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FOR YOUR INFORMATION

TO: Jane Horvath
Chris Jennings
Dan Mendelson
Rich Tarplin
FROM: Bonnie Washington
DATE: June 10, 1999
SUBJECT: Testimony - Senate Finance Committee Hearing on the Impact of the BBA FFS
Provisions

I thought you would be interested in the attached testimony. Please do not hesitate to let me know if you have questions or need assistance.

Attachments

**UNITED STATES SENATE
COMMITTEE ON FINANCE**

Hearing on the Impact of the 1997 Balanced Budget Act Provisions on the
Medicare Fee-for-Service Program

Thursday, June 10, 10:00 a.m. in 215 Dirksen Senate Office Building

WITNESS LIST

- I. **Robert A. Berenson, M.D.** Director, Center for Health Plans and Providers, Health Care Financing Administration; Washington, D.C.

Paul Van de Water, Ph.D. Associate Director for Budget Analysis, Congressional Budget Office; Washington, D.C.

Gail Wilensky, Ph.D., Chair, Medicare Payment Advisory Commission; Washington, D.C.

William J. Scanlon, Ph.D., Director, Health Financing and Public Health Issues, Health, Education, and Human Services Division, General Accounting Office; Washington, D.C.
- II. **Thomas A. Scully**, President and CEO, Federation of American Health Systems; Washington, D.C.

Charles M. Smith, M.D., President and CEO, Christiana Care Corp., on behalf of the American Hospital Association; Washington, D.C.

D. Ted Lewers, M.D., Vice-Chair, American Medical Association; Washington, D.C.

Susan S. Bailis, Co-Chairman and Co-CEO, Solomont Bailis Ventures, on behalf of the American Health Care Association; Boston, MA.

Mary Suther, President & CEO, Visiting Nurse Association of Texas on behalf of the National Association for Home Care; Washington, D.C.

Testimon of

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

on

BALANCED BUDGET ACT'S IMPACT
ON FEE-FOR-SERVICE MEDICARE

before the

SENATE FINANCE COMMITTEE

June 10, 1999



Testimony of
ROBERT A. BERENSON, M.D., DIRECTOR
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Chairman Roth, Senator Moynihan, distinguished committee members, thank you for inviting us to discuss the impact of the Balanced Budget Act on Medicare fee-for-service beneficiaries and providers. The BBA includes important new preventive benefits and payment system reforms that promote efficiency and prudent use of taxpayer dollars. These reforms are critical to strengthening and protecting Medicare for the future. The Medicare Trust Fund, which was projected to be insolvent by 1999 when President Clinton took office, is now projected to be solvent until 2015.

We have implemented more than half of the BBA's 335 provisions affecting our programs, including the new preventive benefits such as diabetes education, and a prospective payment system for skilled nursing facilities. In most cases, the statute prescribes in great detail the changes we are required to make. We are committed to affording providers maximum flexibility within our limited discretion as we implement the BBA.

Change of this magnitude always requires adjustment. It is not surprising that market corrections would result from such significant legislation. Our first and foremost concern has always been and will continue to be the effect of policy changes on beneficiaries' access to affordable, quality health care. We are proactively monitoring the impact of the BBA to ensure that beneficiary access to covered services is not compromised. Our regional offices are gathering extensive information from around the country to help us determine whether specific corrective actions may be necessary. We should be cautious about making changes to the BBA until we consider information and evidence of problems in beneficiary access to quality care.

It is clear that the BBA is succeeding in promoting efficiency and extending the life of the

Medicare Trust Fund. However, the BBA is only one factor contributing to changes in Medicare spending. Our actuaries tell us that low inflation from a strong economy and aggressive efforts to pay correctly and fight fraud, waste, and abuse are also having an impact on total spending. We have significantly decreased the number of improper payments made by Medicare. And, for the first time ever, the hospital case mix index is down due to efforts to stop “upcoding,” the practice of billing for more serious diagnoses than patients actually have in order to obtain higher reimbursement. It is also important to note that some of the slowdown in spending growth results from slower claims processing and payment during the transition to new payment systems.

The BBA also is only one factor contributing to provider challenges in the rapidly evolving health care market place. Efforts to pay right and promote efficiency may mean that Medicare no longer makes up for losses or inefficiencies elsewhere. We are concerned about reports about the financial conditions of some providers. However, it is essential that we delineate the BBA’s impact from the effects of excess capacity, discounted rates to other payers, aggressive competition, and other market factors not caused by the BBA.

New Preventive Benefits

One set of significant changes brought about by the BBA is coverage of key preventive health benefits. We have:

- ▶ expanded coverage for test strips and education programs to help diabetics control their disease;
- ▶ begun covering bone density measurement for beneficiaries at risk of osteoporosis;
- ▶ begun covering several colorectal cancer screening tests;
- ▶ expanded preventive benefits for women so Medicare now covers a screening pap smear, pelvic exam and clinical breast exam every three years for most women, and every year for women at high risk for cervical or vaginal cancer; and,
- ▶ begun covering annual screening mammograms for all women age 40 and over, and a one-time initial, or baseline, mammogram for women ages 35-39, paying for these tests whether or not beneficiaries have met their annual deductibles.

Payment Reforms

The BBA made substantial changes to the way we reimburse providers in the fee-for-service program. We have made solid progress in implementing these payment reforms. For example, we have:

- ▶ modified inpatient hospital payment rules;
- ▶ established a prospective payment system for skilled nursing facilities to encourage facilities to provide care that is both efficient and appropriate;
- ▶ refined the physician payment system, as called for in the BBA, to more accurately reflect practice expenses for primary and specialty care physicians; and
- ▶ initiated the development of prospective payment systems for home health agencies, outpatient hospital care, and rehabilitation hospitals that will be implemented once the Year 2000 computer challenge has been addressed; and,
- ▶ begun implementing an important test of whether market forces can help Medicare and its beneficiaries save money on durable medical equipment.

Monitoring Access

The payment reforms have created change for many of our providers, even though the percentage of providers who signed Medicare participation agreements increased by more than 6 percent to a record 85 percent for 1999. As mentioned above, our first and foremost concern continues to be the effect of policy changes on beneficiaries' access to affordable, quality health care. We are proactively monitoring the impact of the BBA to ensure that beneficiary access to covered services is not compromised. In addition to these efforts, we are systematically gathering data from media reports, beneficiary advocacy groups, providers, Area Agencies on Aging, State Health Insurance Assistance Programs, claims processing contractors, State health officials, and other sources to look for objective information and evidence of the impact of BBA changes on access to quality care.

We are examining information available from the Securities and Exchange Commission and Wall

Street analysts on leading publicly traded health care corporations. This can help us understand trends and Medicare's role in net income, revenues and expenses, as well as provide indicators of liquidity and leverage, occupancy rates, states-of-operation, lines of business exited or sold by the company, and other costs which may be related to discontinued operations.

We are monitoring Census Bureau data, which allow us to gauge the importance of Medicare in each health service industry, looking at financial trends in revenue sources by major service sectors, and tracking profit margin trends for tax-exempt providers.

We are monitoring the Bureau of Labor Statistics monthly employment statistics for employment trends in different parts of the health care industry. Such data show, for example, that the total number of hours worked by employees of independent home health agencies is at about the same level as in 1996. That provides a more useful indicator of actual home health care usage after the BBA than statistics on the number of agency closures and mergers.

We are being assisted by our colleagues at the HHS Inspector General's office. They have agreed to study the impact of the BBA's \$1500 limits on outpatient rehabilitation therapy. They have also agreed to interview hospital discharge planners as to whether they are having difficulty placing beneficiaries in home health care or skilled nursing facilities. Results of that study should help provide information in addition to surveys done for the General Accounting Office and the Medicare Payment Advisory Commission of home health agencies. And, because home health beneficiaries are among the most vulnerable, we have established a workgroup to develop an ongoing strategy for monitoring beneficiary access and agency closures.

Specific BBA Provisions

Home Health: The BBA closed loopholes that had invited fraud, waste and abuse. For example, it stopped the practice of billing for care delivered in low cost, rural areas for care from urban offices at high urban-area rates. It tightened eligibility rules so patients who only need blood drawn no longer qualify for the entire range of home health services. And it created an interim

payment system to be used while we develop a prospective payment system. We expect to have the prospective payment system in place by the October 1, 2000 statutory deadline. We expect to publish a proposed regulation this October so we can begin receiving and evaluating public comments, and a final rule in July 2000.

The interim payment system is a first step toward giving home health agencies incentives to provide care efficiently. Before the BBA, reimbursement was based on the costs they incurred in providing care, subject to a per visit limit, and this encouraged agencies to provide more visits and to increase costs up to their limit. The interim system includes a new, aggregate per beneficiary limit designed to provide incentives for efficiency until the prospective payment system can be implemented.

Last year Congress raised the limits on costs somewhat in an effort to help agencies under the interim system. We are also taking steps to help agencies adjust to these changes, and in March we held a town hall meeting to hear directly from home health providers about their concerns. We are giving agencies up to a year to repay overpayments resulting from the interim payment system. And, effective July 1, we are ending the sequential billing policy that had raised cash flow concerns for some agencies. This rule was designed to help facilitate the transfer of payment for care not related to inpatient hospital care from Part A to Part B, but we have determined we can accomplish the transfer through other means. At the same time, we are implementing the Outcome and Assessment Information Set (OASIS). OASIS fulfills a statutory mandate for a "standardized, reproducible" home care assessment instrument. It will help home health agencies determine what patients need. It will help improve the quality of care. And it is essential for accurate payment under prospective payment.

To date, evaluations by us and the GAO have not found that reduced home health spending is causing quality or access problems. However, as mentioned above, because home health beneficiaries are among the most vulnerable, we are planning for ongoing detailed monitoring of beneficiary access and agency closures.

Skilled Nursing Facilities: We implemented the new skilled nursing facility prospective payment system called for in the BBA on July 1, 1998. The old payment system was based on actual costs and included no incentives to provide care efficiently. The new system uses mean-based prices adjusted for each patient's clinical condition and care needs, as well as geographic variation in wages. It creates incentives to provide care more efficiently by relating payments to patient need, and enables Medicare to be a more prudent purchaser of these services.

The BBA mandated a per diem prospective payment system covering all routine, ancillary, and capital costs related to covered services provided to beneficiaries under Medicare Part A. The law requires use of 1995 as a base year, and implementation by July 1, 1998 with a three year transition. It did not allow for exceptions to the transition, carving out of any service, or creation of an outlier policy. We are carefully reviewing the possibility of making administrative changes to the PPS, but we believe we have little discretion.

We held a town hall meeting earlier this year to hear a broad range of provider concerns. There were concerns that the prospective payment system does not fully reflect the costs of non-therapy ancillaries such as drugs for high acuity patients. We share these concerns and are conducting research that will serve as the basis for refinements to the resource utilization groups that we expect to implement next year. And we fully expect that we will need to periodically evaluate the system to ensure that it appropriately reflects changes in care practice and the Medicare population. We are concerned about anecdotal reports of problems resulting from the prospective payment system. As stated earlier, we have asked the HHS Inspector General to evaluate the situation.

Outpatient Rehabilitation Therapy: The BBA imposed \$1500 caps on the amount of outpatient rehabilitation therapy services that can be reimbursed. We continue to be concerned about these limits and are troubled by anecdotal reports about the adverse impact of these limits. Limits on these services of \$1500 may not be sufficient to cover necessary care for all beneficiaries. Because of our concern, our HHS Inspector General colleagues have agreed to study the impact

of the BBA's \$1500 limit on outpatient rehabilitation therapy to help us judge whether and how any adjustments to the cap should be made.

Hospitals: We have implemented the bulk of the inpatient hospital-related changes included in the BBA in updated regulations. We have implemented substantial refinements to hospital Graduate Medical Education payments and policy to encourage training of primary care physicians, promote training in ambulatory and managed care where beneficiaries are receiving more and more services, curtail increases in the number of residents, and slow the rate of increase in spending. We have implemented provisions designed to strengthen rural health care systems. And we froze inpatient hospital payments in fiscal year 1998, as required under the BBA, resulting in substantial savings to taxpayers and the Medicare Trust Fund.

The BBA also called for a prospective payment system for outpatient care, which we expect to implement next year. The outpatient prospective payment system will include a gradual correction to the old payment system in which beneficiaries were paying their 20 percent copayment based on hospital charges, rather than on Medicare payment rates. Regrettably, implementation of the prospective payment system as originally scheduled would have required numerous complex systems changes that could substantially jeopardize our Year 2000 efforts. We are working to implement this system as quickly as the Year 2000 challenge allows. We issued a Notice of Proposed Rule Making in September 1998 outlining plans for the new system so that hospitals and others can begin providing comments and suggestions. We are making data files available to the industry, and we have extended the comment period until June 30, 1999 so the industry and other interested parties will have sufficient time and information to comment.

We do have greater concern for rural, inner city, cancer, and teaching hospitals because our analysis suggests that the outpatient prospective payment system will have a disproportionate impact on these facilities. We are reviewing the many comments we have received on the proposed regulation and we are continuing to develop possible modifications to the system for inclusion in the final rule.

Physicians: As directed by the BBA, we have begun implementing the resource-based system for practice expenses under the physician fee schedule, with a transition to full implementation by 2002 in a budget-neutral fashion that will raise payment for some physicians and lower it for others. The methodology we used addresses many concerns raised by physicians and meets the BBA requirements. We fully expect to update and refine the practice expense relative value units in our annual regulations revising the Medicare fee schedule. We plan to include the BBA-mandated resource-based system for malpractice relative value units in this year's proposed rule. We welcome and encourage the ongoing contributions of the medical community to this process, and we will continue to monitor beneficiary access to care and utilization of services as the new system is fully implemented.

We also are seeking legislation to refine the BBA's Sustainable Growth Rate for physician payment. Medicare payments for physician services are annually updated for inflation and adjusted by comparing actual physician spending to a national target for physician spending. The BBA replaced the former physician spending target rate of growth, the Medicare Volume Performance Standard, with the Sustainable Growth Rate (SGR). The SGR takes into account price changes, fee-for-service enrollment changes, real gross domestic product per capita, and changes in law or regulation affecting the baseline.

After BBA was enacted, HCFA actuaries discovered that the SGR system is unstable, and would result in unreasonable fluctuations from year to year. Also, the SGR target cannot be revised to account for new data. The President's fiscal 2000 budget contains a legislative proposal to deal with these issues.

CONCLUSION

The BBA made important changes to the fee-for-service Medicare program to strengthen and protect it for the future. These changes, along with a strong economy and our increased efforts to combat fraud, waste, and abuse, have extended the life of the Trust Fund until 2015. Change of

the magnitude encompassed in the BBA inevitably requires adjustment and fine tuning. It is not surprising that market corrections would result from such significant legislation.

As always, we remain concerned about the effect of policy changes on beneficiaries' access to affordable, quality health care. We are proactively monitoring the impact of the BBA to ensure that beneficiary access to covered services is not compromised. Our regional offices are gathering extensive information from around the country to help us determine whether specific corrective actions may be necessary. And we welcome the opportunity to look at any new information regarding beneficiary access to quality care. We are committed to looking at possible refinements to the BBA that are within our administrative authority. However, we should be cautious about making changes to the BBA until we consider information and evidence of problems in beneficiary access to quality care. We look forward to continuing to work with this Committee to identify issues of concern, and we will keep you up to date on the status our of implementation of the BBA. I thank you for holding this hearing, and I am happy to answer your questions.

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CBO TESTIMONY

Statement of
Paul N. Van de Water
Assistant Director
for Budget Analysis
Congressional Budget Office

on
the Impact of the Balanced Budget Act
on the Medicare Fee-for-Service Program

before the
Committee on Finance
United States Senate

June 10, 1999

NOTICE

This statement is not available for public release until it is delivered at 10:00 a.m. (EDT), Thursday, June 10, 1999.



CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

Mr. Chairman and Members of the Committee, I am pleased to represent the Congressional Budget Office (CBO) at this hearing on the fee-for-service portion of the Medicare program. After many years of rapid increases, the growth of Medicare spending has slowed sharply in the past two years. My statement discusses the reasons for that slowdown and presents CBO's assessment of future trends. I will make three main points:

- o The greater-than-expected slowdown in the growth of Medicare spending stems mainly from successful efforts to combat fraud and from delays in payments to health care providers.
- o With one exception, CBO's estimates of the effects of the Medicare provisions of the Balanced Budget Act (BBA) of 1997 still appear reasonable. CBO did not anticipate how home health agencies would implement the interim payment system for home health services, however, and may therefore have underestimated its savings.
- o The factors that are holding down the growth of Medicare spending will be played out in the next few years, and more rapid growth will then resume.

TRENDS IN MEDICARE SPENDING

Between 1980 and 1997, Medicare spending increased at an average rate of 11 percent a year and expanded from 5 percent to 12 percent of the federal budget. Total outlays for Medicare rose by only 1.5 percent in 1998, however, and may decline in 1999. Part of that slowdown was anticipated; the Balanced Budget Act lowered the projected growth of Medicare spending by an estimated 4 percentage points in 1998. The BBA reduced payment rates for many services and restrained the update factors for payments through 2002. Both fee-for-service providers and Medicare+Choice plans are experiencing lower increases in payments as a result.

But the actual rate of spending growth is considerably slower than the BBA provisions alone were expected to produce. Other factors appear to have contributed to the sudden flattening of Medicare expenditures, including greater compliance with Medicare payment rules and a longer time for processing claims.

Widely publicized efforts to clamp down on fraud and abuse in the program have resulted in greater compliance by providers with Medicare's payment rules. Those efforts include more rigorous screening of claims by Medicare contractors and tougher enforcement of Medicare laws by the Departments of Justice and Health and Human Services. Through investigations and lawsuits, those agencies have pursued a wide range of providers—including hospitals, teaching physicians, home health

agencies, clinical laboratories, and providers of durable medical equipment—as well as Medicare contractors themselves. Although the total reduction in spending growth attributable to the improved compliance cannot be quantified, CBO estimates that one response alone to recent enforcement efforts—less aggressive billing by hospitals—lowered growth in Medicare spending by 0.75 percentage points in 1998.

The average time for processing Medicare claims rose dramatically in 1998. Expanded compliance activities, combined with major efforts to prepare computer systems for 2000, contributed to longer payment lags, which can have a substantial effect on Medicare outlays. An increase of one week, for example, in the average time for processing claims reduces Medicare outlays for the fiscal year by 2.3 percent. But that reduction is only temporary because the delay merely moves outlays into the next fiscal year.

CBO expects that improved compliance with payment rules and longer claims-processing times will have little or no effect on the rate of growth of Medicare spending in the longer run. Our projections assume that payment lags will begin to return to more typical levels late in 2000, with a catch-up in spending and a resumption of normal spending growth in 2001 and 2002 (see Table 1). Most of the projected increase over the next few years reflects rising expenditures per enrollee. The leading edge of the postwar baby boom will not reach age 65 until after 2010.

TABLE 1. MEDICARE OUTLAYS (By selected fiscal year)

	1990	1998	1999	2004	2009
In Billions of Dollars					
Gross Mandatory Outlays					
Benefits	107	210	212	298	443
Mandatory administration and grants ^a	<u> b</u>	<u> 1</u>	<u> 1</u>	<u> 1</u>	<u> 1</u>
Total	107	211	213	300	444
Premiums	<u>-12</u>	<u>-21</u>	<u>-21</u>	<u>-34</u>	<u>-53</u>
Mandatory Outlays Net of Premiums	96	190	192	266	391
Discretionary Outlays for Administration	<u> 2</u>	<u> 3</u>	<u> 3</u>	<u> 4</u>	<u> 4</u>
All Medicare Outlays Net of Premiums	98	193	195	269	396
Average Annual Growth Rate from Previous Year Shown (Percent)					
Gross Mandatory Outlays		8.8	1.1	7.1	8.2
Premiums		7.5	3.4	9.7	9.3
Mandatory Outlays Net of Premiums		9.0	0.8	6.7	8.0
Discretionary Outlays for Administration		1.5	7.4	4.7	4.0
All Medicare Outlays Net of Premiums		8.8	0.9	6.7	8.0

SOURCE: Congressional Budget Office.

a. Mandatory outlays for administration support peer review organizations, certain activities against fraud and abuse, and grants to states for premium assistance.

b. Less than \$500 million.

Projections of Spending and Enrollment in Medicare+Choice

Payments for Medicare+Choice plans in CBO's baseline soar from \$37 billion in 1999 to \$141 billion in 2009 as enrollment in those plans continues to expand. The spending increase also reflects the expected growth in expenditures per enrollee. CBO projects that risk-based plans will account for 16 percent of Medicare enrollees in 1999, 22 percent in 2004, and 31 percent in 2009, assuming that the second phase of risk adjustment is implemented on a budget-neutral basis.

Projections of Spending and Enrollment in the Medicare Fee-for-Service Program

CBO projects that spending in Medicare's fee-for-service program will increase from \$175 billion in 1999 to \$302 billion in 2009 (see Table 2). That growth will occur despite shrinkage in fee-for-service enrollment, which will decline by 1.5 million over the next decade, and cuts in the growth of payment rates for many services.

Spending growth for different services will vary considerably over the same period. The extent of the recent slowdown in spending has also varied by type of service, although spending for all services has been affected by the 1.9 percent drop in fee-for-service enrollment that occurred in 1998 and the further 0.8 percent decline expected in 1999.

TABLE 2. OUTLAYS FOR MEDICARE BENEFITS, BY SECTOR (By fiscal year)

Sector	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
In Billions of Dollars												
Medicare+Choice ^a	32	37	41	49	48	60	70	88	88	108	124	141
Fee-for-Service												
Skilled nursing facilities	13	13	13	14	14	15	16	17	18	19	21	22
Home health	15	15	17	16	17	18	20	21	23	24	26	28
Hospice	2	2	2	2	3	3	3	3	3	3	4	4
Hospital inpatient ^b	87	86	91	95	99	104	108	112	117	123	129	135
Physicians' services	32	32	33	34	35	36	37	38	39	40	41	43
Outpatient facilities	17	16	17	18	20	21	23	25	26	28	30	33
Other professional and outpatient ancillary services	<u>12</u>	<u>12</u>	<u>14</u>	<u>15</u>	<u>17</u>	<u>20</u>	<u>22</u>	<u>25</u>	<u>28</u>	<u>31</u>	<u>34</u>	<u>38</u>
Subtotal	178	175	186	194	205	217	228	241	255	269	285	302
Total	210	212	228	243	253	277	298	328	343	378	409	443
Annual Growth Rate (Percent)												
Medicare+Choice ^a	26.3	14.0	11.7	18.0	-1.3	25.0	16.7	24.7	0.8	22.8	14.6	13.4
Fee-for-Service												
Skilled nursing facilities	8.9	-3.8	1.7	5.3	5.1	6.4	6.0	6.4	6.5	6.4	6.4	6.4
Home health	-14.9	0.8	10.3	-5.8	10.1	6.6	7.2	7.9	7.8	7.4	6.8	6.6
Hospice	1.0	2.5	8.6	6.3	4.6	5.7	5.3	5.7	5.8	5.7	5.8	5.8
Hospital inpatient ^b	-2.5	-1.5	5.7	4.7	4.5	4.7	3.9	4.1	4.5	4.6	4.9	4.8
Physicians' services	3.0	0.6	4.2	2.3	2.4	3.4	2.6	2.8	3.0	3.0	3.3	3.5
Outpatient facilities	-5.5	-6.6	8.4	8.5	7.1	7.7	7.2	7.4	7.3	7.3	7.6	7.9
Other professional and outpatient ancillary services	0.7	0.6	14.0	13.0	12.5	13.2	12.3	12.3	12.1	11.0	10.7	10.2
All Fee-for-Service	-2.1	-1.4	6.4	4.4	5.5	5.8	5.2	5.5	5.8	5.8	5.9	5.9
All Medicare Benefits	1.4	1.0	7.3	6.8	4.1	9.5	7.7	10.0	4.4	10.1	8.4	8.2

SOURCE: Congressional Budget Office.

a. Includes spending for health maintenance organizations paid on a cost basis, certain demonstrations, and health care prepayment plans, which are paid on a cost basis for Part B services.

b. Includes subsidies for medical education that are paid to hospitals that treat patients enrolled in Medicare+Choice plans.

Postacute Care Services. Growth in payments for skilled nursing facility (SNF) and home health services—the fastest-growing areas of fee-for-service spending in Medicare during the decade preceding passage of the Balanced Budget Act—slowed significantly in 1998. The most dramatic change was in spending for home health care, which actually fell by 14.9 percent in 1998. SNF expenditures, by contrast, continued to rise but at less than half the rate of growth in 1997—8.9 percent compared with 21.1 percent. The slowdown in spending reflects the implementation of new prospective payment systems and increases in the time for processing claims.

The transition to prospective payment systems is expected to hold down the average annual rate of growth in these categories of spending through 2001. Spending is then projected to increase through 2009 at an average annual rate of 6.2 percent for SNF services and 7.5 percent for home health services.

Inpatient Hospital Services. Medicare payments for inpatient hospital services fell 2.5 percent in 1998, to \$87 billion. The factors contributing to that drop include a decline in the volume of services provided (reflecting the drop in fee-for-service enrollment) and several provisions in the BBA that froze payment rates for most operating costs, reduced capital-related payment rates by 17.8 percent, and cut subsidies for medical education. In addition, the case-mix index—a measure of the relative costliness of the cases treated in hospitals paid under the prospective payment system—fell 0.5 percent in 1998. Much of that unprecedented drop in the

index is probably attributable to widespread adoption by hospitals of less aggressive billing practices following antifraud initiatives that focused on those practices.

For most hospitals, the BBA limits cumulative increases in payment rates for operating costs to about 6 percentage points below inflation over the 1999-2002 period. CBO projects that the limit on rate increases, in combination with declining fee-for-service enrollment, will result in a 1.5 percent drop in payments for hospital inpatient services in 1999. Those payments are projected to begin rising in 2000, with annual growth rates averaging 4.5 percent from 2000 through 2009.

Physicians' Services. Medicare payments for physicians' services rose 3.0 percent in 1998, to \$32 billion. Payments are projected to remain flat in 1999 and to grow at an average annual rate of 2.8 percent over the next decade, reaching \$43 billion in 2009. That growth rate is a result of payment formulas enacted in the BBA that tie the growth of per-enrollee expenditures for physicians' services to the growth of gross domestic product per capita. Those formulas generate annual rate changes that oscillate widely around a smooth trend. CBO projects stable growth rates, however, because the timing of those oscillations is impossible to predict.

Outpatient Services. Payments to outpatient facilities—such as hospital outpatient departments, dialysis facilities, and rural health clinics—fell by 5.5 percent in 1998 and are projected to decline another 6.6 percent in 1999. Those reductions result

largely from lower payment rates accompanying the transition to a prospective payment system for hospital outpatient services. Outpatient payments are projected to rebound in 2000 and grow at annual rates of 7 percent or more for the rest of the decade.

Spending for outpatient therapy services and other outpatient ancillary services—including pharmaceuticals, durable medical equipment, and chiropractic care—rose only 0.7 percent in 1998 as a result of reductions in payment rates and a cap on payments for therapy services performed outside hospitals. Projected payments for nonphysician professional services and outpatient ancillary services will grow only slightly in 1999 before taking off again in 2000. Annual spending growth is expected to average 11.3 percent from 1999 through 2009.

EFFECTS OF THE BALANCED BUDGET ACT

In January 1997, CBO projected that net mandatory outlays for Medicare would grow from \$189 billion in 1997 to \$288 billion in 2002. That January 1997 baseline was the basis for CBO's estimate of the savings from the BBA. CBO estimated that the BBA would reduce net mandatory spending for Medicare by \$6 billion in 1998, \$41 billion in 2002, and \$112 billion over the 1998-2002 period. As a result, in its August 1997 analysis of the BBA, CBO projected that net mandatory outlays for

Medicare would grow to \$247 billion in 2002, rather than the \$288 billion projected the previous January (see Table 3).

CBO's current baseline, prepared in March 1999, projects that net mandatory Medicare spending will grow from \$192 billion in 1999 to \$227 billion in 2002. Those figures are \$18 billion and \$20 billion, respectively, below the levels projected in August 1997.

TABLE 3. COMPARISON OF AUGUST 1997 AND MARCH 1999 PROJECTIONS OF NET MANDATORY OUTLAYS FOR MEDICARE (By fiscal year, in billions of dollars)

	1997	1998	1999	2000	2001	2002
January 1997 Projection	189	206	226	250	261	288
Minus Effects of Balanced Budget Act	<u>0</u>	<u>-6</u>	<u>-16</u>	<u>-29</u>	<u>-20</u>	<u>-41</u>
August 1997 Projection	189	200	210	220	241	247
March 1999 Projection	187	190	192	206	219	227
March 1999 Projection Minus August 1997 Projection	-1	-9	-18	-15	-22	-20

SOURCE: Congressional Budget Office.

NOTE: Numbers may not add up to totals because of rounding.

Why the Projections Have Changed

Each year CBO updates its budget projections to account for legislative changes, updated economic assumptions, and other new information. Since the enactment of the BBA, the only noticeable legislative effect on Medicare spending has been the modification of home health payment rates included in last year's omnibus appropriation bill (Public Law 105-277). CBO estimated that legislation will increase Medicare outlays by \$2 billion in 2000 and reduce them by \$1 billion in 2001. CBO's current projections of inflation rates are slightly lower than they were in January 1997. Those lower inflation rates account for about \$3 billion of the annual differences between the August 1997 and March 1999 projections.

Most of the difference between the two sets of projections is attributable to new information—most notably the unanticipated slowing of spending growth in 1997 and 1998 resulting from improved compliance with Medicare payment rules. In essence, the 1997 projections were too high because CBO did not anticipate the full effects of Operation Restore Trust—Medicare's program to combat fraud. CBO also did not foresee the increasing lag in 1998 and 1999 between when services are furnished and when payment is made and implementation of adjustments to payments to Medicare+Choice plans on the basis of risk in a manner that will reduce spending.

CBO has not revised its estimates of the effect of the BBA on Medicare spending. With one possible exception, CBO believes that its estimates of the Balanced Budget Act were reasonable.

Spending for Home Health Services

The one policy for which CBO may have significantly underestimated savings is the interim payment system for home health agencies. CBO's current projection of outlays for home health services is much lower than projected in August 1997. Those lower projections are largely attributable to new information about the effects of Operation Restore Trust and other antifraud initiatives and to increases in the lag between when services are furnished and when payment is made; they do not fully incorporate our revised assessment of the effects of the interim payment system.

Lower payments for home health services also explain most of the shortfall in Medicare spending so far this year. Some of the drop in home health spending stems from longer payment lags resulting from a new method of processing claims known as sequential billing, in which a claim is paid only if all prior claims have been processed. Medicare will suspend that billing process in July, which should increase spending during the last quarter of the fiscal year. In addition, the use of home health services seems to have dropped substantially, probably as a result of

both antifraud activities and an unexpectedly cautious response by home health agencies to the per-beneficiary limit under the interim payment system. That limit applies to aggregate payments: payments for individual beneficiaries may exceed the limit as long as the average payment for all beneficiaries served by an agency does not exceed the per-beneficiary limit. Some agencies, however, apparently believe that the limit applies to each beneficiary and are cutting off services to patients who have reached the per-beneficiary limit. Thus, the average payment per beneficiary is well below the allowable amount.

CONCLUSION

CBO is currently updating its projections of Medicare spending and will release them on July 1, as called for in the budget resolution. Because the rate of Medicare spending through May of this year has been lower than CBO estimated in March (and about 2½ percent below the rate for the first eight months of last year), the July projections of Medicare spending in 1999 and 2000 will probably be several billion dollars lower than the March estimates.

Medicare will replace the interim payment system for home health services with a prospective payment system in 2001. Because that system will remove much of the uncertainty about payments that has contributed to the current apparent drop in utilization, spending for home health services could rebound in 2001 and

subsequent years. Therefore, CBO does not now anticipate significantly revising its projections of spending on home health services—or other categories of services—beyond 2000. CBO expects that total Medicare spending will resume growing at an average rate of 7 percent to 8 percent a year in the decade after 2000.

June 10, 1999

The Impact of the Balanced Budget Act of 1997 on Medicare's Fee-for-service Sector

Gail R. Wilensky, Ph.D.

Chair

Medicare Payment Advisory Commission

before the Committee on Finance
United States Senate

Good morning Chairman Roth, Senator Movenhan, members of the Committee. I am Gail Wilensky, chair of the Medicare Payment Advisory Commission (MedPAC), and I am pleased to be here to discuss the implications of the Balanced Budget Act (BBA) of 1997 for beneficiaries and providers in Medicare's traditional fee-for-service program.

My testimony today focuses on what we know about the effects of payment changes for five types of services—inpatient hospital, outpatient hospital, skilled nursing, home health, and physician—that have been the subject of much discussion this spring. It draws on MedPAC's March report to the Congress, which presented the Commission's recommendations on Medicare payment policy, and our June report, issued last week, which discusses our recommendations on a range of issues in Medicare, including quality of care and access to care.

A greater than expected slowdown in Medicare spending began in fiscal year 1998 and has continued this year. Unfortunately, we cannot draw definitive conclusions about what in Medicare's fee-for-service sector is generating this slowdown. Data for the BBA period are extremely limited, and we cannot easily isolate the effects of the BBA from other changes. Hospitals, for example, have argued that the changes in Medicare payments stemming from the BBA are reducing their margins and impinging on their ability to provide quality care. But the most recent complete information we have for the Medicare program is from fiscal year 1997, the year before the BBA took effect. For home health services, we have seen lower than expected outlays, closures of home health agencies, and declines in the use of services. But our

interpretation of these findings is clouded by other policy changes, notably efforts by the Health Care Financing Administration (HCFA) to cut down fraud and abuse in the home care industry.

The BBA had an ambitious objective for Medicare's fee-for-service program: modernizing payment systems and slowing the growth in spending while preserving Medicare beneficiaries' access to high-quality health care. To expect legislation as sweeping as the BBA to achieve this objective flawlessly is unrealistic and, as I discuss, in a number of instances targeted changes in statute or in regulation could improve Medicare's payments and access to care for beneficiaries. But providers' complaints notwithstanding, we have no evidence that wholesale changes in the BBA are either necessary or desirable.

Provisions of the Balanced Budget Act affecting fee-for-service providers

The BBA enacted the most far-reaching changes to the Medicare program since its inception. In Medicare's fee-for-service sector, it made changes to a number of payment mechanisms for inpatient hospital services. The law established, or directed to be established, new prospective payment systems for services provided by hospital outpatient departments, skilled nursing facilities, home health agencies, and rehabilitation hospitals and units. It introduced a new mechanism for updating fees for physician services. Finally, it reduced payment updates or otherwise slowed the growth in payments to virtually all fee-for-service providers.

The changes enacted in the BBA and implemented by the Health Care Financing Administration reduced Medicare spending relative to what it would have been otherwise and, not surprisingly, have generated concerns among providers about their effects. These concerns arise from perceptions that the effects have been more harsh than what the Congress intended, or that the effects, while intended, have nonetheless imposed burdens on providers, and that there are specific problems with how HCFA has implemented the law.

Providers' concerns are clearly relevant to any assessment of the BBA. But at the same time, we must remember that the primary objective of the Medicare program is to maintain access to high-quality care for beneficiaries. Assessing the implications of the BBA should therefore focus on whether access to or quality of care has been hampered and, if so, what can be done about it.

In evaluating the impact of the BBA, two issues seem especially important. One is whether the case-mix adjustments used in the new payment systems adequately reflect predictable differences in patient care costs that result from differences in patients' health status. This issue is important because inadequate case-mix adjustments create financial incentives for providers to deny access to care or undertreat identifiable groups of patients.

A second critical issue is how payment policies for different services may interact to affect providers' incentives to furnish efficient, high-quality care. Some providers, such as many hospitals, furnish most types of services. Consequently, they must consider and respond to the

combined effects of policy changes that have altered payments for virtually every service they provide.

Inpatient hospital services

The BBA changed payments for inpatient hospital services in a number of ways. For hospitals under Medicare's prospective payment system (PPS), the law provided for no update to operating payments in fiscal year (FY) 1998 and limited updates in FY 1999 through FY 2002. It phased in reductions in the per-case adjustments for the indirect costs of medical education and for hospitals serving a disproportionate share of low-income patients. And it instituted a new transfer policy for 10 high-volume diagnosis related groups (DRGs), reducing the payment rates when hospitals discharge patients in these DRGs to post-acute care facilities following unusually short stays.

In formulating its recommendations for the FY 2000 update, MedPAC noted that hospitals have responded to an increasingly competitive market by improving their productivity and shifting services to other sites of care. These two responses generated substantially lower rates of growth in inpatient costs—with costs per case actually falling every year between 1994 and 1997—and sharply higher Medicare inpatient margins. Hospitals' average Medicare inpatient margin in 1997—17.1 percent—was the highest it had been since the inception of the PPS.

At the same time, MedPAC recognized several factors pointing to the need for caution in specifying future updates, including emerging evidence that the decade-long trend in rising case mix complexity, which automatically increases PPS payments, may be subsiding. We also questioned whether the unusually low rate of hospital cost inflation observed in recent years can be sustained without adverse effects on quality of care. With these factors in mind, we concluded that the operating update for FY 2000 enacted in BBA—1.8 percentage points less than the increase in HCFA's operating market basket index—will provide reasonable rates. (Under current forecasts, that would be an update of 0.9 percent.) MedPAC's recommendation took into account part, but not all, of the cumulative reduction in costs per case due to shifts in the site of care.

Since MedPAC made its recommendation in March, the hospital industry has issued several reports projecting the impact of the BBA on hospital revenues and margins. These reports contain new projections but no new data. In response to congressional requests, MedPAC staff have analyzed these studies and found that all of them project a more adverse impact of the BBA than we believe to be the case. Some present a particularly inaccurate picture of the impact in FY 1998 by assuming a rate of increase in costs that substantially exceeds what we already know has occurred. Data from the American Hospital Association's National Hospital Panel Survey suggest that when complete Medicare cost report data become available, we will again see a decline in Medicare cost per discharge for FY 1998, the fifth year in succession.

Although we believe that these reports overstate to some degree the impact the BBA will have on hospital margins, the overall direction of that impact is correct. The law has thus reversed a six-year trend of Medicare payments rising more rapidly than the costs of treating Medicare payments. But changes in total margins also reflect developments in the private sector, where HMOs and other payers have continued to exert strong downward pressure on hospital revenue flows. As Medicare tightened its payment policies in 1998, the combined pressure on revenues has caused the financial distress that hospitals are currently experiencing.

Projections of margins also need to be interpreted with caution. Because hospitals will respond to financial pressures, MedPAC views projected margins only as a gauge of the pressure that Medicare payment policies will impose on hospitals but not as a prediction of what will occur. Evaluating whether those responses affect quality and access to care will be just as important as measuring financial performance. MedPAC has seen no evidence that the changes to date have affected either quality or access in the inpatient sector, but we will continue to monitor developments.

Outpatient hospital services

In addition to changes in payments for inpatient services, the BBA also enacted major changes in Medicare's payments for services provided in hospital outpatient departments. It eliminated the so-called formula-driven overpayment under which Medicare's payments did not correctly take into account the effect of beneficiaries' cost sharing and extended the reduction in payments for

services paid on a cost-related basis. The law also directed the Secretary to establish a prospective payment system for services that previously had been paid under a blend of fees and cost-based reimbursement.

In contrast to the payment changes for inpatient services, hospitals have not yet felt the full impact of the BBA provisions affecting outpatient services. MedPAC estimates that elimination of the formula-driven overpayment, which took effect in FY 1998, reduced payments by about 8 percent. However, the PPS that was to have gone into effect in January 1999 will not be put in place before next spring. HCFA originally estimated that the PPS would reduce payments by 3.8 percent; the agency recently revised its estimate to 5.7 percent.

MedPAC's principal concern with the PPS proposed by HCFA is that it is too aggregated. In basing payments on groups of services instead of individual services, the system is likely to overpay for some services and underpay for others. This could lead to access problems for beneficiaries needing services whose payments fall short of costs. In our March report, MedPAC recommended that the PPS be based on the costs of individual services.

Implementing the outpatient PPS will reduce payments for virtually all hospitals but could have much larger effects on specific types of hospitals. For example, based on HCFA's original estimates, small rural hospitals would see a 10 percent decline in payments, and payments to cancer hospitals would drop almost 30 percent. Given the magnitude of these changes, MedPAC recommends that the Secretary closely monitor the use of hospital outpatient

services to ensure that beneficiaries' access to appropriate care is not compromised.

Consideration should also be given to phasing in the new payment system to help us detect any problems before they become severe.

Services in skilled nursing facilities

The BBA enacted a prospective payment system for services provided in skilled nursing facilities (SNFs). These services had previously been paid on the basis of costs, subject to certain limits.

Under the new system, patients in SNFs will be classified under the Resource Utilization Group system, version III (RUG-III), which groups patients by their clinical characteristics for determining per diem payments. Payments are intended to cover the routine, ancillary, and capital costs incurred in treating a SNF patient, including most items and services for which payment was previously made under Part B of Medicare. The PPS is being phased in over a three-year period; during the phase-in, payments are based on a blend of federal rates and facility-specific rates.

Industry representatives and others have asserted that the SNF PPS does not adequately account for the costs of high-acuity patients, which may impair access for these people. The RUG-III classification system is based on the time providers spend furnishing nursing and therapy services. But SNF patients can vary significantly in their use of ancillary services and supplies, such as respiratory therapy, lab tests, imaging services, drugs and biologicals, and

transportation. Variation in the use of these services is reflected in the RUG-III system only to the extent that their use is correlated with the use of nursing and therapy services.

Although anecdotal, early evidence indicates that some Medicare patients are in fact having difficulty accessing care in SNFs. The problem is not the PPS by itself, but the mismatch between payments and costs for patients who require relatively high levels of nontherapy ancillary services and supplies. Accordingly, the Commission recommended in our March report that the Secretary continue to refine the classification system to improve its ability to predict the use of nontherapy services and supplies. An improved classification system would match payments more closely to beneficiaries' needs for services and help to avoid access problems among medically complex patients.

Home health services

Before the BBA, home health agencies were paid on the basis of costs, subject to limits based on per-visit costs. The BBA directed the Secretary to implement a prospective payment system effective October 1999 and established an interim payment system (IPS) to control the growth in spending until the PPS was implemented. The IPS reduced limits based on costs per visit and added an average per-beneficiary cost limit based on a blend of agency-specific costs and average per-patient costs for agencies in the region. Home health agencies are now paid the lower of their actual costs, the aggregate per-beneficiary limit, and the aggregate per-visit limit.

Following a decade of extremely rapid growth, outlays for home health services actually fell in 1998, the first year of the IPS. The home health industry contends that the IPS has been responsible for large numbers of agency closures and that it has adversely affected care. Beneficiary advocates have echoed these sentiments. In response to such concerns, the Congress last fall directed MedPAC to examine the impact of the IPS on access to home health services. Our analysis is contained in our June 1999 report.

MedPAC found that fewer Medicare beneficiaries are receiving home health care than in the recent past, the number of visits per user has decreased, and the number of agencies has declined. Based on a survey of home health agencies conducted for MedPAC by Abt Associates, Inc., we found that some agencies report they no longer accept, or are likely to discharge earlier, certain types of patients because of the payment changes. We also convened a panel of experts familiar with beneficiaries' problems accessing home health services. The panel indicated that some beneficiaries are having more difficulty obtaining services to which they believe they are entitled under Medicare's home health benefit.

These findings are consistent with the claim that the IPS has hampered access, but they do not tell the whole story. First, numerous concurrent policy changes have contributed to the changes we observed. These policies include efforts by HCFA to reduce fraud and abuse by stepping up oversight of home health care providers, imposing a four-month moratorium on the certification of new agencies in early 1998, and adopting a new bill-processing policy. Concurrent policy changes also include enactment by Congress of a much stricter per-beneficiary

limit for new home agencies. The new limit has probably reduced entry into the home health care market significantly.

Changes in the use of home health services may also reflect confusion about the IPS on the part of home care providers. Anecdotal evidence suggests that some home health agencies have interpreted the per-beneficiary limits to apply to specific Medicare beneficiaries, not to the agency's average cost per beneficiary as intended by the BBA. Thus, some agencies may be failing to recognize that costs for beneficiaries who use a large number of visits can be balanced against the costs of short-stay users.

Finally, it is impossible to determine whether the changes in use of home health services that have been observed during the past two years are appropriate. It is difficult in part because Medicare's standards for eligibility for and coverage of home health services are too loosely defined. MedPAC recommends in our June report that the Secretary should speed the development of regulations that would outline home health care coverage and eligibility criteria based on the clinical characteristics of beneficiaries and that she should recommend to the Congress the legislation needed to accomplish the implementation of those regulations.

MedPAC is also concerned that the timetable for implementing prospective payment for home health services is very tight. Accordingly, we recommend in our June report that Congress explore the feasibility of establishing a process for agencies to exclude a small share of their patients—say 2 percent—from the aggregate beneficiary limits. Under our recommendation,

Medicare would reimburse care for excluded patients based on the lesser of actual costs or the aggregate per-visit limits. MedPAC believes that such a policy should be implemented in a budget-neutral manner.

Physicians' services

The BBA replaced the volume performance standard system that had been used to update physicians' fees with a new sustainable growth rate (SGR) system. Under the SGR, the annual update each year depends on how Medicare's cumulative actual fee-for-service spending from 1997 to the update year compares with cumulative allowed spending for the same period. Cumulative allowed spending reflects actual and projected fees for physicians' services, anticipated Part B fee-for-service enrollment, projected real gross domestic product per capita, and changes arising from laws and regulations other than the SGR system.

Two technical aspects of the SGR system have come under criticism: the Secretary's lack of authority to correct for projection errors and the potential for oscillations in fee updates. MedPAC concurs with these criticisms and recommended in its March report that Congress enact legislation to address them.

Because the SGR is cumulative, uncorrected projection errors affect all subsequent updates. This happened in 1999, when an unexpected slowdown in Medicare+Choice enrollment growth led to a smaller than projected decline in Part B fee-for-service enrollment. To address

this problem, MedPAC recommended in its March report that the Congress require the Secretary to correct estimates used in SGR system calculations every year.

The potential for oscillation in fee updates arises from problems with the data and methods used to calculate the updates. These problems are likely to lead to extreme positive and negative updates. MedPAC recommends legislation to correct these problems and modulate swings in updates.

Before the Committee on Finance, U.S. Senate

For Release on Delivery
Expected at 10:00 a.m.
Thursday, June 10, 1999

BALANCED BUDGET ACT

Any Proposed Fee-for-Service Payment Modifications Need Thorough Evaluation

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



Mr. Chairman and Members of the Committee:

I am pleased to be here today as you discuss the effect of the Balanced Budget Act of 1997 (BBA) on the Medicare fee-for-service program. The BBA set in motion significant changes that attempted to both modernize Medicare and rein in spending. The act's combination of constraints on provider fees, increases in beneficiary payments, and structural reforms is projected to lower program spending by \$386 billion over the next 10 years. Because certain key provisions have only recently or have not yet been phased in, the full effects on providers, beneficiaries, and taxpayers wrought by the BBA will not be known for some time.

My comments focus on the payment reforms for providers under the fee-for-service portion of the program. I will concentrate on the changes made to skilled nursing facility (SNF) and home health agency (HHA) payment policies. Although the BBA mandated similar reforms for other types of providers, the SNF and HHA changes are, at this time, farthest along in their implementation. These provisions were enacted in response to continuing rapid growth in Medicare spending that was neither sustainable nor readily linked to demonstrated changes in beneficiary needs. These provisions represented bold steps to control Medicare spending by changing the financial incentives inherent in provider payment methods to promote more efficient service delivery. Yet the Congress is coming under increasing pressure from providers to revisit these reforms. As additional BBA provisions are implemented, and other providers feel the effects of the mandated changes, calls for modifications may continue or even intensify. How responsibilities to current and future seniors, the American taxpayer, and the health care provider community are balanced will shape the resulting responses. Achieving the appropriate balance will require recognition of legitimate concerns about beneficiary access and the ability of providers to adjust to the new payment methods.

Calls by providers to moderate the effect of BBA changes come at a time when federal budget surpluses and smaller-than-expected increases in Medicare outlays may make it easier to accommodate higher Medicare payments. Indeed, many provider groups contend that BBA changes produced more savings than originally intended. The Congressional Budget Office has revisited and lowered its estimates of Medicare spending since BBA enactment. As a result of the lower projected spending, the estimated savings from the BBA provisions will represent a proportionately larger share of Medicare expenditures. Lower projected Medicare spending, however, does not necessarily mean that the effect of the BBA changes was greater than intended. Rather, it merely raises again issues of how much the federal government should pay for health care for the elderly and what payment levels are appropriate for the various provider groups.

The BBA mandated the continued movement of fee-for-service Medicare away from cost-based reimbursement methods and toward prospective payment systems (PPS). The goal is to foster more efficient provision and use of services to lower spending growth rates, replicating the experience of acute care hospitals after a PPS was implemented, beginning in the mid-1980s. The BBA mandated such payment systems for SNFs, HHAs, hospital outpatient services, and certain hospitals. On July 1, 1998, SNFs began a 3-year transition to a PPS.¹ An interim payment system (IPS) for HHAs was phased in beginning on October 1, 1997, and a PPS is scheduled to be implemented for all HHAs on October 1, 2001.²

In brief, both SNFs and HHAs have felt the effect of the BBA provisions, and both industries will need time to adapt, but the calls to amend or repeal the new payment systems are, in our view, premature. The SNF PPS was implemented with a 3-year transition to the fully prospective rates, and facilities are phased into this transition schedule according to their fiscal year; thus, the adjustment time has been built into the PPS schedule. Current concerns that the PPS is causing extreme financial pressures for some SNFs need to be systematically evaluated on the basis of additional evidence. Several factors suggest that the problem may be less severe than is being claimed by providers. Nevertheless, certain other modifications to the PPS may be appropriate because there is evidence that payments are not being appropriately targeted to patients who require costly care. The potential access problems that may result from underpaying for high-cost cases will likely result in beneficiaries' staying in acute care hospitals longer, rather than forgoing care. This is a safety net for beneficiaries while modifications are made. The Health Care Financing Administration (HCFA), which has responsibility for managing the Medicare program, is aware that payments may not be adequately targeted to high-cost beneficiaries and is working to address this problem.

As a result of the swift implementation of the home health IPS and the lack of a transition period, the BBA's impact on home health agencies has been more noticeable. The number of participating agencies declined by 14 percent between October 1997 and January 1999, and utilization has dropped to 1994 levels, the base year for the IPS. However, since the number of HHAs and utilization had both grown considerably throughout most of the decade, beneficiaries are still served by over 9,000 HHAs—approximately the same number that were available just prior to the

¹The SNF PPS will be phased in on the basis of facility cost-reporting years. During the transition, payment rates will be a blend of a declining portion of a facility-specific historical amount and an increasing portion of the national prospective rate.

²The BBA required the HHA PPS to be in place in fiscal year 2000. Subsequent legislation delayed the implementation by 1 year and eliminated the phasing in of the system.

recent declines. Our interviews with HHAs, advocacy groups, and others in rural areas that lost a significant number of agencies indicated that the recent decline in HHAs has not impaired beneficiary access. While the drop in utilization does not appear to be related to HHA closures, it is consistent with IPS incentives to control the volume of services provided to beneficiaries. In short, after years of substantial increases in home health visits, the IPS has curbed the growth in home health spending. Some of the decline in utilization appears to involve greater sensitivity to who qualifies for the home health care benefit, with some who do not qualify, but who may have been previously served, not receiving services now. There are indications, however, that beneficiaries who are likely to be costlier to serve than the average may have more difficulty than before in obtaining home health services because the revenue caps imposed by the IPS are not adjusted to reflect variations in patient needs. This problem should be ameliorated with the implementation of the PPS. In designing the PPS, it will be essential that HCFA adequately adjust payments to account for the wide differences in patient needs.

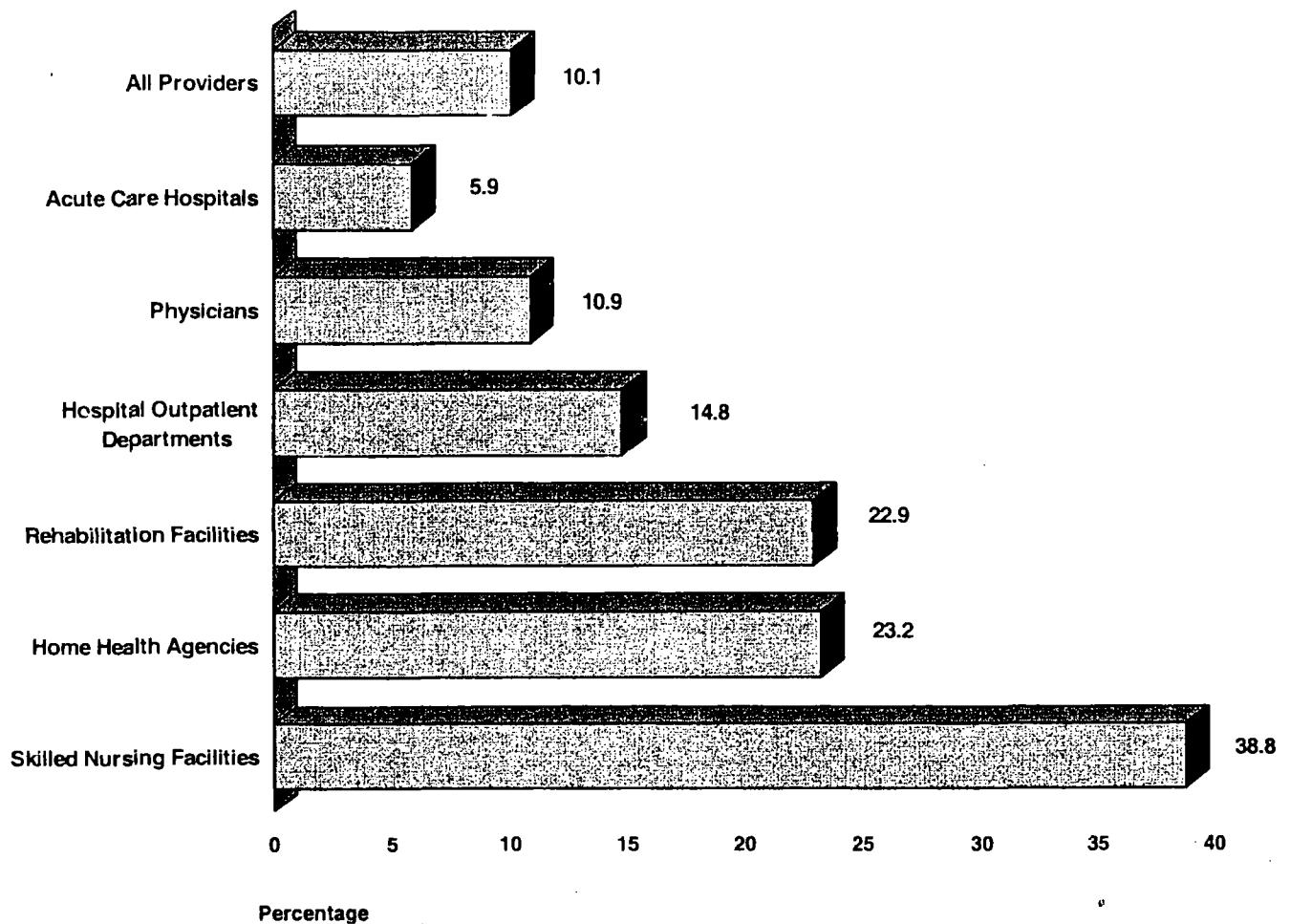
To date, the principal lessons to be drawn from the SNF and HHA payment reforms and their implementation are that

- the particulars of payment mechanisms largely determine the extent to which a reform option can control excess government spending while protecting beneficiary access to care and
- revisions to newly implemented policies should be based on a thorough assessment of their effects so that, at one extreme, policies are not unduly affected by external pressures and premature conclusions and, at the other extreme, policies do not remain static when change is clearly warranted.

BACKGROUND

Medicare is the nation's largest health insurance program, covering about 39 million elderly and disabled beneficiaries at a cost of more than \$193 billion a year. The sheer size of this program during a period of particular concern over government spending made it the target of spending reforms. That Medicare was growing faster than the overall economy and the Medicare Hospital Insurance Trust Fund was facing imminent depletion only heightened attention on this program. Medicare expenditures had been rising at an average annual rate of 10.1 percent between 1985 and 1995 (see fig. 1). While the outlook for the federal budget has changed, with projected surpluses replacing deficits, the importance of ensuring that Medicare is an efficient purchaser of health services remains.

Figure 1: Average Annual Rate of Growth in Medicare Expenditures, 1985-95, by Type of Provider

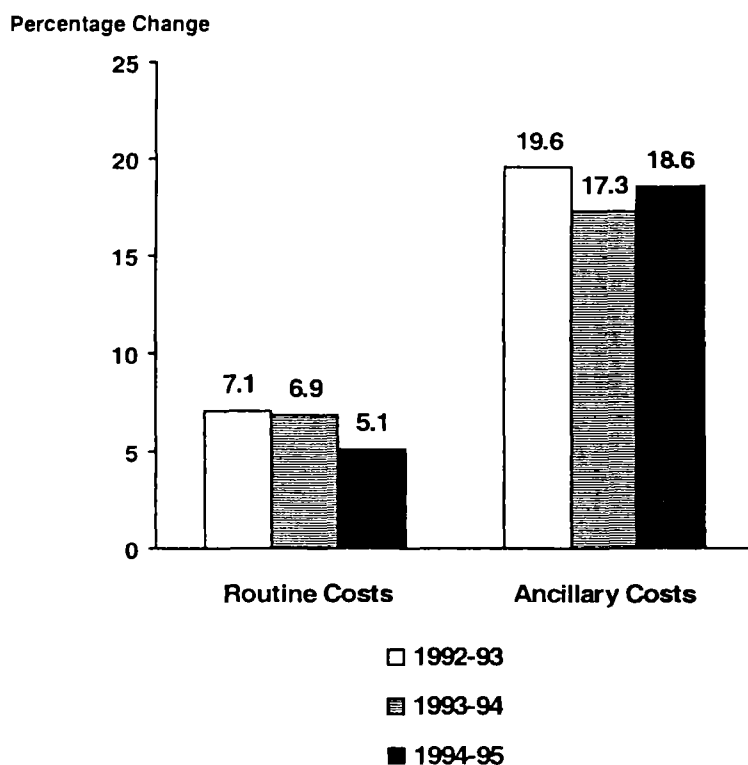


Despite significantly lower projected spending due to BBA reforms, there is a growing consensus among experts, including the trustees of the Medicare Hospital Insurance Trust Fund, that additional reforms are needed. As the baby boomers reach retirement age, the pressures on Medicare program spending will intensify. Fueled by medical technology advancements that allow more and better treatments for a larger portion of the elderly, Medicare spending growth will continue to be an important budgetary issue. The Congressional Budget Office projects that by 2009 Medicare's expenditures as a portion of the gross domestic product will rise almost one-third.

INDUSTRY AND OTHER CONCERNS ABOUT SNF PPS REQUIRE THOROUGH ANALYSIS

Prior to the PPS, SNFs were paid the reasonable costs they incurred in providing Medicare-allowed 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 other costs—primarily 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. Thus, growth in ancillary costs far outpaced the growth in routine service costs between 1992 and 1995 and drove up overall Medicare payments to SNFs (see fig. 2). Moreover, new providers were exempt from even the routine caps for their first 4 years of operation, which encouraged expansion of the industry.

Figure 2: Percentage Growth in SNF Routine and Ancillary Costs per Day, 1992-95



Under the new PPS, facilities receive a payment for each day of care provided to a Medicare-eligible beneficiary. This per diem rate is based on the average daily cost of providing all Medicare-covered services, as reflected in facilities' 1995 costs, adjusted to take into account the nature of each patient's condition and expected care needs. By establishing fixed payments and including all services provided to beneficiaries under the per diem amount, the PPS attempts to provide incentives for SNFs to deliver care more efficiently and judiciously.

The PPS represents a major change to the previous incentives of cost-based reimbursement and, as a result, Medicare treatment patterns that were influenced by the previous payment method will need to be modified. Previously, SNFs benefited from providing more ancillary services, without regard to the price paid for those services, since Medicare's payment was based on each facility's actual costs. SNFs that boosted their Medicare ancillary costs—either through higher use rates or higher prices—will need to make more modifications than those that did not. Scaling back these services, however, will not necessarily affect the quality of care. There is little evidence to indicate that the rapid growth in Medicare spending was due to a commensurate increase in Medicare beneficiaries' needs. Further, practice pattern changes may not be very disruptive because Medicare patients constitute a small share of most SNFs' business. And, blending facility-specific costs with the national PPS rates during the transition will ease the adjustments for facilities that have a history of providing many ancillary services.

Recent industry reports, however, have questioned the ability of some organizations operating SNF chains to adapt to the new PPS. Indeed, claims of pending bankruptcies have been linked to the Medicare payment changes. It is likely, however, that a combination of factors has contributed to the poor financial performance of these businesses. For example, many of the organizations have other lines of post-acute-care services—including the provision of outpatient rehabilitation therapy and ancillary services to affiliated SNFs as well as independent SNFs. The PPS may have affected the demand for these services, but other BBA provisions likely have had an effect as well.³ In addition, some of these organizations invested heavily in the nursing home and ancillary service businesses not long before the enactment of the PPS, both expanding their acquisitions and upgrading facilities to provide higher-

³The BBA applied a per beneficiary payment cap of \$1,500 for outpatient physical and speech therapy and a \$1,500 cap for outpatient occupational therapy, although neither cap is applicable to services provided through a hospital outpatient department. These limits will not apply to Medicare beneficiaries during a Medicare-covered SNF stay, but could affect Medicare SNF residents if their stay is not covered by Medicare. This provision, in combination with consolidated billing for all services under the PPS, could limit some providers' ability to sell therapy and other ancillary services to other SNFs.

intensity services. Yet HCFA had been developing a PPS for some time that would curtail unnecessary growth in ancillary payments. We are studying these issues and will provide more details later this year on the effect of the PPS on solvency and beneficiary care.

While we think that industry concerns about the financial viability of SNFs operating under PPS have not been substantiated and may be premature, we have identified three key PPS design issues that may affect Medicare's ability to realize program savings and may limit beneficiaries' access to care. First, we are concerned about the SNF case-mix adjusters, which are needed to ensure that facilities serving patients with more intensive care needs receive adequate payments and, conversely, that SNFs are not overcompensated for patients with lower care needs. The current case-mix adjusters preserve the opportunity for SNFs to increase their compensation by supplying potentially unnecessary services. A SNF can benefit by manipulating the services provided to beneficiaries, rather than increasing efficiency. For example, the payment for a patient who requires 143 minutes of therapy care daily is \$286 per day, compared with \$346 for a patient who requires 144 minutes (see table 1). Thus, by providing an extra few minutes of therapy to certain patients, a facility could increase its Medicare payments without a commensurate increase in its costs. Rather than improving efficiency and patient care, this might only raise Medicare outlays. We believe that HCFA needs to continue its research into a classification system that is less dependent on service use and more closely tied to patient characteristics and needs. It also must provide adequate oversight to ensure that providers properly classify patients and do not manipulate service provision to take advantage of the classification system.

Table 1: Comparison of Length of Average Daily Therapy and per Diem SNF Payments for Different Rehabilitation Case-Mix Groups

Rehabilitation case-mix groups	Length of average daily therapy (for 5 days per week)	Per diem payment (federal unadjusted rate for urban facilities)
Ultra high	144+ minutes	\$346
Very high	100 to 143 minutes	286
High	65 to 99 minutes	250
Medium	30 to 64 minutes	239

Our second concern is whether the system adequately identifies the most expensive patients and adjusts payment rates accordingly. This concern emanates from limitations in the data HCFA had available to establish the case-mix groups and the rates. The classification system was based on a small sample of patients and, because of the age of the data, may not reflect current treatment patterns. As a result, the classification system may aggregate expensive patients with widely differing needs into too few groups to distinguish adequately among patients' resource needs. In addition, the classification system does not take into account varying nontherapy ancillary service needs and is likely to overpay SNFs for treating patients with low service needs and underpay those SNFs treating patients with high service requirements. These design weaknesses could result in access problems or inadequate care for some high-cost beneficiaries. Hospitals have reported an increase in placement problems due to the reluctance of some facilities to admit certain beneficiaries with high expected treatment costs, which will increase hospital lengths of stay for these patients. HCFA is aware of the limitations of the case-mix adjusters and is working to refine these measures to more accurately reflect patient differences.

Finally, we are concerned that the cost reports submitted to Medicare for the year on which payments are based (1995) include unreasonable costs and may establish payments levels that are too high. Most of the data used to establish these rates have not been audited and are likely to include excessive ancillary costs, because the prior system had no incentives to constrain such costs. Moreover, it is likely that the base year includes too many services and that the costs per service were inappropriately high.

HHA CLOSURES AND DECLINING
UTILIZATION SIGNAL IPS IMPACT, BUT
THERE IS LITTLE EVIDENCE OF IMPAIRED ACCESS

Medicare spending for home health care rose at an annual rate of 25.2 percent between 1990 and 1997. Several factors accounted for this spending growth, most notably the relaxation of coverage guidelines. In response to a 1988 court case, the benefit was essentially transformed from one that focused on patients needing short-term care after hospitalization to one that serves chronic, long-term-care patients as well.⁴ Thus, Medicare may now be covering services that would previously have been paid for by Medicaid or by beneficiaries themselves. The loosening of coverage and eligibility criteria contributed to an increase in the number of beneficiaries receiving services. Between 1990 and 1997, the number of Medicare home health users per 1,000 beneficiaries increased from 57 to 109.⁵ Associated with the increase in

⁴Duggan v. Bowen, 691 F. Supp. 1487 (D.D.C. 1988).

⁵These numbers reflect Medicare fee-for-service beneficiaries only.

beneficiaries being served over this period was the near doubling of Medicare-certified HHAs to 10,524 by 1997.

Also contributing to the historical rise in spending were a payment system that provided few incentives to control how many visits beneficiaries received and lax Medicare oversight of claims. Between 1990 and 1997, the average number of visits per user climbed from 36 to 73. HHAs could boost revenues by providing more services to more beneficiaries, a strategy that could actually help HHAs avoid being constrained by Medicare's limits on payments per visit.⁶ There is evidence that some HHAs provided visits of marginal value. For example, as we noted in a previous report, even when controlling for diagnoses, substantial geographic variation exists in the provision of home health care.⁷ In 1996, the average number of visits per user in the West South Central region (Arkansas, Louisiana, Oklahoma, and Texas) was 129, compared with 47 in the Middle Atlantic region (New York, New Jersey, and Pennsylvania). While the precise reasons for this variation are not known, there is no reason to assume that it was warranted by patient care needs. Evidence indicates that at least some of the high use and the large variation in practice represented inappropriate care.⁸ Medicare oversight declined at the same time that spending mounted, contributing to the likelihood that inappropriate claims would be paid. The proportion of claims that were reviewed dropped sharply, from about 12 percent in 1989 to 2 percent in 1995, while the volume of claims almost tripled.

To control spending while ensuring the appropriate provision of services, the BBA mandated expeditious implementation of the IPS while the PPS was under development. Prior to BBA, HHAs were paid on the basis of their costs, up to preestablished limits. The limits were set for each type of visit but were applied in the aggregate for each agency; that is, costs above the limit for one type of visit could still be paid if costs were sufficiently below the limit for other types of visits. The IPS lowered the visit payment limits and subjected HHAs to an aggregate Medicare

⁶Agencies could avoid the payment limits by lowering their per visit costs in two ways: by serving less expensive patients with shorter visits and by providing more visits and thereby spreading fixed costs over more visits.

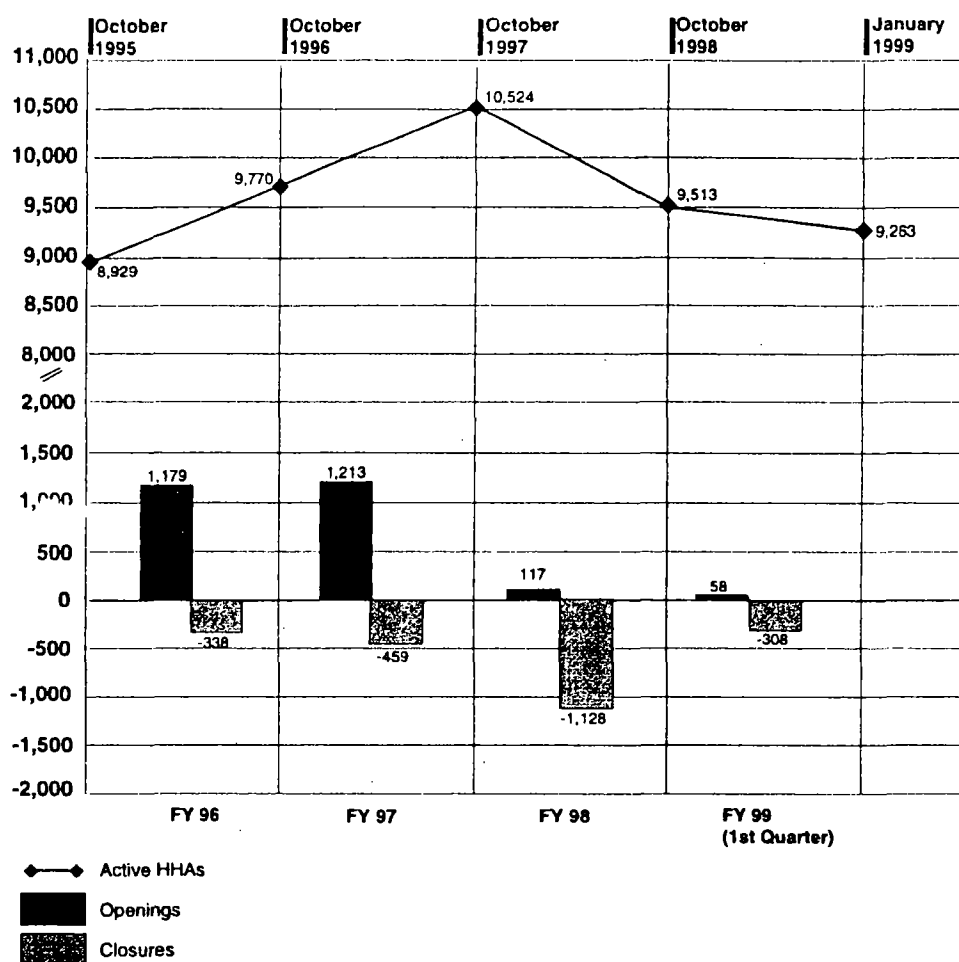
⁷Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996).

⁸Medicare: Improper Activities by Mid-Delta Home Health (GAO/T-OSI-98-6, Mar. 19, 1998) and Department of Health and Human Services, OIG, Variation Among Home Health Agencies in Medicare Payment for Home Health Services (Washington, D.C.: HHS, July 1995). Our 1997 analysis of a small sample of high-dollar claims found that over 40 percent of these claims should not have been paid by the program. See Medicare: Need to Hold Home Health Agencies More Accountable for Inappropriate Billings (GAO/HEHS-97-108, June 13, 1997).

revenue cap based on a historical per beneficiary amount that factors in both agency-specific and regional average per beneficiary payments. The purpose of the cap is to control the number of services provided to users. The blending of agency-specific and regional amounts accounts for the significant differences in service use across agencies and geographic areas. For new HHAs, without historical cost data, the caps are based solely on the national median. Because per beneficiary limits are tied to fiscal year 1994 payments, the new payment limits will be more stringent for agencies and areas that experienced significant growth in the number of visits per user between 1994 and 1997. Notably, the growth in Louisiana, Oklahoma, and Texas, where 1994 utilization levels were approximately twice the national average, greatly exceeded the average increase nationally. By comparison, utilization levels declined in one-fifth of the states with utilization levels below the national average in 1994, making it easier for HHAs in those states to cope with the cap.

In contrast to the SNF PPS, the IPS had a more immediate effect on the operation of providers because there was no gradual transition to imposition of the revenue cap. The IPS was phased in according to an HHA's cost reporting year—61 percent of agencies came under the IPS by January 1, 1998, and the remainder by September 30, 1998. Moreover, unlike the situation with SNFs, Medicare beneficiaries represent a substantial proportion of the patients served by HHAs. The closure of a significant number of HHAs occurred after the IPS was implemented. Between October 1, 1997, and January 1, 1999, 1,436 Medicare-certified HHAs stopped serving Medicare beneficiaries. However, because of the growth in the industry since 1990, there were still 9,263 Medicare certified HHAs in January 1999—only 500 fewer than in October 1996. (See fig. 3.)

Figure 3: Change in Number of Medicare-Certified HHAs, October 1, 1995, Through January 1, 1999



Forty percent of the closures were concentrated in three states that had experienced considerable growth in the number of HHAs and had utilization rates (visits per user as well as users per thousand fee-for-service beneficiaries) well above the national average (see table 2). Furthermore, the majority of closures occurred in urban areas that still have a large number of HHAs to provide services. The pattern of HHA closures suggests a response to the IPS. The IPS revenue caps would prove particularly stringent for HHAs that provided more visits per user, for smaller agencies, for those with less ability to recruit low-cost patients, and for newer agencies. In fact, HHAs that closed had provided over 40 percent more services per

user than agencies that remained open. Closing HHAs were also about half the size of those that remained open, and they had been losing patients before the implementation of IPS.

Table 2: Decline in HHAs and Changes in Utilization Nationally and in Three High-Use States

	HHA closures as a percentage of active agencies, Oct. 1, 1997	Number of Medicare-certified HHAs, Jan. 1, 1999	People served per 1,000 Medicare fee-for-service enrollees			Visits per user		
			1994	1997	Percentage change	1994	1997	Percentage change
Nationwide	-14.0	9,263	94.2	109.2	15.9	66.0	72.9	10.5
Louisiana	-21.6	407	138.6	157.3	13.5	125.8	161.0	28.0
Oklahoma	-23.2	299	108.9	131.9	21.1	105.7	147.0	39.1
Texas	-20.1	1,580	106.9	133.7	25.1	97.4	141.0	44.8

Despite the widespread attention focused on closures, the critical issue is whether beneficiaries who are eligible to receive services are still able to do so. Utilization rates during the first 3 months of 1998 are consistent with IPS incentives to control costs. Home health utilization in the first quarter of 1998 was lower than during a comparable period in 1996 but was about the same as during a comparable period in 1994—the base year for the IPS. Moreover, the sizeable variation in utilization between counties with high and low use has narrowed. In counties without an HHA, both the proportion of beneficiaries served and the visits per user declined slightly during the first 3 months of 1998, compared with a similar period in 1994, but these counties' levels of utilization remained above the national average. Our February 1999 interviews with officials at HHAs, hospital discharge planners, advocacy groups, and others in 34 primarily rural counties with significant closures indicated that beneficiaries continue to have access to services. Some of the decline in utilization appears to be for beneficiaries who no longer qualify for the home health care benefit. However, these interviews also suggested that as HHAs change their

operations in response to the IPS, beneficiaries who are expected to be costlier than average to treat may have increased difficulty obtaining home health care. The pending implementation of the PPS, which will adjust payments to account for costlier patients, has the potential to ameliorate future access problems.⁹

CONCLUSION

The BBA made necessary and fundamental changes to Medicare's payment methods for SNFs and HHAs to slow spending growth while promoting more appropriate beneficiary care. Further refinements are required to make these systems more effective. However, the intentional design of these systems is to require inefficient providers to adjust their practice patterns to remain viable.

The very boldness of these changes has generated pressure to reverse course. In the current environment, the Congress will face difficult decisions that could pit particular interests against a more global interest in preserving Medicare for the long term. As PPSs are implemented for rehabilitation facilities and hospital outpatient services, and as SNFs continue their transition to full PPS rates, provider complaints about tight payment rates and impaired beneficiary access will continue to be heard. It is important that the implementation of these new payment mechanisms is monitored to ensure that the correct balance between appropriate beneficiary access and holding the line on Medicare spending is being achieved. Our work suggests that it would be premature at this juncture, however, to significantly modify the BBA's provisions without thorough analysis or a fair trial of the provisions over a reasonable period of time.

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

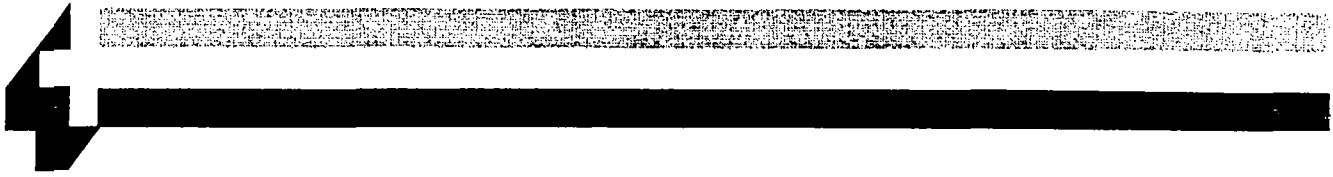
GAO CONTACT AND ACKNOWLEDGMENTS

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⁹For additional information on the impact of the home health IPS on beneficiary access, see Medicare Home Health Agencies: Closures Continue With Little Evidence Beneficiary Access Is Impaired (GAO/HEHS-99-120, May 26, 1999).

Federation of American Health Systems



**Thomas A. Scully,
President & CEO
Federation of American Health Systems**

*Testimony before the U.S. Senate Finance Committee on
the "Impact of the 1997 Balanced Budget Act Provisions
on the Medicare Fee-for-Service Program"*

Dirksen Senate Office Building, Washington, D.C.
Thursday, June 10, 1999

Testimony before the U.S. Senate Finance Committee

Mr. Chairman and Members of the Finance Committee, thank you for inviting the Federation to testify today. The Federation represents almost 1700 privately-owned and managed hospitals nationwide. Within our membership are a large number of specialty hospitals, including rehabilitation facilities, an area which will receive special attention in my testimony.

I will focus briefly on four topics this morning:

1. **The 1997 BBA cut Medicare spending by almost \$200 billion over five years — almost \$100 billion more than was expected when it passed in October 1997. Medicare had been growing at an average annual inflation rate of 10% in the '90's. The goal of the BBA was to slow that growth to about 5.5% a year. Last year, the first year under the BBA, Medicare hospital spending actually fell, and all Medicare spending increased just 1.5%. For FY '99, Medicare spending will fall by 1.6% and Medicare Part A spending will fall by 5.2%.**
2. **Recent studies have shown that these cuts are having a significant negative impact on hospital margins and hospital operations. Rural hospitals have been impacted most dramatically.**
3. **Priorities for BBA Repair. While many services have been hit hard by the 1997 BBA, the Federation has prioritized three areas where Congress could most effectively address hospital policy and reimbursement problems:**
 - *Fix Unplanned and Unfair Outpatient PPS Cut of 5.7%, or \$900 million per year*
 - *Repeal Hospital Transfer Policy*
 - *Restore Excess Cuts in Bad Debt Reimbursement*
4. **Prospective Payment for Rehabilitation Hospitals. HCFA is crafting rehabilitation hospital PPS rules, as directed by the BBA, for release in FY 2000. This system must be a per discharge base system (like DRGs) similar to that in place for acute care hospitals, and not a per diem system (like RUGS) similar to what has been adopted for nursing facilities.**
 - i. **The BBA Far Overshot Its Savings Targets. The Budget Process That Produced This Result Is Fundamentally Flawed**

The goals of the 1997 Balanced Budget Act were laudable, and hospitals and the communities they serve are pleased that the federal budget is balanced and that significant surpluses were created. Still, the fact is that Medicare provider payments were far and away the largest contributor to deficit reduction in the 1997 BBA, with \$103 billion in net Medicare savings, as it was scored at passage. In real terms, however, the

1997 policies far overshot the mark for Medicare savings in the BBA. Real Medicare savings from the BBA are now likely to exceed \$200 billion from FY98-FY02. Unfortunately for health providers, budget reductions are a “one way ratchet”. When HCFA and the CBO underestimate the impact of budget reduction policies, the “extra” money that is saved is gone – forever – into the great beyond of the budget surplus.

The 1995 Budget Reconciliation Bill that was vetoed contained a “look back” provision that would have ensured that only the intended level of Medicare spending reductions took place. Under the 1995 provisions, Medicare policies could have been adjusted periodically to ensure that the Medicare program hit the targeted savings in the bill. As we all know, that bill was vetoed. Unfortunately, the 1997 BBA included no such provision. So when the actual savings from the 1997 BBA far exceeded those projected by CBO and HCFA, health care providers had no recourse -- nor did Congress. The money is gone. It certainly helps the surplus. But, it also certainly is unfair to health providers and the seniors they care for.

If we look at FY99, in March, CBO projected that Medicare would spend almost \$20 billion less than was expected under the BBA when it passed. Actual spending now appears likely to be over \$25 billion less than targets in the BBA. Pre-BBA, Medicare was projected to spend \$248.2 billion in FY99. The BBA was expected to reduce that number to \$233 billion, but based on actual spending from the Treasury, Medicare spending will actually be about \$208 billion for FY99. *This is \$25 billion less than anticipated in the legislation just 18 months ago. (See Attachment “A”)*

For hospitals, under the BBA, Medicare spending was expected to be held to \$107.3 billion for FY99—about a 1.5 growth rate. Reality is that Medicare hospital spending is now expected to be just \$101.4 billion, a 2.3% *real reduction from FY98*, and over \$6 Billion less for FY99 than was projected only 18 months ago. For most hospitals, there is no way to handle *negative* 2.5% spending trends without an impact on patient care. It is simply not possible.

How could this happen? There are many factors, and I would be happy to address the details in the question period. But the vast bulk of these traumatic spending reductions resulted from policy changes in the BBA -- policies whose impact was not fully understood and thus were significantly underestimated at the time the BBA was crafted. Contrary to what others might argue, enhanced fraud and abuse and inflation differences are a very small piece of the \$100 billion scoring difference in the last 18 months. This isn't CBO's fault, or HCFA's. They do the best scoring they can, at the time they are asked. It is a fundamental structural flaw in the budget process. CBO is asked to project -- or “guesstimate” - the impact of major policy changes in the behavior of health providers over a five-year period -- a multi-billion dollar snap shot in a rapidly changing system. In past Reconciliation Bills in 1987, 1990 and 1993, they had over-estimated the savings impact of many Medicare proposals, and were frustrated when spending did not fall. But in 1997, partly due to that historical experience, they massively underestimated the impact on virtually all providers -- hospitals, nursing homes, home health, and Medicare risk contractors. It is a virtually impossible task to project accurately. Still,

sadly, the government's contractors have to try to live with the very unpleasant results of a very inaccurate science. There are better ways – the model in the vetoed 1995 BBA is just one example.

So, what is the impact of the 1997 Medicare BBA policies?

- ii. Two major recent studies have shown that there is a significant and growing negative impact on hospitals, and that pain is growing. For rural hospitals the impact is most damaging.**

In recent months, two comprehensive studies have been completed analyzing the impact of the 1997 BBA, one by Ernst and Young and HCIA, and another by the Lewin Group, commissioned by the AHA. Guy King, HCFA's former Chief Actuary, now working with Ernst and Young, oversaw the study commissioned by the Federation, "*A Comprehensive Review of Hospital Finances In the Aftermath of the Balanced Budget Act of 1997*". The studies had similar findings, with both finding very negative margin impacts across virtually all care settings, as a result of the BBA.

A summary of the "Key Findings" of the Ernst and Young/HCIA is attached to this testimony. (See Attachment "B") Among the findings:

- Medicare hospital margins have declined to .1% in 1999.
- Medicare outpatient margins are negative 17% now, declining to negative 2.8% by 2002 under the BBA. And this is BEFORE the additional 5.7% unanticipated reduction in the new Outpatient PPS Regulation crafted pursuant to the BBA.
- Total margins for small, rural hospitals will fall from 4.2% in 1998 to negative 5.6% in 2002, largely due to the BBA.

The impact of the BBA has been severe across all sectors of health care, regardless of type of provider or their capital structure. The bond and stock markets have certainly taken note of the impact the Balanced Budget Act is having on health care concerns. Moody's Investors Service, in its February 1999 report, noted the negative credit health of health systems and said that it expects high rating volatility and deteriorating credit to continue, largely due to the BBA. For the first time, Moody's noted significant credit difficulties for Aa-rated hospitals. As credit ratings decline, the cost of capital increases – which puts additional pressure on hospital operating margins. Health care stocks have plummeted over the course of the last 18 months, with many sectors, including hospitals, dropping 40% in value. (See Attachment "C") This, at a time when the rest of the market is reaching new highs. Health care has been the worst sector of the economy for the past two years. Why? The BBA.

Hospitals invest heavily in capital and assets to finance improvements in their infrastructure and technology. The ability to borrow capital to finance equipment purchases to maintain and improve patient care is key to maintaining the health care quality of patients in communities across the nation.

So, if the BBA went too far, what should Congress fix?

- iii. **Priorities for BBA Repairs.** The BBA reduced spending by almost \$100 Billion more than intended, yet we know Congress will not restore that level of spending. There are easily \$25-30 Billion, over 5 years, of legitimate BBA fixes that are needed, but understanding that a package of repairs is more likely to be in the \$10-\$20 Billion range, we have strictly prioritized our concerns:

a) Outpatient PPS

Outpatient payment policy has been flawed for many years; the chief flaw being that beneficiaries were paying too much for their share of the cost of the services they received in outpatient settings. Over the course of a number of years, HCFA, hospitals and beneficiary groups worked together to fashion a remedy that was based on sound policy that was fair and that involved compromise of all parties. The essence of that policy was included in the 1997 BBA, and was clearly intended to be implemented in a package that was budget neutral. Budget savings totaling \$7.2 billion were included as part of the BBA through a number of outpatient related provisions, including the elimination of the so-called “formula-driven overpayment.” While these BBA payment reductions clearly have serious financial implications for hospitals, hospitals accepted those cuts in good faith, as a painful but necessary step toward a more rational prospective payment system (PPS) that was budget neutral and included no additional cuts.

The language in both *the House and Senate versions of BBA that were voted on by both chambers and went to Conference were identical versions of the OPD PPS system*. In the final drafting of the Conference language, technical changes were made to the provision. When the bill was signed into law, both HCFA and hospital groups believed the final language had the same budget neutral effect as what was included in the House and Senate bills. It wasn’t until August 1998, when HCFA began drafting the implementing rule, that the agency discovered the minor formula change in the Conference Report language governing budget neutrality. **HCFA estimates that its interpretation of that language will cost hospitals an additional \$900 million per year or \$4.5 billion over five years – a totally unexpected, unfair and massive additional cut.**

Allow me to elaborate. The way the Secretary of HHS was instructed to calculate the total amount of beneficiary co-payments was ambiguous. HCFA, in its interpretation of the statutory language, has proposed in its rule that hospitals, due to the technical change made in the final drafting process, would be expected to shoulder an additional 5.7% cut in their outpatient payments. The 5.7% is an average, across all hospitals; rural hospitals are estimated by HCFA to face an additional 7.4% cut. We believe strongly that HCFA’s interpretation is fundamentally inconsistent with Congressional intent. Never was there a discussion among Members, or with HCFA, of the technical change in the language or the intent behind the change. There is no mention in the Conference

Report of any intention to further reduce payments for services in outpatient settings to achieve additional savings. There is no mention anywhere in the legislative record or any analysis of the provision of this additional cut aimed at hospitals. The provision was never reviewed by CBO for scoring purposes. Basically, hospitals have been “sucker-punched” with a new and totally unexpected \$900 million per year cut. And this is just the latest estimate of overall impact -- when this was discovered last summer the impact was estimated to be 3.8% or a \$450 million cut on hospitals. Earlier this year that figure was revised to 2.8%, then just a few weeks ago that figure was revised upwards to 5.7%. Clearly this uncertainty adds enormously to the angst hospitals already feel from the BBA. But more importantly, Mr. Chairman, how can we be certain that the cuts will not run even higher?

Hospitals and outside legal experts believe that HCFA is not required to follow its current narrow reading of the language of the statute. We believe it has the flexibility to adopt a rule reflecting Congress’ clear intent. **Moving to outpatient PPS was intended to be budget neutral policy – and \$900 million additional cut to hospitals’ bottom lines is not neutral to their budgets!**

Outpatient margins have been estimated to fall to a negative 27.8% by 2002, even without the additional cut. Adding this cut would push hospital reimbursement for outpatient services even further into the red. (*See Attachment “D”*) This is bad for hospitals and worse for patients.

We believe that HCFA has the ability, under the statute, to change its proposed rule and initial interpretation. We hope Congress will clarify its intent to HCFA to restore budget neutrality and fix this clear inequity.

b) Repeal Hospital Transfer Policy

As part of the BBA, Congress enacted what is commonly known as “transfer policy.” This policy cuts hospital payments for patients who are discharged to post-acute settings such as rehabilitation centers, nursing homes or to their home when they receive home health care. This policy is ill advised and is fundamentally inconsistent with the essence of a prospective payment system. The foundation of PPS is to reward hospitals for efficient behavior, one indicator of which is shorter hospital stays. Transfer policy undermines the incentive to act efficiently because hospitals suffer a financial penalty for doing so.

Even more important, transfer policy turns its back on advances in patient care. One of the key advances of this decade with regard to patient care is the ability of hospitals to be responsive to each patient’s medical needs and treat those needs in the most appropriate care setting. Clearly, it is in patients’ interest to move them to less intensive care settings where appropriate.

In addition, transfer policy creates an administrative nightmare for hospitals. They are now required to keep track of what happens after a patient is discharged to another setting. An illustration: A patient is discharged with no plan for further treatment. Several days later the patient's physician decides that they should begin receiving home care, but does not notify the hospital. The hospital is now at financial and legal risk. The original payment must now be adjusted to reflect the per diem methodology rather than payment based on the DRG. This creates a nightmare for hospitals by making them track patients post discharge and requires them to constantly go back and readjust their charges.

Finally, it is unfair to areas of the country that have shorter than average lengths of stay. Even when a patient is transferred for legitimate treatment purposes, these hospitals are penalized with lower reimbursement simply because they have better practice patterns and shorter lengths of stay.

c) Medicare Bad Debt

Under federal law, hospitals, as part of their contract with communities and patients, treat all patients, regardless of their ability to pay. Until the enactment of BBA, hospitals were fully reimbursed for Medicare-based bad debt, once a hospital could show they exercised due diligence to collect the unpaid bill from the patient. BBA cut that reimbursement to 55%.

As you know, there is a hefty \$768 deductible charged to Medicare beneficiaries for in-patient hospitalizations as part of the Medicare program. Almost 80% of seniors are covered by Medigap insurance, which helps defray the costs of the deductibles and co-pays. About 10% of seniors are poor enough to qualify for Medicaid, which covers these costs. The remaining 10% of Medicare recipients – the near poor – often cannot and do not pay their Medicare hospital deductible. It is this population that accounts for the bulk of Medicare bad debt. The bottom line is these patients do not have the money to pay, no matter how much time and resources a hospital expends in attempting to collect the money.

This is a government program – hospitals that care for near-poor seniors should not be financially disadvantaged for serving these deserving patients. Full Medicare reimbursement for bad debt is essential to the survival of many hospitals, particularly those with a high percentage of near poor Medicare patients. Without this reimbursement, areas with a high concentration of elderly poor patients, such as many rural areas, could be faced with reduced access to services.

This policy was intended to impact all Part A providers in 1997, but due to a drafting error, it unfairly singled out hospitals. Congress should restore reimbursement for Medicare bad debt, as well as equity in its application to all Part A providers. While there is a limited impact on the federal budget – approximately \$100 million per year – this funding is critical to the financial

health of hospitals that provide quality care across this nation to low income seniors.

Prospective Payment System for Rehabilitation Facilities

Some provisions of the BBA have yet to take effect, such as implementation of a prospective payment system (PPS) for rehabilitation facilities, which are currently paid under a cost-based method. The BBA requires the Secretary of Health and Human Services to develop a prospective payment system for rehabilitation hospitals and units by October 1, 2000. The Federation has supported this move to a PPS. However, whether the new PPS is a win for the program, taxpayers and Medicare beneficiaries depends largely upon the choice of payment unit and patient classification system. Congress did not specify a particular approach when it enacted the BBA.

Rehabilitation hospitals and units provide medical care and intensive physical, occupational and speech language pathology services and other rehabilitation therapy services to patients, who because of disease, injury, stroke or similar conditions are physically and cognitively impaired. Because many of these conditions are associated with aging, Medicare beneficiaries account for about 70% of admissions to rehabilitation facilities. As such, it is critical that the Secretary design a PPS that accurately reflects the duration and intensity of services needed by, and provided to these patients. If the PPS is flawed, patient access to quality rehabilitation services will suffer.

To avoid adding rehabilitation services to the list of BBA problems, we support the PPS approach recommended by the Medicare Payment Advisory Commission (MedPAC) in its March 1 report to Congress. The Commission has recommended a per-discharge payment unit that classifies patients based upon functional status, diagnosis and age and resources needed to lead the patient back to optimal functional recovery -- often referred to as functional-related groups, or FRGs. In making this recommendation, the Commission rejected a per-diem or daily payment approach.

We are concerned, however, that the Health Care Financing Administration (HCFA) may be considering a per diem approach that would closely rely on the patient classification system used for skilled nursing facilities, known as resource allocation groups or RUGs. We believe strongly, as does MedPAC, that such an approach is misguided for several reasons. First, it would not adequately account for the range of patients served by rehabilitation providers. Second, it would result in longer lengths of stay, thereby penalizing the most cost-efficient facilities. Last, but not least, it would lead to higher costs, without improving quality of care. A per discharge PPS has worked for acute care hospitals and is far more appropriate for rehabilitation facilities than is a per diem, or RUGs-like system.

Given the important role rehabilitation providers play in meeting the health care needs of our senior citizens, we urge Congress to direct HCFA to develop a per-discharge PPS based on function-related groups. We also believe that the new PPS should not be fully implemented until a final rule has been adopted.

Conclusion

The Federation of American Health Systems and its member hospitals worked closely with Congress to enact legislation to balance the federal budget. Many of the policies were, frankly, hard for hospitals to swallow. Estimates of the impact of legislative provisions contained in this bill were just that, estimates. They have been proven by the government's own spending reports to be woefully inaccurate. Congress voted on \$103 billion in payment reductions to the Medicare program; it did not vote on the \$220 billion plus in cuts that is the more accurate impact today.

Hospitals across the country are feeling the impact of these cuts. In fact, more than one-third of all hospitals are facing bottom lines in the red due to BBA – a 55% increase. (*See Attachment "E"*) So, clearly, tough choices are being made every day about whether there will be enough capital to buy new technology that is needed to serve patients, whether there needs to be staff layoffs, or whether to cut back on services. A hospital's mission is to serve and to heal patients. It is a fact of life that the bulk of a hospital administrator's time now is spent navigating a myriad of complicated regulations and payment cuts arising from the BBA.

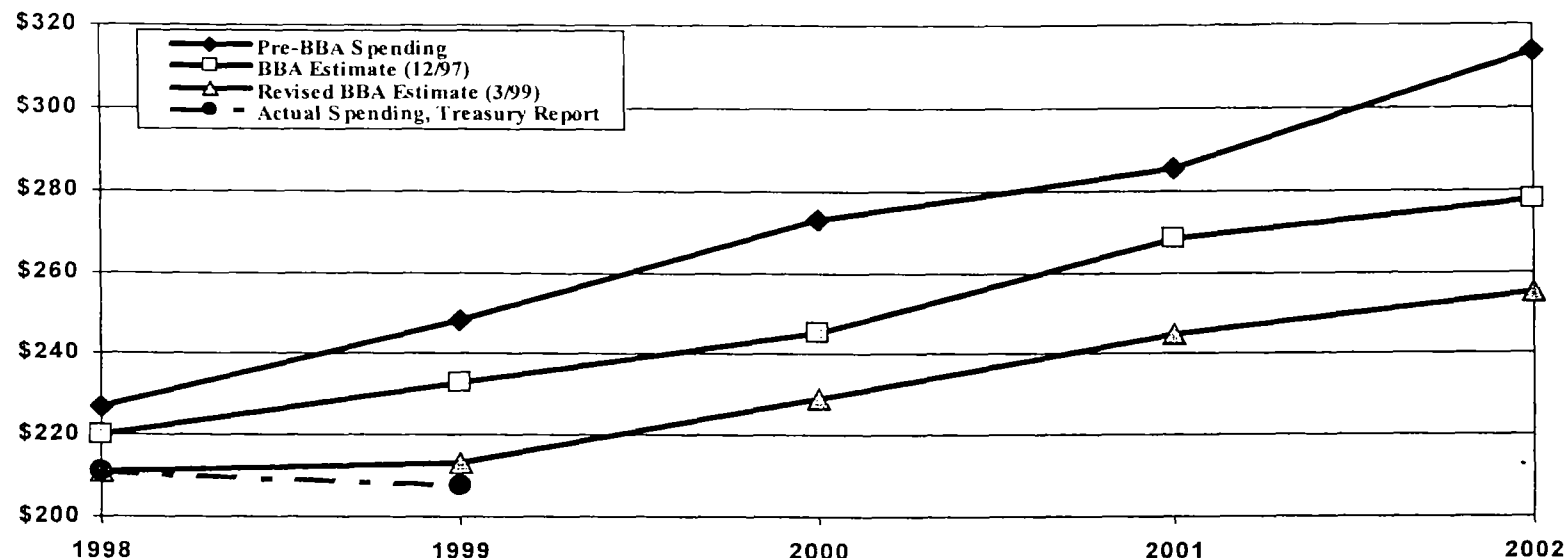
The Federation has prided itself in the past on working with the Finance Committee to craft effective hospital policies and payment reforms. I doubt any Member of the Committee foresaw the full impact of the BBA when it passed in 1997. We would hope to work with you again to identify fair and rational policies that can address these issues, while meeting our shared goal of providing high quality care at a reasonable cost that protects patients and the Trust Funds.

Again, thank you for this opportunity, and I'd be happy to try and answer any questions that the Committee may have for me.

Medicare Spending \$91.7 Billion Less Than Projected (FYs 1998-02)

Medicare Spending Estimates
(in Billions)

BBA Savings Nearly Double Original Estimate



Projections Pre- and Post-BBA (in billions)	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	Five -Year Difference
Pre-BBA spending estimated	\$227.0	\$248.2	\$273.0	\$285.6	\$313.7	-
Estimated spending reductions under BBA (12/97)	(6.9)	(15.5)	(27.6)	(17.1)	(35.9)	(\$103.0)
Estimated spending under BBA (12/97)	220.1	232.7	245.4	268.5	277.8	-
Additional spending reductions per revised estimate	(9.1)	(19.4)	(16.5)	(23.8)	(22.9)	(\$91.7)
Revised estimated spending under BBA (3/99)	211.0	213.3	228.9	244.7	254.9	-
Actual Spending Treasury * Report	211.0	207.7	-	-	-	-
Real Additional Spending Reduction	0.0	(5.6)	-	-	-	-

Sources: CBO, "An Analysis of the President's Budgetary Proposals for FY 2000: A Preliminary Report", March 3, 1999; CBO, "Budgetary Implications of the Balanced Budget Act of 1997," December 1997. *Treasury 3/31/99 Estimates Projected to Entire Year.

REPORT ON HOSPITAL MARGINS FOLLOWING IMPLEMENTATION OF BBA 1997

Last Fall, the Federation of American Health Systems Board of Directors retained Ernst & Young and HCIA to attempt to measure the impact of the BBA on the hospital industry. The analysis used current cost reports and MedPAC's methodology to project the impact of BBA provisions from 1998-2002.

Key Findings and Other Issues

The purpose of this document is to provide a comprehensive, accurate picture of the current and anticipated state of the hospital industry's financial health. Key findings of these analyses are highlighted below.

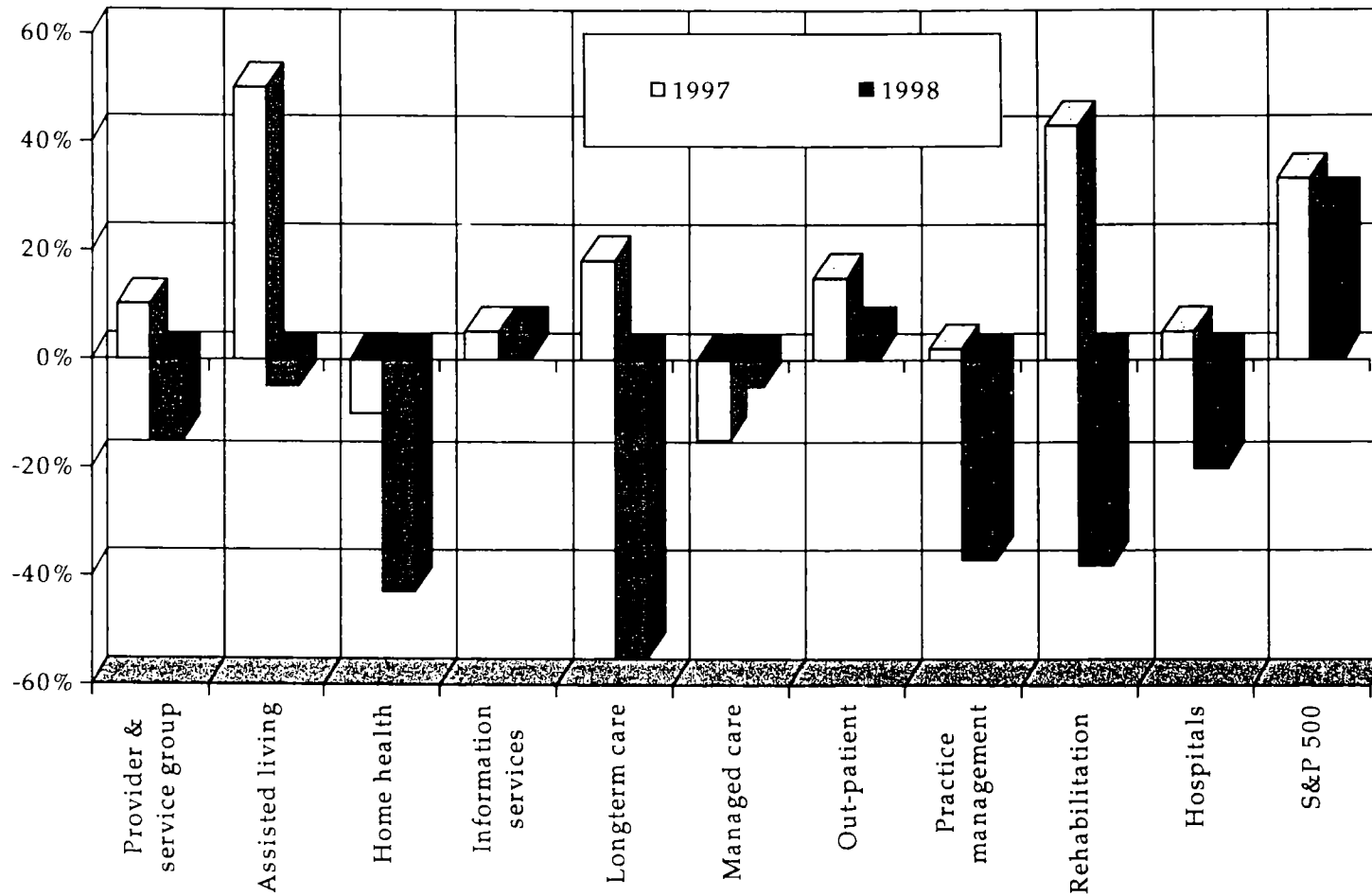
- *Total hospital Medicare margins are expected to decline from 4.3 percent in FY 1997 to only 0.1 percent in FY 1999.* These margins are projected to remain below 3 percent through FY 2002, the duration of the Balanced Budget Act (BBA) payment reduction provisions.
- *Total hospital margins are projected to decline 48 percent in just five years, from 6.9 percent in FY 1998 to 3.6 percent in FY 2002.* While total hospital margins for all hospitals would have decreased even if the BBA had not been enacted, these margins are significantly smaller under the BBA and decrease at a much faster rate during the five-year period (see page 13).
- *Total hospital margins for small, rural hospitals are expected to fall from 4.2 percent in FY 1998 to negative 5.6 percent by FY 2002, a decline of 233 percent.*
- *Findings on hospital Medicare inpatient margins are consistent with MedPAC.* While these findings—which revealed that hospital Medicare inpatient margins decreased from 16.9 percent in FY 1997 to 16.5 percent in FY 1998—are consistent with those of the Medicare Payment Advisory Commission (MedPAC), they represent only a portion of the overall fiscal picture for hospitals.
- *Hospital outpatient margins are already negative 17 percent in FY 1998, and are projected to get substantially worse, dropping to negative 27.8 percent by FY 2002.* The BBA has significantly reduced outpatient payments, payments that were already inadequate. This analysis modeled the impact of the elimination of the formula-driven overpayment (FDO), but not the impact of the outpatient prospective payment system (PPS). The PPS would reduce margins another 3.8 percent, according to HCFA's impact analysis that was published in a September 1998 proposed rule. As outpatient revenues continue to increase as a portion of total hospital revenues, the impact of these negative margins will be even more injurious to hospitals.
- *The BBA's transfer payment policy reduces hospital inpatient payments by approximately two and a half times more than original estimates.* The transfer policy reduced inpatient payments between \$500 and \$800 million in FY 1998, and by approximately \$3 billion between FYs 1998 and 2002. The Congressional Budget Office (CBO) had estimated a \$1.3 billion five-year budget impact when the BBA was enacted in 1997.

The magnitude of these reductions in margins and Medicare payments must be considered in light of two other significant outcomes attributable largely to the BBA:

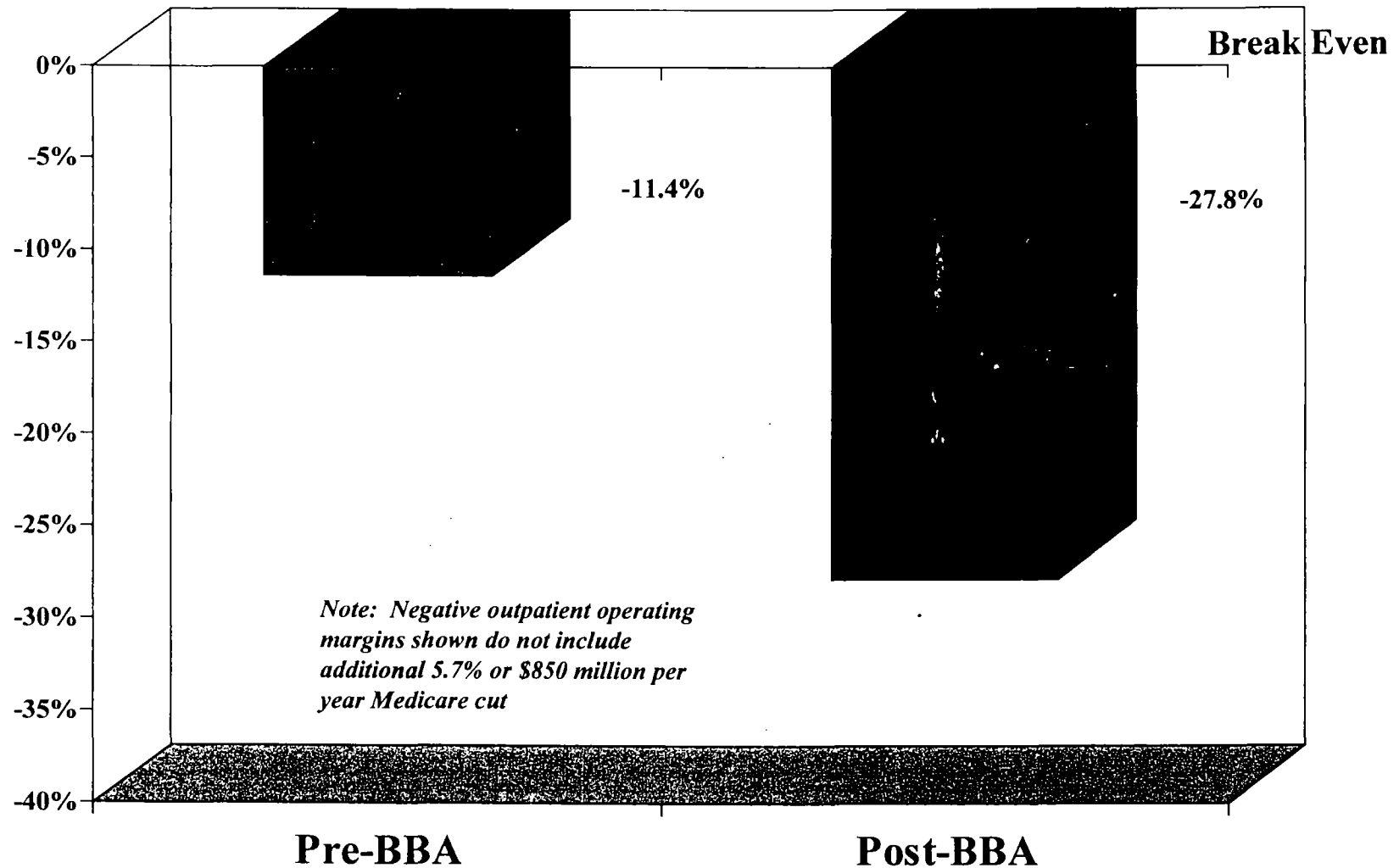
- *The CBO projects Medicare spending to be \$88.5 billion lower than anticipated when the BBA was enacted.* Recent CBO spending estimates for Medicare project total spending to be \$191.5 billion less than original estimates for FYs 1998 through 2002. CBO's estimate of Medicare spending reductions at the time of BBA enactment was \$103 billion.
- *BBA cuts have shaken confidence in the health care industry and have lead to numerous downgrades in bond ratings for community hospitals.* Many analysts are attributing much of the precipitous drop in health care bond ratings to the impact of the BBA. Lowered bond ratings ultimately impair a hospital's ability to access capital to finance technological and facility improvements which, in turn, negatively affect patient access to, and quality of, care.

Health Care Stock Performance, 1997 and 1998

Percent stock price from previous year

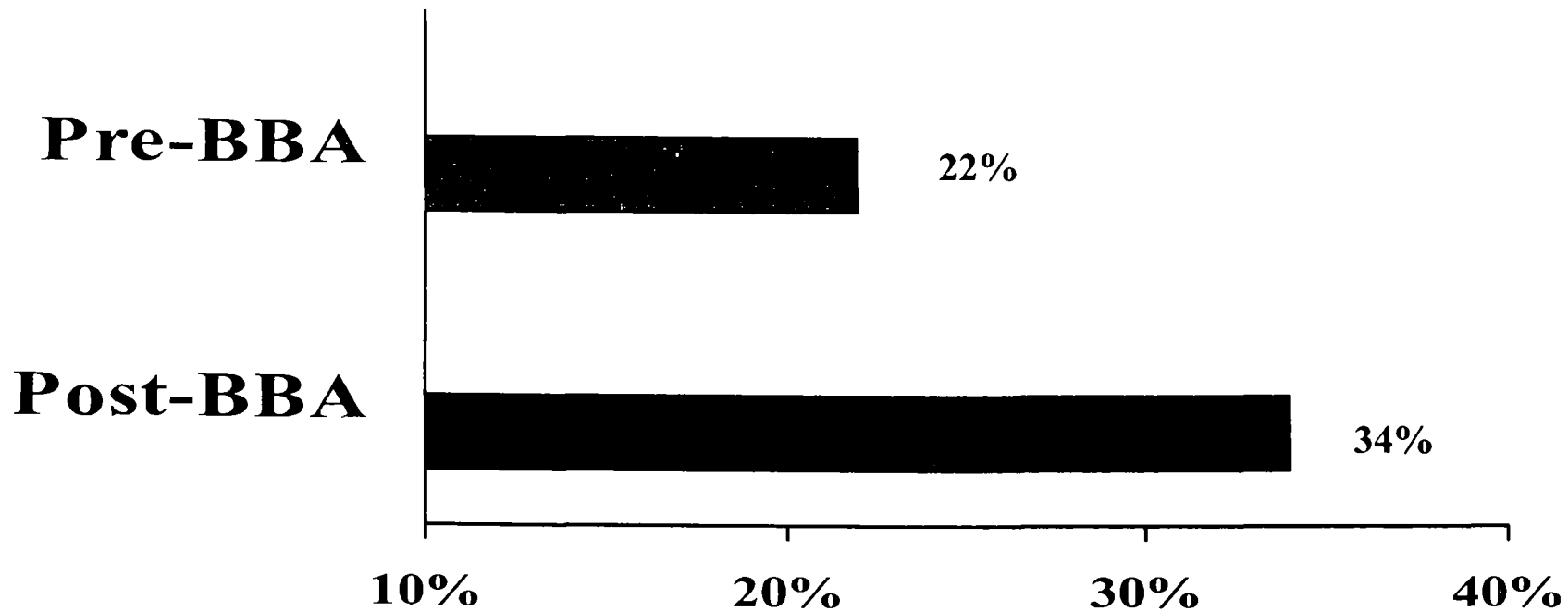


Medicare Outpatient Margins



Total Hospitals Operating in the Red

** Post-BBA, there is a 55% increase in hospitals with negative total margins. **





**Testimony
of the
American Hospital Association
before the
Committee on Finance
of the
United States Senate
on
The Balanced Budget Act of 1997**

June 10, 1999

Mr. Chairman, I am Charles M. Smith, M.D., president and CEO of Christiana Care Corporation in Wilmington, DE. I am here today on behalf of the American Hospital Association (AHA) and its nearly 5,000 hospitals and health systems, networks and other providers of care. We appreciate this opportunity to present our views on an issue that is critical to our members and their communities: the need for relief from the unintended consequences of the Balanced Budget Act of 1997.

Christiana Care is a not-for-profit, coordinated health care system that provides health care services to a four-state area. In addition to many other services, Christiana Care includes two teaching hospitals with 1,100 licensed beds and 225 residents and fellows in training; a long-term care facility; a preventive medicine and rehabilitation institute; a home health care company; a primary physician network and a wide variety of other outpatient services including

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school and senior wellness centers. The Balanced Budget Act of 1997 and the changes it has brought about in Medicare reimbursement affect all of our services.

The Balanced Budget Act was the biggest reform of the Medicare program ever undertaken during the past 30 years. It was a major piece of legislation encompassing approximately 350 changes that have significant implications and consequences for the program, for caregivers, and for the people we serve. Hospitals and health systems are greatly affected by those changes. I urge the committee to seriously evaluate the consequences of the Balanced Budget Act – intended or unintended. Such consideration will lead to the conclusion that change is needed as soon as possible.

UNINTENDED CONSEQUENCES

Balancing America's budget shouldn't deprive Americans of the health care they need and deserve. But that's exactly what's happening across the nation, even though two-thirds of the cuts have yet to take effect. Today's hospitals and health systems encompass all elements of health care delivery affected by the Balanced Budget Act: home health, skilled nursing, outpatient and inpatient hospital, and health plans. This makes the act's changes particularly burdensome, and the worst is yet to come, as a new analysis from The Lewin Group, a highly respected health care consulting firm, makes clear.

The Lewin Group was asked by the AHA to forecast the Balanced Budget Act's impact through the year 2002 on payments for hospital services including inpatient, outpatient, hospital-based home health, rehabilitation, long-term care, psychiatric and cancer services. The Lewin Group

report shows that the actual cost of the Balanced Budget Act for hospitals will be \$71 billion over five years -- \$18 billion more than was anticipated when the bill passed. Further findings from the analysis:

- For all hospitals, total Medicare margins are projected to be between negative 4.4 percent and negative 7.8 percent in 2002.
- Already in the red when treating Medicare patients, rural hospitals' total Medicare margins may plummet to between negative 7 percent and negative 10.4 percent in 2002 as a result of BBA payment cuts. Urban hospitals' total Medicare margins in three years are predicted to range from negative 3.9 percent to negative 7.3 percent.
- Outpatient service margins also are expected to drop. Medicare outpatient margins – already negative in 1999 – are estimated to be negative 28.8 percent if costs increase at the historical rate of growth; and negative 20.3 percent if hospital costs increase more slowly.
- In just one year, margins for hospital-based home health services are predicted to drop dramatically from negative 4 percent in year 2000, to negative 11.6 percent margin in 2001. Fifty percent of hospitals now provide home health care.

The new report contributes to the growing evidence that hospitals and their communities are facing hardship. A report released in April by Moody's Investors Services stated that U.S. not-for-profit hospitals' credit deteriorated at a faster clip in the first quarter of 1999 than the entire

previous year. Moody's cited the fiscal pressures of the Balanced Budget Act as one of the reasons for the downward slide. And other recent analyses by Ernst & Young and HCIA Inc. and the Association of American Medical Colleges echo that hospital margins and, therefore, their stability, will be greatly eroded.

CHRISTIANA'S STORY

At Christiana Care, the post-hospital care part of the system cannot provide adequate care to home health and nursing patients because of the Balanced Budget Act's reductions in reimbursement for those services. As a result, a genuine "Catch-22" has been created: Hospitals are unable to discharge Medicare patients when acute care is completed and nursing home placement or home health support is needed. At the same time these hospitals are being penalized by the system for not discharging these patients. We now have an ever-increasing number of patients in the hospital awaiting placement. Recently, this number reached 80 – as opposed to about 25 prior to the Balanced Budget Act.

This creates several significant problems. The most important is that hospitalization of the elderly, when not needed for acute care reasons, is bad patient care. Older people may manifest dramatic physical and mental deterioration during periods of hospitalization, and some may never recover their previous functional state.

It's also a problem for the operation of the hospital. We now have beds filled with patients who do not need to be in the hospital. The fact that these beds cannot be used for the care for which

they were intended interrupts the normal flow of patients through the hospital, from more acute to less acute settings, creating what might be termed “medical gridlock.”

The financial consequences of all this is an unintended and unnecessary increase in health care costs. Of course, these costs are largely uncompensated and will result in losses to hospitals because Medicare, quite appropriately, pays only for necessary hospitalization.

The medical education programs at Christiana Care are very important for providing medical manpower in our state. We have developed a special program to introduce our medical residents to underserved areas in Delaware, and as many as 45 percent of our graduating primary care residents stay in the state to practice. Without our residency programs, it would probably be impossible – certainly much more expensive – to continue providing the enormous amount of uncompensated care that we provide now to the underprivileged and uninsured. We are the only level one trauma center in the state and without our residents we could not retain that designation and trauma care would be disrupted. As a result, we are very worried about the already implemented, as well as future, BBA reductions in support for medical education and the impact they will have on our community.

Because Christiana also provides so much outpatient care, we also are worried about the changes in the prospective payment system for Medicare outpatient services. Currently, Medicare outpatient payments do not cover our costs, and these changes will make the situation worse. And because we provide so much care to low-income people, we are very concerned about changes in Disproportionate Share Hospital payments.

WHAT CAN BE DONE?

America's hospitals, and the patients and communities they serve, must have relief from these unintended consequences of the Balanced Budget Act. We need both administrative and legislative solutions. Medicare should be treated like Social Security: a portion of the federal budget surplus should be used to address the Balanced Budget Act's unintended consequences ... because Medicare is Social Security.

Relief from the Balanced Budget Act should include:

- Repeal of the Balanced Budget Act's unreasonable transfer provision, as proposed in H.R. 405 and S. 37, as proposed by Senator Grassley. The transfer provision redefined discharges to post-acute care as transfers for up to 10 types of cases (with authority for the HHS secretary to add more), in effect penalizing hospitals for providing efficient care in the right setting.
- Easing the reductions in the proposed Medicare outpatient prospective payment system (PPS). The new outpatient PPS greatly reduces and redistributes payments for services, and includes a "volume cap" that penalizes hospitals for adopting new technology. It also includes a formula for setting payment rates that, contrary to Congress' intent, cuts payments by an additional 5.7 percent. Our solutions: Establish a transition for implementation of outpatient PPS that ensures that no facility will receive reductions of more than 5 percent per year; repeal the volume cap; and encourage the Health Care Financing Administration (HCFA) to revisit its decision to further reduce outpatient payments by another 5.7 percent, which it has the administrative authority to do.

- Increase the Medicare inpatient hospital service update by 0.5 percent, as recommended by the Medicare Payment Advisory Commission, to reflect the costs hospitals are incurring to prepare for Y2K. This would help offset some of the Balanced Budget Act's cuts, as well as ease the sting of the nearly \$8.2 billion hospitals nationwide are expected to spend to make sure the change to the Year 2000 does not affect health care services.
- Relief from reductions for teaching hospitals and academic medical centers. The Balanced Budget Act limits payments for "indirect medical education," causing significant hardship for teaching hospitals and academic medical centers, many of which are the only place for America's urban poor to receive care. AHA thanks Senators Moynihan and Kerrey for introducing S. 1023, which would freeze these payments at current levels and prevent future scheduled cuts.
- Repair the damage the Balanced Budget Act has caused to America's small and rural hospitals. Ensure that a portion of the federal budget surplus is devoted to providing relief to small and rural hospitals through repeal of the transfer provision of the BBA, and prevention of deep losses on the outpatient side.
- Restore adequate reimbursement for skilled nursing facilities (SNF). The new SNF PPS does not adequately account for the high costs of treating medically complex cases. It also penalizes newer skilled nursing facilities, causing many to limit services or shut down completely. In the short term, a pool of funds should be established from which additional

payments can be made available to help offset the cost of caring for medically complex SNF patients. In the long run, SNF PPS must be revised.

- Redress for inequities in home health care services. Address both the short-term inequity in the interim payment system, which has severely diminished the availability of these services, and the scheduled 15 percent cut in payments for home health services.
- “Carve out” disproportionate share hospital (DSH) payments. For providers participating in Medicare managed care, Medicare DSH payments are made to Medicare+Choice plans without requiring that the payments be passed on to the providers who actually incurred the costs of caring for large numbers of the poor. AHA thanks Senators Moynihan and Kerrey for introducing S. 1024, which would mandate that these payments be made by HCFA directly to those providers, not to the plans.
- Encourage HCFA to develop a rehabilitation PPS that uses a per-discharge payment method rather than a per-case method. HCFA is contemplating using the SNF PPS per-case model for rehabilitation PPS, but the SNF PPS model may not adequately recognize the unique elements involved in providing rehabilitation care. AHA believes that HCFA should adopt MedPAC’s recommendation that the Secretary develop a discharge-based PPS for rehab patients based on the Functional Independence Measure-Function Related Groups.
- Remove barriers to expanded Medicare options through Medicare+Choice.

CONCLUSION

Mr. Chairman, the environment for hospitals and health systems today is filled with uncertainty – financial pressures in the private market, mergers and consolidations, the ebb and flow of managed care, implementation of the Balanced Budget Act, unstable Medicare revenue streams that result, and the specter of even more change on the horizon. For many hospitals, Medicare has been an anchor in choppy waters. It has been a major and relatively stable source of revenue that has allowed hospitals to provide the care their communities need.

The Balanced Budget Act has changed all that. Hospitals today are struggling to make up for the shortfalls caused by the Act. They refuse to compromise the quality of services they provide, but they can't afford to continue providing those services if their costs aren't even covered. As a result, communities are losing access to vital health care services even as Washington debates how to spend a federal budget surplus of billions of dollars.

This is a trend that must be reversed, now. When the government acted to reduce Medicare spending to help balance the budget, no one was certain what effect such enormous reductions would have. Now, the evidence is pouring in from all over the country: the Balanced Budget Act is causing real pain for real people. We look forward to working with you to repair these unintended consequences of the Balanced Budget Act.

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American Medical Association

Physicians dedicated to the health of America



1101 Vermont Avenue, NW
Washington, DC 20005

Statement

to the

**Committee on Finance
United States Senate**

Re: Medicare Sustainable Growth Rate Update

Presented by D. Ted Lewers, MD

June 10, 1999

Division of Legislative Counsel
202 789-7426

Statement
of the
American Medical Association
to the
Committee on Finance
United States Senate

RE: MEDICARE SUSTAINABLE GROWTH RATE UPDATE

Presented by D. Ted Lewers, MD

June 10, 1999

The American Medical Association (AMA) appreciates the opportunity to present to this Committee our views concerning improvements to the Medicare sustainable growth rate (SGR) system for physicians' services, and appreciates the Committee's focus on this important issue.

In its March 1999 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) identified serious problems in the SGR system and recommended significant improvements to the SGR. The AMA and the national medical specialty societies share MedPAC's concerns and believe that improving the SGR is a critical component of efforts to ensure that the 85% of Medicare beneficiaries who are enrolled in the fee-for-service program continue to receive the benefits to which they are entitled.

Specifically, the physician community is concerned that the growth limits in the current SGR system are so stringent that they will have a chilling effect on the adoption and diffusion of

innovations in medical practice and new medical technologies. Also, the Health Care Financing Administration (HCFA) did not revise the estimates it used in the 1998 SGR when data proved HCFA erroneous, nor will it correct 1999 SGR errors without a congressional mandate. These errors have shortchanged payments by \$645 million in 1999 alone. The SGR could also cause future payments to be highly volatile and fall well behind cost inflation.

MEDICARE PHYSICIAN PAYMENTS AND THE BALANCED BUDGET ACT

Medicare payments for physicians' services are updated annually by HCFA. Payment rates are based on a relative value scale system, enacted under OBRA 89, that reflects the physician work, practice expense and professional liability insurance costs involved in each service. The relative value for each service is multiplied by a dollar conversion factor to establish actual payment amounts. The conversion factor is required to be updated each calendar year, which involves, in part, establishing an update adjustment factor (UAF) that is adjusted annually by the SGR.

The SGR system was intended to slow the projected rate of growth in Medicare expenditures for physicians' services.

MedPAC recommends that Congress revise the SGR system as follows—

- The SGR should 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;
- The Secretary should be required to publish an estimate of conversion factor updates by March 31 of the year before their implementation;

- The time lags between SGR measurement periods should be reduced by allowing calculation of the SGR and update adjustment factors on a calendar year basis;
- HCFA should be required to correct the estimates used in the SGR calculations every year; and
- The SGR should reflect changes in the composition of Medicare fee-for-service enrollment.

THE SUSTAINABLE GROWTH RATE SYSTEM

The SGR system was enacted under the BBA and replaces the Medicare Volume Performance Standard system, which had been the basis for setting Medicare conversion factor updates since 1992. The SGR sets a target rate of spending growth based on four factors: changes in payments for physician services before legislative adjustments (essentially inflation); changes in Medicare fee-for-service enrollment; changes in real per capita gross domestic product (GDP); and an allowance for legislative and regulatory factors affecting physician expenditures. Growth in real per capita GDP represents the formula's allowance for growth in the utilization of physician services.

The target growth rate of spending growth is calculated each year and is designed to hold annual growth in utilization of services per beneficiary to the same level as annual GDP.

Physician payment updates depend on whether utilization growth exceeds or falls short of the target rate. If utilization growth exceeds GDP, then payment updates are less than inflation.

If utilization is less than GDP, payment updates are above inflation.

Although real per capita GDP growth has varied from as low as -3 percent to as high as +6 percent, average growth is only about 1.6 percent per year. At 5.9 percent, average annual per

beneficiary growth in utilization of physicians' services was three to four times higher than GDP growth from 1981-1996. The BBA placed limits on annual changes to the Medicare conversion factor under the SGR. The conversion factor update in any year can be no greater than inflation (as measured by the Medicare Economic Index, or MEI) plus 3%, and the update can be no lower than inflation minus 7 percent. **An "update" of MEI minus 7 percent would mean that, in a single year, physician payments were reduced by 7 percent below the rate of inflation in the costs of medical practice.**

PROBLEMS WITH THE SGR SYSTEM

There are two major types of problems with the SGR system. The first set of problems arises from the way in which the current system is being administered by HCFA. To address these problems, MedPAC recommends that Congress direct HCFA to correct the errors in its SGR estimates when actual data are available. HCFA does not believe that it currently has the legislative authority to make such corrections. The second set of problems clearly requires a legislative solution to refine the way the SGR system was designed in the BBA: GDP growth alone is inadequate; a variety of factors will lead to tremendous instability in Medicare payment levels over time; and there is not currently any means for anticipating and responding to problems in the updates before they occur.

Unlike some other Medicare payment issues, the problems with the SGR system and their solutions are a matter on which the physician community is unified. National organizations representing diverse medical specialties, including surgeons, primary care physicians and others, as well as organizations representing medical colleges and group practices, have been

working closely together with the AMA to address these complex issues. On behalf of the entire physician community, we are asking Congress to take the steps necessary to assure that we can continue to afford to provide our Medicare patients with the best medical care available in the world.

The Projection Error Problem

The SGR formula requires HCFA to make projections about the factors used to calculate the SGR. Although HCFA initially had indicated it would correct any projection errors once actual data had become available, the agency now asserts it does not have the authority to make such corrections. We adamantly believe these projection errors must be corrected. If not, the SGR will continue to be based on erroneous projections that result in shortages in the payment levels that the law requires be paid to physicians. This problem is seriously compounded by the fact the SGR system is cumulative. Thus, any projection errors that are left uncorrected will carry over from year to year.

Even if HCFA's projections were to be based on the best available data, methods, and judgment, because of the uncertainty that will always exist at the particular time period when the statute requires the projections to be made, they will nearly always be wrong. As a result, actual changes in these factors will differ from what was projected.

Although HCFA initially stated in a *Federal Register* notice it would correct its projection errors in subsequent years when actual data becomes available, it currently is asserting that it does not have the statutory authority to make such corrections. We believe HCFA has the

authority to correct its projections errors, and that it is imperative to do so. Failure to correct projection errors has and likely will continue to result in severe underpayments to physicians.

HCFA has already established an SGR for 1998 and 1999 that are based on erroneous projections. That is, to determine the 1998 SGR, HCFA, in late 1997, made projections of GDP growth and changes in fee-for-service enrollment. Because HCFA did not correct the error in the 1998 SGR, the 1999 conversion factor update of 2.3 percent is too low.

Specifically, HCFA projected only 1.1 percent growth in real per capita GDP for fiscal year 1998, whereas actual growth was closer to 2.8 percent, according to federal government estimates. When combined with other, smaller projection errors in the 1998 SGR, HCFA made a net underestimate in the 1998 SGR of 1.5 percent. With Medicare spending on physician services currently at about \$43 billion annually, the projection errors led HCFA to set the payment update for 1999 about \$645 million lower than is otherwise required by law.

In addition, HCFA has already made at least one major error in estimating the 1999 SGR by projecting that fee-for-service enrollment would decline by 4.3 percent in 1999. Such a decline would require Medicare+Choice enrollment to increase by 29 percent during the same time period. In fact, with the exception of one month, the percentage rate of increase in Medicare managed care enrollment has already been declining every month since November 1997 through May 1999, and in December 1998 and January 1999, managed care enrollment actually decreased. Moreover, information from the first quarter of this year suggests HCFA's projection of GDP growth for 1999 will also be significantly understated. Over time, due to the cumulative nature of the SGR, even if HCFA made no further projection errors,

simply leaving the 1998 and 1999 projection errors uncorrected would shortchange physician service payments by billions of dollars.

If the SGR system is to work at all, HCFA's projection errors must be corrected. Indeed, the statute was based on recommendations by the Physician Payment Review Commission (PPRC), an advisory body to Congress (and predecessor to MedPAC). In its 1995 and 1996 Reports to Congress, MedPAC recommended that projection errors in the factors used to calculate the SGR be corrected in subsequent years. In 1996, it stated that "[o]ver time, more Medicare beneficiaries are expected to enroll in risk contract arrangements. This will make it harder to project fee-for-service Part B enrollment growth. The resulting errors in projection could become substantial, significantly affecting the accuracy of the conversion factor updates." To address these problems, the PPRC stated that "[a]ny revision to the Volume Performance Standard system should annually correct for any projection errors in the target growth rate from prior years...This limitation [projection errors] could be readily addressed by incorporating an adjustment into the sustainable growth rate that corrects for previous errors in the projection."

Because the SGR system was adopted at the PPRC's recommendation, we believe it is reasonable to conclude that Congress intended for HCFA to correct projection errors when actual data are available instead. Since HCFA has refused to do so, however, we strongly agree with MedPAC's recommendation that Congress should require HCFA every year to correct its projection errors made when calculating the SGR.

Specifically, to further implement MedPAC's recommendation, the AMA believes that Congress should require that HCFA immediately, or as soon as practicable in the case of 1999 projections—

- Adjust its SGR estimate for fiscal year 1998 to reflect actual data on real per capita GDP growth and Medicare enrollment changes, as well as estimates of allowed expenditures for physician services impacted by these erroneous SGR calculations;
- Correct the 1999 conversion factor to reflect the corrected SGR; since the correct 1999 conversion factor should have been implemented on January 1, 1999, HCFA should “prorate” the conversion factor correction so that total payments for physician services this year will equal the total amount of payments that would have been made over the course of the year had the conversion factor been implemented correctly on January 1; and
- Revise the 1999 SGR, as well as estimates of allowed expenditures for physician services, to reflect available data on GDP growth and enrollment changes prior to computing the update adjustment factor to be used in establishing the 2000 payment update.

The SGR Must Allow for Technological Innovations and Other Factors Impacting Utilization of Health Care Services

MedPAC has also recommended that Congress revise the SGR 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.

The system is currently designed to hold annual utilization growth at or below annual GDP growth. A common method for policymakers to evaluate trends in national health expenditures is to look at growth in health spending as a percentage of GDP, but this approach is replete with problems. There is no true relationship between GDP growth and health care needs. Indeed, forecasts by Congressional Budget Office and the U.S. Census Bureau indicate that real per capita GDP growth will average about 1.5 percent per year over the next

decade. This is far below historical rates of Medicare utilization growth. If history is any guide, then holding utilization growth to the level of GDP growth virtually guarantees that Medicare physician payments will decline.

A primary reason for this lack of congruity between GDP and Medicare utilization is that GDP does not take into account health status trends nor site-of-service changes. Thus, if there were an economic downturn with negative GDP growth at the same time that a serious health threat struck a large proportion of Medicare beneficiaries, the consequences could be disastrous.

Secondly, GDP does not take into account technological innovations. The only way for technological innovations in medical care to really take root and improve standards of care is for physicians to invest in those technologies and incorporate them into their regular clinical practice. The invention of a new medical device cannot, in and of itself, improve health care—physicians must take the time to learn about the equipment, practice using it, train their staff, integrate it into their diagnosis and treatment plans and invest significant capital in it. Yet physician spending is the only sector of Medicare that is held to as stringent a growth standard as GDP and that faces a real possibility of payment cuts of as much as 5 percent each year. Keeping utilization growth at GDP growth will hold total spending growth for physician services well below that of the total Medicare program and other service providers. **To address this problem, as recommended by MedPAC, the factor of growth under the SGR relating to GDP must be adjusted to allow for innovation in medical technology.** We believe to implement adequately MedPAC's recommendation, the SGR should be set at

GDP + 2 percentage points to take into account technological innovation, as discussed further below.

In addition, we urge that Congress consider a long-term approach to setting an appropriate growth target that takes into account site-of-service changes, as well as health status and other differences between Medicare's fee-for-service and managed care populations that lead to differential utilization growth. Thus, we believe that the Agency for Health Care Policy and Research (AHCPR) should be directed to analyze and provide a report to MedPAC on one or more methods for accurately estimating the economic impact on Medicare expenditures for physician services resulting from improvements in medical capabilities and advancements in scientific technology, changes in the composition of enrollment of beneficiaries under the fee-for-service Medicare program and shifts in usage of sites-of-service.

Technological Innovation

Congress has demonstrated its interest in fostering advances in medical technology and making these advances available to Medicare beneficiaries through FDA modernization, increases in the National Institutes of Health budget, and efforts to improve Medicare's coverage policy decision process. The benefits of these efforts could be seriously undermined if physicians face disincentives to invest in new medical technologies as a result of inadequate expenditure targets.

As first envisioned by the PPRC, the SGR included a 1 to 2 percentage point add-on to GDP for changes in medical technology. Ever-improving diagnostic tools such as magnetic

resonance imaging, new surgical techniques including laparoscopy and other minimally-invasive approaches, and new medical treatments have undoubtedly contributed to growth in utilization of physician services and the well-being of Medicare beneficiaries. For example, a recent paper published by the National Academy of Sciences indicated that from 1982-1994 the rates of chronic disability among the elderly declined 1.5 percent annually.

With GDP projected to grow by 1.5 percent annually, the failure to allow an additional 1 to 2 percentage points to the SGR for technological innovation means that the utilization target is only half the rate that was originally planned. **Technological change in medicine shows no sign of abating, and the SGR should include a technology add-on to assure Medicare beneficiaries continued access to mainstream, state-of-the art quality medical care.**

Site-of-Service Shifts

Another concern that should be taken into account by the GDP growth factor is the effect of the shift in care from hospital inpatient settings to outpatient sites. As MedPAC has pointed out, hospitals have reduced the cost of inpatient care by reducing lengths-of-stay and staff and moving more services to outpatient sites, including physician offices. These declines in inpatient costs, however, are *partially* offset by increased costs in physician offices. Thus, an add-on to the SGR target is needed to allow for this trend.

Beneficiary Characteristics

The SGR should also be adjusted for changes over time in the characteristics of patients enrolling the fee-for-service program. A MedPAC analysis has shown that the fee-for-service

population is older, with proportions in the oldest age groups (aged 75 to 84 and those age 85 and over) increasing, while proportions in the younger age group (aged 65-74) has decreased as a percent of total fee-for-service enrollment. Older beneficiaries likely require increased health care services, and in fact MedPAC reported a correlation between the foregoing change in composition of fee-for-service enrollment and increased spending on physician services. **If those requiring a greater intensity of service remain in fee-for-service, the SGR utilization standard should be adjusted accordingly.**

Stabilizing Payment Updates under the SGR System

The AMA strongly agrees with MedPAC's further recommendation that Congress should stabilize the SGR system by calculating the SGR and the update adjustment factor on a calendar year basis.

Instability in annual payment updates to physicians is another serious problem under the SGR system, as has been acknowledged by HCFA. Projections by the AMA, MedPAC and HCFA show the SGR formula producing alternating periods of maximum and minimum payment updates, from inflation plus 3 percent to inflation minus 7 percent. Assuming a constant inflation rate, these alternating periods could produce payment decreases of 5 percent or more for several consecutive years, followed by increases of similar magnitude for several years, only to shift back again. These projections are based on constant rates of inflation (2 percent), enrollment changes, GDP growth and utilization growth. There is a serious problem when constant, stable rates of change in the factors driving the targets lead to extreme volatility in payments that are entirely formula-driven.

A primary reason for this instability is the fact that there is a time lag in measurement periods for the SGR. Specifically, while physician payment updates are established on a calendar year basis, SGR targets are established on a federal fiscal year basis (October 1 through September 30) and cumulative spending (used to calculate the SGR) is established on an April 1 through March 31 basis. These time periods must all be consistent and calculated on a calendar year basis to attempt to restore some modicum of stability to the SGR system.

Simulations by the AMA and MedPAC have also shown, however, that the change to a calendar year system will not, by itself, solve the instability problem. Additional steps would be needed. The wide range of updates that are possible under the current system, from inflation + 3 percent to -7 percent, is one reason for the instability. The lower limit is also unacceptably low, and, assuming an MEI of 2 percent, represents an actual 5 percent cut in the conversion factor in a single year. These levels of payment cuts would be highly disruptive to the market, and likely would have the “domino effect” of impacting the entire industry, not simply Medicare fee-for-service. Many managed care plans, including Medicare+Choice and state Medicaid plans, tie their physician payment updates to Medicare’s rates. **Thus, payment limits under current law must be modified to assist in stabilizing the SGR system. We recommend that the current limits on physician payment updates (MEI +3 percent to MEI -7 percent) be replaced with new, narrower limits set at MEI +2 percent and MEI -2 percent.**

Finally, use of the GDP itself also contributes to the instability of the payment updates since GDP growth fluctuates from year to year. **Thus, we recommend measuring GDP growth on the basis of a rolling 5-year average.**

Payment Preview Reports

Finally, MedPAC has also recommended that Congress should require the Secretary of the Department of Health and Human Services to publish an estimate of conversion factor updates prior to the year of implementation. We agree.

When the SGR system was enacted to replace the previous Medicare Volume Performance Standards, the requirements for annual payment review reports from HCFA and the PPRC were eliminated along with the old system. Without these reports, it is impossible to predict what the payment update is likely to be in the coming year, and it is impossible for Congress to anticipate and respond to any potential problems that may ensue from an inappropriate update or a severe projection error.

Changes in Medicare physician payment levels have consequences for access to and utilization of services, as well as physician practice management. These consequences are of sufficient importance that the system for determining Medicare fee-for-service payment levels should not be left unattended on a kind of “cruise control” status, with no “brake” mechanism available to avoid a collision.

The AMA, therefore, urges that the payment preview reports be reinstated. Specifically, we believe that HCFA should be required to provide to MedPAC, Congress and organizations representing physicians quarterly physician expenditure data and an estimate each spring of the next year's payment update. MedPAC could then review and analyze the expenditure data and update preview, and make recommendations to Congress, as appropriate.

PRACTICE EXPENSE REFINEMENT

With strong AMA support, the BBA directed HCFA to revise its resource-based practice expense proposal for the Medicare physician payment schedule. HCFA issued a June 1998 proposed rule and November 1998 interim final rule. In developing the new relative values, HCFA is also required, among other things, to "develop a refinement process to be used during each of the 4 years of the transition period."

The AMA is available and willing to work with HCFA in this refinement process. We are in the process of developing a new survey of medical practice cost data, to be pilot-tested in late summer of 1999 and implemented in 2000. Many experts and potential users of the data are being consulted in the development of this survey. We are also planning to meet with HCFA staff to discuss potential use of AMA survey data to refine and/or update specialty practice expense data.

Finally, we applaud the General Accounting Office (GAO) for its cooperation and oversight of this process, as embodied in its two reports on HCFA's development of the resource-based practice expense values. GAO's efforts have been enormously helpful, and we appreciate its

contributions to this process. For example, the GAO recommended in its February 1999 report that HCFA develop plans for updating the practice expense relative value units that address “how to (1) assign practice expense [relative value units] to new codes, (2) revise the [relative value units] for existing codes, and (3) meet the legislative requirement for a comprehensive 5-year review...” The AMA agrees that such a plan for the refinement and updating process is critical and, because the current methodology relies significantly on data collected by the AMA, we have expressed to the HCFA Administrator our willingness to work cooperatively with the agency in developing a comprehensive plan for future data collection and refinement.

The GAO has also recommended that HCFA “use sensitivity analysis to identify issues with the methodology that have the greatest effect on the new practice expense [relative value units] and to target additional data collection and analysis efforts.” The AMA agrees. We have noted particular specialty society concern over the approach used by HCFA in its interim final rule for assigning relative values to technical component services, as well as HCFA’s failure, to date, to incorporate corrections in the data into the relative values. Some of these corrections have been provided to HCFA on multiple occasions.

CONCLUSION

Enactment of the SGR system improvements recommended by MedPAC and completion of the practice expense refinements recommended by the GAO are critical to the continued ability of our nation’s physicians to be able to offer our Medicare patients the benefits of the finest medical care available in the world. If these improvements and refinements are not put

in place, the SGR system could lead to severe payment cuts in the Medicare physician fee schedule and payments for services that do not accurately reflect their costs. The cuts resulting from both the statutory design of the SGR system and administration of the system by HCFA would be in addition to more than a decade of cuts in physician payments. For example, in the six years from 1991-1997, overall Medicare physician payment levels fell 10 percent behind the rate of growth in medical practice costs. Many individual services and procedures faced even deeper cuts.

Recent survey data from the AMA's Socioeconomic Monitoring System indicates that these payment changes are having very significant effects on the practice of medicine. Of 2,450 randomly selected physicians that were surveyed from April-August 1998, 35 percent reported they are not renewing or updating equipment used in their office, are postponing or canceling purchasing equipment for promising new procedures and techniques, or are performing many procedures in hospitals that were formerly performed in the office. Three quarters of these physicians reported that Medicare payment cuts were an important factor in their decisions to defer or cancel these investments in capital.

With these kinds of changes already taking place in response to previous payment changes, we have grave concerns about the effects of the further reductions that could take place due to the SGR or incorrect practice expense values. In order for the medical innovations that will come from Congress' enhanced funding of biomedical research, FDA modernization, and better Medicare coverage policies to translate into ever-improving standards of medical care, physicians must be able to adopt these innovations into their practices. It is already clear that

Medicare payment cuts are threatening continued technological advancement in medicine, and this is a threat that affects all of us, not just Medicare beneficiaries. Clearly, reversal of the trend to move services away from inpatient sites into ambulatory settings could also have severe consequences for health care costs, as well as patient care.

We appreciate the efforts of the members of this Committee to explore the problems presented by the SGR system, as well as the opportunity to discuss our views on this extraordinarily important matter. We urge this Committee and Congress to consider MedPAC's recommendations and the recommendations we have discussed today, and are prepared to engage fully in detailed discussions with this Committee and Congress as we work to achieve a workable and reasonable solution.

AMERICAN HEALTH CARE ASSOCIATION

**MEDICARE SKILLED NURSING FACILITY
PROSPECTIVE PAYMENT SYSTEM**

TESTIMONY

before the

SENATE FINANCE COMMITTEE

June 10, 1999

SUSAN S. BAILIS

Thank you, Chairman Roth and Members of the Senate Finance Committee, for this opportunity to share the concerns of skilled nursing facility (SNF) providers as we navigate our way through the recently implemented prospective payment system (PPS) -- and other changes brought about by the Balanced Budget Act of 1997 (BBA).

Let me state for the record that my name is Susan Bailis, and I am the co-chairman and co-chief executive officer of a company that develops innovative health care services and provides consulting with a specialty in eldercare. I have overseen the operations of nursing homes and SNFs with 5,000 beds for more than 13 years. I have served on ProPAC -- the predecessor to the Medicare Payment Advisory Commission -- and I am also a clinical social worker. I speak today on behalf of the American Health Care Association (AHCA), a federation of 50 affiliated associations representing over 11,000 non-profit and for-profit assisted living, nursing facility, and subacute providers nationwide.

Mr. Chairman, let me express our sincere appreciation for the opportunity to share with you our concerns regarding the implementation of the SNF PPS and its impact on residents for whom we have the privilege to care. Controlling Medicare spending is a laudable goal, but the unintended consequences of the most recent cuts in Medicare have been severe. A change from cost-based reimbursement to a prospective payments system (PPS) has been -- by definition -- dramatic. With a transformation of that magnitude, the need for corrective adjustments along the way is inevitable. Hearings like this one demonstrate this Committee's willingness to recognize that Congress must redress some

of the unintended problems that have emerged from the BBA. In that same spirit, I come before you today to relay our concerns -- and more important, to propose solutions.

Comprehensive data has been difficult to come by because the PPS is relatively new. However, based on recent data collected among the SNF community by Muse and Associates -- a Washington, D.C.-based research firm -- one startling fact has emerged, and that is that SNFs have experienced an average reduction in their daily Medicare payments of \$50 per day per patient. The study also shows that Medicare beneficiary use of skilled nursing facilities has dropped by more than 10 percent, and patient length of stay has decreased by nearly 15 percent. These numbers tell an important story. Nursing homes are reevaluating the extent to which Medicare resources will allow them to appropriately care for the sickest patients. The result is a very real access problem to skilled nursing services, which is causing backups in hospitals throughout the country. This squeeze has put SNFs in a difficult situation, and we are concerned about the impact it will have on Medicare beneficiaries -- specifically high-acuity patients. Naturally, SNFs will be hard-pressed to continue to provide service when patients' costs of care exceed the resources available.

I want to share with you a few examples of the difficulties SNFs are experiencing under PPS -- reports from the front-lines, if you will, in the skilled nursing field -- to illustrate the seriousness of the problems we face, and the real threat of reduced access to skilled care.

In Florida, Mrs. Y (89 years of age) arrived at a Lakeland SNF on March 25th to recover from pneumonia and a chronic urinary tract infection. Due to her weakened condition she needed respiratory, physical, occupational and speech therapy plus IV

antibiotics to gain the strength she needed to go home. Mrs. Y returned to her home on May 17th thanks to the excellent care she received at the skilled nursing facility; however, the Medicare system failed to reimburse the skilled nursing facility \$20,000 worth of direct and ancillary care that were provided to Mrs. Y, so that she could return to health. This included \$3,000 of pharmacy costs alone. And even though Mrs. Y was in a high Medicare reimbursement category, she consumed over \$350 more a day in respiratory, IV and other therapies than Medicare paid for. Yet, if she did not get that care, she would have used up her Medicare days, then flipped to Medicaid and probably stayed in the home indefinitely. Staff at the center report that nearly half of their Medicare discharges in a typical month consume an average of \$8,000 to \$10,000 worth of services and supplies more than the center receives in compensation. Since their policy is to take all Medicare recipients regardless of acuity level, the center's viability is continuing to be severely impacted by the BBA.

In Delaware, Mrs. D, an 85 year old woman, who was recently recovering from an infection and heart problems in a Delaware hospital found out about the shrinking number of Medicare beds in her state. She was ready for nursing home placement but, given Medicare's inability to provide adequate resources, she had difficulty locating a SNF, and, as a result, she had no choice but to stay in the hospital an extra two weeks. Eventually, a provider offered to take her to a center in neighboring Maryland despite the fact that she needed an expensive IV antibiotics at a cost of \$410 a day. Her Medicare level dictated the center would only be compensated \$260 a day for her care. Since then her doctor has prescribed a \$1,700 knee brace that the center will provide as part of her routine care costs.

In the state of Washington, a locally-owned and managed independent provider operates a 30-bed skilled nursing facility with a nearby hospital. The facility primarily serves short-term (usually less than 20 days) high-acuity patients – many of whom were patients in the hospital's oncology department. The facility enabled patients to be treated by the hospital's doctors and eliminated the need for these very sick patients to travel between facilities.

The result of PPS on this facility is unmanageable losses of between \$20,000 and \$40,000 per month. The unit is well-managed and has provided uninterrupted high quality care, but it cannot overcome the fact that so many of its patients are very high acuity and require, in many cases, expensive treatments and medications that are not compensated for by the PPS rate. If the financing system is not changed, the facility anticipates it will be left no choice but to close its doors creating access problems for its local Medicare beneficiaries. Additionally, its functions will have to be assumed by another facility several miles away.

The Medicare cuts that are denying Medicare beneficiaries access to care are not just affecting Medicare beneficiaries, but also affecting our employees as well. The bleak outlook for SNFs – the “open-season on caregivers” mentality that seems to prevail in some quarters -- is turning away high quality professional staff. These deep cuts have forced layoffs of tens of thousands of employees. Mr. Chairman, the job of skilled care staff is challenging under any circumstances – but I can say with certainty that these dramatic reductions add a new degree of difficulty in providing access to high-quality care that Medicare beneficiaries expect and deserve.

As you know, we are concerned that the situation has worsened to the point that many facilities will opt out of Medicare altogether. These cuts are forcing both independent providers and large national corporations to make difficult choices of whether to provide services in a system that does not provide adequate resources for care. This means that Medicare beneficiaries will have less access to quality care. If you think things are bad now, imagine how much more the situation will deteriorate if 1,000-plus facilities go out of business. Congress and the Administration should not stand by -- forcing our states to make contingency plans for the care of hundreds of thousands of elderly residents needlessly uprooted from the facilities and the caregivers they've come to know. This would create a logistical nightmare, the most pressing problem being transfer trauma -- which has been proven to increase mortality rates among the elderly.

The examples I've cited today show that the PPS, for a whole host of reasons, is threatening quality, continuity of care, and access -- the very goals we share for the elderly and infirm Americans for whom we care. Mr. Chairman, the bottom line is that the deep cuts in Medicare create a clear and present danger to the well-being of our nation's elderly. The problems are critical and require immediate attention. To that end, I would like to outline what we believe to be fair solutions to four critical challenges -- solutions that take into account the constraints of Congress and HCFA in implementing change.

First, we propose that HCFA replace the current market basket update for SNFs with an output economic index that better reflects the changes in intensity and mix of resident services. Simply put, HCFA should replace the current inflation rate update factor for SNFs with a more accurate measurement of the cost of services they are

required to provide. This current market basket grossly understates the actual market conditions for SNFs because it understates the annual change in the costs of providing an appropriate mix of goods and services produced by SNFs. SNFs have changed dramatically the services we provide and the acuity levels of the patients we care for. Additionally, this more accurate index exists within the Bureau of Labor Statistics. This change could be made by HCFA under existing law. Using the new index would restore funding back into the system and would help to alleviate the crisis SNFs are experiencing. HCFA has the authority to make this change, and Congress should encourage them to do so.

Second: Congress, HCFA and MedPAC all recognize that the new payment system for SNFs -- Resource Utilization Groups III [RUGs III] -- fails to account for certain Medicare beneficiaries with medically complex conditions. That is especially true for patients with high utilization of non-therapy ancillary services, such as prescriptions, respiratory care, IV antibiotics and chemotherapy. AHCA has proposed a patient-condition based payment modifier targeted to those patients most likely to fall outside the reimbursement system. In other words, if a patient comes into a SNF with a condition, such as ventilator care needs or advanced stage pressure ulcers, the facility treating that patient would be eligible for additional reimbursement to compensate for providing the required high cost services. This is the measure that we support, but we would certainly entertain other solutions.

Third, PPS rates are based on cost reports that date all the way back to 1995. Providers should have the option of maintaining the current blended rate for the second year of the PPS transition --currently 75% facility specific/25% federal -- or elect to

move to the full federal rate immediately. This would prevent facilities that changed the type and volume of Medicare services after 1995 – the PPS base year – from being disadvantaged by the transition rate. Again, this is a matter of equity, and a means of easing the transition to PPS. We believe this can be done administratively by HCFA.

Fourth and finally, residents would benefit if Congress would address the problems posed by the imposition of \$1,500 annual caps on Part B outpatient rehabilitation services. The BBA imposed these arbitrary and capricious caps without the benefit of data or of hearings. Mr. Chairman, I assure you – speaking from the front-lines of the skilled care community, no one who was part of this process could have intended this cap to create the kind of patient impact we're seeing. I urge this Committee to support S. 472, legislation sponsored by Senators Grassley and Reid, which would create criteria to trigger exceptions to the caps for the sickest and most vulnerable Medicare beneficiaries. Let me express our appreciation to Senators Grassley, Conrad, Hatch, Robb, Mack and Graham – for being early supporters of this legislation. But let me also challenge this Committee to translate that early support into immediate action.

Mr. Chairman, as I conclude my remarks, I would like to convey to the Committee that we know the constraints that exist. That is why we've worked so hard to put forward solutions that are reasonable and consistent with the aim of the BBA. Each of the four actions I've outlined today is realistic, responsible – and within reach. Each of the actions we recommend would restore funding that would ensure continued quality and access to Medicare beneficiaries. And that is why each of the actions we recommend should be adopted – for the sake of the patients entrusted to our care. These

solutions can only be achieved in a bipartisan fashion, and we look to your leadership.

Our nation's seniors expect and deserve no less.

Mr. Chairman and Members of the Committee, I thank you for the opportunity to be here today. On behalf of AHCA, I want to make clear our commitment to providing high quality care to America's frail and elderly. The situation is critical, but it will get worse unless Congress and the Administration work with providers to fix the system.

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**TESTIMONY BEFORE THE
FINANCE COMMITTEE
UNITED STATES SENATE**

**IMPACT OF 1997 BBA PROVISIONS
ON THE MEDICARE FEE-FOR-SERVICE PROGRAM**

**June 10, 1999
10:00 a.m.**

presented by

**MARY SUTHER
Chairman and Chief Executive Officer
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**ON BEHALF OF THE
NATIONAL ASSOCIATION FOR HOME CARE
228 Seventh Street, S.E.
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(202) 547-7424**

Thank you for the opportunity to present testimony today on issues relating to the Medicare home health benefit. My name is Mary Suther. I am the Chairman and CEO of the Visiting Nurse Association (VNA) of Texas. I am also chairman of the Board of Directors of the National Association for Home Care (NAHC).

NAHC is the largest national organization representing home health care providers, hospices, and home care aide organizations. Among NAHC's nearly 6000-member organizations are every type of home care agency, including nonprofit agencies like visiting nurse associations, for-profit chains, hospital-based agencies and freestanding agencies.

NAHC is deeply appreciative of the attention the Chairman and Members of this Committee have shown to the problems created by the home health provisions of the Balanced Budget Act of 1997 (BBA97) and the regulatory burdens imposed by the Health Care Financing Administration (HCFA).

RECENT REPORTS ON HOME HEALTH ACCESS

The Medicare home health benefit has undergone tremendous change as the result of the BBA97 and recent program requirement changes. Home health providers are finding it increasingly difficult to serve the same population of beneficiaries they served even two years ago. Many providers have left the Medicare program, and those remaining have reduced clients, staff, service areas, and made other changes in an effort to remain financially viable. These dramatic changes have compelled providers, beneficiaries, and their advocates to press for relief.

In response, the Congress has sought the input of both the General Accounting Office (GAO) and the Medicare Payment Advisory Commission (MedPAC) to determine the scope of the problem in home care and to make recommendations for needed changes. In recent weeks both of these advisory bodies to the Congress have reported on their findings.

While, in general, both of these studies convey the sense that whatever problems exist in home care are not of crisis proportions, we would urge that members of the Committee take a closer look at their findings. Both GAO and MedPAC found that beneficiaries are losing access to home care services. Both have indicated that the number of visits per patient, the number of admissions, and the number of agencies participating in Medicare have gone down significantly. Both reports confirm that the beneficiaries who are most costly to treat are at risk for losing access to care.

Perhaps of greatest importance for you as policy makers to consider is that the home health utilization findings of GAO and MedPAC are based, for the most part, on data from the first quarter of calendar year 1998. During this period of time many agencies had not yet transitioned to the interim payment system (IPS). Additionally, agencies that were on IPS had not yet received notices of their per beneficiary limits. Yet the data indicate that the home health program had already gone back to 1994 utilization levels. Given there is no indication that the deceleration in home health utilization is "leveling off", the current situation is much more severe. We believe that the GAO and MedPAC findings must be trended forward in order to get

an accurate picture of the devastation that is occurring to the home health benefit and in the home care field.

The home care community has experienced the same difficulty that GAO and MedPAC have had in attempting to precisely quantify the impact of BBA97 on beneficiaries and providers and isolate that from other programmatic changes. However, we've received reports from home care providers, beneficiaries, and from media throughout the nation that have showcased individual cases where access to care has become a serious problem. Real people who are in need of and eligible for home health services are going without care. We have attached some examples of these reports to our testimony.

We understand the need for Congress to make prudent decisions with respect to changes in the Medicare program. We also believe that the highest priority must be to target resources to ensure that beneficiary access is protected, and that the vital home health infrastructure be stabilized so that it is positioned to respond to future needs of the disabled and elderly.

We believe that the concerns expressed in the GAO and MedPAC reports closely mirror our own and those of our member agencies. For this reason, we have put a high priority on legislative relief for the home health program that would:

1. Target specific resources through some type of outlier provision to high-cost, heavy needs patients to ensure that eligible beneficiaries maintain access to needed home health services;
2. Eliminate the 15% additional cut scheduled for October 1, 2000; and
3. Provide relief from financially disabling overpayments in order to preserve the home health infrastructure so that it may help address future care needs.

These proposals, which will be discussed in depth later in our testimony, are in keeping with the concerns that the GAO and MedPAC have outlined and that led members of this Committee and others in the House and Senate to reexamine the home health program changes in the first place. We are grateful for your leadership, and look forward to working with you in these and other important areas.

REDUCTION IN MEDICARE HOME HEALTH EXPENDITURES PROJECTED TO BE NEARLY THREE TIMES GREATER THAN EXPECTED UNDER THE BBA

BBA97 was expected to reduce Medicare home health spending by \$16.1 billion over five years. Although home care represents only 9% of Medicare, it was slated for about 14% of the reductions in Medicare spending. The 1999 Congressional Budget Office (CBO) analysis of anticipated Medicare program expenditures showed a dramatic, unintended reduction of the Medicare home health program.

At the time of BBA97's enactment, CBO reported that the effect of BBA97 would be to reduce home health care expenditures by \$16.1 billion between fiscal years 1998 and 2002. CBO's revised analysis now projects those reductions to exceed \$47 billion--nearly three times the anticipated budgetary impact.

When Congress passed BBA97, Members believed they were voting for a modest reduction in the rate of growth of home care, not slashing the benefit itself. Over the last two years, more than 2,000 home health agencies (HHA) across the country have been forced to close, and hundreds of thousands of Medicare beneficiaries are no longer receiving home health services. The changes enacted by Congress in 1997 have had a serious, unintended result of severely reducing access to the Medicare home health benefit.

CBO projected that home health expenditures in 1998 would be \$20 billion, and in fact those expenditures ended up at less than \$15 billion. Congress now has the hard evidence necessary to take action to put an end to the dismantling of the home health benefit.

INTERIM PAYMENT SYSTEM

The most devastating change for HHAs under BBA97 has been the enactment and implementation of IPS. The severe payment reductions under IPS coupled with other HCFA initiatives have had severe repercussions for home health providers and beneficiaries alike. Thousands of agencies have gone out of business, jeopardizing access to needed home care services. Agencies who have survived have, in many cases, been forced to refuse to take on patients with more intensive care needs, lest they risk financial ruin. Despite some measure of relief in the last Congressional session, severe problems remain, which must be dealt with in this Congress to ensure the continued viability of the home care program.

1. Medically complex patients

A 1998 study conducted by The Lewin Group entitled "Implications of the Medicare Home Health Interim Payment System (IPS) of the 1997 Balanced Budget Act" and a 1998 study by the Center for Health Policy Research of the George Washington University entitled "Medicare Home Health Services: An Analysis of the Implications of the Balanced Budget Act of 1997 for Access and Quality" both found that IPS curtails access to covered services for the sickest, most frail Medicare patients. Under IPS, HHAs have strong financial disincentives to care for patients with more intensive care needs because taking on these patients could threaten the financial stability of the agency.

HCFA has taken the position that there is no statutory authorization for exceptions to the annual aggregate per beneficiary limit. Since the base year for the per beneficiary limits is fiscal year 1994, agencies are using data from 1993 as their base year. Many agencies have experienced significant changes in case mix and services provided since that base year. Currently, no adequate case mix adjuster exists which reflects the characteristics of patients served that influence cost. IPS uses agency-specific data in establishing the per beneficiary

limits as a proxy for case mix under the theory that an agency's case mix does not vary significantly from one year to the next. The validity of this assumption is severely tested when utilizing base year data that is four to five years old.

Technological advances in recent years have vastly expanded the scope of services that can be provided to Medicare beneficiaries in their homes. Services such as parenteral and enteral nutrition, chemotherapy and care of ventilator/trach-dependent patients, which used to be provided only on an inpatient basis, can now be provided in the home, thus reducing the need for more costly hospitalization. These services are costly for the home health agency to provide, however. These services often require nursing staff who have had additional training in administration of drugs and procedures, as well as patient monitoring. In addition, such services require prolonged visits in the patients' homes, as well as high standby costs, extensive case management, transition discharge planning and other activities that add further to the cost per visit.

A type of outlier provision is needed for purposes of recognition of the higher cost of serving certain patients who qualify for Medicare home health services.

2. Per beneficiary limits

CBO, in estimating savings that would result from implementation of IPS, used an unprecedented 2/3 behavioral offset. What this means is that CBO directed Congress to cut \$48 billion to yield \$16 billion in savings over five years. To yield \$48 billion in savings, Congress was forced to go all the way back to FY94 data for the base year in determining per beneficiary limits. It is now painfully clear, given recent CBO data, that this was completely unnecessary. But this mistake has had devastating consequences. The per beneficiary limits, based on 1993-94 data, clearly do not reflect changes that have occurred in the population served by home care or the types of services agencies are providing today. Further, IPS fails to distinguish between efficient cost-effective HHAs and providers that have high visit utilization and per-visit costs. In some circumstances, the use of a per beneficiary limit based upon agency-specific data perpetuates Medicare expenditures for overutilization. The lack of an effective case mix adjustor which distinguishes patients based upon needs and service costs prevents IPS from properly setting reimbursement limits. As a result, historically efficient HHAs may have lower payment limits than historically high cost providers. Agencies who serve a greater number of medically-complex patients may have limits insufficient to care for those patients, despite higher per beneficiary limits.

3. Per visit limits

BBA97 reduced the per visit cost limits from 112% of the mean to 105% of the median per visit costs by freestanding agencies. As a result, agencies have been forced to dramatically reduce the costs of delivering home health services. In many cases, agencies are reducing expenditures by reducing the number of visits they provide. However, as the number of services provided in a visit increases, costs per visit go up. Given the reduction in the per visit limits

under BBA, many providers, in an attempt to stay within the per beneficiary limit, are being caught by the per visit limit.

Under the 1998 Omnibus Consolidated and Emergency Supplemental Appropriations Act (OCESAA), the per visit limits were raised from 105% to 106% of the median. This 1% increase was insufficient to help HHAs who are operating under cost limits that have been reduced from 14-22% under BBA97. The current cost limits are inadequate to cover the costs of providing care and to account for the increased administrative costs of participation in the Medicare program.

Reduced per visit cost limits jeopardize patients' access to necessary home health services. Under IPS, many HHAs have been forced to be more selective about the patients they accept, especially with respect to patients in rural or inner-city areas and those who have special needs and require more intensive care. Especially vulnerable have been individuals who need therapy services to restore their ability to care for themselves and inner-city residents for whom caregivers may require security escorts and language translators. Agencies in rural areas have been particularly hard hit by reductions. Their costs tend to exceed national averages because of longer travel times between visits and higher wages resulting from the lingering personnel shortages in rural areas.

4. Overpayments

BBA97 did not require HCFA to publish information on calculating the per visit limits until January 1, 1998, even though the limits went into effect beginning October 1, 1997. Likewise, HCFA was not required to publish information related to calculation of agencies' annual aggregate per beneficiary limit until April 1, 1998, despite an October 1, 1997, start date. More than a year after IPS began, many agencies had not yet received notice from their FIs providing the visit and per beneficiary limits under which they were expected to operate. Some agencies were operating for more than a year under IPS before they received information regarding their limits.

In other cases, where agency limits were provided, the FIs' calculations of agencies' limits were wrong due to the use of faulty data. Additionally, most of the FIs never modified agencies' payments to reflect the IPS reductions; rather, they continued to pay agencies according to the previous year's levels, resulting in significant overpayments to many HHAs across the country.

The BBA97 home health reductions were so deep and occurred so quickly that many agencies were not aware of the full impact the cuts would have on their reimbursements, particularly since most agencies did not even know their reimbursement limits until months after care was delivered. More importantly, most agencies continued full access to care within the scope of the Medicare benefit rather than terminate care to patients.

FIs have been issuing notices of overpayments to agencies and demanding repayment. The IPS reductions make it near impossible for agencies to provide high quality, appropriate care to Medicare beneficiaries and to comply with repayment requests. These overpayments are not the result of abuse or inefficiency. Rather, most overpayments have occurred because HHAs continued to serve high-cost patients within the scope of Medicare coverage and the payments have already been used to provide legitimate needed care to eligible beneficiaries. Without some relief from these overpayments, it can be expected that agency closures, and the attendant access problems, will accelerate.

5. Mandatory 15% reduction in home health limits

Under the BBA97, expenditures under a prospective payment system (PPS) were to be equal to an amount that would be reimbursed if the cost limits and per beneficiary limits were reduced 15%. Even if PPS was not ready to be implemented on October 1, 1999, the Health and Human Services Secretary was required to reduce the cost limits and per beneficiary limits in effect on September 30, 1999, by 15%. The OCESAA delayed the 15% reduction for all HHAs until October 1, 2000.

IPS already significantly reduces the reimbursement rates for providers. On average, agencies are receiving 31% less in reimbursement under IPS than they did previously. HCFA has projected that nearly all HHAs under IPS will receive reimbursements that are lower than their actual costs of providing care. Given CBO's estimates of outlay reductions far in excess of those anticipated (nearly \$48 billion as opposed to the expected \$16 billion), further cuts to home health of 15% would be devastating to providers, severely jeopardize the ability of beneficiaries to access care, and restrict the level of care beneficiaries could receive.

6. Proration

BBA97 stipulates that the per beneficiary limit will be prorated among agencies when a patient receives services from more than one agency. This provision is unnecessary and too complicated for routine administration of the payment system.

The per beneficiary limit is calculated from the 1994 fiscal year where patients were also served by more than one agency. Therefore, the per beneficiary limits already account for patients being served by more than one agency and prorating of fees is unnecessary. However, it is recognized that one method of circumventing the per beneficiary limits would be to transfer patients to another agency. HCFA should have a mechanism to deal with these situations if they arise.

The tracking required to comply with this provision would be problematic for both providers and HCFA. HHAs do not have access to the information that would allow them to sufficiently track beneficiaries' use of other home health services and do not have control over where patients receive services before and after the home care they provide. Prorating becomes even more complicated given that agencies have different limits and fiscal years over which

those limits are applied. Further, proration of the limits would interfere with a patient's right of choice of an HHA and potential access to care. A patient previously served by another provider may bring high-cost care needs and a reduced payment limit, thereby discouraging the patient's admission.

7. Periodic interim payments (PIP)

Medicare allows for periodic interim payments (PIP) for many Medicare providers in order to maintain a steady cash flow for services rendered on behalf of Medicare beneficiaries. PIP payments to HHAs are based on volume experience which is adjusted on a quarterly basis.

BBA97 eliminated PIP for HHAs effective for cost reporting periods beginning on or after October 1, 1999, a date intended to coincide with implementation of PPS for home health. OCESAA extended PIP to fiscal year 2001, eliminating it for portions of cost reporting periods occurring on or after October 1, 2000.

Under IPS, maintaining PIP is more important than ever in allowing agencies to serve Medicare beneficiaries effectively. The cash flow generated by PIP is critical to the financial viability of small HHAs that do not have large cash reserves to support delayed payments from HCFA. Congress should maintain PIP or, at a minimum, extend it at least one year beyond implementation of PPS.

VENIPUNCTURE

Effective February 5, 1998 a provision included in the BBA removed blood drawing (venipuncture) as a qualifying service for the Medicare home health benefit. Before this date, if a beneficiary needed venipuncture and met all other home health criteria, he or she could receive venipuncture from a home health nurse along with other Medicare-covered home health services, including home health aide services, ordered by his or her physician. Under the new policy, if venipuncture is the sole skilled service needed, Medicare will only cover venipuncture provided by lab technicians under Part B, and homebound beneficiaries in need of blood monitoring will lose eligibility for home health services.

Beneficiaries who qualified for home health services based on venipuncture are some of the oldest and most disabled Medicare beneficiaries, many with multiple diagnoses including diabetes, heart disease, stroke and clinical depression. Many homebound individuals with chronic conditions and complex medication regimens no longer receive nurse assessments for purposes of preventing acute episodes and hospitalizations. The home health aide services that were sometimes provided by the agencies in conjunction with blood monitoring made it possible for beneficiaries to remain in stable condition and at home. Without such services, many of these individuals are admitted to long-term care facilities. NAHC has received hundreds of phone calls and letters from consumers, physicians, providers, and other organizations raising concerns about the severe impact on patients resulting from the removal of venipuncture as a qualifying service under the Medicare program.

15 MINUTE INCREMENT REPORTING

BBA 97 required that claims for home health services on or after July 1, 1999, must contain a code that identifies the length of time for each service visit, measured in 15-minute increments. HCFA issued instructions to the FIs on February 18, 1999, directing them to initiate necessary steps to implement this new billing requirement for all HHAs participating in the Medicare programs (Transmittal No. A-99).

This new administrative burden imposes a complex time-keeping requirement for agencies to stop the in-home clock when an interruption in active treatment occurs. The HCFA transmittal defines the "time of service visit" to begin at the beneficiary's place of residence, when delivery of services has actively begun. Agencies must count the number of 15-minute intervals, but cannot report services lasting less than 8 minutes.

Since the time counted must be actual treatment time, providers are expected to discount time spent on non-treatment related interruptions during the in-home visit. For example, if a beneficiary interrupts a treatment to talk on the telephone for other than a minimal amount of time (less than 3 minutes), then the time the beneficiary spends on the telephone and not engaged in therapy does not count in the amount of service time.

In-home time represents only a portion of the total time invested by an agency in caring for a patient. Numerous activities required by the Medicare Conditions of Participation and needed to ensure effective patient care are often times performed outside the home, including communication with physicians and family members, coordination of services with other home health personnel and community agencies, care planning, and clinical documentation. In order for home care treatment time to be meaningfully quantified, visit time must be better defined and recognized as only part of the resource cost involved in providing home care services.

Neither Congress nor HCFA has indicated how this information will be used. Its value is questionable in light of the ongoing move from a per-visit reimbursement system to a prospectively set per-episode of payments that are not tied to number of visits or visit length. In light of the substantial financial and administrative strains already being experienced by agencies, we urge you to revisit this requirement.

CONCLUSION

Thank you again, Mr. Chairman, for the opportunity to present our views. You and the Committee have our thanks for bringing home health issues to this level of consideration. We look forward to working closely with you to resolve these issues.

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Monday, April 26, 1999

Medicare's drive to cut costs forces many companies to go belly up Home health care companies die en masse

Economic survival is the theme at the Virginia Association for Home Care's annual conference, which begins today at the Hotel Roanoke and Conference Center

By SANDRA BROWN KELLY
THE ROANOKE TIMES

Interim Home Health of Roanoke Valley this month became one of the latest casualties of a financial tidal wave in the home health care industry that was one consequence of the drive to balance the federal budget.

The 18-year-old company had recently cut its full-time employees from 44 to 22. Now, it has filed a Chapter 11 petition for debt reorganization in U.S. Bankruptcy Court.

In the Galax-Hillsville area, Deertfield Home Health Care in Mouth of Wilson and Tri-County Home Health in Hillsville are completely bankrupt.

This trend is why survival is the theme of the agenda for the Virginia Association for Home Care's annual conference, which begins today at the Hotel Roanoke and Conference Center, said Bobbye Terry, director of legislative affairs.

The conference program includes speakers on the financial effect of Medicare changes, ways agencies can be more efficient, and how they can retain staff during a period of turmoil.

A temporary capped payment plan Medicare set up for home health agencies has driven more than 1,000 of them into bankruptcy or out of business since last October, according to data collected from 23 states by the National Association for Home Care. When all states report in, the association expects the number of agencies lost to reach 2,000, about 20 percent of the U.S. total.

"The home health industry has been under the gun for a year and a half," Terry said.

Most of what has happened can be traced to the Balanced Budget Act of 1997, which included a dictum that Medicare trim home health payments by about \$16 billion over four years. (Medicare is a federal program that pays for some health care services for people older than 65 or disabled.) To do this, the Health Care Financing Administration (HCFA), which runs Medicare, had to figure out a new way of reimbursing for home health services. In the meanwhile, it placed home health agencies on a temporary payment system based on the agencies' 1994 expenses. In April 1998, HCFA gave each agency an annual cap per patient and made it retroactive to 1996.

If a company was really efficient in 1994 or provided less expensive services, it got a lower per-patient cap than another company that might have been less efficient or was delivering more complicated services. Because of these caps, which in this area average about \$3,000, agencies must have the right mix of patients to stay in business. The cap amount gets paid whether a patient is seen twice overall or twice a day, so the ideal is to have lots of patients who get well within a few visits to offset the cost of caring for patients with more intensive and long-term needs.





The cap amount is not guaranteed income. Medicare might decide after an audit that a company's expenses don't warrant that level of reimbursement.

Services provided by home health agencies vary greatly by agency. Most employ a combination of registered and licensed nurses and home health aides. Others also have therapists on staff. The services are intended to be short term and designed to help a patient go home from the hospital as soon as possible and become self-sufficient. An agency might offer therapy to a patient who has had a knee replacement, care for wounds, or provide a companion for someone who temporarily cannot be alone.

Housecall Home Healthcare in Salem, one of the area's largest agencies, offered a broad range of services, including physical therapy, and had a lot of patients in 1994, so its per-beneficiary cap is higher than some other agencies' cap, administrator Joe Hearst said.

Hearst said he expects Housecall to grow larger at the same time "the cap is wiping out small agencies."

"I heard a consultant say that at least 4,000 agencies are out of business and don't know it because they haven't yet gotten their bills for overpayments," Hearst said. "We're going to be one of the survivors."

"It's a bad time to be in home health, though," he said.

Donna Peery of Galax knows that for sure. She and her husband, Tom Peery, recently filed Chapter 7 debt liquidation for Tri-County Home Health, which they had operated since 1994.

"We couldn't provide the quality of care with a per-patient beneficiary limit below \$2,800," Donna Peery said. "It was all well and good if somebody had surgery and just needed a couple of days of dressing changes. We had patients who needed dressings changed twice a day and patients needing daily insulin injections."

When the Peerys officially closed Feb. 12, they faced an \$87,000 bill from Medicare for overpayments. Both are nurses. He now works for a hospice, and she draws unemployment.

In addition to the pressure put on agencies, Peery anticipates that patients who need longer-term visits will eventually be shunned by agencies.

"Home health care got to be more than what it started out to be, and people have become dependent on it," she said.

Kimberly Wilson, a former Tri-County Home Health employee who opened Southwest Virginia Home Health Care Inc. in Galax in July 1997, doesn't know if she can stay in business.

"I've yet to take an income home," Wilson said. She owes money back to Medicare, maybe as much as \$25,000, which she hopes to be allowed to pay over time.

Wilson says the government has been too strict on what it will pay for. For example, since February 1998, it has refused to pay for a home health worker to draw blood samples for a patient taking the blood thinner Coumadin, although too much of the drug can cause dangerous bleeding.

Her home area has a number of widows who don't drive who need the Coumadin blood checks, she said.

When Medicare eliminated payments for blood withdrawals, called venipuncture, many agencies lost large numbers of patients. The home health service run by the Roanoke Health Department lost 50 percent of its patients, said Linda Hudgins, director of the program.

Some of the patients were kept on through the health department's free services, she said.

The annual payment cap pressures the health department's program just as much as it hits the private companies, said Hudgins, who considers some of Medicare's expectations unrealistic.

For example, she said, Medicare expects a home health worker to wean away a patient who needs dressings on a wound changed by teaching family members or the patient to change the dressings. Her agency has a patient who has a back wound that the patient can't reach, and no family members are available to provide the care.

"We will lose money on that patient," Hudgins said.

The cost pressures on home health are driving health departments' home health services out of the business, too, she said. Thirty health departments in the state used to provide the services, but only nine do now, she said.

Home health has had fraud and abuse in it, Hudgins said, but she argues that home care also has been instrumental in keeping people in their home and out of nursing homes, which cost the government more than home health visits.

Leland Sigmon, who owns the Interim franchise in Roanoke, said he expects to pay his bills and stay in business, but said he needed the protection of the courts while he revamps. His company operated at a loss in 1998 for the first time since it opened, Sigmon said.

In addition, he just paid \$38,000 back to Medicare for overpayments in 1996, and he expects he will owe more to the government once his books are audited for 1997 and 1998. Because of the complexity of the Medicare reimbursement system, it's not unusual for home health agencies to owe money back after an audit. But the repayment coupled with a drop in reimbursement amounts proved to be too much, Sigmon said.

"The unknown is what's difficult to deal with," Sigmon said.

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200 protest cuts that threaten home care

■ Elderly Rhode Islanders, visiting nurse groups, home health aides and politicians rally against Medicare cuts that have forced some agencies to close.

By JONATHAN SALTZMAN
Journal State House Bureau

WOONSOCKET -- As Roland Trudel lay dying of brain cancer five years ago, his wife of 48 years made him a promise: She would strive to keep him out of a nursing home so he could die at home.

To help make good on her pledge, Alice Trudel turned to the Visiting Nurse Service of Greater Woonsocket. The agency sent a nurse or nursing assistant to the couple's house daily to bathe Roland Trudel, give him medication and ease his pain.

When the 75-year-old retired Texas Instruments manufacturing worker died in late 1994, he was home, in his living room, surrounded by cherished photographs of their three children, four grandchildren and one great-grandchild.

"It would have broken my heart if I had to break my promise," said Alice Trudel, 77. "But if they didn't come, I would have had to put him in a nursing home."

Yesterday, Trudel joined more than 200 elderly Rhode Islanders, home health workers, civic leaders and politicians at a spirited rally to protest federal cutbacks in Medicare reimbursements that threaten home care agencies.

The cuts, which are squeezing agencies across the country, led to the recent closing of two in Rhode Island that provided home health aides.

Meanwhile, visiting nurse associations throughout the state are laying off scores of workers, or considering merging or reorganizing in the face of enormous losses.

One of the hardest hit agencies has been the Visiting Nurse Service of Greater Woonsocket. An agency official said it has lost 130 workers through layoffs or attrition in the past year.

"This is something that's very real, very now, and directly hurting people," said former Lt. Gov. Roger N. Begin, a Woonsocket native who hosted the event in a packed dining room of the Woonsocket Senior Citizens Center.

Elected officials at the rally, all of them Democrats, traced the problems to the 1997 federal Balanced Budget Act passed by Congress and signed by President Clinton. The act reduced the growth of Medicare, the health insurance program for the elderly, but had what detractors describe as disastrous consequences on home health care.

It led to enormous cutbacks in reimbursements to visiting-nurse agencies, reductions in the number of visits that Medicare would finance and the amount it would pay for each visit.

The new formula for reimbursement was based on past spending, and in the Northeast -- where costs have typically been low -- agencies were hard hit. Some closed; all had to cut back sharply.

Patients who could no longer get care through Medicare turned to the state. Some were eligible through the Medicaid program for the poor; others qualified for a state program that subsidizes home care for people whose incomes are just above the cutoff for Medicaid.

But the network of 35 home health agencies in the state was already struggling with a shortage of qualified home health aides.

These employees have less training and earn less than visiting nurses. In Rhode Island, they are particularly low-paid. Home health agencies get a base rate of \$10.94 an hour for an aide's services compared with \$19.60 in Massachusetts and \$20.22 in Connecticut. After paying for costs such as overhead and worker's compensation insurance, the agencies typically have \$6 to \$7 an hour left to pay their workers.

The low pay and tight labor market have left many agencies strapped for workers. When a small health agency in Providence, Advanced Home Care, closed recently, its owner cited an inability to find qualified employees.

Rep. Patrick J. Kennedy, one of the key speakers at the senior citizens center, said that when he voted against the Balanced Budget Act, critics called him a big spender.

But, he said, he knew the measure was "penny-wise and pound-foolish." Cuts in home health care have forced elderly Rhode Islanders to go to hospitals or nursing homes, he said, usually paid for by the state at many times the cost of home care.

Apart from the burden on taxpayers, he said, the cuts have taken an intangible toll on patients who would rather stay home, and families who would prefer to have them there.

Kennedy said he understands that desire from his own experience. His grandmother, Rose Fitzgerald Kennedy, was the "real glue" in his family, he said, and he was grateful she could live out her final days at home. She died in 1995 at the age of 104.

Sen. Jack Reed, another speaker, said the Balanced Budget Act may have been well intended, but "solvency is no justification for running a program that's insufficient."

He and Kennedy vowed to lobby Congress to increase the Medicare payments to home health agencies.

The issue is heading for debate at the State House as well.

Republican Governor Almond, who did not attend the rally, said in a recent statement that the Balanced Budget Act was "landmark legislation" that stoked the economy. But he conceded that it had "unintended consequences" on health care programs such as home health care.

He has earmarked \$350,000 in the state budget that begins July 1 for home health care. He has promised to add \$1.65 million, assuming May estimates of state revenue remain optimistic. The nearly \$2 million would enable the state to increase hourly reimbursements of home health aides by \$2.50, according to the Almond administration.

But Lt. Gov. Charles J. Fogarty, a Democrat and vocal proponent of improving the long-term-care system, said that's not enough.

He has asked two Democratic legislators in the General Assembly to introduce bills that would increase state aid by \$3.6 million. That would enable the state to raise the reimbursement rate to \$16 an hour.

"It's really economically foolish for us to underfund home health care because the direct result will be people going to more expensive care in institutions," Fogarty said.

By increasing the reimbursement rate, he said, the state will be able to expand the pool of home health workers before the situation becomes dire.

"As agencies are reducing services and some are closing their doors," he said, "it's becoming more and more apparent that this is not a problem -- it's a crisis, and we have to deal with it."

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The Salt Lake Tribune

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Sunday, April 4, 1999

Utah Has Lost About Half of Home Health Agencies Due to Cuts

BY NORMA WAGNER
THE SALT LAKE TRIBUNE


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Article

Utah has lost about half of its home health-care agencies in the past two years because of benefit cuts in the Medicare program.

"We had over 112 at one point and our latest count is around 55 [agencies]," said Allan Elkins, who oversees inspections and certifications for agencies that care for Medicare and Medicaid patients.

Small agencies were forced out of the business as were some larger ones in rural Utah and along the Wasatch Front.

The Columbia hospital chain divested its home health services across the nation, including seven agencies in Utah. Intermountain Health Care (IHC) no longer houses its home health-care services in some of its rural hospitals.

"We've had to reduce overhead, administrative services, brick and mortar," said Boyd Woolsey, spokesman for IHC home health services. "But we're still offering the services to the patients in those areas."

"And we've had small ones close who had so few clients it was no longer [financially] beneficial to stay in the program," said Royal Simpson, manager of the state Health Department's hospital and ambulatory-care survey section.

Elkins, also of the Utah Department of Health, said the drop "is amazing to us. We're hoping there's adequate agencies left out there to meet the consumers' needs."



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The Salt Lake Tribune

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Sunday, April 4, 1999

Lawmakers Scrambling to Fix Medicare

Spending cuts have severe impact on home health-care industry

BY LARRY WHEELER
GANNETT NEWS SERVICE



Email
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Article

WASHINGTON -- A budget-balancing law Congress approved in 1997 was supposed to slow federal spending on Medicare home health services. Instead, it resulted in the largest benefit cut in Medicare history and lawmakers are scrambling to fix the problem.

More than 1,400 Medicare home health providers have closed since the Health Care Financing Administration, the agency that administers the Medicare program, began implementing a new payment system last year, agency records show.

The nation's largest home health industry trade association estimated the cuts have left 700,000 Medicare beneficiaries without home health-care services, but some experts challenge that estimate because of weaknesses in Medicare data.

What is not debatable is that mounting anecdotal evidence points toward an extensive impact.

In Florida, where the state has a well-developed safety net for retirees, state agencies are seeing significant increases in demand for homebound personal-care services, an increase they attribute directly to Medicare benefit cuts.

And an Illinois visiting nurse agency recently decided to discharge 25 patients whose care was so costly the agency said it faced certain bankruptcy if it continued to care for the patients.

Similar stories can be found across the country.

The Congressional Budget Office, which predicted cost-cutting measures would reduce Medicare home health spending by \$16 billion, now estimates the cuts will exceed \$47 billion over a five-year period.

Last year, Medicare spent \$14.9 billion to provide home health services to more than 3 million elderly and disabled patients, the first time in the history of the Medicare program that spending declined from the previous year.

"This is clearly the largest cutback that we have seen," said Barbara Markham Smith, senior researcher at George Washington University Center for Health Policy Research. "The nature of this particular cutback is pretty much unprecedented."

President Clinton announced Tuesday that the latest Medicare trustees report extended the projected solvency of the Medicare trust fund from 2008 to 2015. The extra seven years were due in part to savings generated by cutting the home health benefit.

Home health industry officials, patient advocates and some lawmakers believe the new payment system and other cost-cutting measures have been a disaster both for elderly patients and the small businesses that send nurses and aides to care for the homebound Medicare beneficiaries.

Medicare managers and government auditors say they have detected no adverse impact on the Medicare population.

The cost-cutting measures, which include increased audits and more stringent screening of providers, are difficult but necessary reforms, said Robert Berenson, director of Medicare's Center for Health Plans and Providers.

"We are looking very carefully at whether beneficiaries are losing access to needed services," Berenson said. "As of now, we don't have any information that beneficiaries who need home health care are not receiving it."

Despite the alarming number of agency closures since 1997, there still are more than 9,000 active Medicare home health providers nationwide, which Berenson said appears to be an adequate number.

Next year, the interim payment system will be replaced with a prospective payment system designed to repay home health agencies based on the nature of a patient's illness rather than based on historic spending patterns in a particular county.

"The prospective payment system will be better for everyone," Berenson said. "Patients who have more health-care needs will get substantially more payment."

But the law Congress passed requiring the prospective payment system also dictates that home health spending will decline another 15 percent in addition to the cuts already under way.

Senators and House members aren't waiting for official confirmation for a problem they already

know exists.

"A lot of people are trying to deny nothing bad is happening," said Sen. Russ Feingold, D-Wis. "But the reality is we have lost a lot of agencies crucial to providing home care for older people and those with disabilities."

Feingold successfully amended the recently passed Senate budget resolution with language that calls on the Senate to alter the new payment system and other changes that have had a "negative impact" on Medicare home health delivery.

A similar amendment was included in the House budget resolution.

With 55 of his state's 150 Medicare home health agencies out of business, an alarmed Sen. Jeff Bingaman, D-N.M., summoned Health and Human Services Secretary Donna Shalala to his office.

Following the meeting, Shalala dispatched a special team to New Mexico to investigate. Since then, the investigation has grown to include other states, but the group has not reported its findings, Bingaman said.

"We were getting lots of complaints from providers essentially advising us they were having to fire their employees, go out of business and terminate their services," Bingaman said. "After you hear that from several sources, you begin to think this is a problem worthy of attention."

At least four government and academic studies are under way in an attempt to measure the impact of the Medicare home health reforms.

Home health-industry representatives are cautiously optimistic that senators and House members will be able to repair some of the damage.

"We recognize the world of the budget is such that monies aren't readily available to bring about significant fixes," Dombi said. "At the same time, our cautious optimism is triggered by the many visits our industry members have had with their members of Congress where the member says,

'We know we didn't fix all the problems and we have to revisit it.'"



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By April M. Washington

Balanced Budget Act a bitter pill for some

GRAND PRAIRIE - Janis Fisher awoke from emergency surgery in an Oak Cliff hospital 35 years ago paralyzed from the waist down. The Grand Prairie resident broke her back in three places when she flew out of the back seat of a 1956 Ford convertible and smacked into a utility pole on Santa Fe Road in Duncanville. She was 16 years old, in the prime of her young life.

The nephew of her stepfather drank one too many beers before picking up Mrs. Fisher from her best friend's house. On the way home, he sped around a sharp corner and lost control of the car. She barely knew the boy.

Since the accident, the 52-year-old Mrs. Fisher estimates she has been operated on more than 20 times. Her greatest fear is being forced out of her modest duplex built in the 1940s.

"I just want to remain in my own environment - just me and my cats," said the wheelchair-bound Mrs. Fisher. "Just thinking about being in a nursing home scares me out of my mind."

Medicare decided Mrs. Fisher's home health care wasn't a medical necessity earlier this month and cut the benefit, moving her one step closer to the nursing home she dreads.

She's not alone. Thousands of chronically ill and elderly patients are losing some or all of the home-health-care services once covered by Medicare.

Last summer, Congress passed legislation as a part of the broad-sweeping 1997 Balanced Budget Act that limits the amount of payments home-health agencies can receive for taking care of homebound patients.

Lawmakers took action to curtail exploding home-health-care costs and rampant fraud, waste and abuse.

Once a small component of Medicare, spending for home health care soared in the last decade, said U.S. Rep. Joe Barton, a Republican whose District 6 includes parts of Arlington.

The costs to care for homebound patients quadrupled, from about \$3 million in 1990 to \$17 billion in 1996, said Mr. Barton, who supported the new guidelines.

For that reason, Congress imposed a cap on the amount of funds Medicare reimburses home-health-care agencies per year for the care they provide to people like Mrs. Fisher.

Under the old guidelines, health care providers had no incentive to streamline their costs, said Mr. Barton, chairman of a congressional oversight subcommittee conducting Medicare hearings around the country.

As a result, many bilked the Medicare system for services not covered by the law, he said.

"While you had a lot of good health care providers, you also had a number, if not fraudulent, that were wasteful in spending taxpayers' dollars," Mr. Barton said. "The system started out as a less expensive way to let people out of the hospital to receive short-term medical care in their homes.

"Then people started going into the home supposedly to treat medical conditions. Instead, they were cooking, cleaning and giving patients baths and charging Medicare.

"That's what's going to come to an end. The people who really need home health care are going to get home health care."

Mrs. Fisher received notification about the elimination of her home health care benefits April 1.

No joke

"I thought it was an April Fools' Day joke," she said. "I really rely on the care the nurses give me.

"I'm afraid they {lawmakers} didn't understand how much damage the changes were going to have on a lot of people like me who live alone and have no family close enough to take care of them."

Poor blood circulation forced doctors to amputate Mrs. Fisher's right leg in 1975.

Just last year, a nurse who visits her home once a week treated Mrs. Fisher for eight kidney infections and taught the woman how to care for sores that develop from sitting for extended periods.

She has grown to depend on the care she receives from Arlington-based Cuidado Casero Home Health Care Services.

"I get so sick sometimes that I can't even get out of bed to dress myself, to get on a bus, or call a taxi to get to the doctor," Mrs. Fisher said.

Complaints from distraught beneficiaries like Ms. Fisher have flowed into the congressional offices of Mr. Barton and Democratic U.S. Rep. Martin Frost, D-Dallas, the other congressman who represents parts of Arlington and Grand Prairie.

Like Mr. Barton, Mr. Frost voted for the far-reaching health care changes. But unlike Mr. Barton, he has since had a change of heart. He now wonders whether Congress acted too hastily.

"We were trying to bring the deficit down," said Mr. Frost, who recently co-sponsored legislation that would delay the new payment system until Congress can reassess its effect.

"The home-health-care provision needs to be looked at again and changed. People ought to be able get as much help as possible.

"There were some concerns about fraud, and I think Congress overreacted in trying to address that."

First-hand experience

The 20-year incumbent said he began realizing the severity of the cost-cutting changes after his mother fell and broke her hip about two months ago.

Mr. Frost has had to make several trips to San Antonio to look after his 79-year-old mother's medical needs.

"I've been down there quite a bit," he said. "She's had to pay quite a bit out of her pocket for some of her home health care.

"It's so much, she can't afford to pay as much as she needs. This is an issue that's hit close to home."

U.S. District 24 GOP challenger Shawn Terry assailed Mr. Frost for supporting a bill he argues unfairly cuts the medical care of constituents like Mrs. Fisher.

"Mrs. Fisher is a classic example of someone who doesn't need to live in a nursing home, but under the current system might be forced into one," said the Dallas management consultant, who met the Grand Prairie resident after accompanying a nurse to her home last month.

"Frost voted for a bad bill that doesn't take into account the fact that people have different medical needs and requirements. I think home health care can save this country money. It can avoid unnecessary hospitalization that some find troublesome and expensive.

"We can't have a blanket, one-size-fits-all approach to health care. We have to strike a balance."

A day before Medicare terminated Mrs. Fisher's benefit, Cuidado Casero Home Health Care Services owner Carmen Santiago learned her agency would be limited to a maximum of \$3,310 per year to care for minor to critically ill patients.

That's a drop in the bucket compared to the average \$8,100 the Health Care Financing Administration paid agencies annually per patient, according to the Texas Association for Home Health Care. The health care administration oversees Medicare.

Business groups protest

Mrs. Santiago, who estimates Medicare payments represent about 95 percent of her company's income, said "that's what it costs us to take care of really sick patients in one week.

"We take care of patients that are totally bedridden, blinded by diabetes, paralyzed. They take a lot of care," she said. "A nurse has to go out twice a week to care for them.

"The \$3,310, that won't cover the gas or supplies."

Mrs. Santiago and the state's home health care association insists the new payment cap penalizes reputable agencies, forcing some out of business and their chronically ill patients into nursing homes.

For now, Mrs. Santiago's multimillion-dollar agency is able to survive the cutbacks. Some longtime friends with other agencies

aren't so lucky, she said.

"It's sad to watch people you've worked with for years, knowing they have families to support and take care of, go by the wayside because of all these horrible changes," Mrs. Santiago said.

The Texas Association for Home Care and Rockwall Home Health, Inc., filed a lawsuit last month seeking an injunction to prevent the U.S. Department of Health and Human Services from implementing the new payment caps.

The class-action lawsuit, filed in the U.S. Northern District Court in Dallas, contends the new limits inadequately cover the cost of caring for homebound patients, particularly those like Mrs. Fisher with multiple medical needs.

The association, which represents more than 1,200 home-health-care agencies throughout the state, also charges that more than half of the 3,000 such businesses in Texas will go bankrupt if the changes are allowed to stand.

'Devastation' assailed

"Realistically, these cuts are so severe that Texas home-health agencies cannot continue to care for most of their higher-cost patients," said Sara Speights, director of government affairs for Texas Association for Home Care. "They are really underestimating the devastation it caused to some human beings.

"They have blown a lot of isolated cases of fraud out of proportion and created a whole new system that verges on the insane."

Cuidado Casero representatives have trekked to Washington, D.C., in recent months, attending a series of hearings and forums to implore lawmakers to revise the changes.

"They've done this to balance the budget," said Gloria Carrillo, Cuidado Casero's director of human resources. "But they've balanced the budget on the backs of the elderly and the chronically ill."

U.S. Rep. Greg Ganske, R-Iowa, a member of Mr. Barton's oversight committee, accused home-health-care providers of exaggerating the threat of reduced services.

"Faced with new policies to eliminate fraud, some home care agencies have tried to frighten their patients into becoming advocates against the reforms," said Dr. Ganske, who operated a private medical practice before he was elected to Congress in 1994.

"The service will still be there, but will cost a lot less. And it won't be an opportunity to exploit the program for unnecessary services."

Mrs. Santiago said lawmakers like Dr. Ganske just don't get it.

"They only see the outside. They don't know what we go through to make sure our patients are taken care of, whether it's paying for a patient's prescription, gas bills or toys for their kids out of our own pockets."

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Anchorage Daily News

50 CENTS
.. LIII, NO. 155

ANCHORAGE, ALASKA, THURSDAY, JUNE 4, 1998★

FINAL EDITION
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Medicare cutbacks strand housebound poor, elderly

By EVE ROSE
Daily News reporter

Karen Jones has been going to Emmitt Soldin's home for two years to sample his blood and make sure the steroids he takes have not caused him to bleed internally.

Soldin's arthritis has left his hands and feet deformed, making it painful for the 74-year-old Anchorage man to walk the few feet from his bedroom to the kitchen.

Last week, Jones showed up at

Soldin's home the same as always. The only difference this time was that she was not getting paid.

Jones is one of an unknown number of nurses, aides and other health care workers across the city who are continuing to provide their services for free out of fear their elderly and disabled patients who receive care at home will get sicker or even die if they do not.

They say major cuts in federal

funding have forced them to make the difficult choice of leaving patients to fend for themselves or continuing to care for them without pay.

In the last two months, three Anchorage firms providing home health care for the poor and elderly have shut down, one has changed hands and the four remaining have had to cut back on the amount of care they provide to Medicare patients, according to home health

care industry officials.

Many in the industry fear that in the long term, the cuts could severely limit the poor's access to home health care — long praised for improving the quality of life of the old and disabled by enabling them to be at home instead of housed in institutions.

The cuts and other changes that took effect in October are

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CARE: Medicare cuts back

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the result of the 1997 Balanced Budget Act in which Congress slashed billions from Medicare funding in an attempt to hold down federal spending on the service, which had skyrocketed in the past seven years, said Pam Negri, a health insurance specialist for Medicare in Seattle.

Home health care visits — in which nurses and others do everything from administer chemotherapy to change bandages on foot ulcers — can cost \$150 to \$200 per visit.

The old system, which allowed almost unlimited visits, gave agencies little incentive to cut costs and opened the door to widespread fraud, Negri said. The new rules put a cap on the number of some visits and eliminate some services.

While many in the local health care industry believe there was fraud in the Lower 48, they do not think it extended to Alaska.

"One bad apple tends to make everyone look bad," said Roxanne Thygeson, director of clinical services for Geneva Woods Home Health.

With agencies shutting the doors, hundreds of Anchorage patients are scrambling to find care. The four remaining agencies in Anchorage are picking up many of the patients and say they can handle more.

In some cases, however, patients are no longer covered under the new rules. For example, the federal program no longer covers the cost of taking blood tests in a person's home. If the patient can get to a lab or doctor's office, Medicare will cover the service, but for some that is impossible or risky.

For Soldin, a former Bush pilot who can no longer walk down the stairs of his home, the trip would be extremely painful and dangerous to his health, Jones said. Soldin could pay the \$150 per visit cost himself, but Jones feared it would be too hard on him financially, which is why she continues to provide the service for free.

Some health care workers said they feared for some patients who are simply falling through the cracks — people who can't make it to the doctor's office for blood work, can't afford to pay the cost of someone coming to their home or simply won't make the trip.

"There are a lot of old, stoic pioneers out there who aren't going to go to the doctor's of-

fice or the hospital to get their blood checked, but they would take the care from someone coming to their home," said Cindi Swarts, administrator of Alascare, who shut down her Medicare home-health arm this week because of the cuts.

Meanwhile, agencies that are still open are struggling to survive with less funding from the government.

Pacific Home Health has had to lay off a few administrative workers and cut nurses' benefits, said Margo LaChapelle, the agency's administrator. "We are committed to maintaining the quality of care as best we possibly can," she said.

But some in the industry fear the cuts will end up putting pressure on agencies to cut back on the number of visits, pushing people back into hospitals for longer stays or into nursing homes.

"The government is going to see that it has come full circle and won't have saved any money in the process," LaChapelle said.

Kathy Lum, director of Providence Alaska Medical Center's home health care operation, the largest in the city, hopes the government will see how shortsighted some of the changes are and the "pendulum will swing back again."

Ron Cowan, a supervisor with the state's health facilities and licensing bureau, said his agency has not received any complaints from patients, but he has heard from area health care providers about their concerns.

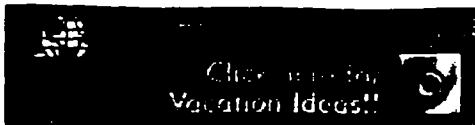
"If it's having this kind of ripple effect, I would hope the federal government would change the policy. I can't believe we would cut off our nose to spite our face," he said.

Meanwhile, people like Danita Fischbach plan to spend their own money to fill the gap.

Fischbach, an owner of Professional Infusion Pharmacy, was so concerned about a few of her patients she's decided to pay for them to continue to receive care from their nurses. They could have gone to another provider, but it would be too traumatic for them, she said.

"Right now, I can't go tell that little old man that he's not going to see his nurse anymore. Morally, I can't do that."

□ Reporter Eve Rose can be reached at erose@adn.com.



Funding cuts leave home care facilities in poor health

By CHUCK ERVIN World Capitol Bureau
11/18/98

OKLAHOMA CITY -- More than 100 home health-care agencies in Oklahoma have gone out of business in the past year because of cuts in federal funding, and state senators expressed concern Tuesday that people could be forced into nursing homes because of that.

The number of private agencies providing health-care services to homebound patients has fallen from a peak of 531 in July 1997 to the current level of 428.

Nearly half of the agencies that closed were in metropolitan areas.

The largest number of closures were in Oklahoma County, with 32. Tulsa County is second with eight, and Cleveland County is third with seven.

Gary Glover, a state Health Department official, said home health care still is available in all 77 counties.

"If the closures continue, it could be a problem," he said.

Despite assurances from Glover that most of those clients served by agencies that have gone out of business are receiving similar services from other agencies, several senators expressed concern that many people have fallen through the cracks.

"I suspect many have been cut off and don't know what to do about it," said Sen. Gene Stipe, D-McAlester, the chairman of a special committee studying the problem.

Glover said the problem was an outgrowth of the federal Balanced Budget Act of 1997. He said funding declined from an average of \$7,000 per beneficiary to \$2,600 after the legislation took effect.

"They don't know anything about the Balanced Budget Act," Stipe said of people wanting home care. "They just know they need care, and they aren't getting it."

He said home health care allows many Oklahomans to remain at home at a relatively low cost rather than have to go to more expensive nursing home care.

Glover concurred, but he said there has been some abuse, in which services have been provided to patients who are not truly homebound.

Glover said the federal government is scheduled to start a new payment system next year, which may improve the situation.

Chuck Ervin can be reached at (405) 528-2465.

Tulsa World

Vermont Business Magazine

06/01/1998

Main Topics: IPS; Medicare; Vermont; agencies; health care

By Anonymous

Home health care: The interim payment system

The treatment was a success, but the patient died. That sums up the state of affairs for Vermont's 13 non-profit Medicare certified home health agencies. Because of recent federal government mandates, they are beginning a battle for economic survival that will be played out in the homes of frail, elderly and disabled Vermonters as well as in the courts. The agencies are trying to preserve home health care benefits for Medicare recipients in the face of some of the most severe budget cuts to hit the program. Most home care industry insiders not only see the cuts as Draconian but also ill conceived and unconstitutional.

In order to understand the complexity of the problem one needs to look at the recent history of the Medicare home health benefit.

Over the past few years greater numbers of Medicare beneficiaries have been receiving home health care provided by nurses, therapists, social workers and home health aides. It is care that has helped people remain at home without the need for more costly institutional care.

This is a national trend that is reflected in Vermont statistics. In 1990, 7,100 Medicare patients were served by Vermont home health agencies. That number nearly doubled to 13,463 in 1997. While Vermont's overall numbers are not high, what is impressive is the fact that over this period of time Vermont's average cost per visit has been the lowest in the nation at \$42-\$45.

During this period of rapid growth in the utilization of the Medicare home health benefit, the Health Care Financing Administration (HCFA), the agency that runs Medicare, helped to create the Operation Restore Trust (ORT) program. ORT has been a federal initiative executed by the Office of the Inspector General (OIG) to weed out wasteful, fraudulent and abusive over-utilization of the Medicare home health benefit.

The reasoning behind the creation of ORT was the assumption that the Medicare home health program must have a lot of fraud and abuse in it if it is growing at such a rapid rate. Home health providers are quick to point out that the program has grown so rapidly because people are living longer and they are deciding that they prefer to receive health care in their homes when possible.

As the ORT initiative proceeded, fraud and abuse was found in states such as Tennessee, Texas and Florida. Not a single case of fraud and abuse was found in Vermont.

Whenever the ORT inspectors found fraud and abuse it made headlines, and the public as well as federal legislators started to see the Medicare home health benefit as something rife with fraud and in need of change. So it was logical that when the Balanced Budget Act (BBA) was passed in the summer of 1997 it included a change in the Medicare home health benefit payment system.

Prior to the BBA, home health agencies were reimbursed by Medicare based on their actual cost per visit; a cost-based reimbursement system. During the years of a cost based system, non-profit Visiting Nurse Associations (VNAs) still struggled for economic survival, but they were able to recapture the cost of doing business.

Unscrupulous agencies inflated their cost per visit and made more visits than honest agencies and they were able to rake in millions of dollars in the process. There was minimal oversight of this system in the early 1990's prior to ORT.

The BBA of 1997 changed the payment system to one which imposes a yearly payment cap on agencies. That cap was determined by looking at agency costs across the nation during 1993 and 1994, when most of the fraud and abuse was going unchecked.

This means that an agency in Tennessee that may have been operating inefficiently and possibly unscrupulously in 1993 will be rewarded for its fiscal irresponsibility while agencies in Vermont that were keeping their costs the lowest in the US will be punished.

This new payment system is called the Interim Payment System (IPS). It is supposed to be in effect for two years and is projected to save the Medicare program \$3.1 billion dollars, according to Congressional Budget Office (CBO) estimates. IPS was put in place without any public hearings and implemented in record time for any government program.

Medicare and the US home health industry have been working on a plan to implement a Prospective Payment System (PPS) similar to the Diagnosis Related Group (DRG) system put in place in hospitals in 1983. All parties have agreed that as long as a PPS system reimbursement is fair, that they can live with it. The IPS came as a surprise and a shock to many in the home health industry looking forward to a PPS.

As home health agencies in Vermont look at their reimbursement under IPS they are realizing they have been discriminated against for keeping their per visit costs low for so many years. Under IPS, the average statewide Medicare reimbursement limit for Vermont will be based on 1993 or 1994 figures, setting it at \$2,696 a year. Tennessee's average will be based on \$6,500 per person. That means that patients in Tennessee will have more of their visits paid for than patients in Vermont even though benefits for all Medicare beneficiaries are identical under Medicare regulations.

Vermont agencies will have to keep track of each patient's account in terms of how close they come to meeting or exceeding the yearly cap. The reality in Vermont and across the nation is that the health care needs of people at home are more intense and complex than they have ever been. Patients continue to be discharged from hospitals sicker and quicker. In addition, Vermont has cut back on the number of nursing home beds in

an effort to funnel more care into people's homes under Act 160.

Home care patients tend to have periods of intense illness that repeat cyclically over the course of years. One visit a week in July may meet a patient's needs, but when bouts of worsening heart failure or progressive chronic lung disease occur in January, it may take two, three or more visits a week to keep that patient at home and in a near functional state. A typical home care patient such as this could run up a yearly visit cost of over \$6,000, meaning the home health agency would have to absorb a loss in excess of \$3,000.

Under IPS, every time a Vermont home health agency sees a patient with complex needs, usually at a greater cost than the Medicare reimbursement, they put their financial future on the line. It is expected that Vermont's home health agencies will lose \$5.1 million dollars a year under IPS.

The comments of Peter Cobb, executive director of the Vermont Assembly of Home Health Agencies, reflect the statewide frustration over IPS.

"This (IPS) is crazy. Vermont has had the lowest costs in the nation for years and we get rewarded with the lowest payments. The cap is highly discriminatory against the people served by low cost, not for profit home health agencies," Cobb said.

Commenting recently on IPS, Vermont Governor Howard Dean said, "I can understand why the federal government wants more efficiency and I support that, but to attack the states that are doing a good job with the same vigor which you're attacking the states that are doing a bad job is mindless nonsense."

Dean has called IPS an atrocity and said that he would be sending a letter to Washington asking that Vermont be granted a waiver of exemption from IPS. Department of Social Welfare Commissioner Jane Kitchel echoed the governor's sentiments and urged that Vermont's Washington delegation support legislation to correct the IPS.

Betsy Davis, CEO of the Visiting Nurse Alliance of Vermont/New Hampshire, has emphasized that the overall mission of her organization will not change despite the fiscal uncertainties that lie ahead. She emphasized that agencies such as hers will, "need to look to the community for more support, not only fund but volunteer help such as providing support services for patients."

She does admit however that in the longer term, if there are no changes, home health agencies may have to say to hospitals that, "We cannot take care of your sickest patients." That means that all of the health care providers in the state will be affected by IPS, and Davis believes they will all work together to find common solutions to problems they are facing.

The current IPS problem in Vermont has a uniquely regional twist in the sense that there are two roads diverging and the home health agencies in the state will most likely travel one of them. It will not be a matter of choice, but something that will be dictated by circumstance.

One road will take two years to travel. It will be the worst case situation in which the IPS stays in place for the mandated two years while home health agencies struggle for survival. Some agencies will survive and some will not. Many lives of frail, elderly and disabled people will be adversely affected.

The other road is shorter and offers more hope. The Vermont Assembly of Home Health Agencies has filed papers in the US District Court in Burlington seeking an injunction to the IPS in Vermont, based on the belief that IPS violates the Fifth Amendment of the United States Constitution that protects people from arbitrary, irrational and discriminatory action by the federal government. The motion for preliminary injunction also addresses issues of lack of due process, the rewarding of fraud and abuse and the assurance that, "no good deed shall go unpunished."

The court date has been set for June 1.

The shorter road also has a detour that could solve the IPS problem without the need for a court injunction. There are bills in Congress, one the so-called Collins Bill, that if passed would change the IPS inequities by using a combined national and regional blend formula to determine reimbursement to home health agencies.

The short-term treatment prescribed by Medicare to preserve its budget is the Interim Payment System. It will save money, but will Vermont's 13 non-profit Medicare certified home health agencies survive the treatment? These agencies will be forced to react to the changing political climate and hope that communities rally to their support to preserve an essential service for Vermonters ***** Copyright Lake Iroquois Publishing, Inc. d/b/a Vermont Business Magazine Jun 01, 1998

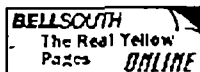
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The Palm Beach Post

Home health-care firms struggling after cuts in Medicare

By Phil Galewitz
Palm Beach Post Staff Writer

The federal government's cuts in Medicare payments to home health-care businesses this year has caused 10 percent of the businesses in Florida to stop operating and has forced others to lay off workers and reconsider how they can afford to treat patients needing long-term care.

Forty-five of Florida's 450 Medicare home health-care businesses have given up their Medicare licenses since January, according to the state Agency for Health Care Administration. In Palm Beach County and on the Treasure Coast, two companies have closed some of their offices and laid off employees.

Nationwide, about 800 of the nearly 10,000 Medicare-certified home-health agencies have closed, according to the National Association for Home Care, a Washington, D.C. trade group.

Until now, the home-health industry has soared in the 1990s, with hospitals having the financial incentive to get patients out quicker and home-care businesses having better technology to make it easier to provide care at home. Home health care means medical services delivered at a person's home; it does not include home assistance such as delivering meals or helping the ill or elderly bathe.

The costs of home health care have grown, too. Medicare this year will spend about \$20 billion on home health care - seven times what it spent in 1990.

After years of hearing from government investigators about how much money Medicare squandered from unnecessary care, Congress last year finally did something about it.

Rather than continuing to pay home-health businesses a fee of \$63-\$88 per visit to a patient, Congress placed limits on how much Medicare would pay businesses annually for each patient. In Florida, the average cap is about \$3,100 a patient. The range is from \$2,000 to \$5,000 per patient.

The home-health industry says the government went too far. Industry officials say not only will the changes force many companies to leave the Medicare program, but it will leave many chronically ill patients without care.

Fort Pierce-based RN Home Health last month closed its Medicare offices in Boca Raton and West Palm Beach. It maintains offices in Martin, St. Lucie and Okeechobee counties.

Redi-Nurse, a West Palm Beach-based chain of home-health agencies, closed its Medicare office in northern Indian River County. It still operates from Boca Raton to Vero Beach.

Redi-Nurse also laid off 33 of its 136 staff members this year to prepare for the cuts, said controller Kenneth Healy. "I've been in this business for 24 years, and this is the worst I've ever seen it," he said.

The National Association for Home Care estimates the Medicare changes resulted in businesses getting an average of 31 percent less for each patient.

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Industry analysts also complain that rates are inconsistent, varying from company to company because the rate each company is paid now is based in part on its average charges in 1994. The companies that charged Medicare more in 1994 are receiving more today, analysts say. They say such a system rewards inefficiency and penalizes agencies that worked to keep costs down.

The companies hurt the most by the change are small, not-for-profit home-health chains, such as the Visiting Nurse Association of Florida, which covers the Treasure Coast. Such companies generally rely on Medicare for much of their business, and the only business they do is home health care. Other business such as hospitals have other lines of business to subsidize their home health-care operations.

The VNA this year reduced its administrative staff by 10 percent. It also switched most of its nurses from full-time employees to per diem, which meant they lost benefits such as health insurance from the VNA.

"The system Medicare has now does not make any sense," said Bob Quinn, director of operations of the VNA. "Why would you want to drive the most economical people out of business?"

A spokesman for the Health Care Financing Administration, which oversees Medicare, said the industry should have known the changes were coming. He said the new payment system is a result of Congress trying to rein in runaway home-health spending.

Anne Menard, manager of the home health-care unit at the Florida Agency for Health Care Administration, said her agency has received more than 70 complaints this year from patients worried they may lose their home health care. When a Medicare home-health company leaves the business it is supposed to make arrangements for its patients, but there are no guarantees.

"I worry there are very sick patients falling through the cracks," Menard said. *The number for the AHCA is 888-419-3456.*

Originally published in *The Palm Beach Post* on Saturday, July 11, 1998.

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Group keeps abreast of spiral effects

Some state residents already affected by congressional cuts

BY MANNIX PORTERFIELD
REGISTER-HERALD REPORTER

Like a mighty steamer sinking in the ocean, the balanced budget movement is leaving many homebound patients to fend for themselves with neither life preserver nor lifeboat to reach an island of safety.

Already in West Virginia, since Congress began curtailing home health services, some 3,000 lost benefits when the venipuncture program was altered.

And that, one official warns, could be only the tip of the iceberg.

The venipuncture program now only covers blood work if another primary service is performed in the home, such as dressing a wound or working with a catheter.

From her Beckley office, Violet Burdette is monitoring the spiraling effects of the rollbacks in her role as president of the West Virginia Council of Home Health Agencies.

Burdette's group is seeking to enlist the help of West Virginia's congressional delegation. The council is attempting to learn effects of the cuts and invites agencies and patients alike to call

Burdette at 252-2146, or the state headquarters in Morgantown at 1-800-210-4663. Such data will help arm the council in taking its case to Congress.

The group represents about 60 of the 113 providers in this state. Cuts in Medicare forced two out of business this year, and Burdette fears others may follow.

State lawmakers sought to soften the blow in the venipuncture program by covering the service via Medicaid.

"So they're paying a nominal amount for people to be able to continue to receive services in their home under Medicaid," Burdette said. "But if they have Medicare, they won't cover it. Only through Medicaid."

Burdette sees two other major setbacks to home health providers.

One is a requirement for \$50,000 surety bonds to participate in Medicare and Medicaid.

"Home health agencies don't have a lot of physical assets," Burdette said. "They provide services, so you'll see them rent spaces. They don't own buildings."

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HEALTH

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"It wasn't the intent of Congress for everyone to have to have bonds, actually," she said. "It was the intent that new providers or providers that had problems with fraud and abuse, and other issues, would be required to have bonds."

"When the regulation was written by Medicare, it included everybody."

The other setback, which will have the greatest impact, is in the payment system, she said.

"Medicare has decided that the payment structure for home health is wrong, and that's probably true, because it's cost-based reimbursed," Burdette said.

"There was not a lot of incentive for providers to keep down costs as long as they kept them down to a certain degree. So now, they're going back and saying, 'We shouldn't have reimbursed like that.' And they're going to a perspective payment system..."

This means payment is based on the types of patients' needs.

"They're going to pay home health providers based on what their costs were in 1993 or 1994," Burdette said. "They're not taking into consideration that the patients' needs have changed, or they're sick, or any of those kinds of things."

"That's the one that's starting to really harm providers at this point."

If an agency handled 1,000 patients five years ago for a combined \$200,000, it would be allowed \$2,000 for each under the new system.

"That's an aggregate," she said. "If it cost you \$1,000 for one patient, and \$5,000 for another patient, they'd still pay you just the \$2,000. That's an aggregate. They don't pay you the \$1,000 and the \$5,000."

Ripples are evident within the public health sector, as well. Witness the demise of the West Virginia Family Home Health Agencies, with 16 units that operate such agencies.

"They're disbanding," Burdette said. "They're eliminating that group. One is going to try to make it on their own. They can't make it under this new payment system as a unit."

Elimination of the venipuncture service alone translates into a \$4.9 million loss this year for the public agencies, she said.

"Now, with this additional cut, based on this new reimbursement system, many of those agencies may go out of business," Burdette said.

"This state, I think, has some concerns that other states don't even have because we don't have backup systems. If we don't have home health, where is the service going to be provided? There is just not a backup to that."

"A lot of people are starting to recognize that this system is probably not working. That's the whole crux of the problem. Instead of just saying the government can't afford to meet all of your needs, so we're going to cut this benefit, they disguised that cut in terms of provider payment..."

Albert "Mac" Tieche, former administrator at Beckley Hospital, sees a disturbing old trend manifesting itself.

"They're doing the same thing to home health care agencies that they did to hospitals 20 years ago," he said.

"They start off and say, 'All right, we're going to do cost-based reimbursement. Everybody have a good time.' Then they turn around and say, 'We're going to go to perspective payments.'"

In the switch to perspective payments, based on a state or national average, the government claimed cheaters would get hurt and responsible providers would be helped, Tieche said.

The idea was to keep more efficient providers in the market to absorb the service of less efficient ones.

"So you were efficient and you get penalized for it," Tieche said. "The inefficient ones get rewarded for that because they had built-in gaps there."

"They can back up three or four years. They can cut enough costs to survive until the next round and figure out another way to get by. It's a terrible way to do things. And they continue to do it."

Tieche scorned such tactics as "an election-year bonanza" when voters are dished out something that appears "really big and really great."

"And then we go privately and quietly ream people or cre-

ate victims that are silent victims, that are not voting victims," Tieche said.

"These are minority people that get home health. And the workers. They don't have a big lobby like the teachers or the veterans."

In 10 states to date, 350 agencies have thrown in the towel, Burdette said.

"This is one of the cases where they have kind of thrown out the baby with the bath water," she said.

"They recognized home health was the fastest growing industry in the health care industry. Well, it should have been. We were putting people out of hospitals and we were pushing them into the home environment, which is more cost effective."

Val Halamandaris, president of the National Association for Home Care, recently pointed out that 1995 marked the first time in the nation's history that more people died of chronic illness than acute illness.

"By definition," he said, "this means a greater need for home care services."

Echoing this sentiment, Burdette said many West Virginians face years of chronic illness with black lung and heart diseases. Many enrolled in home health care are seeing a decline in services.

"You're going to start seeing patients who need a lot of care having difficulty finding home health agencies that will be willing to take them at the beginning of their care," she said.

Many of the 3,000 eliminated from home health care in February wound up in nursing homes, meaning that Medicaid is picking up much of the tab.

"Unfortunately, when it comes to reimbursement, there's a lot of it that makes no sense," Burdette said.

Burdette produced a Medicare statistic showing 93 percent of home health care providers will get reimbursed below costs.

"If you're running a business and 93 percent of the businesses are getting less than the costs, who's going to be left to provide the services?" she asked.

"This is truly the first time I believe we're in danger of losing an entire service, an entire part of the continuing care."

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December 21, 1998

Health Matters

Business of health care is a human and humanitarian endeavor

John W. Rodat

Just by looking at the header of this section--"Strategies"--you can tell that this column is mostly about the business and organizational aspects of health care.

This is, after all, the Business Review. But as we enter the holiday season, it's worth reminding ourselves how the health care "business" is not just commerce. So here are a couple of stories. As usual, some names have been changed.

Health care professionals

Joe Doolittle tells a story of four nurses in the continuing-care department of a health maintenance organization receiving a bouquet of roses from a 61-year-old patient. The patient had died two weeks earlier.

But the card was addressed to each of them, signed in the patient's own hand and read, "Thank you for all that you did for me."

These nurses will tell you that they didn't do all that much for her. Well, yes, they had known her since her initial diagnosis two years prior, and had been with her through her surgery and chemotherapy. Since the patient lived alone, they had made sure there were rides for her, and people to be there with her.

As time passed, they saw a lot of her at home and in and out of the hospital. Despite the fact that these nurses didn't think they had done much, the patient obviously thought differently; they had done a lot for her. She'd planned ahead to say thank you to people who had become an important part of her life.

For these professionals, it may have seemed all in a day's work. But to the patient, it was far from routine. It was valuable enough to be recognized at the end.

Health care organizations

Jane is a 47-year-old grandmother. Because her daughter has a drug problem, Jane has taken in her grandchild, who is about 8 years old. Painfully, this is a pretty common story these days.

What makes Jane's story even more wrenching is that she herself has multiple sclerosis.

Each day, staff from a visiting nurse organization help Jane get up and into her wheelchair, take her medications and take care of her catheter. Under new federal rules, this agency's payments for Jane's care are based on an average number of

visits far below what's required for Jane's care and far below what's necessary for her to live independently

This agency is going to lose money on Jane, and it had resigned itself to that fact.

However, when Jane was hospitalized a few months ago, she was discharged from the agency's care. Of course, when Jane was ready to leave the hospital, she wanted to return home. Under both federal and state rules, nothing required the agency to take her back. It did anyway.

Knowing it was going to lose money (and probably a lot), this agency promised to continue the services that allow Jane to continue living at home and caring for her grandchild. Absent those services, Jane likely would have spent the rest of her life in a nursing home, and her grandchild would have spent the rest of his youth in foster care.

A neighbor

Pat was in her late 20s when she died of cancer. After 15 months of trying just about everything, her physicians finally told her there was nothing left they could do, and she went home.

Her last few weeks were just what you would expect: painful for her and her family. Pat lived in a rural community with no hospice. She had gotten extraordinary hospital care during her illness (despite being uninsured), but during her last few weeks, the organizational supports pretty much disappeared.

Mary was a nurse who lived down the road. She knew Pat, but really only enough to say hello when they passed on the road. When Pat went home for the last time, Mary simply arrived, having heard about Pat's plight.

During those last weeks, Mary went to see Pat every morning before she went to work, every afternoon after she returned, and every night before bed. She often left work during her lunch hour to drop by.

Mary was the one who gave Pat her pain medication, who called the doctor when it was time to increase the dosage, and who remained a steady presence during those last weeks. She never asked for anything.

After Pat's death, her family offered to pay Mary, but she shrugged it off. "Yes, it's my profession, but I'm a neighbor," she said. "My profession simply enables me to do things that I couldn't otherwise."

Every day, thousands of professionals, family members, friends, neighbors, volunteers and just folks share in the joys of a healthy newborn and the relief of a recovery from illness or injury. Every day, these same folks struggle with the issues that arise in the most intimate, vulnerable and painful moments of our lives.

At the end of the year, it's worth remembering them and reminding ourselves that every day, they do it with skill, energy, generosity and grace.

So in this month's column, we'll ignore business strategy, the economics of health insurance, government regulation and whatever the latest aggravation is. Instead, we'll salute and thank all of those folks and remind ourselves that the real core of the health care enterprise is both human and humanitarian.

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CBO TESTIMONY

Statement of
Paul N. Van de Water
Assistant Director
for Budget Analysis
Congressional Budget Office

on
the Impact of the Balanced Budget Act
on the Medicare Fee-for-Service Program

before the
Committee on Finance
United States Senate

June 10, 1999

NOTICE

This statement is not available for public release until it is delivered at 10:00 a.m. (EDT), Thursday, June 10, 1999.



CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

Mr. Chairman and Members of the Committee, I am pleased to represent the Congressional Budget Office (CBO) at this hearing on the fee-for-service portion of the Medicare program. After many years of rapid increases, the growth of Medicare spending has slowed sharply in the past two years. My statement discusses the reasons for that slowdown and presents CBO's assessment of future trends. I will make three main points:

- o The greater-than-expected slowdown in the growth of Medicare spending stems mainly from successful efforts to combat fraud and from delays in payments to health care providers.
- o With one exception, CBO's estimates of the effects of the Medicare provisions of the Balanced Budget Act (BBA) of 1997 still appear reasonable. CBO did not anticipate how home health agencies would implement the interim payment system for home health services, however, and may therefore have underestimated its savings.
- o The factors that are holding down the growth of Medicare spending will be played out in the next few years, and more rapid growth will then resume.

TRENDS IN MEDICARE SPENDING

Between 1980 and 1997, Medicare spending increased at an average rate of 11 percent a year and expanded from 5 percent to 12 percent of the federal budget. Total outlays for Medicare rose by only 1.5 percent in 1998, however, and may decline in 1999. Part of that slowdown was anticipated; the Balanced Budget Act lowered the projected growth of Medicare spending by an estimated 4 percentage points in 1998. The BBA reduced payment rates for many services and restrained the update factors for payments through 2002. Both fee-for-service providers and Medicare+Choice plans are experiencing lower increases in payments as a result.

But the actual rate of spending growth is considerably slower than the BBA provisions alone were expected to produce. Other factors appear to have contributed to the sudden flattening of Medicare expenditures, including greater compliance with Medicare payment rules and a longer time for processing claims.

Widely publicized efforts to clamp down on fraud and abuse in the program have resulted in greater compliance by providers with Medicare's payment rules. Those efforts include more rigorous screening of claims by Medicare contractors and tougher enforcement of Medicare laws by the Departments of Justice and Health and Human Services. Through investigations and lawsuits, those agencies have pursued a wide range of providers—including hospitals, teaching physicians, home health

agencies, clinical laboratories, and providers of durable medical equipment—as well as Medicare contractors themselves. Although the total reduction in spending growth attributable to the improved compliance cannot be quantified, CBO estimates that one response alone to recent enforcement efforts—less aggressive billing by hospitals—lowered growth in Medicare spending by 0.75 percentage points in 1998.

The average time for processing Medicare claims rose dramatically in 1998. Expanded compliance activities, combined with major efforts to prepare computer systems for 2000, contributed to longer payment lags, which can have a substantial effect on Medicare outlays. An increase of one week, for example, in the average time for processing claims reduces Medicare outlays for the fiscal year by 2.3 percent. But that reduction is only temporary because the delay merely moves outlays into the next fiscal year.

CBO expects that improved compliance with payment rules and longer claims-processing times will have little or no effect on the rate of growth of Medicare spending in the longer run. Our projections assume that payment lags will begin to return to more typical levels late in 2000, with a catch-up in spending and a resumption of normal spending growth in 2001 and 2002 (see Table 1). Most of the projected increase over the next few years reflects rising expenditures per enrollee. The leading edge of the postwar baby boom will not reach age 65 until after 2010.

TABLE 1. MEDICARE OUTLAYS (By selected fiscal year)

	1990	1998	1999	2004	2009
In Billions of Dollars					
Gross Mandatory Outlays					
Benefits	107	210	212	298	443
Mandatory administration and grants ^a	<u>b</u>	<u>1</u>	<u>1</u>	<u>1</u>	<u>1</u>
Total	107	211	213	300	444
Premiums	<u>-12</u>	<u>-21</u>	<u>-21</u>	<u>-34</u>	<u>-53</u>
Mandatory Outlays Net of Premiums	96	190	192	266	391
Discretionary Outlays for Administration	<u>2</u>	<u>3</u>	<u>3</u>	<u>4</u>	<u>4</u>
All Medicare Outlays Net of Premiums	98	193	195	269	396
Average Annual Growth Rate from Previous Year Shown (Percent)					
Gross Mandatory Outlays		8.8	1.1	7.1	8.2
Premiums		7.5	3.4	9.7	9.3
Mandatory Outlays Net of Premiums		9.0	0.8	6.7	8.0
Discretionary Outlays for Administration		1.5	7.4	4.7	4.0
All Medicare Outlays Net of Premiums		8.8	0.9	6.7	8.0
SOURCE: Congressional Budget Office.					
a. Mandatory outlays for administration support peer review organizations, certain activities against fraud and abuse, and grants to states for premium assistance.					
b. Less than \$500 million.					

Projections of Spending and Enrollment in Medicare+Choice

Payments for Medicare+Choice plans in CBO's baseline soar from \$37 billion in 1999 to \$141 billion in 2009 as enrollment in those plans continues to expand. The spending increase also reflects the expected growth in expenditures per enrollee. CBO projects that risk-based plans will account for 16 percent of Medicare enrollees in 1999, 22 percent in 2004, and 31 percent in 2009, assuming that the second phase of risk adjustment is implemented on a budget-neutral basis.

Projections of Spending and Enrollment in the Medicare Fee-for-Service Program

CBO projects that spending in Medicare's fee-for-service program will increase from \$175 billion in 1999 to \$302 billion in 2009 (see Table 2). That growth will occur despite shrinkage in fee-for-service enrollment, which will decline by 1.5 million over the next decade, and cuts in the growth of payment rates for many services.

Spending growth for different services will vary considerably over the same period. The extent of the recent slowdown in spending has also varied by type of service, although spending for all services has been affected by the 1.9 percent drop in fee-for-service enrollment that occurred in 1998 and the further 0.8 percent decline expected in 1999.

TABLE 2. OUTLAYS FOR MEDICARE BENEFITS, BY SECTOR (By fiscal year)

Sector	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
In Billions of Dollars												
Medicare+Choice ^a	32	37	41	49	48	60	70	88	88	108	124	141
Fee-for-Service												
Skilled nursing facilities	15	13	13	14	14	15	16	17	18	19	21	22
Home health	15	15	17	16	17	18	20	21	25	24	26	28
Hospice	2	2	2	2	3	3	3	3	3	3	4	4
Hospital inpatient ^b	87	86	91	95	99	104	108	112	117	123	129	135
Physicians' services	32	32	33	34	35	36	37	38	39	40	41	43
Outpatient facilities	17	16	17	18	20	21	23	25	26	28	30	33
Other professional and outpatient ancillary services	12	12	14	15	17	20	22	25	28	31	34	38
Subtotal	178	175	186	194	205	217	228	241	255	269	285	302
Total	210	212	228	243	253	277	298	328	343	378	409	443
Annual Growth Rate (Percent)												
Medicare+Choice ^a	26.3	14.0	11.7	18.0	-1.3	25.0	16.7	24.7	0.8	22.8	14.6	13.4
Fee-for-Service												
Skilled nursing facilities	8.9	-3.8	1.7	5.3	5.1	6.4	6.0	6.4	6.5	6.4	6.4	6.4
Home health	-14.9	0.8	10.5	-5.8	10.1	6.6	7.2	7.9	7.8	7.4	6.8	6.6
Hospice	1.0	2.5	8.6	6.3	4.6	5.7	5.3	5.7	5.8	5.7	5.8	5.8
Hospital inpatient ^b	-2.5	-1.5	5.7	4.7	4.5	4.7	3.9	4.1	4.5	4.6	4.9	4.8
Physicians' services	3.0	0.6	4.2	2.3	2.4	3.4	2.6	2.8	3.0	3.0	3.3	3.5
Outpatient facilities	-5.5	-6.6	8.4	8.5	7.1	7.7	7.2	7.4	7.3	7.3	7.6	7.9
Other professional and outpatient ancillary services	0.7	0.6	14.0	13.0	12.5	13.2	12.3	12.3	12.1	11.0	10.7	10.2
All Fee-for-Service	-2.1	-1.4	6.4	4.4	5.5	5.8	5.2	5.5	5.8	5.8	5.9	5.9
All Medicare Benefits	1.4	1.0	7.3	6.8	4.1	9.5	7.7	10.0	4.4	10.1	8.4	8.2

SOURCE: Congressional Budget Office.

a. Includes spending for health maintenance organizations paid on a cost basis, certain demonstrations, and health care prepayment plans, which are paid on a cost basis for Part B services.

b. Includes subsidies for medical education that are paid to hospitals that treat patients enrolled in Medicare+Choice plans.

Postacute Care Services. Growth in payments for skilled nursing facility (SNF) and home health services—the fastest-growing areas of fee-for-service spending in Medicare during the decade preceding passage of the Balanced Budget Act—slowed significantly in 1998. The most dramatic change was in spending for home health care, which actually fell by 14.9 percent in 1998. SNF expenditures, by contrast, continued to rise but at less than half the rate of growth in 1997—8.9 percent compared with 21.1 percent. The slowdown in spending reflects the implementation of new prospective payment systems and increases in the time for processing claims.

The transition to prospective payment systems is expected to hold down the average annual rate of growth in these categories of spending through 2001. Spending is then projected to increase through 2009 at an average annual rate of 6.2 percent for SNF services and 7.5 percent for home health services.

Inpatient Hospital Services. Medicare payments for inpatient hospital services fell 2.5 percent in 1998, to \$87 billion. The factors contributing to that drop include a decline in the volume of services provided (reflecting the drop in fee-for-service enrollment) and several provisions in the BBA that froze payment rates for most operating costs, reduced capital-related payment rates by 17.8 percent, and cut subsidies for medical education. In addition, the case-mix index—a measure of the relative costliness of the cases treated in hospitals paid under the prospective payment system—fell 0.5 percent in 1998. Much of that unprecedented drop in the

index is probably attributable to widespread adoption by hospitals of less aggressive billing practices following antifraud initiatives that focused on those practices.

For most hospitals, the BBA limits cumulative increases in payment rates for operating costs to about 6 percentage points below inflation over the 1999-2002 period. CBO projects that the limit on rate increases, in combination with declining fee-for-service enrollment, will result in a 1.5 percent drop in payments for hospital inpatient services in 1999. Those payments are projected to begin rising in 2000, with annual growth rates averaging 4.5 percent from 2000 through 2009.

Physicians' Services. Medicare payments for physicians' services rose 3.0 percent in 1998, to \$32 billion. Payments are projected to remain flat in 1999 and to grow at an average annual rate of 2.8 percent over the next decade, reaching \$43 billion in 2009. That growth rate is a result of payment formulas enacted in the BBA that tie the growth of per-enrollee expenditures for physicians' services to the growth of gross domestic product per capita. Those formulas generate annual rate changes that oscillate widely around a smooth trend. CBO projects stable growth rates, however, because the timing of those oscillations is impossible to predict.

Outpatient Services. Payments to outpatient facilities—such as hospital outpatient departments, dialysis facilities, and rural health clinics—fell by 5.5 percent in 1998 and are projected to decline another 6.6 percent in 1999. Those reductions result

largely from lower payment rates accompanying the transition to a prospective payment system for hospital outpatient services. Outpatient payments are projected to rebound in 2000 and grow at annual rates of 7 percent or more for the rest of the decade.

Spending for outpatient therapy services and other outpatient ancillary services—including pharmaceuticals, durable medical equipment, and chiropractic care—rose only 0.7 percent in 1998 as a result of reductions in payment rates and a cap on payments for therapy services performed outside hospitals. Projected payments for nonphysician professional services and outpatient ancillary services will grow only slightly in 1999 before taking off again in 2000. Annual spending growth is expected to average 11.3 percent from 1999 through 2009.

EFFECTS OF THE BALANCED BUDGET ACT

In January 1997, CBO projected that net mandatory outlays for Medicare would grow from \$189 billion in 1997 to \$288 billion in 2002. That January 1997 baseline was the basis for CBO's estimate of the savings from the BBA. CBO estimated that the BBA would reduce net mandatory spending for Medicare by \$6 billion in 1998, \$41 billion in 2002, and \$112 billion over the 1998-2002 period. As a result, in its August 1997 analysis of the BBA, CBO projected that net mandatory outlays for

Why the Projections Have Changed

Each year CBO updates its budget projections to account for legislative changes, updated economic assumptions, and other new information. Since the enactment of the BBA, the only noticeable legislative effect on Medicare spending has been the modification of home health payment rates included in last year's omnibus appropriation bill (Public Law 105-277). CBO estimated that legislation will increase Medicare outlays by \$2 billion in 2000 and reduce them by \$1 billion in 2001. CBO's current projections of inflation rates are slightly lower than they were in January 1997. Those lower inflation rates account for about \$3 billion of the annual differences between the August 1997 and March 1999 projections.

Most of the difference between the two sets of projections is attributable to new information—most notably the unanticipated slowing of spending growth in 1997 and 1998 resulting from improved compliance with Medicare payment rules. In essence, the 1997 projections were too high because CBO did not anticipate the full effects of Operation Restore Trust—Medicare's program to combat fraud. CBO also did not foresee the increasing lag in 1998 and 1999 between when services are furnished and when payment is made and implementation of adjustments to payments to Medicare+Choice plans on the basis of risk in a manner that will reduce spending.

Medicare would grow to \$247 billion in 2002, rather than the \$288 billion projected the previous January (see Table 3).

CBO's current baseline, prepared in March 1999, projects that net mandatory Medicare spending will grow from \$192 billion in 1999 to \$227 billion in 2002. Those figures are \$18 billion and \$20 billion, respectively, below the levels projected in August 1997.

TABLE 3. COMPARISON OF AUGUST 1997 AND MARCH 1999 PROJECTIONS OF NET MANDATORY OUTLAYS FOR MEDICARE (By fiscal year, in billions of dollars)

	1997	1998	1999	2000	2001	2002
January 1997 Projection	189	206	226	250	261	288
Minus Effects of Balanced Budget Act	<u>0</u>	<u>-6</u>	<u>-16</u>	<u>-29</u>	<u>-20</u>	<u>-41</u>
August 1997 Projection	189	200	210	220	241	247
March 1999 Projection	187	190	192	206	219	227
March 1999 Projection Minus August 1997 Projection	-1	-9	-18	-15	-22	-20

SOURCE: Congressional Budget Office.

NOTE: Numbers may not add up to totals because of rounding.

CBO has not revised its estimates of the effect of the BBA on Medicare spending. With one possible exception, CBO believes that its estimates of the Balanced Budget Act were reasonable.

Spending for Home Health Services

The one policy for which CBO may have significantly underestimated savings is the interim payment system for home health agencies. CBO's current projection of outlays for home health services is much lower than projected in August 1997. Those lower projections are largely attributable to new information about the effects of Operation Restore Trust and other antifraud initiatives and to increases in the lag between when services are furnished and when payment is made; they do not fully incorporate our revised assessment of the effects of the interim payment system.

Lower payments for home health services also explain most of the shortfall in Medicare spending so far this year. Some of the drop in home health spending stems from longer payment lags resulting from a new method of processing claims known as sequential billing, in which a claim is paid only if all prior claims have been processed. Medicare will suspend that billing process in July, which should increase spending during the last quarter of the fiscal year. In addition, the use of home health services seems to have dropped substantially, probably as a result of

both antifraud activities and an unexpectedly cautious response by home health agencies to the per-beneficiary limit under the interim payment system. That limit applies to aggregate payments: payments for individual beneficiaries may exceed the limit as long as the average payment for all beneficiaries served by an agency does not exceed the per-beneficiary limit. Some agencies, however, apparently believe that the limit applies to each beneficiary and are cutting off services to patients who have reached the per-beneficiary limit. Thus, the average payment per beneficiary is well below the allowable amount.

CONCLUSION

CBO is currently updating its projections of Medicare spending and will release them on July 1, as called for in the budget resolution. Because the rate of Medicare spending through May of this year has been lower than CBO estimated in March (and about 2½ percent below the rate for the first eight months of last year), the July projections of Medicare spending in 1999 and 2000 will probably be several billion dollars lower than the March estimates.

Medicare will replace the interim payment system for home health services with a prospective payment system in 2001. Because that system will remove much of the uncertainty about payments that has contributed to the current apparent drop in utilization, spending for home health services could rebound in 2001 and

subsequent years. Therefore, CBO does not now anticipate significantly revising its projections of spending on home health services—or other categories of services—beyond 2000. CBO expects that total Medicare spending will resume growing at an average rate of 7 percent to 8 percent a year in the decade after 2000.