS

As noted earlier, all five national home health associations—NAHC, the American Federation of HomeCare Providers, the Home Care Association of America, the American Association for Home Care, and the Visiting Nurse Associations of America—have reached a consensus on the reforms necessary to protect the Medicare home health program and the beneficiaries it serves. The associations have established two priorities of equal importance—to restore and to preserve the Medicare home health benefit. All five national home health associations agree that Congress must take the following action in this legislative session:

Eliminate the 15 percent cut scheduled to take effect October 1, 2001. Although federal budget projections show growth in home health following implementation of the PPS in October 2000, these projections are overly optimistic in accounting for the 15 percent reduction in payment rates scheduled for October 2001. Agencies that have eliminated staff, reduced utilization and cut costs to the bone to cope with the IPS, and whose PPS payments are based on the IPS budget, will not likely

respond to a payment system that pays them 15 percent below their previous year's amounts by increasing services. It is much more likely that a 15 percent cut in payments and below-inflation update factor will translate into additional agency closures, layoffs and even greater access problems.

Restore access to care for high needs and vulnerable patients. While outright elimination of the 15 percent will relieve the future threat or further devastation, an immediate infusion of dollars is necessary if access for certain hard to serve patients is to be restored. The following actions will help agencies throughout the country take on these patients with significantly reduced risk of financial devastation:

- Allow an additional expenditure of \$500 million in each of the next five years to be used as outlier payments for services to the most medically complex and costly patients;
- Increase payments for home health services in rural areas by 10% to address the higher costs of delivering care in these areas; and
- Remove medical supplies from the per episode payments under the prospective payment system and make payments under a fee schedule for only the supplies that are actually used. Such a proposal should be fashioned so that it is budget neutral.

It is also the consensus of the five national associations that Congress should direct HCFA to:

- Confine the OASIS data collection and reporting requirements to only Medicare and Medicaid patients;
- Limit the OASIS assessment items to only the 20 questions which are actually needed to implement the new PPS; and
- Provide for an emergency payment mechanism during at least the first six months of the new payment system to ensure that there is no interruption in payments for services.

Copayments

While not a focus of this hearing, the issue of imposing copayments on home health services has recently surfaced in the context of a Medicare prescription drug benefit. NAHC and the other national associations take serious issue with any Medicare program "reforms" that restrict or eliminates any current benefits.

Home care plays an important role in the American health care system. Home care patients tend to be older and poorer than the average Medicare beneficiary, and in greater need of care. Copays would penalize the most vulnerable Medicare beneficiaries because of their illness.

NAHC urges Congress to reject any attempt to place a copayment on the Medicare home health benefit for the following reasons:

- Copays are regressive and tax the sick;
- The elderly already pay high out-of-pocket health care costs, despite Medicare and Medicaid coverage;
- Copays represent an unfunded mandate to the states whose Medicaid programs will be responsible for the copay if the beneficiary is dually eligible for both Medicare and Medicaid benefits;
- Copays would be another administrative burden on home health providers;
- Copays discourage use of cost-effective home care services, which may result in the need to use higher cost care, thereby increasing Medicare outlays; and
- Copays may require further subsidization of the Medicare program by financially ailing home health agencies since many low-income beneficiaries will be unable to finance copays.

CONCLUSION

Mr. Chairman and members of the Subcommittee, these legislative and regulatory changes would go a long way toward strengthening the home health infrastructure and restoring beneficiary access to quality home care services. We thank you for your sincere interest, and look forward to working with you and your colleagues as you draft legislation to further refine the BBA97 with respect to home care services. I am happy to answer any questions that you might have at this time.

Mr. BILIRAKIS. Thank you very much, Ms. Connolly.
Mr. Williams?

STATEMENT OF DAVID T. WILLIAMS

Mr. WILLIAMS. I guess this is batting cleanup.

Mr. BILIRAKIS. And that is a compliment, is it not?

Mr. WILLIAMS. I do not know. Mr. Chairman, Congressman Brown, and members of the committee, thank you for having this hearing and providing me the opportunity to speak. In addition to my position at Invacare Corporation, I am also on the board of the American Association for Home Care, which is a national trade association representing home health agencies and HME providers.

HME providers are Invacare's direct customers, so what I say here today really represents the issues important to our customers and to an industry which is really the complementary staff to the home health agency. We like to say that there would be no HME if there were home health agencies, and we know that home health agencies are able to serve folks in their home because of the HME we manufacture and provide.

The challenge for me in the clean-up position today is to impress upon you the importance of a couple issues that are critical to our industry. We have been on a panel where we have talked about billions and billions and the need for restoration and regulatory relief, and I represent an industry that is a tiny fraction of the Medicare budget. So hopefully, I will be able to pull something off and at least impress you that there are two key issues that we would like this committee to address.

Before I launch into that, I would really like to emphasize once again that the industry that I am part of, home care and the home medical equipment industry, is often cited by bureaucrats and regulators as needing to be reigned in because it is growing too fast, and I would challenge that position because growth in home care, growth in the HME industry, is good news for America. It is good news because what we are talking about is a cost-effective, clinically appropriate, and patient-preferred alternative to more costly options. This is an irrefutable fact.

The Hudson Institute Study in 1998 showed two things about home care that were really important, and they included people with severe disabilities in that cohort of their study. They said by investing a little more money in home care, they were able to reduce the dependence on more costly facility-based care by 50 percent and that the people they diverted from facility-based care, the cost of serving their health needs was 50 percent lower than in a facility setting. So it is cost effective.

It is clinically appropriate. The best example that home care is clinically appropriate is the fact that every major heart transplant program in the country prepares their patients for surgery in their homes because they get better clinical outcomes. That is a fact.

And patient preferred, the State of Ohio Department of Aging did a study a few years back where they interviewed 10,000 Ohioans age 55 and older and they asked them, if they ever needed long-term acute care, what would they want. Ninety-some percent of them said, in their home. So home care is patient preferred, and there are studies all over that duplicate that number.

So I just ask you to keep that in mind as you are shaping some form of BBA relief. Now the two issues.

The first issue that I would like to talk about is a cost of living adjustment for the HME services benefit. In the Balanced Budget Act, that was frozen through the year 2002. In BBRA in 1999, Con-

gress acknowledged that maybe that was a little too much and they restored 0.3 percent in 2001 and 0.6 in 2002. I do not think it takes a whole lot of insight to realize that the freeze of the Medicare fees has effectively reduced payments, because our customers, and indeed Invacare itself, we experience dramatic increases in the cost of raw material, fuel, and labor. And so, effectively, we are in a negative right now and it is continuing to go downhill and 0.3 percent is not really going to make up very much of it.

The effect has been really profound. Remember, the HME industry is largely made up of small entrepreneurial companies and they just cannot withstand this kind of onslaught, and large companies have been adversely hit, also. So full restoration of the cost-of-living adjustment is critically important.

The other piece, quickly, is we would ask Congress to exercise a little more oversight as HCFA uses the new expedited inherent reasonableness authority that was contained in the BBA. HCFA has proven time and time again that they are incapable of promulgating rules around a program that is reasonable. They use flawed data and they use questionable practices. In fact, in the BBA, report language was included to require HCFA to use statistically valid and relevant data and a sound costing methodology. One would think that was a prerequisite for the program.

So those are the two things our industry is asking for and I will stand for questions with the rest of the panel.

[The prepared statement of David T. Williams follows:]

PREPARED STATEMENT OF DAVID T. WILLIAMS, DIRECTOR OF GOVERNMENT RELATIONS, INVACARE CORPORATION ON BEHALF OF THE AMERICAN ASSOCIATION FOR HOMECARE AND THE HOME MEDICAL EQUIPMENT (HME) SERVICES INDUSTRY

Mr. Chairman, Congressman Brown and Members of the Committee: my name is David T. Williams and I am the director of government relations for Invacare Corporation. I am pleased to be here to offer testimony on the impact of the Balanced Budget Act of 1997, as it pertains to home-based health care and the home medical equipment services industry.

Invacare Corporation is the world's leading manufacturer and distributor of medical equipment and supplies for use in post-acute care settings. The company employs more than 5,000 people and is headquartered in Elyria, Ohio. Invacare has domestic facilities in Ohio, Florida, Massachusetts, California, Maryland, Michigan, Missouri and Texas. Invacare also has manufacturing operations in Canada, Mexico, Australia, New Zealand, Denmark, the United Kingdom, France, Germany, Sweden, Switzerland and Portugal.

I am also a member of the Board of Directors of the American Association for Homecare (AAH), a national trade association representing home health agencies and HME providers. AAH was formed earlier this year by the merger of the National Association for Medical Equipment Services, the Home Health Services and Staffing Association and HIDA Homecare. It is the only association representing the spectrum of providers committed to quality health outcomes in the home.

With your indulgence, I will speak on behalf of both Invacare and the Association.

In the course of this hearing, you have or will have heard compelling statements from a wide spectrum of health-care providers. Each witness will try to make a case for restoring some funding, correcting some error or eliminating a new regulatory burden. I am no different than those witnesses who have preceded me and those who will follow me. The purpose of my testimony is to bring to the attention of this Committee, three provisions of the BBA that deserve your immediate attention. However, before going into detail on these provisions, I would like to offer some observations about health care in the home.

Let there be no mistake, home-based health care has grown faster than any other segment of the health care continuum. But, the growth in home care is not an indicator that something has gone wrong. The growth in home-based health services is good news for America.

It is good news because homecare is a clinically appropriate, cost-effective and patient-preferred alternative to facility-based health services. Please allow me to elaborate.

A study conducted by the Hudson Institute in 1998 concluded that home-based health services are cheaper than and can reduce admissions to facility-based care. This study was an in-depth look at the State of Indiana's In-home/CHOICE program. A copy of this study will be forwarded to each member of this committee. For the purpose of this hearing, however, two of the study's conclusions are worth noting. First, the researchers noted that by placing increased emphasis and funding on home-based health services, they were able to reduce institutionalization of Indiana's frail elderly population by 50 percent. Second, the Hudson Institute reported that home-based health services reduced spending for health care on this population by 50 percent or more. *Home care is cost effective!*

There are a variety of studies that talk about improved clinical outcomes obtained when a patient receives health services in the familiar surroundings of their home. In one study conducted by Tufts University, a small group of 100 patients, diagnosed as frail elderly, was divided into two groups. One group received their health care in a facility setting (a nursing home). The other group was provided with home-based health services. The mortality and morbidity statistics for the first group was dramatically higher than those served in their home. A less "academic" demonstration of the clinical appropriateness of homecare can be found in heart transplant centers across the country. In preparation for their surgeries, transplant patients go on strict regimens of pharmaceutical and dietary therapy. Virtually every major transplant center arranges for this therapy to take place in the home. Surgeons report that patients who come from a loving home environment are better prepared and yield better outcomes. *Homecare is clinically appropriate!*

The Ohio Department of Aging surveyed a large number of adults over the age of 55 years. Ninety percent of the respondents said that if they ever needed long-term care, they wanted that care to be delivered in their home. Several other studies report similar results. *Homecare is patient preferred!*

Yes, homecare has grown over the last two decades and it will continue to grow. Advances in medical technologies and changes in Medicare's payment structure have spurred a considerable growth in the use of home care. As in every other aspect of modern medicine, home health care has benefited from an explosion of new and emerging technologies. Things such as, the use of space-age materials to make wheelchairs and mobility aids lighter and the application of micro-chip computer technology in implantable devices used to dispense critical medication, make it possible for the care received in the home to equal or exceed that received in a hospital, at a fraction of the cost. Today, it is common for a Medicare beneficiary to undergo chemotherapy in the comfortable surroundings of his or her own home, a feat that was inconceivable just a few years ago. In the future, advances in tele-medicine and similar technologies will make it possible to further reduce health care costs and improve the quality of health care provided in the home. None of these advances could have been envisioned at Medicare's inception in 1965.

I ask that the Members of this Committee, as you go about fashioning legislation to refine the BBA, keep in mind the irrefutable fact that the growth in the utilization of homecare is good news for America.

Congress can go a long way toward insuring that America has a strong and vibrant homecare system that is capable of meeting the growing healthcare needs of this country by addressing three provisions of the BBA. Our industry asks that this Committee address the pending 15 percent reduction in payments to home health agencies, the freeze on the annual cost of living adjustments for home medical equipment and HCFA's use of inherent reasonableness in any Medicare provider "give-back" legislation.

Eliminate the pending 15 percent reduction in payments to home health agencies (HHA). The BBA included a congressional mandate to change the way payment is made for home health services from a "cost plus" methodology to a prospective payment system. Because so little was known about the level of savings that could be achieved under PPS, Congress included a provision to reduce payments to HHAs by an additional 15 percent, if saving targets were not hit. The Congressional Budget Office estimated the transition would save \$16 to \$19 billion over five years. The transition is not even complete and the savings to Medicare is conservatively estimated to exceed \$45 billion.

But the threat of an additional 15 percent cut continues to hover over home health agencies and threatens the financial stability of these organizations. As you can well imagine it is difficult, if not impossible, to attract investors or secure loans when there's a potential for a devastating reduction in fees on the books. It is a mat-

ter of fundamental fairness that Congress acknowledge that home health agencies have done their part by permanently removing the proposed 15 percent reduction.

Restore the annual Cost of Living Adjustments for HME services. The BBA included a freeze on the Medicare fee schedules for durable medical equipment for the years 1998 through 2002. This cut was in addition to a 30 percent reduction in the fees paid for home oxygen therapy. The impact of this combination, on an industry populated by many small entrepreneurial enterprises, has been devastating. Invacare is the largest creditor in the HME industry. Since 1997, there has been a dramatic increase in bad and unrecoverable debt. The number of customers who have filed for bankruptcy is unprecedented. Small providers are going out of business or being forced into consolidation at a record rate.

Large/national HME providers have also been hit very hard. *PriceWaterhouseCoopers (PWC)* has released some startling findings in an update of a 1999 survey of nine publicly held companies that provide home medical equipment and services. PWC observes that the nine companies were earning a positive net income in 1996, but *three years later, two-thirds of them were losing money, bankrupt or out of existence.* This occurred during a period in which U.S. corporate profits for all industries rose by 18 percent.

The HME industry asks Congress to restore the Cost of Living Adjustment (COLA) for fiscal years 2001 and 2002. Income from Medicare, not only was cut 30 percent for home oxygen but, all income for Medicare home medical equipment and services has declined in real terms in the absence of a COLA, while costs to HME providers—particularly labor and fuel costs—have continued to increase. By restoring two years of the COLA, the industry can regroup and begin to rebuild so its members can be viable partners with Congress and HCFA in the mission to better serve Medicare beneficiaries.

Note: Invacare and other vendors to the HME providers have done their best to help our customers survive perilous economic conditions. Our company has assiduously avoided price increases in deference to our customers. At the same time, the costs of raw materials, fuel and labor have continually increased and we can no longer “subsidize” the Medicare program with artificially low wholesale prices. On the first of October this year, Invacare will impose its first price increase since passage of the BBA.

Congress must provide oversight as HCFA begins to use its “expedited inherent reasonableness authority.” The BBA empowered HCFA to develop a process for reducing the Medicare fee schedules for durable medical equipment using an expedited process. The HME services industry acknowledges the fact that HCFA must be able to make reasonable adjustments in the fee schedules for the goods and services it purchases for beneficiaries. However, HCFA has repeatedly abused this authority and clearly demonstrated its inability to exercise it in a reasonable and rational manner.

In the Balanced Budget Refinement Act of 1999 (BBRA), Congress acknowledged that HCFA was “not playing fair” with its IR procedures. Report language was included in the BBRA requiring the agency to develop and use a sound costing methodology based on statistically valid and relevant data. Notwithstanding this provision, HCFA appears to be ready to impose several reductions of significant consequence, ignoring the mandate contained in the BBRA.

The attached table describes the potential consequences of this action, as they pertain to 3 specific products manufactured by Invacare. HCFA proposes reducing the Medicare fee schedule for these three products by an average of 38% (48% to 28%). If HCFA proceeds with this action, American businesses and Medicare beneficiaries will get hurt.

To demonstrate this point, let’s consider one product, a basic folding walker (HCPCS E0135). Invacare sells this product to its customers, HME providers, for \$33.20. The provider must deliver the unit to the beneficiary’s home, measure and adjust the unit for the individual, instruct the patient in its use and go through the laborious process of collecting the copayment and billing Medicare. Using the principles of Activity Base Costing, it is estimated that the additional cost of providing this product would be \$55.91. Thus, the total retail cost—without any consideration for profit margin—is \$89.11. The proposed new Medicare fee schedule is \$50.50. This is neither reasonable nor rational.

Providers will be unable to take assignment on this product and Medicare beneficiaries will have to pay the full retail cost out-of-pocket and will have to have the provider submit unassigned claims for the allowable amount. This is an unreasonable economic hardship for beneficiaries.

Equally important is the impact this kind of shortsighted policy has on American businesses. While it is doubtful that anyone can produce a folding walker that can yield profit at this price, some companies who have little interest in quality or effec-

tiveness will enter the market. HCFA will price legitimate American companies out of the market opening the door to foreign products of dubious quality and questionable clinical effectiveness. The offshore products are not as durable, well engineered and, often, are not as clinically appropriate as those manufactured by American companies, like Invacare. Why should Medicare beneficiaries have to settle for less than America's best?

An interesting side note: Many of the offshore products flooding the market do not even meet Medicare's definition of medical equipment. To be considered a medical device federal law requires that the manufacturing location be registered with the Food and Drug Administration. Registration with the FDA requires performance with that agency's good manufacturing practices (GMP). Many of these offshore companies are not known to, much less registered, with the FDA. Thus, Invacare and other American companies are placed at a competitive disadvantage by products that do not even meet the definition of medical equipment.

Congress should mandate that HCFA promulgate final rules that demonstrate "sound costing methodology" and define what constitutes "statistically valid and relevant data." The development of these final rules should be done in conformance with the Administrative Procedures Act and incorporate the active and substantial input of the HME services industry.

Conclusion: Home health care continues to evolve and expand to meet the increasingly complex needs of today's Medicare beneficiaries. By capitalizing on technical innovation, home care providers can conduct increasingly complex medical and therapeutic regimens in the comfort of beneficiary's own homes. In addition, recent studies have shown that an expanded home care benefit would reduce Medicare expenditures by avoiding costly institutionalization. We urge the Committee to recognize the many benefits of home care by strengthening Medicare's commitment to the home health benefit. You can do that by making sure that the following items are incorporated into any "BBA Fixer" or "Medicare Provider Give-back" legislation.

We ask that Congress acknowledge the contribution that home health agencies have made to Medicare cost containment and permanently eliminate the pending 15 percent cut. Further, Congress should restore the annual Costs Of Living Adjustment (COLA) for durable medical equipment. Finally, we believe that Congress must exercise its oversight responsibility and insist that final rules addressing IR be promulgated in full compliance with the Administrative Procedures Act and if the procedures outlined and that these rules reflect the a sound costing methodology that uses statistically valid and relevant data.

I want to thank the Chairman and Congressman Brown for providing me with the opportunity to offer this testimony today. I would be happy to answer any questions you may have at this time. However, if any member of the Committee needs additional information on any of the points raised in this testimony, please feel free to contact me.

Comparison of HME Provider Costs to Proposed Medicare Fees

	E0135 ¹ Folding Walker	E0143 ² Wheeled Walker	E0163 ³ Commode Chair
Invacare Wholesale Cost (Dealer Price)	\$33.20	\$46.00	\$37.40
Other Costs*	\$55.91	\$57.06	\$55.66
Total Retail Costs	\$89.11	\$103.06	\$93.06
Acquisition Cost/Retail Cost	62%	55%	59.8%
Current Medicare Fee Schedule	Floor \$67.97 Ceiling \$79.97	Floor \$97.48 Ceiling \$114.08	Floor \$89.42 Ceiling \$105.20
Proposed Medicare Fee Schedule	\$50.50 (\$38.61)	\$75.88 (\$46.00)	\$62.85 (\$30.21)
Difference Between Proposed Fee and Total Retail Costs			
Number of Units Covered by Medicare in 1998	293,301	363,392	441,235
Reductions to HME Industry	11,324,351	16,716,032	13,329,709

* Other costs include costs for delivery technicians, personnel costs, vehicle depreciation and fuel and maintenance, paperwork, billings costs, staff education and support, inventory, and indirect overhead (rent, utilities, etc.).

NOTE: Through the SADMERC, Medicare has assigned Invacare's Rollators (Spartan, Stingray and Slargazer Models) to HCPCS E0147. Wholesale costs for these units range from \$134 to \$204 further demonstrating the gross inadequacy of the HCPCS coding system.

Mr. BILIRAKIS. Thank you so much, Mr. Williams.

Of course, my gratitude to all of you for your efforts to try to help us wade through this. I think I speak for all of us when I say that we wish we had a magic wand that we could wave to solve all of the problems. What we did in BBA 1997 had to be done. We thought it had to be done the way we did it, and, of course, it turned out that we did some bad in the process of the good.

Mr. Williams, you did not go into the issue of copayments. Ms. Connolly did. Dr. Ganske earlier went into this in some detail. I, in the past, am on the record as opposing copayments on home health care. But taking a look at the real world today, an awful lot of these home health care centers are possibly going out of business—and you are not going to sit there and tell me you support copayments. Your job is probably every bit as political as ours.

But taking all that into consideration in a process of wanting to save, or at least to keep the program from deteriorating any more, is the subject of \$5 copayments. For instance, just using it as a figure, throwing that out there, is that really such a really terrible thing? Very quickly, because I do want to get into some of the other areas.

Mr. WILLIAMS. I think the issue of copayments right now, to impose copayments at the time an industry is transitioning to a totally new payment system, that is just throwing gas onto the fire. And if you want to make it not work and come away with even less data to say whether or not PPS is the solution and if it needs further tweaking. If you throw copayments on there, it is like gas on the fire.

Mr. BILIRAKIS. You probably would agree with that, Ms. Connolly.

Ms. CONNOLLY. Yes, I would agree. I think adding copayments adds still another administrative layer that a home care agency will have to deal with.

Mr. BILIRAKIS. God knows we have got too many of them out there already, do we not?

Ms. CONNOLLY. We are going to add to our cost to collect a minimal amount of money that many people will not want to pay.

Mr. BILIRAKIS. Ms. Tavenner, it seems almost like yesterday that you testified, we have dragged this thing out so much because of all these votes. I believe you said your four facilities would suffer \$70 billion in cuts as a result of BBA 1997, is that correct?

Ms. TAVENNER. Seventy million dollars.

Mr. BILIRAKIS. Oh, million, not billion.

Ms. TAVENNER. Million, over a 5-year period.

Mr. BILIRAKIS. That is better.

All right. In any case, I will ask my question. That is as a result of BBA 1997. How much of those cuts are the result of overdoing BBA 1997? In other words, as you testified, the contemplation was that there would be a savings of, oh, I do not know, we have been throwing around, let us say, \$100 billion and it turns out there is a savings of double that. So are we saying that you would have contemplated half of those cuts as intended under BBA 1997 and could probably have lived with those cuts that were intended, although you cannot live with the cuts as it ultimately has turned out?

Ms. TAVENNER. I certainly think that in our original contemplation, going back to 1997, we were estimating about half of those cuts, and while we were not happy with that—I do not think anyone is happy to see the cuts—

Mr. BILIRAKIS. Yes, of course.

Ms. TAVENNER. [continuing] we had made and started and continue to make a lot of aggressive cost-reduction activities, particularly in the non-clinical area. So, yes, that would have been a much better solution for us.

What has, I think, compounded where we are today is the labor force issue and the drug issue, which I do not think any of us speculated. We thought we would have better control over the rate of increase in those two areas and they have been out of control.

Mr. BILIRAKIS. I do not have that much time left and I trust that Mr. Burr will go into the community health centers in addition to so many other things that he is interested in. Being a strong supporter, as you know Mr. Hawkins, of community health centers and the wonderful proven work that they do, I am just so very grateful for his support and Mr. Brown's. They really have been leaders on the subject.

But I would ask you just one quick question. Apparently, and your testimony supports this, the community health centers now serve approximately 4.5 million uninsured, and yet we have, depending on whose figure you accept, maybe up to 8 or 10 times that of uninsured. Could you do a better job with those uninsured, in other words, increasing the amount of uninsured you serve?

Mr. HAWKINS. Well, we could certainly do so with some increased resources. I mean, the cost of a year's worth of care at a health center for each one of the people served is about \$325, and that is an average of four visits, including lab, x-ray, pharmacy, health and nutrition education, et cetera.

Mr. BILIRAKIS. As related to what?

Mr. HAWKINS. As compared with?

Mr. BILIRAKIS. Yes.

Mr. HAWKINS. An average of about \$450 on the average cost for you and me according to Health U.S. and other statistics. It is not all the care that they need. It is not the inpatient care. It is not the specialty care.

Mr. BILIRAKIS. Right. Of course.

Mr. HAWKINS. But it is the primary and preventive health care. What we could do, though, and this is what is important, is if Medicaid continues to pay its fair share for its beneficiaries, then we can continue to grow and serve more.

I might make one last point. Every dollar that this Congress appropriates for health centers generates another \$3 in State and local support for the health centers which they put together in a pool along with the payments made by the uninsured, because everybody pays something, at least a little something, a buck, two bucks for the cost of their care. But they put that all together to put a package together of resources to support care for those uninsured individuals.

What we can do and what has grown even more rapidly than Federal grant support for health centers has been State, local, and private philanthropic support, and we can do more to secure yet

additional resources from those. It is not just relying on Uncle Sam for every dollar needed. We do serve, health centers, this little small contingent of 1,000 providers, 1 out of every 10 uninsured Americans today, but we want to serve more. We serve one out of every five low-income pregnant women who deliver every year.

Mr. BILIRAKIS. If we could only get our legislation in the managed care bill enacted, being able to expand your managed care participation would be very helpful, but we are having some problems with that, as you know, over in the Senate.

Mr. Brown to inquire. Thank you.

Mr. HAWKINS. Thank you, sir.

Mr. BROWN OF OHIO. Thank you, Mr. Chairman.

Mr. Richtman, all of us are concerned, I think all of us on this panel are concerned about provider payments and the impact that these cuts have on the beneficiaries and I think you have all laid that out very well, but I think there may be other ways we can adjust Medicare to help seniors. We have a patchwork of protections for low-income Medicare beneficiaries. Some are dually eligible, get Medicare and Medicaid. Others get assistance with premiums and cost sharing, others with just a portion of the premium.

But even though this assistance is available, the number of beneficiaries enrolled is obviously much too low. What can we do to get more seniors enrolled in programs that provide this kind of assistance to them?

Mr. RICHTMAN. Congressman Brown, you are talking, I think, about the QMB program and the SLMB program, and as you know, we found it very difficult to get people who are eligible to enroll in these programs. Part of it is a lack of awareness. People not knowing the programs are there for them, and another part of it, frankly, is when the Medicaid program, I think, is involved in determining the eligibility, there is for some people a stigma associated with that part of the eligibility that might be considered welfare, Medicaid, as opposed to support for Medicare eligibility.

We have talked with some of our members about, and the Social Security Administration about, having the Social Security Administration take a more active role in enrolling eligible beneficiaries for both of these programs and actually enrolling them through the Social Security Administration, and that would obviate the need to go to Medicare and to Medicaid.

Mr. BROWN OF OHIO. Can HCFA do that or does that have to be done by Congress?

Mr. RICHTMAN. Well, we think the Social Security Administration could do that.

Mr. BROWN OF OHIO. Thank you.

Mr. Hawkins, thank you for the good work that community health centers do. I very much appreciate your work and the work of the people in Ohio, also.

Mr. Williams, talk if you would, briefly, elaborate on the cost-of-living adjustment issue.

Mr. WILLIAMS. Well, again, BBA froze the fee schedule for durable medical equipment at the same time that there was a major hit, a reduction in the fee paid for home oxygen therapy services, and that freeze was to go through the year 2002. Like I said, our costs continue to go up. We would like to have that restored to the

full COLA, which is about 2.3 percent for the year 2001. Considering the numbers that have been discussed in this committee, that is really budget dust. I mean, we are talking about, it would scare me, but about \$500 million to \$700 million for those 2 years.

But what our industry is looking for as much as anything is a period where we can be stable, where we know that there is nothing else going to happen, where there is enough money to get in there and to look at our inventories and to stabilize our businesses so that we can grow and be a good partner with Medicare. Right now, the HME industry is at a tremendous disadvantage and providers are constantly under attack with increased regulatory burdens and costs.

It is important to remember that the HME benefit, which people have a tendency to look and see a wheelchair or a crutch or an oxygen concentrator and see it as a commodity, but the HME benefit is a service. Our customers deliver the product to the patient's home, so they have been experiencing first-hand the fuel cost thing. They have to measure the patient, adjust and fit. They have to educate the patient. And then they go through the Medicare billing process, which is a tremendously costly thing.

Under activity-based costing principles, it was recently estimated that for a \$30—the wholesale price is \$30, \$32 for just a basic walker—that the non-equipment acquisition cost to the provider are around \$55. So the cost of our products are huge. All we are asking is to be able to keep up with those and the full restoration of the COLA would be a great step in the right direction.

Mr. BROWN OF OHIO. Thank you.

I just wanted to explain and sort of mention a frustration I think several of us feel. Ms. Coughlin, you mentioned that when you asked for \$15 billion, the President's plan, in 5 years, the President wants \$21 billion, has asked Congress for \$21 billion. Many think we will not get that much. You are asking for five-sevenths of that money, \$15 billion over \$21 billion, for one-sixth, one-seventh of the beneficiaries.

What a lot of us have a lot of frustration about what managed care has done in our districts, there are senior citizens in my district that 2 years ago were in United Health. They got cutoff last year, went into QualChoice. They got cutoff this year, went into Aetna. They got cutoff. They had to switch plans, switch doctors, switch providers three times.

To come in here when GAO has said that you are overpaid and to ask for \$15 billion out of \$21 billion available seems to be a bit overkill, does it not?

Ms. COUGHLIN. Well, Congressman, it may seem like overkill to individuals who are not involved directly in managed care. I am trying to help understand how managed care plans can deal more effectively and be more responsive to seniors and to individuals with disabilities.

When you look at the painful decisions that we in our company go through in determining whether or not we can stay in a particular marketplace, for example, the example you just gave is a very vivid one, I think, because there are places where seniors have switched from one plan to another and then that plan has to pull out for that given year.

And just making the decisions myself for the areas I am responsible for, is painful. That is the only way I can describe what you go through, because in order to become eligible to offer Medicare in a particular area, you go through a rather grueling process with HCFA. It is very expensive to sell the plan. And then when you realize that you lose significant amounts of money—the example I gave in my testimony is very real. When you pay out \$1.10 in care for every \$1 you bring in and you are not even counting any administrative costs, even a modest amount to administer the plan, there are tough decisions. But we would not pull out if we could make it work. It is sort of counter-intuitive.

Mr. BROWN OF OHIO. You want us to believe that, and I have looked at the lists of executive salaries at Aetna and executive salaries in other for-profit managed care companies and you talk about the painful decisions that you make—I am not saying you are one of those executives that has those salaries, but I think that there is never acknowledgement of over-promises.

I mean, managed care makes these promises to senior citizens. You are either over-promising on purpose or you are not very good at predicting any kind of future cost that most businesses in this society have to predict. And then 2,000 seniors citizens and Dave Williams in my county pay for it year after year and counties all over the State and the country pay for those decisions that your very, very, very well-paid executives have made when they make these cuts and force these people into different decisions.

Then you have the chutzpah to come into this committee and ask for 71 percent of the \$15 billion that we may or may not give out when you see everyone sitting up here asking particularly for the safety net hospitals and the community health centers and the people that Mr. Richtman represents, when those are the people that are really hurting and your industry comes in here and asks for 71 percent of the \$21 billion that this Congress might vote?

Ms. COUGHLIN. I think what—

Mr. BILIRAKIS. A very, very brief response to it, please.

Ms. COUGHLIN. Okay, I will. What I am trying to focus on is being able to accommodate the needs of the seniors and the individuals with disabilities on 2 percent increase per year, and I do not think there is anybody in the room that could believe that medical costs are only going up by 2 percent a year. That is the increase that we are getting at this point in time, compared to the Federal employees, who cover a lot of people in this room who have gotten 29 percent increase over the past same 3-year period that I am talking about we got 2 percent a year.

Mr. BROWN OF OHIO. And some hospitals in the inner city have less and the community health centers may have less. I think we have gone far enough.

Mr. BILIRAKIS. Dr. Ganske to inquire.

Mr. GANSKE. Dr. Zetterman, you raised some important issues on the site of service differential issue and mentioned how this would affect gastroenterology services. Are there other services that Congress should consider if we address site of service differentials?

Mr. ZETTERMAN. I think there are a number of areas that could be considered, but, of course, at this moment, there are 13 GI procedures that have been specifically affected by this bifurcated fee

proposal that sits there and is in place, and therefore we would propose that those be the 13 that be initially dealt with in some sort of a legislative fix.

Mr. GANSKE. Can you mention some other specialty areas?

Mr. ZETTERMAN. I think that perhaps one of the issues would be to look at some sort of an articulated standard as to where this should be put into place. All those things that are affected right now in gastroenterology are things that occur less than 10 percent of the time. I think another standard is the one that you yourself raised earlier, and that is what can be appropriately and safely done in an office setting might additionally be one other factor, and you certainly raised that in earlier comments.

Mr. GANSKE. What would be your suggestions specifically for a broad rule, rather than dealing with specific codes?

Mr. ZETTERMAN. I think one thing to do would be to articulate or actually define a specific standard as to when that threshold should be crossed, and we initially proposed that that be for procedures that are done less than 10 percent of the time in the office would not be affected.

Mr. GANSKE. What would be your suggestions to this committee for GME changes?

Mr. ZETTERMAN. I think there is no question but what we need to protect the safety net hospitals. We have heard today much testimony about how the Balanced Budget Act affected particularly the large teaching hospitals. There have been a number of proposals out there as how to effectively deal with it. I can provide to the committee, if you wish, for example, a paper that is a physician paper of the American College of Physicians-American Society of Internal Medicine specifically on GME as a public good.

These hospitals in which graduate medical education occur include those hospitals that have a disproportionate number of indigent or uninsured patients, have a large percentage of elderly patients, have the group of patients that clearly need access to care and sometimes have no other means to get it than through those teaching hospitals. As a consequence, it really can be a public good in how it provides care.

Therefore, we need to, I think, continue where we are. Perhaps we should limit and stop progression of the indirect reductions that are occurring right now and at least put a moratorium on it until we can safely determine what those cuts and the impact of those cuts can be.

Mr. GANSKE. I thank you and I yield back, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman.

Ms. DeGette?

Ms. DEGETTE. Thank you, Mr. Chairman.

Ms. TAVENNER. I think that you have quite accurately described some of the issues that your group and others are facing, what with both increased numbers of uninsured and also some of the other measures that we have seen that affect institutions like the ones you manage and other disproportionate share hospitals, and also your answer to the question to the chairman about what kind of cuts you expected and then what kind of cuts you got.

I wonder if you can expand on that answer a little bit and tell me what you think will happen if we do not give some relief under

H.R. 3710, my legislation on DSH assisted by Congressman Bilbray, Whitfield, and others, and also Congressman Burr's bill, H.R. 2341, for the community-based institutions.

Ms. TAVENNER. I think that, again, going back to both DSH and community-based institutions, what we are seeing is the increase in the uninsured and the increase in folks who have inability—

Ms. DEGETTE. If you can just move that microphone a little closer.

Ms. TAVENNER. We are seeing those numbers rise—

Ms. DEGETTE. Right.

Ms. TAVENNER. [continuing] and we are seeing the cost of them rise. And what the hospital is left with is, I think, ethically, hospitals cannot put the patient, ethically and legally, back into the street. So we are a 24-hour-a-day, 7-day-a-week operation, so we cannot control who comes into our organization and we are federally bound and State bound to care for those patients and we want to care for those patients.

So what happens in a reimbursement situation where we continue to see decreases is that then we are forced to look at services that basically are on the fringe, or what I call not our core services, and make business decisions about whether or not we can continue those. Home health is one. Hospice is another. So you start to look at what services you can eliminate. Therefore, the patient ends up staying longer in acute care, so you kind of have a cyclical effect.

Ms. DEGETTE. And that is more expensive, too, to you.

Ms. TAVENNER. Absolutely.

Ms. DEGETTE. Is there going to come a point, do you think, without relief that your core services will begin to be affected?

Ms. TAVENNER. I think we have seen that in some communities already, and—

Ms. DEGETTE. Could you give me a couple of examples?

Ms. TAVENNER. Yes. Rehab services would be an example. Skilled nursing units within hospitals, which in rural areas are frequently a safety net for patients. We have seen skilled nursing facilities within hospitals close. We have seen home health and hospice services close. We have seen rehab services close. Then I think once you eliminate those services, then you start to look at psychiatry and others where the payment mechanism just does not cover the cost.

Ms. DEGETTE. Mr. Hawkins, would you like to talk a little bit about how you see some of those issues?

Mr. HAWKINS. Well, yes. If I could, although we are not bound by the Emergency Medical Treatment and Labor Act, EMTALA, which I think is being referred to here, and that refers to care to the individual until they are stabilized, okay, not necessarily inpatient care unless that is what is necessary to stabilize the individual's treatment, I think there is a little bit of a difference between that and the legal obligation to take anybody who walks in the door, regardless of their ability to pay.

Ms. DEGETTE. Right.

Mr. HAWKINS. But much the same as has been alluded to with respect to the hospitals. As payment rates fall, the first thing to go typically are services, and the first services to go are those services that are either non-reimbursable and which are important to either help get the patient into care—transportation, outreach, trans-

lation to help the care be meaningful—or the therapeutic regime, the care that the doctor recommends or the nurse practitioner recommends be useful, like health or nutrition education, taking a pregnant woman and saying, this is how you engage in good self-care, good nutrition during pregnancy.

Ms. DEGETTE. Let me stop you right there.

Mr. HAWKINS. Yes.

Ms. DEGETTE. About that pregnant women issue, you heard me ask that question before. Do you think that some of these problems I talked about with the last panel in terms of the most expensive infant care issues would be eliminated if we could somehow cover pregnant women under Medicaid and CHIP.

Mr. HAWKINS. Oh, sure. I mean, many of those issues we struggle with that every day in health centers. Trying to get individuals covered under Medicaid and CHIP, and I might add that for those who keep talking about the stigma associated with Medicaid and welfare, a study is about to be released which is going to essentially point to the fact that the so-called stigma relates to where these people have to go to enroll and how they are treated. That stigma disappears when they can enroll at a provider site or at a community-based site, such as what your legislation is recommending, closer to home, that knows the individual, cares for them both in a medical sense but also in a personal sense.

Ms. DEGETTE. Mr. Chairman, with your indulgence, would you mind if I asked Ms. Tavenner to also answer that question about the pregnant women?

Mr. BILIRAKIS. As long as she does so in a brief manner, please.

Ms. TAVENNER. I can be brief. I certainly think that working with pregnant women, getting them in prenatal care and seeing them through their pregnancy would reduce the complications of newborns. So yes, I would support it.

Ms. DEGETTE. Mr. Chairman, I would like to ask unanimous consent to enter into the record a letter dated July 18, 2000, from a number of groups, some who are here today, expressing support both for my legislation and also Congressman Whitfield's legislation.

Mr. BILIRAKIS. Without objection.

Ms. DEGETTE. Thank you.

[The information referred to follows:]

July 18, 2000

Honorable TOM BLILEY
Chairman
Committee on Commerce
U.S. House of Representatives
2125 Rayburn Building
Washington, DC 20515

DEAR CHAIRMAN BLILEY: The Medicaid Disproportionate Share Hospital (DSH) program is our nation's primary source of financial support for safety net hospitals that serve the most vulnerable Medicaid, uninsured and underinsured patients. At a time when the number of people without insurance continues to rise, and hospitals are losing billions of dollars caring for low-income patients, further cuts in DSH are ill-advised at best. That is why the undersigned hospital organizations strongly support legislation (H.R. 3698 and H.R. 3710) before the House Commerce Committee that would stop Medicaid DSH program cuts scheduled for 2001 and 2002.

We are also writing to announce the results of a new analysis that finds hospitals lose \$7.9 billion per year caring for Medicaid and uninsured patients. The analysis is based on the American Hospital Association survey data and was conducted by

The Lewin Group. The new analysis highlights that despite the DSH program, significant Medicaid payment shortfalls exist for safety net hospitals serving Medicaid and uninsured patients.

According to analysis:

- Hospitals lost \$7.9 billion in 1998 on Medicaid and uninsured patients (even factoring in state and/or local governments appropriations that fund indigent care);
- Over five years, the estimated payment losses to hospitals total almost \$40 billion;
- In 1998, on average, hospitals received 84 cents in Medicaid revenue and tax appropriations for every dollar it cost them to care for Medicaid and charity care patients. This is the lowest payment-to-cost ratio for any payer, including Medicare and . . .

Protecting federal DSH allotments from reductions beyond FY 2000 levels, and permitting federal DSH growth, does not completely fill the payment gap between what Medicaid programs pay hospitals and the costs these hospitals bear caring for Medicaid and uninsured patients. However, it will provide substantial relief for many struggling safety net hospitals. We urge the House Commerce Committee to report legislation introduced by Congressmen Whitfield and Bilbray and Congresswoman DeGette to stop the scheduled reductions in FY 2001 and 2002 in the Medicaid DSH program and prevent further losses for hospitals treating our most vulnerable Americans.

Sincerely,

AMERICAN HOSPITAL ASSOCIATION; ASSOCIATION OF AMERICAN MEDICAL COLLEGES; CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES; FEDERATION OF AMERICAN HEALTH SYSTEMS; NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS; NATIONAL ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS; NATIONAL ASSOCIATION OF URBAN CRITICAL ACCESS HOSPITALS; PREMIER, INC.; AND VHA, INC.

Mr. BILIRAKIS. I would like to say to the gentlelady here publicly that her legislation in this regard, who should quarrel against it? I should think none. But we are going to be faced with a limited amount of money to try to save what exists now and I am not sure that we are going to be looking at brand new types of benefits, that sort of thing, so—

Ms. DEGETTE. If the gentleman will yield just for one moment, let me just assure you, my legislation is very fiscally conservative, even more fiscally conservative than some others, and I do not think it gives new benefits. I hope you will—

Mr. BILIRAKIS. Well, from a preventative standpoint, I mean. I have made that argument many times in the past, and unfortunately, with CBO, it does not carry very far. But in any case, we will talk about that.

Mr. Burr to inquire.

Mr. BURR. Thank you, Mr. Chairman. I do not know whether to take a minute or to try to take 30 minutes because I think every member could go one way or the other. I think we all have a pretty good idea of what we need to do. The realities are, we do not have enough money to do it.

But Mr. Brown raised a very good point, and I would tell you that my answer would be slightly different than his conclusion when he talked about the promises. What we have done is we have over-promised as a Congress. We made people believe that, in fact, we could produce a dollar's worth of services for 85 cents and this would be never ending, and the fact is that it cannot. We talked about it earlier in the first panel, that this insane health care system that we have got right now, its reimbursements are based upon historical cost.

Well, you know, try to tell historical costs to the future of health care. We will all pay the same thing for what technology supplies us, and that is the reason that we cannot figure out this transition

that we are going through. It is the reason that you cannot produce a formula that will take into account for home care the spike for 6 months of a 100 percent increase in gasoline costs and GAO will not figure that in when they try to figure out where the profit or loss is in a particular industry.

And it is insane, but just think about it. We sit here and talk about GAO and CBO and PPS and IPO and IPS and HCFA and HHS. We just made it too damn complicated, and unfortunately, with every attempt to fix it, and they are all good intentions—mine are better, but Mr. Brown's are good, too—we are all well-intended, but you are exactly right. What we have a tendency of doing is moving a little further out the uncertainty that exists today. My hope, and I wish we could have gotten the first panel to say, yes, you should do away with the 15 percent for home health. It should not be there. There is no way for private sector companies to run with that type of knife hanging over their head if you expect anybody to invest today, much less in the future of businesses.

Long-term care is the greatest example. I think it is the one area that this Congress has not paid enough attention to, because we know the demographics in this country. If you understand those demographics, we have to start today with the bricks and mortar to supply enough facilities to meet the need 10 years down the road.

Mr. Richtman, if you are talking about the preservation of Social Security and Medicare, then long-term care is in there somewhere with the people that you are here representing, and if you are not an advocate out there saying, we need to make long-term care predictable, we need to make sure that the financial markets look at this, not as a place to flee from but as a place to invest in, then we have made a real mistake and you have made a real mistake and your association has.

Let me get to some specific questions, because I think I could keep this up really all day. I think our whole attempt is to try to address some short-term problems and to begin to bring some predictability to every one of the sectors that are represented here. I hope that when we complete it, we can look back and say, we are not there but we have accomplished a few things that we needed to accomplish.

Let me go to you, Mr. Hawkins. GAO kept referring to the fact that we had to get away from cost-based reimbursements, and, in fact, the Safety Net Preservation Act is to move to a prospective pay system. Would you please elaborate on that just a little bit?

Mr. HAWKINS. That is right. I am so glad that you raised that, because as I heard that this morning, we have got to move away from cost-based, my reaction was, well, that is exactly what the Safety Net Preservation Act does. Not only does it do that, however, it also provides the stability that you just referred to and some equity in the form of a payment mechanism. It sets a floor. It allows State flexibility.

And, by the way, it is amenable. If at some future point health centers are found to be overpaid, it is amenable to adjustment because it basically sets a rate for the first year and then calls for an adjustment thereafter based on a cost-of-living adjustor, the Medicare Economic Index, which is in law. It is the same mechanism that is used to adjust other primary care payments, and when

you look at other PPS systems, they can then be adjusted back downward for MEI minus 1 percent or minus 2 percent, or perhaps the MEI is not going to be sufficient.

I guess my thought was when I heard Mr. Scanlon say that this morning, but you can move to provide permanent, fair, stable, common sense relief through the Safety Net Preservation Act. You do not have to wait for that GAO report. First of all, you have three other reports out there on the street in the last 3 months alone, the Institute of Medicine, an earlier GAO report, and one by the Kaiser Commission on Medicaid and the Uninsured, all of which have said that cutbacks in Medicaid payments are hurting already and seriously and negatively affecting health centers' ability to care for the growing numbers of uninsured and relief is needed. The Safety Net Preservation Act does that without necessarily going back to 100 percent cost-based reimbursement, and that is why it meets all those tests.

Mr. BURR. I appreciate that. I will make sure to send that statement to Mr. Scanlon just to clarify it for him.

Mr. Richtman, let me ask you something from the standpoint of who you represent and the interest that I think we would all agree with. Specifically as it relates to the outpatient PPS issue with hospitals, what effect would a delay have on the implementation of that, if any, on your beneficiaries?

Mr. RICHTMAN. Well, we feel, of course, our beneficiaries are already paying a lot of out-of-pocket costs and are not in a position to pay even more. One fact or figure that I heard recently was kind of astounding, that today, and this looks at a lot of out-of-pocket costs, but today, a Medicare beneficiary on average pays out-of-pocket health care costs as a percent of their income at a higher cost than before we even had Medicare. On average, a Medicare beneficiary is paying more for health care as a percent of his or her income out of pocket than before we had the Medicare program.

Mr. BURR. I remember when I was sworn in as a Member of Congress just 6 long years ago that wonderful health care plan, Mr. Chairman, that I heard that all Members of Congress had was, in fact, the same one I had in Winston-Salem when I worked for a company with 50 employees. There was only one big difference, that the same family plan that I paid \$72 for with the company paying 75 percent and me paying 25 percent for, when I became a Member of Congress it now cost me \$142 for the same coverage.

I very quickly called the president of the insurance company—I felt that as a Member of Congress, I could do that now—and I asked him, I said, you know, I am getting the same coverage and it went from \$72 to \$144 and he laughed and I said, what is so funny? He said, "Congressman, never let the Federal Government negotiate your health care."

Now, I am proud to tell you that it has worked its way down over those 5½ years, but that statement has never left me.

Mr. Chairman, if I could for just a second—

Mr. BILIRAKIS. Well, you are already almost 4 minutes over.

Mr. BURR. I appreciate the indulgence of the chair.

Mr. BILIRAKIS. Without a unanimous consent request, I might add, but go ahead very quickly so we can finish.

Mr. BURR. One of the challenges that we have is to make sure that we have a health care system in total that is ready to handle the great changes and the great opportunities that will come in pharmaceuticals, in devices, those that will be used every day at the hospitals, that will be used at the community health centers, they will be used in home care. One of the questions I had to ask, if there is not home care, where do these people go? They stay in the hospital. It is more expensive.

I mean, we try to sort of hide our head in the sand and say we do not know the answer. We do know the answer. That is the reason that we created this segment of health care and now we sort of run from it because, gosh, people use it. It grows too fast. Well, whatever we create, there are going to be people there to game the system.

I would only hope to say to each of you that as we begin to hopefully put some of these fixes back in, that you will work aggressively to make sure that we find the right balance, that we do not go too far, and that, in fact, you help us with the structure of it so that this system of health care in this country is able to handle the technological changes that come in devices and pharmaceuticals and in care, because if we cannot, then, in fact, we will flunk on that promise of supplying the best health care system available in the world.

Mr. BILIRAKIS. And I would add to that, that we are really in an ivory tower. We make these decisions up here, and with the exception of a couple of physicians that we have on this subcommittee, we do not have the practical knowledge, practical experience. Unfortunately, that is when these unforeseen consequences, unintended consequences take place.

So your help, not only today but your continuing help is so important. We worked awfully hard on trying to undo somewhat BBA 1997. Did we get adequate support, adequate honest type of inputs from you all, from the industry? I am not sure. The industry would say, hey, do not cut us at all, in effect.

So, basically, we are going to tie this all up now and thank you. I would ask you if you would be available to respond to written questions that might be submitted to you and do it within a relatively short period of time, because hopefully this is on a fast track. I know we all want to see that. And in the process, let us not approach it from the standpoint of, hey, we want all the money back, all right? It is not going to happen. It just is not going to happen. So approach it from a realistic, practical understanding that we have a tough job to do up here. It is a job that we created by virtue of the unintended consequences in BBA 1997. So, hopefully, we can do a little better this time around.

Thanks so very much for being here. This hearing is adjourned. [Whereupon, at 3:47 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
July 17, 2000

The Honorable MICHAEL BILIRAKIS
2369 Rayburn House Office Building
Washington, D.C. 20515

Re: Modifications to the Balanced Budget Act of 1997

DEAR CONGRESSMAN BILIRAKIS: As Congress reviews various proposals to reverse certain restrictions on funding to hospitals, nursing home facilities and home health providers from the Balanced Budget Act of 1997 (BBA), I would like to share with you our concerns in these areas and ask your support for certain important modifications this year. They include:

- Freezing Disproportionate Share Hospital (DSH) cuts at F/Y 2000 level;
- Restoring funding to skilled nursing facilities; and
- Increasing home health provider payments.

Freezing Disproportionate Share Hospital Cuts:

Florida's safety net hospitals that provide critical in-patient care for the uninsured and under-insured have been particularly affected by BBA reductions. State disproportionate share hospitals have experienced significant cuts since fiscal year 1998. Additional cuts of \$46 million are slated through fiscal year 2001, for a total Florida reduction of \$80 million over five years. Freezing these DSH cuts at the fiscal year 2000 level, as proposed in various House and Senate bills, would preserve important health care delivery systems and maintain \$46 million of critical funds within our communities.

Three of Florida's teaching hospitals serving large populations of the poor (Jackson Memorial in Miami, Shands Jacksonville, and Tampa General Hospital) rely upon disproportionate share funding. These facilities are committed to a three-fold mission of patient care, medical education, and research. In addition, they are engaged in highly specialized, state-of-the-art care, which is delivered to residents from throughout the State. These hospitals provide trauma care, burn treatment, neonatal and family care, and organ transplantation services to all Floridians. Developed and delivered through these vital DSH funds, these services save lives, reduce traumatic injuries and complications from strokes, and return people to their lives sooner and healthier.

Skilled Nursing Facilities and Home health Providers Payments:

Other critical health areas that are emerging as fragile systems requiring repair from the BBA include Florida's nursing homes and home health providers. As you know, concern for the viability of our nursing homes is the focus of a statewide review by a Long-term Care Task Force chaired by Lieutenant Governor Brogan. They will be considering issues related to our elderly in nursing homes and alternative care arrangements. Restoring funding to skilled nursing facilities, and increasing home health provider payments—providing home care choices for our elders—would offer some important assistance as we seek comprehensive solutions to address future viability of these critical industries.

To avoid potential declines in access to health care and to address deteriorating financial conditions, which are accumulating in Florida's hospitals and nursing home, I urge your assistance in modifying the BBA before Congress adjourns. Thank you for all you do to strengthen our communities, and assure all Floridians quality of care.

Please feel free to call on me, or our Florida/Washington office at (202) 624-5885, for any additional information on these timely and important issues.

Sincerely,

RUBEN J. KING-SHAW, JR.
Secretary

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION FOR HOMECARE

The American Association for Homecare is pleased to submit the following statement to the Subcommittee on Health and Environment for House Commerce Committee. The American Association for Homecare is a new national association resulting from the merger of the Home Care Section of the Health Industry Distributors Association, the Home Health Services and Staffing Association and the National Association for Medical Equipment Services. The American Association for Homecare is the only association representing home care providers of all types:

home health agencies and home medical equipment providers, be they not-for-profit, proprietary, facility-based, freestanding or governmentally owned.

WHAT IS A HOME HEALTH AGENCY?

Home Health Agencies provide skilled nursing care, therapy and home health aide services to individuals recovering from acute illnesses and living with chronic health care conditions. Health care services in the home setting provide a continuum of care for individuals who no longer require hospital or nursing home care, or seek to avoid hospital or nursing home admission. The range of home care services includes skilled nursing; respiratory, occupational, speech, and physical therapy; intravenous drug therapy; enteral feedings; hospice care; emotional, physical, and medical care; assistance in the activities of daily living; skilled assessments; and educational services.

WHAT IS AN HME PROVIDER?

Home medical equipment (HME) providers supply medically necessary equipment and allied services that help beneficiaries meet their therapeutic goals. Pursuant to the physician's prescription, HME providers deliver medical equipment and supplies to a consumer's home, set it up, maintain it, educate and train the consumer and caregiver in its use, provide access to trained therapists, monitor patient compliance with a treatment regimen, and assemble and submit the considerable paperwork needed for third party reimbursement. HME providers also coordinate with physicians and other home care providers (e.g., home health agencies and family caregivers) as an integral piece of the home care delivery team. Specialized home infusion providers manage complex intravenous services in the home.

HOME CARE IS JUST BEGINNING

Over the last two decades, advances in medical technologies and changes in Medicare's payment structure have spurred a considerable growth in the use of home care. 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 microchip computer technology in implantable devices used to dispense critical medication, technology makes it possible for the care received in the home to equal or exceed that received in a hospital, at a fraction of the cost. Today, it is common for a Medicare beneficiary to undergo chemotherapy in the comfortable surroundings of his or her own home, an advance 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 health care provided 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, the Health Care Financing Administration'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 access home health services. At roughly the same time, Medicare instituted a prospective payment system for hospital inpatient care, 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 increasingly complex health services. All indicators show that as the 'baby-boomers' continue to age, this trend will continue. The American Association for Homecare believes that the increased utilization of home health care prompted by these changes should be seen as a rational response to the changing needs of Medicare beneficiaries and the increased ability of home health providers to meet these needs.

HOME CARE IS ECONOMICAL

Importantly, home care is not only patient-preferred, it is also cost effective. Numerous studies have shown that home care providers are a cost-efficient component of the healthcare delivery system, as they help keep beneficiaries out of costly inpatient programs. One study, conducted by an independent research organization, particularly demonstrates these savings. This study, *The Cost Effectiveness of Home Health Care*, examines the highly successful In-Home/CHOICE program instituted by the State of Indiana in 1985. Indiana provides 100% of the funding for this pro-

gram, which covers the costs of home health care for qualified residents in need of long term care in order to prevent institutionalizations.

The authors of the Study note that the coming crisis in health care funding for America's rapidly growing elderly population could be alleviated by home health care programs such as Indiana's. By avoiding institutionalized care, Indiana was able to reduce inpatient caseload costs by 50% or more, while allowing patients to receive care in the comfort of their own homes. The cost savings associated with this increased reliance on home care were considerable. The study states that home care for the elderly in Indiana can be provided for one half the cost of skilled nursing facility care. Similar care for the disabled costs 1.5 times more in a skilled facility than in the home. In addition, the quality control and screening procedures used in the Indiana program have successfully avoided problems with fraud and abuse. The Hudson Institute Study concludes that "Properly crafted and administered, home health care can play a critical role in helping society meet the looming health care needs of the 'Baby Boom' generation."

CONCLUSION

Home health care continues to evolve and expand to meet the increasingly complex needs of today's Medicare beneficiaries. By capitalizing on technical innovation, home care providers can conduct increasingly complex medical and therapeutic regimens in the comfort of beneficiary's own homes. In addition, recent studies have shown that an expanded home care benefit would reduce Medicare expenditures by avoiding costly institutionalizations. We urge the Committee to recognize the many benefits of home care by strengthening Medicare's commitment to the home health benefit.

PREPARED STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION

The American Hospital Association (AHA), on behalf of our nearly 5,000 member hospitals, health systems, networks, and other providers of care, appreciates this opportunity to tell you first hand the dramatic impact of the Balanced Budget Act of 1997 (BBA) on America's hospitals and health systems.

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

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

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

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

Rural hospitals have been especially victimized by BBA Medicare and Medicaid spending cuts. An independent analysis by the University of Washington's Rural Health Research Center in Seattle concluded that, for rural hospitals, the BBA's cut "will sharply escalate in intensity and affect a wide range of the services they provide to Medicare beneficiaries. These hospitals will have to cut services to survive."

The study looked at six small, rural hospitals in separate states. The BBA's effect on them:

- Two rural health clinics had been closed.
- One that was scheduled to open never did.
- The hospitals' home health agencies can't take as many patients because of payment limits.
- Access to physical, occupational and speech therapy has declined at all the sites studied.

Across the country, hospitals are struggling. Services are being cut and facilities are being impacted:

- For Wilkes-Barre General Hospital in Wilkes-Barre, Pennsylvania, BBA Medicare and Medicaid spending cuts have forced the hospital to make some tough decisions... like eliminating a diabetes center; health promotion programs; geriatric

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

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

THE CASE FOR BBA RELIEF 2000

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

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

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

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

The cost of prescription drugs has increased dramatically. The average price for new drugs is about \$71, more than twice the average price for previously existing drugs. New and more expensive drugs are constantly emerging, replacing older drugs and increasing the overall use of drugs in patient care. Yet, only a fraction of the cost of new drugs is included in the inflation measurement the government uses to calculate hospital payment updates.

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

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

The economic outlook is so grim, that financial experts are losing confidence in what has historically been a fairly stable industry. Moody's Investor Service reports

that downgrades in bond ratings for hospitals were the most ever in 1999, outpacing upgrades 5-1. And this month, Moody's reported that the 2000 financial picture is not improving. In fact, the rating agency warned that the amount of debt affected by downgrades in 2000 may be on course to actually exceed the total amount of debt downgraded for 1999. A poor financial prognosis means it costs hospitals more to borrow and invest in the people, technology and infrastructure necessary to keep pace.

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

The Medicaid DSH program is the primary source of financial support for safety net hospitals that serve the most vulnerable citizens. Without this important funding source, these hospitals would be incapable of providing adequate access to health care for many of these patients.

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

WHAT OTHERS ARE SAYING

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

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

Also, a recent analysis of 1998 data from the American Hospital Association survey, by the Lewin Group, found that hospitals lost \$7.9 billion on Medicaid and uninsured patients. Over the next 5 years, the estimated payment losses to hospitals will total almost \$40 billion. In 1998, on average, hospitals received 84 cents in Medicaid revenue and tax appropriations for every dollar it cost them to care for Medicaid and charity care patients. This is the lowest payment-to-cost ratio for any payer, including Medicare and commercial insurers.

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

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

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

BBA RELIEF 2000

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

Indeed, Washington has taken notice and the momentum for BBA relief is growing. The AHA is pleased to cite that 217 representatives have cosponsored the Medicaid Preservation Act (H.R. 3698/3710), legislation to prevent further reductions in the Medicaid disproportionate share hospital (DSH) program. Similar legislation in

the Senate is also gaining support with 24 senators cosponsoring Medicaid DSH relief (S. 2299/2308).

The AHA is also asking Congress for relief, including:

- For all hospitals, repeal of the last two year's of the BBA's inpatient market basket reductions;
- For rural hospitals, a package of relief that would include: equalizing the qualification threshold for payments to rural hospitals under the Medicare disproportionate share (DSH) program; improving flexibility for Medicare critical access hospital program; updating current rural payment classification systems; providing a payment adjustment for rural ambulance providers; and several technical changes for rural hospital services; and
- For teaching hospitals, continuation of the current adjustment for indirect medical education of 6.5 percent;

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

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

PREPARED STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION

We appreciate the opportunity to provide this written statement to the Subcommittee concerning the American Medical Association's (AMA) recommendations as the Subcommittee moves forward in its consideration of amendments to the Balanced Budget Act of 1997 (BBA).

The BBA imposed tremendous cuts in Medicare payments for various medical services. Although these provisions required regulatory implementation, the Health Care Financing Administration (HCFA) has imposed massive amounts of burdensome regulatory requirements on the physician, provider and beneficiary communities beyond what Congress had ever intended. Some of these BBA provisions or their implementing regulations have adversely impacted or threaten to have such impact on Medicare patient access to and quality of care. Thus, certain BBA "fixes" are needed to ensure that these results do not continue to plague beneficiaries.

Accordingly, the AMA recommends that the Subcommittee approve the following amendments to the BBA:

Health Care Financing Administration (HCFA) Reform

The AMA recommends that the Subcommittee include in any BBA-reform package provisions to (1) ensure that HCFA and its carriers devote the proper level of resources to educating physicians concerning Medicare coding, billing and documentation requirements and (2) reform HCFA's post-payment audit process.

As discussed above, HCFA, under the BBA, has imposed on physicians an overwhelming amount of burdensome regulatory requirements. As we recently testified before this Subcommittee, physicians must comply with over 100,000 pages of complex regulations. Although HCFA expects physicians to understand all of these regulations, notices, fraud alerts, and program memoranda, the agency does not adequately educate physicians, especially with regard to Medicare billing requirements. Indeed, physicians cannot receive written consistent and clear answers from their carriers regarding coding, documentation and coverage issues.

Further, HCFA contractors have been sending post-payment review letters to physicians, which require the physician to submit to invasive, protracted and expensive government audits in order to preserve his or her due process rights. In these post-payment review letters, HCFA contractors are identifying possible billing errors from a small batch of claims and using these possible errors to "extrapolate" enormous overpayment amounts from physicians, suppliers and providers. During this process, many HCFA contractors have no direct, face-to-face communication with the physician, supplier, or provider who frequently have difficulty obtaining answers from the carrier regarding their audit.

Many physicians are opting to retire or to no longer see Medicare patients, rather than deal with the HCFA/carrier hassles and possibly undergo costly and lengthy post-payment audits. This threatens patient access to care—especially in rural areas—which, in turn, affects quality.

Accordingly, we urge the Subcommittee to ensure that any BBA-reform legislation requires HCFA to remedy its over-zealous regulatory approach to implementation of the BBA, especially with respect to the agency's phy-

sician and provider education process as well as its post-payment review enforcement activities.

HHS Accountability for Regulatory Costs

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

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

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

Loan Deferment for Residents

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

The Medicare cuts imposed on the health care industry under the BBA have economically drained the system and have made it even more difficult on medical residents who generally are not paid enough to make ends meet, especially when they are required to re-pay enormous amounts on their student loans during their residency.

Currently, under the Higher Education Act, there is a very strict formula based on "economic hardship" for determining whether a student can get a loan deferment. This formula is much too narrow to be effective, and many medical residents who legitimately need a loan deferment for economic reasons fail to qualify. By the time medical students begin their residency programs, which are generally four or more years in duration, they must begin to repay their medical school loans, yet they typically are not paid enough to make ends meet. Last year's national average gross annual salary for first-year residents was about \$34,000.

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

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

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

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

PREPARED STATEMENT OF THE AMERICAN MEDICAL REHABILITATION PROVIDERS
ASSOCIATION

Mr. Chairman: This statement is submitted on behalf of the American Medical Rehabilitation Providers Association (AMRPA). AMRPA is the national trade association representing approximately 325 freestanding rehabilitation hospitals, rehabilitation units in general hospitals, and other outpatient rehabilitation providers. The majority, if not all, of our members participate in the Medicare program. For rehabilitation hospitals and units, Medicare accounts for approximately 70% of all discharges and revenues. Therefore, even temporary changes in Medicare reimbursement can threaten the security of a great number of facilities and consequently, the patients we serve.

BACKGROUND

Rehabilitation hospitals and units provide medical care and various therapies to patients who, because of disease, injury, stroke or similar incidents, have impairments in their ability to function, either physically or cognitively. Our goals are to help them regain their maximum level of functional capability and to return them to independently living in their own homes. More than 80% of patients admitted to rehabilitation hospitals and units return to their homes, in spite of the fact that many have experienced severe disabilities. Many of the conditions producing the need for rehabilitation are associated with aging, a significantly high percentage of patients in rehabilitation hospitals and units are covered by the Medicare program. In 1997, over 70% of patients admitted to such facilities were covered by fee-for-service Medicare. Accordingly, the policies of the Medicare program largely determine the availability and quality of rehabilitation services. And, there is little room for error.

Rehabilitation hospitals and units are currently reimbursed for providing Medicare services under a payment methodology mandated by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). This arrangement, which was intended to be temporary, reimburses facilities on the basis of reasonable cost, subject to a payment ceiling (known as the "TEFRA limit").

Over time, this system developed a number of negative incentives, which led the industry to advocate for implementation of a prospective payment system (PPS) for inpatient rehabilitation facilities. In recognition of the need to modify payment methodology, in the Balanced Budget Act of 1997 (BBA 97), Congress enacted a PPS for inpatient rehabilitation to be implemented over two years, starting with cost reporting periods beginning on or after October 1, 2000. BBA 97 calls for a 2% reduction in total expenditures for rehabilitation services from that which would have been spent absent the PPS. It also included several provisions aimed at reducing costs during the transition period until full PPS implementation. These included a 15% cut in inpatient capital reimbursement and reductions in bonus incentive payments and the TEFRA limits.

These interim measures, imposed by the BBA and intended to reduce Medicare costs during the period prior to PPS implementation, now threaten the financial security of the nation's rehabilitation providers as well as the access to services relied upon by rehabilitation patients.

Earlier this year, the Health Care Financing Administration (HCFA) announced that it is delaying the implementation of the rehabilitation inpatient PPS until cost reporting periods beginning on or after April 1, 2001. Since HCFA has not yet promulgated the rehabilitation PPS rulemaking, this timeline is now highly questionable. These significant delays in the development of the PPS system render it unlikely that facilities will begin the transition to the PPS until the end of 2001, more than a year later than originally planned.

Overall Medicare outlays for services delivered by rehabilitation hospitals or units have been reduced by more than \$600 million over three years. And although rehabilitation spending comprises just 2.3% of total Medicare spending, rehabilitation hospitals and units have been forced to absorb almost 4.3% of BBA 97 spending reductions. Moreover, the sought-after cost reductions have already been realized. The Medicare Payment Advisory Commission's (MedPAC) June, 2000 Report to Congress, for example, noted that from 1997 to 1998, Medicare margins for rehabilitation facilities decreased from 6.3% to 1.8%.

The financial impact of the delayed implementation of the PPS and the realization of Medicare cost savings that were the impetus for the reimbursement changes, as well as the creation of a national budget surplus, make imposition of further financial burdens on the rehabilitation sector both unnecessary and especially risky. Congress should take action to ensure both the short-term financial stability of the rehabilitation hospital industry prior to the implementation of the rehabilitation PPS

and the long-term financial capability of rehabilitation providers to offer care to an aging population that will increasingly need its services.

I. Congress Should Ensure the Continuing Availability of Rehabilitation Services Through Elimination of the 2% Reduction in Total Payments and a Temporary 1% Increase in Incentive Payments.

BBA 97 reduced both the total expenditures for inpatient rehabilitation services under the PPS and changed the current payment methodology, including the bonus incentives payments, that previously had been used to encourage and maintain the most efficient provision of services. As implementation of the rehabilitation PPS continues to be delayed, these changes to the TEFRA payment system continue to contribute to the overall decline in the financial stability of the rehabilitation hospital industry.

Section 4421 of the BBA 97 mandated that, in setting the rehabilitation PPS payment rates, the HHS Secretary reduce total expenditures for inpatient rehabilitation services by 2% from what these would have been absent a PPS. Thus, in determining the rates to be paid under the rehabilitation PPS for FY 2001-02, only 98% of the total amount that otherwise would be paid under TEFRA is to be taken into account. In light of the significant reductions in Medicare spending for rehabilitation services since enactment of the BBA, the additional 2% reduction in FY 2001-2002 reimbursement could devastate an industry already trying to cope with the fiscal restraints resulting from BBA 97 initiatives.

The long-term financial security of the rehabilitation hospital industry would be bolstered substantially by elimination of this reduction. The scheduled reduction was originally enacted as part of the overall BBA 97 effort to obtain savings under the Medicare program. Clearly, as demonstrated by Medicare reimbursement reductions for rehabilitation facilities, BBA 97 savings have already been achieved. Thus, there is no longer any reason for Congress to require this additional reduction in rehabilitation PPS reimbursement, particularly when one considers the additional hardship that it will induce.

Additionally, the BBA 97 imposed several cost-savings measures. These included reduction of bonus incentive payments, the program under which PPS-exempt hospitals and units, including rehabilitation facilities, were eligible to obtain an incentive payment that was the lesser of 50% of the difference between their costs and the TEFRA limit, or 5% of the limit. Section 4415 of the BBA 97 reduced the applicable percentages to 15% and 2%, respectively. The negative effect of this provision was further compounded for facilities that had TEFRA caps lowered to the 75th percentile under another BBA 97 provision. The industry estimates that, as a result of these two provisions, the rehabilitation hospital industry lost approximately \$144 million in payments in one year (based on FY 1997). A modest, yet significant, restoration in the form of a 1% increase in bonus payments until full implementation of the rehabilitation PPS would help to alleviate interim financial concerns and restore a more meaningful incentive to increase productivity.

II. Until the PPS System is Fully Implemented, Congress Should Restore Full Capital Payments for PPS-Exempt Rehabilitation Hospitals and Units.

Because rehabilitation facilities and other PPS-exempt providers are reimbursed on a cost basis, Congress previously exempted them from capital cuts. The rationale for full reimbursement of capital for providers under cost reimbursement is that such providers have no opportunity to make up for the loss of capital payments through operating efficiencies. If costs go down, so does reimbursement. Section 4412 of the BBA changed this. It imposes a 15% reduction in capital payments for PPS-exempt (TEFRA) hospitals and units for FY 1998-2002. This reduction in capital payments was not driven by policy considerations, but instead was implemented solely for budgetary reasons.

As noted above, rehabilitation providers are heavily dependent on Medicare fee-for-service, which covers 70% of rehabilitation admissions and an equally high percentage of revenues. By comparison, other PPS-exempt hospitals (e.g., psychiatric, children's) are far less Medicare-dependent. As such, the capital payment reductions to PPS-exempt hospitals have a comparatively greater detrimental impact on the renovation of plants and the building of more modern facilities by rehabilitation hospitals than by other PPS-exempt hospitals.

In terms of precedents, capital payments to acute care hospitals were decreased with implementation of the acute care PPS only after four full years, and only gradually over time. This progressive implementation initially included a 3.5% cut in FY 1987, with gradual increases to 15% in FY 1989. Rehabilitation providers are being forced to absorb capital reimbursement cuts much more quickly than were acute care hospitals.

A 15% cut in capital reimbursement costs PPS-exempt providers at least \$62 million in one year alone. If capital and bonus incentive payments are not restored in the short run, all rehabilitation providers will continue to receive payments below cost. Therefore, Congress should restore full capital payment for PPS-exempt rehabilitation hospitals and units.

III. Congress Should Permit an Early Opt-In to Inpatient Rehabilitation PPS.

Under BBA 97, the inpatient rehabilitation PPS will be implemented gradually over a two-year period. During the transition, facilities' payments will be calculated using a combination of TEFRA payments and new PPS payments. In year one, these payments will consist of the aggregate of two-thirds of a facility's TEFRA payments and one-third of its PPS payments; in year two, facilities will receive payments based on one-third TEFRA and two-thirds PPS. By the third year, all facilities will be paid 100% under the inpatient rehabilitation PPS.

As noted above, the inpatient rehabilitation PPS was originally intended to go into effect for cost reporting years beginning on or after October 1, 2000. HCFA announced earlier this year that it is delaying implementation of the system until cost reporting periods beginning on or after April 1, 2001. Since HCFA has not yet promulgated the rehabilitation rulemaking, this timeline is now highly questionable. Because most facilities' cost years start later in the year, many facilities will not begin the transition until the end of 2001 or even later, depending on the final implementation timeline.

While the transition period remains extremely important for many rehabilitation facilities, some facilities believe that they can continue to provide high quality, cost-effective care while moving directly to full PPS in the first year. In fact, these facilities perceive that trying to live under two payment systems for two years—TEFRA and PPS—could lead to conflicting payment and service delivery incentives. It is important to ensure, however, that rehabilitation facilities which are not interested in taking an early election to full PPS retain the ability to transition to full PPS over a two-year period.

Permitting immediate movement to full PPS would reward facilities able to revise their costs and service delivery patterns quickly to meet or come in under their PPS limits. Congress provided such an election for the skilled nursing facility PPS, including necessary funding, in the Balanced Budget Refinement Act of 1999 (BBRA). Congress should look to this precedent and allow an early opt-in. This change would preserve facilities' continued financial viability, thereby furthering their capacity to carry out their primary mission, the delivery of care to persons with disabilities.

CONCLUSION

AMRPA believes that patients' continuing access to quality rehabilitation services is currently at risk. The confluence of reductions in total payments for services, including reductions in bonus incentives and capital payments, coming on the heels of dramatic decreases in Medicare margins for rehabilitation services already have resulted in huge losses for the rehabilitation hospital industry. With the following actions, Congress can provide vital relief for rehabilitation facilities and preserve the ongoing availability of rehabilitation services for the nation's increasingly aging population:

- 1) Congress should ensure the short-term financial stability of the rehabilitation hospital industry prior to the implementation of the rehabilitation PPS by increasing the incentive payment by 1%, and ensure the industry's long-term financial stability by eliminating the 2% reduction in the total amount to be paid under the PPS for FY 2001-2002.
- 2) Congress should restore full capital payment for PPS-exempt rehabilitation hospitals and units.
- 3) Congress should permit an early opt-in for those rehabilitation facilities able to more quickly adopt Congress' plan.

In addition to the above priorities, AMRPA supports a three-year extension of the moratorium on outpatient therapy caps. These caps, imposed by the BBA 97, bear no relationship to patients' clinical needs. The current moratorium, instituted by the BBRA in response to the expressed concerns of patients and providers, applies to calendar years 2000 and 2001. This, however, is unlikely to provide HCFA with sufficient time to adequately research and develop appropriate mechanisms to replace the arbitrarily derived limits on beneficiaries' access to needed rehabilitation services embodied in the cap. An extension of the moratorium should provide HCFA adequate time to complete its studies and to develop methodologies that will control costs, while protecting patients' treatment needs.

We thank the Committee for this opportunity to submit testimony. AMRPA looks forward to working with Congress as we face the future.

PREPARED STATEMENT OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION

Mr. Chairman, members of the Subcommittee on Health and Environment, on behalf of the more than 68,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit this statement for your consideration as you examine the impact of the Balanced Budget Act (BBA) of 1997 on providers of health care services and the patients they serve. For the purpose of this hearing, APTA's testimony will focus on the impact the BBA and the Balanced Budget Refinement Act (BBRA) of 1999 have had on the delivery of outpatient physical therapy services under Part B of the Medicare program.

Many Americans will probably need physical therapy services at some time during their life. As people grow older, they may suffer a stroke, break a hip, or sustain other traumatic injury. Many of these illnesses and injuries occur unexpectedly and require physical therapy services, which enable people to return to home, to work, to school, or to an active retirement. If Medicare beneficiaries receive these services on a timely basis, they are able to obtain maximum independence and increase the quality of their life.

Recommendation

Under the current law, passed as part of the BBRA, the \$1,500 caps on outpatient rehabilitation services would be reimposed upon beneficiaries as of January 1, 2002, if Congress takes no action. This year, as Congress considers further legislation to address the impact of BBA provisions on providers and their patients, APTA strongly urges Congress to extend the moratorium on the \$1,500 therapy caps for an additional three years.

The Health Care Financing Administration (HCFA) has only just begun to collect data relating to the delivery of rehabilitation services in the various Part B practice settings. Given the move in January 1999, to the Resource-Based Relative Value Fee Schedule (RBRVS) for so many therapy providers and the imposition of the therapy cap moratorium in January 2000, APTA believes it would be wise for Congress to allow greater time for data collection and analysis of physical therapy utilization under Part B before new mechanisms to limit care are enacted into law.

Background

Both the BBA and BBRA have significantly affected the delivery of physical therapy services to Medicare beneficiaries. Prior to the BBA of 1997, Medicare reimbursement for physical therapy services under Part B varied between practice settings. Outpatient services provided in skilled nursing facilities, rehabilitation hospitals/units, home health agencies, comprehensive outpatient rehabilitation facilities (CORF), and rehabilitation agencies were reimbursed under a retrospective cost-based system. Physical therapists in private practice and physician offices have billed therapy services to Medicare under the RBRVS since 1992. Physical therapists in private practice had also been restricted to billing only \$900 of care per beneficiary in a given calendar year.

The BBA made significant changes to Medicare payment policies for rehabilitation services. Under the BBA, as of January 1, 1999, annual \$1,500 per beneficiary caps for physical therapy (including speech language pathology services) and for occupational therapy were imposed on Medicare beneficiaries requiring outpatient rehabilitation services. This represented a considerable reduction in reimbursement for all settings, except the private practice setting, that had been caring for those with the most serious conditions requiring long-term rehabilitation care (i.e. stroke, Parkinson's Disease, traumatic brain injury, hip replacement). At the same time, the BBA required all Part B providers to begin billing Medicare under the RBRVS system.

These drastic changes sent shockwaves through the rehabilitation community, leaving providers confused on how to comply with the new law and how to instruct their patients to receive necessary care. The changes also left patients confused about what their Medicare benefits actually were.

APTA has long opposed arbitrary limitations on care for beneficiaries. The Association challenged that the \$1,500 caps would not allow some patients with significant rehabilitation needs to receive appropriate coverage for care. The ability of Medicare beneficiaries to receive the necessary physical therapy services under the \$1,500 limit was further exacerbated by Congress' action to group speech-language pathology with physical therapy under one \$1,500 cap.

In its June report to Congress, the Medicare Payment Advisory Commission (MedPAC) stated that in 1996, *“Physical therapy accounted for 70% of outpatient therapy payments. Occupational therapy and speech pathology made up 21% and 9% of payments, respectively.”* The impact on patient care caused by combining physical therapy and speech therapy within one cap is self evident given these utilization numbers. Physical therapists were saddled with difficult decisions on how to treat a patient with significant rehabilitation needs under a payment policy that was inflexible.

MedPAC analyzed the impact of the coverage limits and presented the results of its analysis in its June 1998 report to Congress. MedPAC examined the 1996 claims of patients treated in rehabilitation agencies and CORFs who incurred payments that exceeded the \$1,500 coverage limit. The Commission found that approximately 1/3 of patients in rehabilitation agencies and CORFs exceeded either \$1,500 of outpatient physical and speech therapy or \$1,500 of occupational therapy. MedPAC also found that some types of patients were more likely to exceed the dollar limits. For example, half of the stroke patients served in these settings exceeded the \$1,500 cap.

During the 1997 Medicare debate, APTA argued that the caps would disrupt the continuum of care, particularly since Congress chose not to impose the therapy caps on outpatient hospital departments. APTA argued that patients would be forced to change treatment settings once the cap had been reached in a non-hospital setting and that it would disrupt their progress toward rehabilitation. In fact, APTA members made the Association aware of advertisements published by hospitals letting seniors know that only in their outpatient clinics could they be assured of receiving the necessary therapy they required, since other practice settings were capped at \$1,500 per year.

Rather than saving money for the Medicare program, the therapy caps merely redirected patients to receive care in an outpatient hospital department. APTA argued that the only money that is saved by this policy is for those beneficiaries who deny themselves appropriate care. In fact, this policy increases the cost of care to seniors by forcing them to pay for care out of pocket once the cap had been reached if they wished to stay with their chosen physical therapist.

As was expected, some beneficiaries complained to their physical therapist that they experienced great difficulty obtaining access to needed services, because they did not live near a community with an outpatient hospital clinic that provided physical therapy care.

APTA also argued that the \$1,500 caps would be difficult to administer. Even before the Y2K problems of the Health Care Financing Administration (HCFA) became apparent, it was clear that tracking a beneficiary's care from practice setting to practice setting would be an impossible task. For example, a physical therapist in private practice would have difficulty determining whether a beneficiary has already received \$1,500 of outpatient therapy services in another setting during a given calendar year. In addition, if the beneficiary resided in Michigan for part of the year and in Florida for the remainder, it would be difficult for either setting to know that the beneficiary had already received services in another state.

In 1999, Congress took appropriate action as part of the BBRA to suspend the \$1,500 caps on therapy services to ensure that beneficiaries have access to necessary physical therapy services. Today, all Part B physical therapy services are billed to Medicare under a common fee schedule system. This will allow HCFA the opportunity to analyze care being provided across practice settings. APTA believes HCFA will find that arbitrary limitations on care are unnecessary to control utilization of services. However, HCFA must have the time necessary to make a complete evaluation of the system.

Thus, APTA strongly supports a three-year extension on the present moratorium and subsequent delay of pending reports to Congress relating to utilization of services and a potential new methodology for payment of rehabilitation services.

Thank you for your consideration of these comments. Please feel free to contact Patrick Cooney at (703) 933-0020 should you have questions regarding this statement.

PREPARED STATEMENT OF ASSOCIATION OF PERIOPERATIVE REGISTERED NURSES

OVERVIEW

AORN (the Association of periOperative Registered Nurses) is the professional association representing approximately 43,000 operating room nurses across the country. AORN applauds Chairman Bilirakis for his leadership in examining possible re-

finements to the Balanced Budget Act of 1997 (BBA). For the reasons outlined below, AORN respectfully requests the inclusion of H.R. 3911, the Medicare Certified Registered Nurse First Assistant Direct Reimbursement Act of 2000, in any BBA refinement package.

BACKGROUND

The BBA confirmed and expanded the role of non-physician assistants at surgery. For example, the BBA increased the reimbursement rate received by Physician Assistants (PAs), Nurse Practitioners (NPs) and Clinical Nurse Specialists (CNSs) for assisting a surgeon at surgery. The BBA also removed restrictions on the type of areas and settings in which first assisting services of non-physician first assistants may be covered by Medicare. (See Sections 4511 and 4512.) Regrettably, the BBA failed to appropriately recognize the first assisting role of the certified Registered Nurse First Assistant (CRNFA).

AORN URGES MEDICARE COVERAGE ELIGIBILITY FOR THE SURGICAL FIRST ASSISTING SERVICES OF CERTIFIED REGISTERED NURSE FIRST ASSISTANTS

As this Subcommittee examines possible Medicare refinements to the BBA, AORN respectfully requests the inclusion of H.R. 3911. This important legislation calls for Medicare reimbursement for the surgical first assisting services of Certified Registered Nurse First Assistants (CRNFAs) at a rate of 13.6% of the surgeon's fee. This is the same rate at which Medicare currently reimburses non-physician first assistants.

As first assistants, CRNFAs provide high-quality cost-effective care and perform the same first assisting tasks and duties as surgeons, physicians, physician assistants, nurse practitioners and clinical nurse specialists who may currently receive Medicare reimbursement for first assisting services. Reimbursing CRNFAs for their surgical first assisting services would address this fundamental inequity while improving the quality and cost efficiency of the Medicare system.

MEDICARE REIMBURSEMENT FOR THE SURGICAL FIRST ASSISTING SERVICES OF CRNFAS ALREADY ENJOYS BROAD BIPARTISAN SUPPORT ON THE WAYS AND MEANS COMMITTEE

With strong bipartisan support from his colleagues on the Ways and Means Committee, Rep. Mac Collins (R-GA) introduced H.R. 3911, the Medicare Certified Registered Nurse First Assistant Direct Reimbursement Act of 2000, on March 14, 2000. This legislation would provide Medicare reimbursement for the surgical first assisting services of CRNFAs at 13.6% of the surgeon's fee. The principal sponsor (Representative Collins) and seven of the cosponsors (Representatives English, Foley, Johnson, Lewis, McDermott, Shaw and Thurman) serve on the Ways and Means Committee. Five of those cosponsors (Representatives English, Johnson, Lewis, McDermott and Thurman) serve on the Ways and Means Health Subcommittee.

Cosponsors to date include Representatives Lois Capps (D-CA), John Cooksey (R-LA), Nathan Deal (R-GA), Diana DeGette (D-CO), Philip English (R-PA), Mark Foley (R-FL), Elton Gallegly (R-CA), Paul Gillmor (R-OH), Porter Goss (R-FL), Jim Greenwood (R-PA), Peter Hoekstra (R-MI), Nancy Johnson (R-CT), Patrick J. Kennedy (D-RI), John Lewis (D-GA), Jim McDermott (D-WA), Charlie Norwood (R-GA), Charles Pickering (R-MS), Clay Shaw (R-FL), Ted Strickland (D-OH), Mike Thompson (D-CA), Karen Thurman (D-FL), and Robert Wise (D-WV).

Further, Representative Collins and eight of his colleagues joined together in a June 27, 2000 letter addressed to Chairman Bilirakis and others, which urged inclusion of H.R. 3911 in any appropriate legislative vehicle. Signatories included Representatives Capps, Collins, Deal, DeGette, English, Foley, Greenwood, Norwood and Pickering. The letter, a copy of which is attached, persuasively argues that:

With respect to quality of care, CRNFAs provide a patient-centered continuum of care in the preoperative, intraoperative, and postoperative phases of the patient's surgical experience. CRNFAs often work in tandem with one or a small group of surgeons; this maximizes communication and coordination and minimizes the risk of medical error. In addition, in comparison with other non-physicians who first assist, CRNFAs have significantly more experience and expertise directly in first assisting.

As for cost-effectiveness, CRNFAs seek reimbursement for first assisting at 13.6% of the surgeon's fee; this is the same as currently is received by PAs and NPs who first assist. By contrast, physicians who first assist receive 16% of the surgeon's fee. Health claims data from the Health Care Financing Administration (HCFA) reveal that physicians file more than 90% of the first assistant at surgery claims for Medicare reimbursement. Use of CRNFAs would therefore be

a high quality yet cost-effective alternative for the nation's health care delivery system, affording additional flexibility to surgeons, hospitals and ambulatory surgical centers.

We feel strongly that increased use of CRNFAs in surgical first assisting likely would result in positive patient outcomes such as lower recidivism rates, decreased complications from surgery, higher patient satisfaction levels, and overall lower expected costs per patient.

Many nurses, surgeons, and others in our districts have expressed their support for H.R. 3911. Some of us have witnessed CRNFAs first assist at surgery.

In conclusion, we strongly support extending Medicare coverage eligibility to CRNFAs for their surgical first assisting services at a rate of 13.6% of the surgeon's fee and we respectfully urge that you include this proposal in an appropriate health legislative vehicle.

WHAT IS A CRNFA?

A CRNFA is a registered nurse first assistant (RNFA) who obtains national certification, a voluntary process. An RNFA already is a technically skilled, highly educated nursing professional who renders direct patient care as part of the perioperative nursing process. The certification process raises an already high quality standard and recognizes those RNFAs who have achieved excellence in patient care. The RNFA seeking certification must meet rigid requirements before applying, including:

1. Current licensure as an RN, without provision or condition, in the United States;
2. Certification in perioperative nursing (CNOR);
3. Completion of a minimum of 2000 hours of practice as an RNFA¹ that includes preoperative, intraoperative, and postoperative patient care;
4. Completion of a formal RNFA program that meets criteria established by the Certification Board Perioperative Nursing including training equivalent to a one-year comprehensive post-graduate program involving both classroom and clinical studies in anatomy and physiology, assessment skills, asepsis/infection control, and an extensive surgical assisting curriculum. During the required clinical internship, the prospective RNFA spends a defined number of clinical hours under the supervision of a surgeon preceptor; and
5. A Bachelor and/or a Master of Science Degree in Nursing.

CRNFAs are recognized by the American College of Surgeons, the American Nurses Association, the National League of Nurses, the National Orthopedic Nurses Association, and the 50 State Boards of Nursing. Indeed, at their annual meeting in June 2000, the American Nurses Association House of Delegates adopted Policy Number 3.37, which supports federal recognition and reimbursement for CRNFAs as first assistants.

HOW WOULD CRNFAS SAVE THE HEALTH CARE SYSTEM MONEY?

Health claims data from the Health Care Financing Administration (HCFA) reveal that physicians file more than 90% of the first assistant at surgery claims for Medicare reimbursement. Physicians receive 16% of the surgeon's fee for first assisting. **CRNFAs are requesting only 13.6% of the surgeon's fee for their first assisting services.** Use of CRNFAs is a high quality yet cost-effective alternative for the nation's health care delivery system, affording additional flexibility to surgeons, hospitals and ambulatory surgery centers.

CRNFAs are equally as cost-effective as other non-physician providers (PAs and some NPs) who currently are reimbursed at 13.6% of the surgeon's fee for first assisting. Moreover, CRNFAs receive more advanced education and training in first assisting than any other non-physician provider who first assists. For example, PAs commonly complete much less than the 2,000 hours of surgical assisting currently required before RNFAs may take the CRNFA certification exam. NPs are not required to have any extensive training in first assisting and yet receive direct reimbursement.

¹ There are approximately 4,000 RNFAs in the United States. According to a 1995 survey of the AORN Specialty Assembly, RNFAs are employed by hospitals and physicians, as well as being self-employed as independently contracted health care providers. In addition:

- The average age of an RNFA is 42 years old.
- The average length of time as an RN is 17 years.
- The average length of time in the operating room is 15 years.
- The average length of time as an RNFA is 4.62 years.
- Thirty percent of RNFAs have CRNFA credentials.

In addition, CRNFAs and RNFAs are the only providers—aside from the rare physician making house calls—who sometimes provide post-operative care by actually visiting patients at home following surgery. The result is better continuity of care and positive patient outcomes such as lower recidivism rates, decreased complications from surgery, higher patient satisfaction levels and overall lower expected costs per patient. Until H.R. 3911 is enacted, enabling CRNFAs to receive direct reimbursement, there is no incentive to use these high quality, cost-effective providers for first assisting in surgery.

WHO CURRENTLY REIMBURSES CRNFAS?

Though some commercial insurers provide coverage for the services of CRNFAs, reimbursement is inconsistent and varies on a state-by-state, case-by-case basis. Although payment by BlueCross/BlueShield plans differs by state; generally, if the CRNFA is not a contracted provider, BlueCross/BlueShield will pay the patient directly for CRNFA services. Many Medicaid plans also provide direct reimbursement.

COST ESTIMATE

H.R. 3911 is currently being scored by the Congressional Budget Office. An independent cost estimate by Muse & Associates determined that coverage eligibility for CRNFAs under Part B of the Medicare program would cost \$7.2 million in 2000, increasing to \$25.1 million in 2004 for a total cost over a five-year period of \$84.6 million.

SUMMARY

As BBA Medicare refinements are considered, AORN respectfully urges this Subcommittee to extend Medicare coverage eligibility to CRNFAs for their surgical first assisting services. Working in collaborative practice with surgeons, CRNFAs are cost-effective to the patient and to the health care delivery system. Because CRNFAs would be reimbursed under Medicare at a lower rate than physicians who first assist, and because CRNFAs routinely provide much-needed patient assessment, education and counseling, inclusion of H.R. 3911 in any BBA refinement package could well decrease the frequency and length of hospital stays resulting in improved patient outcomes and net savings to the Medicare program.

AORN appreciates this opportunity to submit its views with respect to the impact of the BBA. Please contact our Washington Counsel, Karen S. Sealander of McDermott, Will & Emery, at 202/756-8024 at any time with questions.

CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS

July 31, 2000

The Honorable MICHAEL BILIRAKIS
United States House of Representatives
Chair, House Commerce Subcommittee on Health & Environment
 2125 RHOB
 Washington D.C. 20515

DEAR MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE: On behalf of the California Association of Public Hospitals and Health Systems (CAPH), I respectfully submit the following written statement for the record of the subcommittee's July 19, 2000, hearing, "BBA '97: A Look at the Current Impact on Providers and Patients."

CAPH is a trade association representing more than two-dozen hospitals, health care systems and academic medical centers in 18 counties—accounting for 86% of the state's population—throughout California. The members of CAPH share a mission and mandate to provide care to all the residents of California, regardless of their ability to pay. Among the members of CAPH are county-owned and operated facilities, University of California medical centers, and private, not-for-profit facilities sharing a common commitment to serving all people.

The Balanced Budget Act of 1997 significantly impacted the public hospitals and health systems of California and the patients they serve. Specifically, BBA '97 mandated reductions in the Medicaid disproportionate share hospital (DSH) program—a critical source of funding for public hospitals and health systems in providing needed health care services for low-income and vulnerable populations. The Congressional Budget Office estimated in 1997 that the reductions to Medicaid DSH program payments imposed by the BBA would reduce expenditures by \$10.4 billion over five years. The reductions were designed to be phased in over a five-year period, with the largest reductions in the final three years. For California, this has resulted in a decline of federal Medicaid DSH payments of more than \$116 million

over the past two years, with a further \$164 million reduction, or 17 percent more, slated over the next two years.

The members of CAPH comprise a public health care safety net in California that serves the health care needs of the Medicaid, low-income, uninsured, and vulnerable populations. These public health care systems form the core of the state's health care infrastructure. As open door providers that share a mission and a mandate to serve the health care needs of all Californians, regardless of their ability to pay, public hospitals and health systems are significant providers of inpatient, outpatient, and specialty health care services in their communities.

These vital institutions serve the bulk of California's 7.3 million uninsured persons and are responsible for providing many critical health services in the community. Seventy percent of expenses at core open door providers are attributable to serving low-income populations, including Medicaid and uninsured patients. Core open door providers comprise six percent of hospitals statewide yet made up almost 40 percent of all uninsured inpatient discharges in California in 1998. Public hospitals and health systems provided ten million outpatient visits in 1998, of which 3.7 million were to uninsured patients. Moreover, care for the uninsured is becoming increasingly concentrated at open door providers. While the total volume of patients at public hospitals and health systems has declined, the number of uninsured patients has grown 16% over the 5 years ending in 1998. These essential institutions also play a critical role delivering high-cost specialty services—such as burn and trauma services—and other public goods that benefit all members of the community. For example, public hospitals and health systems operate more than 60 percent of all Level 1 trauma centers statewide, train about half of California's medical residents and provide over 60 percent of the state's psychiatric emergency care.

The Medicaid DSH program is one of the critical funding sources that has maintained the fiscal viability of open door providers and allowed them to continue their role at the heart of the state's public health care infrastructure. During the mid-1980s Congress recognized that a limited number of hospitals were shouldering a disproportionate share of the responsibility for providing care to low-income populations. These hospitals were generally located in poor urban communities, faced large uncompensated care burdens, did not serve many privately insured patients, and experienced above-average costs due to the medical complexity of patients. Believing that targeted assistance to these hospitals was needed in order to preserve access to care for low-income populations, Congress authorized disproportionate share payments for these hospitals through the Medicare and Medicaid programs.

California's Medicaid DHS program was created in 1991 and generated new federal funding for hospitals that treat the greatest numbers of Medi-Cal and uninsured low-income patients. Medicaid DSH Program dollars are critical to the stability and viability of California's public health care systems and their ability to serve the Medicaid, low-income, and vulnerable populations in our state.

Currently, public hospitals and Health care systems in California are facing increasing financial pressure. Despite the strong economy and budget surpluses at both the state and federal levels, many open door providers in California are facing budget deficits. This situation is the result of a growing uninsured population and an increasing concentration of uninsured patients at open door providers, the rise of Medicaid managed care, and declining patient revenues and subsidies, including reductions in the Medicaid DSH Program, that have historically supported these vital institutions. The loss of tens of millions of dollars in federal Medicaid DSH funds has impacted hospitals' ability to provide care to low-income populations, and continuation of the scheduled reductions imposed by the BBA may potentially jeopardize access to health care for low-income and uninsured Californians.

When Congress deliberated the provisions of the Balanced Budget Act in 1997, it faced a large federal budget deficit. Today, we enjoy a national economy that continues to flourish and a federal budget surplus of billions of dollars. As a result, we can take steps to address the unintended consequences of BBA '97 and ensure that access to health care is preserved for low-income and vulnerable populations. The Balanced Budget Refinement Act (BBRA) of 1999 was an important first step toward remedying the unintended consequences of the BBA and we greatly appreciate the attention of Congress to these issues. However, while BBRA will help relieve some pressing Medicare issues, it did not address the substantial cuts to the Medicaid program.

Prevention of the additional cuts to the Medicaid DSH program mandated by BBA '97 is critical if safety net providers are to continue to meet the health care needs of the communities they serve. Medicaid DSH payments help reimburse hospitals' costs of treating Medicaid and low-income patients, particularly those with complex medical needs and make it possible for communities to care for their uninsured. Eliminating future BBA-imposed reductions in the Medicaid DSH program would al-

leviate some of the financial pressures facing those hospitals treating a disproportionately large number of Medicaid and low-income patients and help preserve access to care for vulnerable populations.

CAPH and its members urge your support for prevention of the additional cuts to the Medicaid DSH program mandated by BBA '97. Thank you for your consideration.

Sincerely,

DENISE K. MARTIN
President & CEO

PREPARED STATEMENT OF HEALTH INDUSTRY DISTRIBUTORS ASSOCIATION

REPEAL PART B SNF CONSOLIDATED BILLING

Position: HIDA favors repealing Part B consolidated billing scheduled to be implemented at skilled nursing facilities (SNFs) as early as January 1, 2001.

SNF consolidated billing for Medicare Part B removes suppliers from the billing and payment cycle, delays payment to suppliers, and threatens the stability of the SNF supply chain. It also places new and considerable financial and administrative burdens to SNFs at a time when many are financially vulnerable and virtually none have the expertise to implement this provision of the 1997 Balanced Budget Act.

Justification:

Suppliers have worked closely and successfully with the four Durable Medical Equipment Regional Councils (DMERCs) created by the Health Care Financing Administration (HCFA) to manage complex Part B claims arising from Medicare-covered stays in skilled nursing facilities (SNFs).

Part B medical equipment suppliers have developed the expertise necessary to bill the DMERCs, including preparation and completion of signed Certificates of Medical Necessity (CMNs) for certain services, signed physician order statements, and other medical documentation deemed necessary by DMERCs. Under consolidated billing, these suppliers would be removed from the billing and payment cycle and their expertise essentially wasted.

SNFs have no experience working with the DMERCs and are unfamiliar with the detailed billing procedures they have put in place. Furthermore, the prospective payment system (PPS) have left many SNFs financially strapped and ill-prepared to assume yet another administrative burden from the Medicare program.

Consolidated billing threatens the stability of SNF supply chain.

It is not clear how and when suppliers can expect to be paid under this scenario.

Few SNFs have the cashflow to pay suppliers up front. It is likely that a supplier would not be paid until a SNF has assembled a consolidated bill, submitted it to the DMERC, and received payment. This may well result in delayed payment to suppliers, many of whom rely on a relatively steady cashflow themselves in order to remain in business.

Claims processing delays caused by incorrect submissions and other errors will ultimately delay payment to suppliers.

Consolidated billing threatens Medicare program integrity, which has seen considerable improvements in recent years.

A report released by the Office of the Inspector General (OIG) in February 2000 (OEI-04-97-00330; see www.dhhs.gov/progorg/oei/reports/a431.pdf) praised the DMERCs for meeting HCFA's objectives to develop medical policies and an aggressive educational and fraud prevention program, and reduce claims processing costs. The OIG singled out the "excellent outcomes" DMERCs have shown in combating fraud and decreasing claims processing costs.

Clearly, the present system works well. The Medicare program would be harmed if suppliers are removed from their role as key DMERC partners and replaced with inexperienced SNF billing staff.

Consolidated billing requires claims to be bundled, going against insurance industry practice to unbundle claims and examine each one for accuracy and appropriateness. This has saved private health plans millions of dollars each year by uncovering and correcting inappropriate billing practices.

Consolidated billing will be expensive to implement, breaching the budget-neutrality of the 1997 Balanced Budget Act.

HCFA must train SNF staff on DMERC policies and procedures, produce training materials, and update manuals.

Claims processing costs will increase. We can expect a high incidence of denied claims submitted by inexperienced billing staff. These claims will have to be resubmitted by the SNFs and reexamined by the DMERCs, which will increase costs for both.

PREPARED STATEMENT OF LAWRENCE A. MCANDREWS, PRESIDENT AND CEO,
NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS

The National Association of Children's Hospitals (N.A.C.H.) is pleased to submit for the hearing record this statement in strong support of House passage of "Medicaid DSH restoration" legislation, such as H.R. 3698, the "Medicaid DSH Preservation Act of 2000," by Representatives Ed Whitfield (R-KY) and Brian Bilbray (R-CA), and H.R. 3710, the "Medicaid Safety Net Hospital Preservation Act of 2000," by Representatives Diana DeGette (D-CO) and Bilbray. The bills enjoy broad bipartisan support, both in the Commerce Committee and in the House.

N.A.C.H. is a nonprofit trade association, representing more than 100 children's hospitals across the country, including freestanding children's acute care hospitals, freestanding children's specialty and rehabilitation hospitals, and children's hospitals organized as part of larger hospital systems. They have missions of clinical care, education, research, and public health promotion for all of the children of their communities, regardless of their medical or economic need.

Background

Since 1981, Congress has required states to make "disproportionate share hospital" (DSH) payment adjustments to hospitals serving disproportionately large numbers of low-income Medicaid-assisted and uninsured patients. This payment adjustment program was established because, historically, many states' Medicaid programs have reimbursed hospitals for less than the actual cost of provided care. As a result, much of the hospital care provided to Medicaid-covered individuals has come from "safety net hospitals"—hospitals with missions of serving patients regardless of their ability to pay—such as children's hospitals, public hospitals and teaching hospitals. Over the years, Congress has rewritten DSH payment policy several times. In 1991, Congress capped the amount of federal DSH funds each state may receive. In 1993, Congress capped the amount of DSH payments an individual hospital may receive. As a consequence, the total amount of spending for DSH funds has been curtailed—it no longer experiences significant growth.

However, in 1997, as a way to find savings in the Medicaid program and to redirect some funding for other purposes, Congress again rewrote DSH policy by reducing federal DSH spending by an estimated \$10.4 billion over the five year period (1998-2002), as part of the "Balanced Budget Act of 1997" (BBA). Each state's reductions in federal DSH funding were written directly into the legislation. Some states received larger reductions than other states, and many states' reductions are largest in the last two years of the BBA's implementation.

This massive reduction in DSH payments can make it increasingly difficult for safety net hospitals, such as children's hospitals, to continue providing quality health care to all individuals, regardless of income.

Children's Hospitals: Nation's Safety Net Providers for Children

In many states, children's hospitals are among the leading recipients of states' DSH funds, in recognition of the fact that they are often the health care safety net for children of low-income families, providing the full spectrum of primary, acute, tertiary level, and post-acute care. Virtually all children's hospitals are designated by their states as "disproportionate share hospitals" serving a disproportionate share of children assisted by Medicaid and children who are uninsured.

Although they represent less than 30% of the nation's population, children account for approximately half of all recipients of Medicaid assistance. In fact, about one in five children and one in four infants in the United States rely on Medicaid to pay for their health care.

Medicaid patients on average account for more than 45% of freestanding children's hospitals' inpatient days. It is not unusual for a children's hospital to devote 60% or even 70% of its care to Medicaid-covered children. In addition, on average, Medicaid patients and uninsured patients together account for almost 50% of children's hospital's total gross revenues.

Why Is Medicaid DSH Policy Vital to Children's Hospitals?

DSH payment adjustments make a major financial difference to children's hospitals. Medicaid payment falls far short of the cost of inpatient care provided by children's hospitals. In 1998, the average Medicaid base payment was \$0.75 for

every \$1.00 in inpatient care expenses a freestanding children's hospital incurred to care for a Medicaid-assisted child. Even with disproportionate share payment adjustments, children's hospitals received payments that on average amounted to \$0.85 cents for every \$1.00 of expense incurred for care.

Without Medicaid DSH payments, some children's hospitals would end the financial year with operating losses that could jeopardize their survival. Some would be forced to curtail their outreach and community services for low-income families as well as high cost specialty services for all children. Some would be jeopardized in their ability to develop integrated networks capable of serving children enrolled in capitated managed care plans.

Unless blocked, the BBA's FY 2001 and 2002 reductions in federal Medicaid DSH funds will threaten the health care safety net for all children and the ability of many individual children's hospitals to sustain financially their complex array of services for all children.

Recommendation

N.A.C.H. strongly supports passage of Medicaid DSH restoration legislation, such as H.R. 3698 by Representatives Whitfield and Bilbray, and H.R. 3710 by Representative DeGette and Bilbray. These bills enjoy broad bipartisan support throughout the Commerce Committee and in the House. Currently, between the two bills, there are over 220 cosponsors, including 32 members of the Commerce Committee. Passage of Medicaid DSH restoration legislation will help children's hospitals across the country to continue serving the health care needs of *all* children, regardless of their economic background.

PREPARED STATEMENT OF MARK MELJER, PRESIDENT, AMERICAN AMBULANCE ASSOCIATION

Chairman Bilirakis, Ranking Member Brown and distinguished members of the Subcommittee, on behalf of the American Ambulance Association (AAA), I thank you for this opportunity to submit written testimony on the impact that the Balanced Budget Act of 1997 (BBA) has had on ambulance service providers and the patients we serve. The ambulance industry is currently under enormous financial stress and, unfortunately, the worst is still yet to come.

For years, ambulance service providers have been reimbursed for services rendered to Medicare patients at levels below their true operating costs. Ambulance providers have struggled to make this system work and still remain in operation, primarily by finding ways to pass on these costs to other payers as well as patients themselves. Due to the mandate to accept assignment in the BBA, ambulance providers can no longer pass on legitimate costs to Medigap insurers.

A critical difference between ambulance operations and other health care providers, is that in most cases ambulance operations are required by law, most often through licensure by the State in which they operate, to treat and transport emergency ambulance patients *without* inquiring into a patient's ability to pay. All of us who operate ambulance response agencies are supportive of this concept, yet it creates additional financial pressures unmatched by other health care providers. Ironically, ambulance services are among the lowest reimbursed health care providers in most state Medicaid programs. This, combined with an increase in the number of uninsured Americans, results in a devastating financial impact on ambulance operations who are mandated to provide emergency medical care and around-the-clock coverage regardless of the ability to pay by those accessing this important service.

Annual Medicare increases have not, and will not, keep up with costs to provide ambulance service.

- Patient care costs have increased as access to high quality, advanced life support/paramedic ambulance services has grown to meet community needs and expectations;
- Administrative costs have dramatically increased due to increased paperwork burdens required by the Health Care Financing Administration (HCFA) and carriers, and costly claims appeals;
- Under the current reimbursement system, ambulance industry rates have been artificially constrained since 1985 by the inflationary index charge. This index limited annual Medicare increases to an annual adjuster set by the HCFA regardless of actual ambulance service cost increases;
- Exacerbating the above limits, a key BBA provision further limits annual increases to one percent less than the national inflation rate which has a compounding five-year effect (1997-2002).

This is all happening at the same time that HCFA is about to issue a new Medicare ambulance fee schedule as authorized by Congress in the BBA. When ambulance service providers feel the full impact of the BBA with the implementation of the new Medicare ambulance fee schedule, the anticipated additional reduction in reimbursement will be too much for many ambulance providers to survive. Unfortunately, at that point, the Medicare patients that we serve and the millions of Americans who rely on the nation's 911 system will also feel the full impact of the BBA.

America's ambulance providers are the backbone of the nation's 911 emergency medical response system. Whatever weakens the ambulance operations weakens the 911 system's ability to respond to calls for medical help. Below cost reimbursement for Medicare ambulance services will seriously degrade the entire emergency response system. Fifty percent of the average ambulance operation's revenue comes from serving Medicare beneficiaries. Therefore, ambulance providers will be unable to operate, response times will increase and people confronting emergency medical situations will be put at risk. Available, quality emergency medical services are a critical access point and safety net for the poor and elderly needing emergency health care services.

The same is true for nonemergency ambulance services provided to Medicare patients. With fewer ambulance service providers and below cost reimbursement for those still in operation, access to quality, timely care for the most vulnerable beneficiaries will be jeopardized. Requiring ambulance companies to provide below-cost services to Medicare undermines our ability to provide not only emergency and non-emergency ambulance services to Medicare patients, but to all Americans.

Project Hope, a highly respected health care think tank, arrived at a reliable estimate for the cost of providing ambulance services throughout the U.S. Applying the Project Hope cost data to the current Medicare volumes and expenditures for ambulance transport services generates a total annual cost estimate of \$3.74 billion to provide ambulance transport services to Medicare beneficiaries. The BBA, however, limits the Medicare reimbursement for ambulance services to just \$2.65 billion, which according to Project Hope data, represents a shortfall of \$1.1 billion in 2001 in the cost of providing service.

In conclusion, the BBA will limit payments under the new ambulance fee schedule to a level that will make it impossible for many, if not most, ambulance operations to answer the call for help when it comes. In order to provide adequate ambulance services for Medicare beneficiaries who access care throughout the nationwide 911 emergency response system, Congress must ensure that ambulance providers are paid their true costs in providing services to Medicare beneficiaries. The safety net of the nation's health care system depends on it.

Again, thank you for the opportunity to provide the Subcommittee with this written testimony.

PRACTICE EXPENSE FAIRNESS COALITION
July 31, 2000

The Honorable MICHAEL BILIRAKIS
Chairman
Subcommittee on Health and the Environment
House Commerce Committee
U.S. House of Representatives
Washington, D.C. 20515

DEAR CHAIRMAN BILIRAKIS: On behalf of the Practice Expense Fairness Coalition, which represents organizations with a combined membership of over 350,000 physicians, we are submitting this statement for the record of the hearing entitled BBA '97: A Look at the Current Impact on Providers and Patients, held by the Subcommittee on Health and the Environment on July 19, 2000.

Specifically, we are contacting you to (1) express our strong opposition to a proposal by the Halt 2000 coalition to stop implementation of resource-based practice expense payments (RBPEs) this year as part of a Medicare giveback bill, and (2) offer an alternative that would address concerns about underfunding of physician services—while preserving the mandate that payments for physician services be based on the relative costs of each service, based on the best available data.

The Balanced Budget Act of 1997 mandated that implementation of RBPEs be phased in over four years, to allow for methodological refinements during each year of the phase in, following a one year delay in implementation. The Halt 2000 proposal would undo this carefully-crafted compromise by stopping the transition to RBPEs for all services, except office visits, at the current blend of 50% charge-based, and 50% resource-based, practice expenses. The 50% charge-based portion would

perpetuate the inequities in payment that Congress resolved to end when it enacted the BBA 97 compromise. Even if a few office visit services were exempted from the halt, *the vast majority of physician services would continue to be paid in large part based on inaccurate historical charges, not on data on the costs of each service.*

Our coalition has a better alternative to Halt 2000. This alternative would address concerns about underfunding of physician services, due to past miscalculations of fee schedule updates, by mandating a 3% increase in the dollar conversion factor for the Medicare fee schedule. Unlike the Halt 2000 proposal, it would not abruptly withdraw support for the ongoing transition to a payment system that bases Medicare payments on the relative costs of each service, based on the best available data.

The General Accounting Office in February 1999 reported "*HCFA's methodology uses what are generally recognized as the best available data on resource-based practice expense values*" (emphasis added). So the question is not if HCFA's methodology is fundamentally flawed—the GAO clearly said that it was not. The refinement process mandated by the BBA 97 is the way to get further improvements made in HCFA's data and methodology. In fact, HCFA's recently published proposed rule on the CY 2001 fee schedule includes numerous changes that directly respond to concerns expressed about its data, including restoring payments for non-physician clinical staff costs for certain services done in the hospital and incorporating more recent survey data into practice expense calculations.

As Congress considers the Medicare giveback legislation, we urge you to support the Practice Expense Fairness Coalition's alternative proposal for a 3 percent increase in the dollar conversion factor for the Medicare fee schedule. Under our alternative, *every physician and every specialty would be better off than under current law. By contrast, under the Halt 2000 plan, some physicians would be worse off and others better off than under current law. The 3 percent solution is simple and fair to all physicians.* Further details are in the attachment.

Sincerely,

AMERICAN ACADEMY OF DERMATOLOGY; AMERICAN
ACADEMY OF FAMILY PHYSICIANS; AMERICAN ACADEMY OF PEDIATRICS;
AMERICAN COLLEGE OF PHYSICIANS-AMERICAN SOCIETY
OF INTERNAL MEDICINE; AMERICAN COLLEGE OF RHEUMATOLOGY; AMERICAN
OSTEOPATHIC ASSOCIATION; AND RENAL PHYSICIANS ASSOCIATION

PREPARED STATEMENT OF RURAL HOSPITAL COALITION

Good morning Chairman Bilirakis; Ranking Member Brown and other distinguished members of the House Commerce Subcommittee on Health and Environment. We submit this testimony on behalf of the patients, providers and communities in which we own or operate a rural hospital. Collectively, Community Health Systems, Inc., LifePoint Hospitals, Inc. and Province Hospital Company, Inc. represent roughly 10 percent of the rural hospitals in the United States. In terms of number of facilities, Community Health Systems is the largest non-urban provider of general hospital services in the United States and is the second largest non-urban provider in terms of revenues.

We appreciate the opportunity to discuss the Balanced Budget Act of 1997 (BBA) and its current impact on rural hospital providers, patients, and the Medicare program. As Congress considers reforms to grant necessary relief to rural providers, we urge the Congress to embrace broad reforms that give relief to the majority of the 2,100 rural hospitals. These reforms should include:

- Equalizing Medicare disproportionate share ("DSH") payments between urban and rural hospitals;
- Providing a wage index floor;
- Eliminating market basket reduction for rural hospitals in FY 2001 and FY 2002; and
- Restructuring qualifying criteria for Medicare dependent hospitals based on their past three cost report years and the payment formula blend applicable to Sole Community Hospitals and make the MDH program permanent.

Rural Health Care Market

Rural hospitals remain the key to providing rural communities with both economic development and access to quality and affordable health care. The loss of a rural hospital to a community results in more than the loss of access to health care. The economic impact of a closing of rural hospital in a rural community cripples a community's ability to attract new doctors, jobs and industry. A recent study indicated that health care provides 10 percent to 15 percent of the jobs in many rural

counties.¹ When the secondary benefits of those jobs are included, health care accounts for 15 to 20 percent of the all jobs in rural communities.

Rural hospitals have been able to survive only because of a patchwork of “special fixes” enacted by Congress in the last decade. The Balanced Budget Refinement Act (BBRA) continued this pattern and provided relief for a small number of special rural hospitals—Sole Community Hospitals (“SCH”), Critical Access Hospitals (“CAH”) and Medicare Dependent Hospitals (“MDH”)—which represent less than 50 percent of the rural hospitals. As a result, most rural hospitals remain in a market that is experiencing higher than expected payment reductions, a reduced number of providers and excessive regulations that are reducing access to care for Medicare beneficiaries in rural areas. The impact of these reductions and regulatory burden is evidenced by:

- *The Congressional Budget Office* (CBO) estimate that Medicare spending fell by \$8 billion dollars between November 1999 and January 2000.
- *The Medicare Payment Advisory Commission* assessment that “rural hospitals have lower inpatient margins...and rural hospitals were disproportionately harmed by the BBA.”
- *The Health Care Financing Administration* (HCFA) notation in the most recent “Inpatient Hospital Prospective Payment System” regulation that “approximately one third of rural hospitals continue to experience negative Medicare margins.” The rule further states that HCFA “now believes that rural hospitals merit special dispensation...”

Special Needs of Rural Hospitals

Rural hospitals tend to be smaller, have difficulty attracting and keeping health care professionals and are more dependent on Medicare patients. In order to remain competitive, hospitals and the communities they serve must continue to be able to recruit additional primary physicians and expand the breadth of services offered in their hospital. To remain a vital part of the United State’s health care delivery system, rural hospitals need fundamental payment reform that extends relief to **all rural hospitals** by improving wages, DSH payments and the hospital market basket update.

Medicare Disproportionate Share Payments

Since 1986, the Medicare program has made special add-on payments to PPS hospitals that treat low income patients. Concern for specific groups of hospitals resulted in Congress creating 8 different DSH formulas. (See Table 1). Each includes a threshold for the low-income share needed to qualify. Medicare’s proxy for low income patients is based on two factors:

- The percentage of Medicaid patient days (“Medicaid Utilization”); plus
- The percentage of Medicare SSI patient days

Charity, indigent care and bad debts are not considered in the DSH calculation. The current program applies a higher qualifying threshold for rural hospitals (30 percent for hospitals with greater than 100 beds and 45 percent for hospitals with less than 101 beds, as compared to 15 percent for urban hospitals with greater than 99 beds and 40 percent for urban hospitals with less than 100 beds) and disproportionately weights Medicaid utilization, despite the fact that Medicaid utilization is a poor measure of overall service to the poor.

Consequently, more than 95 percent of all DSH payments go to urban hospitals and is highly concentrated in about 250 hospitals.²

Further, the BBA 1997 requires that HCFA recommend a new payment formula for DSH adjustments that treat all hospitals equally. Recent MedPAC reports on DSH funds found little evidence of any systematic relationship between the share of poor patients a hospital treats and a per-case cost. Low income seniors and the hospitals that serve them in rural areas deserve a more equitable system.

We urge Congress to equalize DSH payments between urban and rural hospitals. Specifically, Congress should immediately equalize qualifying low income threshold between urban and rural hospitals and phase-in the sliding scale distribution formula used to calculate the DSH payment for urban hospitals over 99 beds. It is also our suggestion that urban hospitals be held harmless and that this proposal be im-

¹ Statement by Dr. Mary Wakefield before the Senate Agriculture Appropriations Committee hearing on Rural Hospitals and Rural Economic Development

² According to the ProPAC 1997, the current formula weighs Medicaid patient days equally with patient days for Medicare beneficiaries who receive Supplemental Security Income (SSI) cash payments, despite the fact the former group accounts for four times as much hospital cost. Consequently, urban hospitals with at least 100 beds benefit from a steeply graduated payment, while rural and small hospitals receive a lower fixed adjustment.

plemented with surplus dollars. Notably, HFCA in recent testimony before the Senate Agriculture Appropriations Subcommittee noted that they would consider "improving equity for rural hospitals in the Medicare DSH formula." In a recent budget analysis prepared by PriceWaterhouseCoopers, the transition to a uniform DSH payment for rural hospitals under 100 beds is estimated to cost \$709 million over five years (2001-2005). Further, a transition into a uniform DSH payment and applying an urban distribution formula in 2001 is estimated to cost \$2.95 billion over five years (2001-2005).

Market Basket (MB) For Rural Hospitals

Rural hospitals have been doubly hurt by three consecutive years of below MB updates. Although hospitals have become more efficient, the industry may be running out of cost cutting initiatives. The problem is more pronounced for smaller hospitals which have less elasticity of cost to volume.

We urge Congress to eliminate the market basket reduction for rural hospitals in FY 2001 and FY 2002. A budget estimate prepared by PriceWaterhouseCoopers estimated that a market basket update for rural hospitals for 2001 and 2002 would cost \$748 million for rural hospitals under 100 beds and \$8.73 billion for all hospitals over five years (2001-2005).

Wage Index Floor

The current wage index reflects area differences in wage levels in the geographic area of the hospital as compared to the national average wage level. Most rural areas have a very low wage index because the index is based on a statewide average hourly wages for rural areas. The wage index formula, while recognizing hourly wage differences, does not take into account the greater number of hours per case that is required in a lower volume setting due to baseline staffing requirements and lower volume than urban hospitals. Thus, small rural hospitals may have a lower average hourly wage but will require, all things being equal, a greater number of hours spread over lower volumes to run their operations.

We urge Congress to provide a national wage index floor of .8500 to .9000 that would provide a bottom end payment boost to the most disadvantaged rural hospitals. In a recent budget analysis prepared by PriceWaterhouseCoopers, a floor wage index of .90 for rural hospitals under 100 beds is estimated to cost \$382 million over the next five years (2001-2005).

Update Criteria For Medicare Dependent Hospitals ("MDH")

A rural MDH is a hospital located in a rural area with 100 beds or less with at least 60 percent of all discharges or days attributable to Medicare. The criteria for the MDH program is based solely on a hospital's 1987 cost report. Facts have changed since then. Some current MDH's may no longer qualify and other hospitals that would otherwise qualify cannot because they did not qualify in 1987.

We urge Congress to make the MDH program permanent and to revise the MDH criteria to (1) permit any three most audited years to be used to determine eligibility and, (2) that would include the current 1996 blend-in afforded to Sole Community Hospitals. In a recent budget analysis prepared by PriceWaterhouseCoopers, the proposed definition change in the MDH criteria is estimated to cost \$144 million over five years (2001-2005).

Conclusion

The problems facing rural health care providers cannot likely be solved this year. *It is critical, however, for Congress to enact legislation that will extend real relief to all rural hospitals by improving wages, equalizing DSH payments, revising the MDH program and providing for a fair hospital market basket update.*

PREPARED STATEMENT OF THE FLORIDA HOSPITAL ASSOCIATION

Mr. Chairman and Members of the Subcommittee:

My name is Charles F. Pierce, Jr., and I am President of the Florida Hospital Association, an association that represents 230 Florida hospitals and health care systems with over 200,000 hospital employees.

America's health care system sits at the crux of a great paradox. In the midst of a booming economy and escalating surplus, the facilities you and I and millions of others have come to rely on for our health care needs face unprecedented financial pressures and uncertainty about their future. Hospital leaders with as much as 20-30 years of experience report they have never experienced anything like their current financial situations. A snapshot of hospitals in Florida following enactment of the Balanced Budget Act shows the magnitude of this somber reality:

- Reductions in Medicare payments to Florida hospitals are estimated at \$3.6 billion.
- Almost 32% of all Florida hospitals reported losses in 1998.
- Over half of all hospitals saw a drop in net income from the previous year.
- Changes in bond ratings were dominated by five times as many downgrades as upgrades.

The Balanced Budget Act cut too deeply in hospitals across the nation. Because Florida has the highest percentage of Medicare beneficiaries in the nation, the impact is exceptionally severe and deeply disturbing. There are 2.8 million elderly in Florida and the numbers are growing. Patients are older and sicker, requiring more intensive services and support. Florida's hospitals are expected to meet the needs of these seniors despite BBA reductions amounting to \$1 billion in the first two years of its implementation and an additional \$2.6 billion in the next three years—even after the BBRA of last year. Though hospitals continue to scrutinize and squeeze their budgets, the cost savings they realize do not begin to match the size of the mandated Medicare cuts. What does the additional reduction of \$3.6 billion mean to our hospitals?

Even after the partial relief offered by the BBRA, Florida's 27 rural hospitals, which serve over 500,000 citizens, are expected to lose \$50.6 million. These cutbacks will have alarming consequences among communities solely dependent on the health care services these facilities provide. Without additional relief, how will our rural hospitals continue to serve these remote communities?

A number of services, particularly outreach services that undergird the health needs of some of the most vulnerable in our society, have been closed. Martin Memorial Medical Center in Stuart, Florida, was forced to close an urgent care center for residents of the isolated community of Indiantown, many of whom are migrant and unskilled workers. The care center lost money every year, but Martin Memorial continued to support it as part of its community mission. This year, the hospital could no longer afford to absorb the cost of the center. "It was a heart-wrenching decision to announce we couldn't finance the center any more," Martin Memorial CEO Dick Harman reported.

Bethesda Memorial Hospital in Boynton Beach had to make a similar, difficult decision when it closed its clinic for poor pregnant women in southern Palm Beach County.

Mercy Hospital withdrew from the Dr. Rafael Penalver Clinic in Little Havana, Miami, after losing \$3.6 million in three years.

And Shands HealthCare, an eight-hospital system providing care to patients from each of Florida's 67 counties, has had to close all but two of its home health care units because it lost more than \$20 million annually after the BBA was enacted.

These are not isolated incidents. Over the last two years in Florida, 34 hospitals experienced the closing of 271 acute care beds, 5 obstetrics programs, 295 psychiatric and substance abuse beds, and 122 skilled nursing beds. Without relief, these kinds of safety net programs and—more importantly—the poor and needy people they serve, will suffer and their access to basic health care will be jeopardized.

Of great and growing concern is the reality that the BBA has forced health care providers to reduce or eliminate other community and senior services. Nationally, over 3,000 independent home health agencies have closed their doors in the past three years. Already, 75 Florida communities have lost home health agencies, and now they have none. Baptist Health Care of Pensacola has had to close two rural health clinics and one home health agency. Memorial Healthcare System in Hollywood, Florida, could not expand its much-needed skilled nursing unit because the BBA reduced its funding by \$623,000. These are just a few of the many examples of what is occurring in Florida. We are deeply concerned that almost 20% of all long-term beds in Florida belong to organizations that have filed for bankruptcy. "We've seen some serious problems develop," said Jim Booth, CEO of Interim HealthCare, one of the largest home health agencies in South Florida. "Due to cutbacks in reimbursement, some chronically ill patients are not getting the necessary care." If Congress does not intervene soon, where will our elderly seniors receive the care they need?

Our hospitals are delaying the purchase of much-needed new and replacement equipment and postponing important renovations. For Baptist Health Systems of South Florida, the BBA delayed by one or more years a more accessible outpatient facility, which would enable more people in the local community to receive basic health care services. This major health care system also is concerned that its ability to invest in critical medical equipment will be significantly limited in the future. Without relief, how will our hospitals keep pace with the latest technology and treatment opportunities our citizens deserve and have come to rely on?

As hospitals struggle with the severity of the BBA's impact, they are confronting other social and economic factors that also dangerously strain their ability to provide necessary health care services. For example:

- There are 2.5 million Floridians (44 million nationwide) who have no health insurance. That number is growing. Crowded emergency rooms provide their only medical recourse. Federal law requires hospitals to stabilize and evaluate anyone who comes into the emergency room, yet no reimbursement accompanies this unfunded mandate. This means that hospitals must absorb these costs. In 1998, Florida hospitals provided over \$1.2 billion in uncompensated care.
- New drugs and medical technology result in higher costs for patient care with no increased payment for them. As you have heard in great detail, the average price for new drugs continues to skyrocket and consumes an alarmingly higher proportion of what it costs to treat patients.
- Severe shortages of nurses—currently Florida has over 4,800 open nursing positions—and shortages of other allied health professionals are causing labor costs to spiral. Hospitals not only pay higher wages, but also offer signing bonuses and increased benefit packages. These costs are rising as Medicare is reducing payments.
- New regulations initiate major, costly compliance issues. Florida hospitals must comply with regulations from 26 federal, 11 state, and 6 voluntary agencies. For example, the estimated nationwide cost of implementing HIPPA is \$43 billion—dwarfing Y2K compliance costs. Where will the funds come from?

Indeed, Florida hospitals are facing unprecedented financial pressures and need your help. We support enactment of legislation (HR3580) that provides a full market basket update for fiscal years 2001 and 2002 under Medicare. BBA set the update at market basket—a measure of hospital inflation—minus 1.1 percentage points for each year. Elimination of the remaining two years of the BBA-mandated market basket reductions provides an estimated \$7 billion relief nationally, with \$716 million for Florida hospitals. This bipartisan bill, which has been co-sponsored by 19 members of the Florida delegation, will simply re-establish a realistic link between cost increases and appropriate payment rates. Under BBA, hospitals have seen costs increase by seven percent while payments were updated by less than two percent. The scenario will worsen during the next two years if no action is taken.

Additionally, we urge Congressional approval of legislation (HR3698, HR3710) to protect federal disproportionate share hospital (DSH) allotments from reductions beyond FY 2000 levels and allow payments for uncompensated care to grow at the rate of inflation. The Medicaid DSH program is the primary source of financial support for safety net hospitals that provide care to the underserved and our most needy citizens. HR3698 and HR3710 provide substantial relief for struggling safety net hospitals, while still achieving significant savings in the DSH program.

Funding for these changes must come from the projected federal surplus and not from payment reductions to hospitals in other areas.

Enactment of these bills provides a framework for Congress to remedy the damage caused by the Balanced Budget Act. Additional repairs will be necessary. There must be a balance between slowing Medicare's growth and responsible program financing. The Florida Hospital Association is encouraged that the Florida Delegation and their bipartisan colleagues in Congress, as well as MedPAC, health care providers, and citizens across the nation are aligned in their conviction that something must be done to reverse the devastating impact of the BBA on hospitals. In Florida, something must be done quickly.

We look forward to working with you to strengthen our hospitals' ability to fulfill their mission—to provide quality care to the citizens in their communities.

NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS
August 31, 2000

The Honorable MICHAEL BILIRAKIS
Chairman, Health and the Environment Subcommittee
House Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

DEAR MR. CHAIRMAN: Thank you for giving the National Association of Community Health Centers the opportunity to testify before your subcommittee in support of H.R.2341, the Safety Net Preservation Act (SNPA), in July. Given the overwhelming support for this legislation among Commerce Committee members (as well as majority support in the House of Representatives and Senate), we are hope-

ful that Congress will recognize the importance of health centers and enact the common sense, long-term Medicaid payment system included in the SNPA.

This letter reflects our written response to the questions submitted by Representative Towns to be included in the hearing record. It is my hope that these responses will further justify the importance of Congress' timely action to provide BBA relief for health centers.

Question 1: If your centers are legally mandated to serve any patient that walks through the door, what services have your members had to reduce in order to honor that mandate?

Health centers are unique providers because of their Congressional mandate, patient/payer population mix and the medically underserved areas they serve. In addition, centers provide more than just primary and preventive health care services. Unlike other providers, health centers are required to provide services that help their patients access the health care services they provide, such as translation services (for non-English speaking patients), transportation services (for elderly or other patients without access to their own vehicle or public transit), and case management services. Without these services, the health services they provide would not be nearly as effective or accessible to everyone in their communities.

In addition, health centers also provide other social service and education services that give low-income people the tools they need to emerge out of poverty. These services include, but are not limited to, health education and nutrition. Likewise, health centers also provide services other than medical, including, in some cases, dental, mental health, and pharmacy services.

Of course, as you understand, when health centers face financial pressure and begin to suffer losses, including losses from Medicaid, they will do everything they can to protect access to the basic primary and preventive health care services that keep their patients healthy. As a result, these vital ancillary and enabling services are among the first to be cut, leaving patients with greater barriers to accessing health care. If a Spanish-speaking patient no longer has the ability to communicate with a clinician, their access to care is severely impaired. Likewise, if a health center can no longer provide van service to the center, an elderly woman who has lost her eyesight loses her access to care. Eliminating these services fundamentally undermines a center's ability to provide the most needed care in the communities. This means that health care needs would go unmet.

Of course, if a health center continues to lose money, it is forced to further restrict its services. Such means could include laying off clinicians or closing service delivery sites, like HIV/AIDS clinics, pediatrics clinics, or other satellite sites. Naturally, if revenue losses are too great, the health center closes, leaving its community without access to affordable health care. It is this result that the *Safety Net Preservation Act* is intended to avert.

Question 2: In your opinion, why have only eight states implemented cost-based systems for health centers?

Unfortunately, the Governors have consistently opposed Federal legislation ensuring adequate reimbursements to health centers designed to protect the integrity of the Public Health Service Act grants for care for the uninsured. While I cannot ascribe motives to particular States, I can draw some conclusions based on the attitudes expressed in the several letters written by the National Governors Association to Congress regarding the *Safety Net Preservation Act*.

First, indicative of the attitude expressed by the NGA, I do not believe that many governors understand the unique role of community health centers. As you know, health centers are required by Federal law to make their care accessible to everyone in the medically underserved area they serve, without regard to insurance coverage or ability to pay. Sadly, by advocating for policies that undermine health centers and suggesting that there is no reason to treat health centers differently from other providers, the NGA demonstrates a fundamental lack of understanding of the crucial role of health centers.

Second, the governors do not have a direct financial interest in protecting health centers, whereas the Federal government has a significant financial interest in doing so. In my opinion, if the governors were investing more than \$1 billion of their own funding in health centers to provide care for the uninsured, they would not be opposing a permanent long-term Medicaid payment system that protects such an investment. Ultimately, because the grant dollars for the uninsured are not State money, the NGA does not have the financial incentive to protect the health center safety net.

Because the NGA does not govern at the local level, it fails to appreciate how crucial these health resources are to the communities they serve. That is why the *Safety Net Preservation Act* has been endorsed by the United States Conference of Mayors and the National Association of Counties—they directly understand how the loss

of a health center will impact their communities. Unfortunately, it appears that the NGA does not view centers in those terms and that is why I believe that so few States have established a long-term Medicaid payment systems.

Question 3: Have community health centers benefited financially from their inclusion as network providers with Medicaid managed care plans?

Health centers provide those services that ensure that Medicaid recipients remain healthy. In addition, centers provide services that provide them with the tools to overcome poverty. That makes them valuable resources to managed care plans. However, because most States have not moved to the widespread use of managed care in their Medicaid programs, it is difficult to get a true sense of the precise impact of Medicaid managed care on safety net providers. In addition, due to the BBA's requirement that health centers receive "wrap around" payments to make up the difference between managed care reimbursement and their reasonable costs, health centers have not suffered as they would have without that "wrap around" protection.

While it is difficult to assess the impact of managed care on health centers in most cases, we do have examples of the impact when managed care is used without the protection of a long-term Medicaid payment system for health centers. In States that have received a waiver of Medicaid requirements through Section 1115 of the Social Security Act, we do have a better understanding of the impact of managed care on health centers. Despite the fact that each of the 1115 States (except Oregon) are required, as part of the terms and conditions of the approval of their waiver, to reimburse health centers on a "cost-related" or "risk-adjusted" basis, few States are actually meeting these requirements. Indeed, health centers in these States are suffering severe losses because Medicaid managed care plans are only reimbursing providers at a fraction of their cost and there is no mechanism to protect health centers' ability to care for the uninsured. Health centers in Tennessee have lost millions of dollars under the State's TennCare program. Likewise, health centers in Oklahoma have been receiving only a fraction of their cost of providing care to Medicaid patients—placing them under severe financial pressure and forcing them to reduce services. In these instances (and throughout Section 1115 waiver States), States are de facto relying on the Federal grant dollars to keep health centers operational while only reimbursing centers at a fraction of their cost of providing care.

I hope that my answers to these questions will provide some insight on the importance of community health centers and the need for a long-term Medicaid payment system for health centers. Please let me know if I can be of any further assistance to you.

Sincerely,

DANIEL R. HAWKINS, JR.
Vice President of Federal and State Affairs