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**DRAFT Testimony on
SNF/HHA Payment Reform**

Introduction

Thank you, Mr. Chairman, for the opportunity to testify today. I am pleased to discuss the growth in skilled nursing facility (SNF) and home health agency (HHA) expenditures and our plans for developing prospective payment systems for these services. When I first encountered these issues in the late 1970s and early 1980s, Medicare was considered to be an acute benefit, and nobody would acknowledge that it covered long-term care services. However, times have changed. In 1996, Medicare will pay for more than \$28 billion in post-acute services -- mostly SNF and HHA services, but also including rehabilitation and long-term hospital care. While Medicare rules still limit these services to beneficiaries who require skilled care, many of these services are furnished to beneficiaries who are long-term care patients.

The 1997 President's budget projects that, in 2002, expenditures for post-acute care services will be more than \$54.7 billion, or 16.7 percent of program expenditures, as opposed to 3.5 percent of program expenditures in 1986. In fiscal year 1995, 23 percent of Medicare Part A and 15 percent of total program dollars paid for post-acute services.

Expenditures for post-acute care services are among the fastest growing components of Part A and total Medicare spending. However, these expenditures represent just the tip of the iceberg on spending for long-term care patients. Total Medicare expenditures for residents of nursing homes were about 9 billion in 1995, even though Medicare pays for only about 10 percent of nursing home care. Although the majority of nursing home stays are not covered by Medicare, most of the other health care services used by nursing home residents is covered -- such as hospital care, physician visits, and therapy services.

The dramatic increase in Medicare expenditures for post-acute services is due to a number of factors, including the increase in the number of providers, decline in acute hospital lengths of stay, changes in medical practice, and provider financial incentives. The number of Medicare-certified SNFs has grown 38 percent since 1986, from 9066 to 12,536, including a more than 250 percent increase in hospital-based SNFs. Home health agency growth has been even more dramatic. In 1986, there were 5907 home health agencies, compared to 7363 currently -- a 20 percent increase. The increased supply has permitted more utilization. We have seen a substantial increase in the numbers of beneficiaries using both SNF and HHA care. In 1984, 298,000 Medicare

beneficiaries used 9.6 million days of SNF service. In 1994, it is estimated that 925,000 Medicare beneficiaries used 36.9 million days of SNF care. Similarly, in 1984, 1.2 million Medicare beneficiaries had 31 million covered HHA visits. This increased to 3.2 million beneficiaries having 209 million covered visits in 1994. Further, we have seen evidence that the intensity of services per user is also increasing; SNF patients are receiving more therapy and other services during their stays, and HHA patients are using more services.

Reasons for the Growth in Post-Acute Care Utilization/Expenditures

Let me highlight just a few of the reasons why such explosive growth in utilization and expenditures occurred. These include policy changes, incentives created by antiquated cost-based reimbursement systems, changing demographics, medical advances, and increases in demand by beneficiaries and physicians.

Policy Changes

First, a number of policy changes have encouraged the use of post-acute care. While some of these changes had unintended consequences, many of these changes were undertaken with the belief that they would reduce total costs by shifting resource use from more expensive (hospital) to less expensive (post-acute) settings. For the most part, these policy changes were not systematic attempts to reform Medicare; rather they occurred piecemeal throughout the years to achieve specific objectives. And, we have found, they have not reduced overall program costs.

Example: Home Health Benefit Expansion

Let me discuss the expansion of home health coverage and eligibility as an illustration. OBRA-1980 transformed the home health benefit into an unlimited benefit -- one that serves the chronic, long-term needs of patients as well as the needs of those who require recuperative care after a hospital visit. Since OBRA-1980, we have witnessed a steady growth in the number of home health visits per beneficiary per year, from an average of about 27 visits per year in 1982 to about 70 visits per year in 1995. Much of the growth in home health outlays is due to patients who receive more than 100 visits per year. For example, in 1994, 21 percent of home health users received more than 100 visits, compared to only 9 percent in 1990. Incidentally, the OBRA-1980 legislation resulted in the Part A Trust Fund financing approximately 99 percent of the financing for the home health benefit, regardless of whether visits are of a post-acute care or long-term care nature. As I'll explain later, this is a problem we seek to fix in our legislative proposals.

OBRA-1980 also allowed for Medicare certification of for-profit home health agencies. Proprietary agencies -- which now represent 48 percent of all certified agencies -- are the fastest growing segment of Medicare home health expenditures. One analysis suggests that beneficiaries receiving care from for-profit HHAs receive 21 more visits, on average, than those receiving care from non-profit agencies, after controlling for the differences in health and functional status of the beneficiary, as well as age, sex, and living situation.

Other policies also contributed to the explosive growth in home health expenditures. In 1989, to comply with the settlement of a court case, HCFA clarified our interpretation of the "part-time or intermittent" eligibility criteria which expanded the benefit's coverage. The clarification of our interpretation has resulted in an estimated 38 percent annual increase in home health expenditures from 1988 to 1992, and a 16 percent increase in visits per beneficiary from 1989 to 1995.

Example: SNF Coverage Guidelines and the Impact of the Medicare Catastrophic Coverage Act of 1988

SNF utilization and expenditures have also increased as a result of a number of policy changes over the years. In April 1988, we clarified the SNF coverage guidelines based on evidence that the existing guidelines were interpreted inconsistently across fiscal intermediaries, resulting in arbitrary and excessively restrictive claims determinations as well as geographic differences in SNF coverage. In some areas, beneficiaries did not apply or were not encouraged to apply for Medicare SNF coverage because of the possibility of retroactive denial of their care. After implementation of the new coverage guidelines, retroactive denials decreased significantly.

The Medicare Catastrophic Coverage Act of 1988 (MCCA) was designed to change the Medicare benefit structure to more fully cover catastrophic conditions. Several aspects of the SNF benefit were changed under the bill, including the elimination of the 3-day prior hospital stay requirement, changes in the copayment, and broadening of coverage (to 150 days in a calendar year). As you know, the MCCA was subsequently repealed in 1989. However, that was not before the industry responded to expand SNF utilization. The elimination of the prior hospital stay requirement and the broadening of coverage led to the potential that Medicare coverage would be substituted for Medicaid coverage of nursing home care. This was especially likely since OBRA-1987 changes in nursing facility certification made Medicare and Medicaid requirements virtually equivalent. In some cases, states actively recruited facilities to obtain Medicare certification so that they could bill Medicare whenever appropriate. (The increase in the number of Medicare-certified facilities was dramatic, from \$1.9

billion in 1986 to \$3.9 billion 1990.) The increase in capacity that indirectly resulted from MCCA, coupled with the clarification of coverage guidelines, led to explosive growth in SNF utilization in the late 1980s.

Example: Impact of Hospital PPS

Finally, the implementation of the Prospective Payment System (PPS) for inpatient hospitals also resulted in increased utilization of post-acute services. Hospital PPS provides payment to hospitals on the basis of the medical characteristics of the patients they treat, rather than the resources they expend in providing care to patients. Hospitals responded to the incentives in PPS by shortening the lengths of stay. Patients were discharged before complete recovery had been made, resulting in increased use of post-acute services. There has been a significant shift in Medicare spending from PPS hospitals to post-acute providers. While acute care hospitals received more than 91 percent of Medicare Part A payments in 1986, their share decreased to less than 74 percent in 1993. Concurrently, payments to post-acute care providers increased from less than 9 percent to more than 26 percent.

In fact, PPS not only created incentives for hospitals to discharge patients earlier, but also to establish hospital-based units for post-acute services. In 1994, almost 60 percent of hospitals had a post-acute care unit. These hospital-based units benefit hospitals in two ways: first, hospitals are better able to discharge patients early, thus profiting under the PPS payment system. Second, HCFA's reimbursement rules allow them to allocate a portion of their overhead to the distinct-part unit, and they receive cost-based payment for these services.

Example: Cost-Based Reimbursement Systems Provide Few Incentives for Cost-Conscious Behavior, Invite New Market Niches, and Allow Room for Fraudulent and Abusive Practices

The result of these policy changes and the incentives of PPS has been to provide an opportunity for providers to exploit the areas of Medicare where expenditure growth is less constrained, and where current law offers relatively few incentives for cost-conscious behavior.

For example, payment for post-acute care services is still based on cost reimbursement subject to limits, and does not incorporate utilization limits. Unlike hospitals, where there are well-established norms of professional practice, such standards do not exist in long-term care. Thus, utilization limits may be more necessary than in acute care.

These cost-based systems have had other outmoded policies such as the new provider exemptions from the cost limits for SNFs, rehabilitation, and long-term hospitals, and the favorable presumption provision that applied to SNFs, HHAs, and hospices. The favorable presumption was designed as a shorthand means of carrying out the limitation on liability protection that is afforded beneficiaries and providers under the law -- but it was a shortcut that went well beyond the intent of the limitation on liability protection. It forced us to automatically pay for non-covered care and we believe this was harmful to the best interests of Medicare program integrity.

The industry's interest in defining a subacute care benefit is another example of providers pursuing opportunities in less constrained areas of Medicare. Industry proponents have created a subacute care "market" financed primarily by Medicare. Providers market these services to patients who would traditionally have received an inpatient hospital stay, and are generally sicker than traditional SNF patients. The major providers of subacute care are hospital-based SNFs, which receive exemptions and exceptions from the payment limits to provide high level care to Medicare patients, although free-standing SNFs and long-term and rehabilitation hospitals are also providing subacute care.

There is scant information about the costs and potential public savings associated with subacute care other than industry estimates. In general, these industry studies significantly overestimate the potential for public savings associated with subacute care. Although a sub-acute benefit may have the potential to decrease hospital lengths of stay, Medicare could end up paying for care twice -- once for the initial hospitalization and again for the subacute care stay -- for patients who would have ordinarily remained in the hospital.

The current payment systems have created a climate that, if not actually encouraging abuse, does not do nearly enough to prevent abusive practices. Under current program policies, providers and suppliers' billing practices are fragmented and uncoordinated, resulting in inappropriate and excessive Medicare charges and payments. For example, a therapy provider may bill Medicare for therapy services provided to nursing home residents. Certain supplies can also be billed directly by a supplier. These policies also encourage abusive billing practices where Medicare is billed for services and supplies that residents do not receive or services that are not medically appropriate (e.g., do not improve patients' functioning). Further, these policies put beneficiaries at risk for Part B coinsurance for services that could have been furnished under Part A. In an effort to ensure quality oversight consistent with the OBRA-1987 reforms, we are seeking to change these policies. Our desire is to ensure that nursing homes coordinate the provision of, and consolidate the billing for, all services that are provided to residents.

But an important secondary effect of these changes would be to signal an intolerance of abusive practices.

Other Factors

I do not want to leave you with the impression that it was policy changes alone that created the explosive growth in post-acute utilization and expenditures. Changing demographics, medical advances, and increases in demand by beneficiaries and physicians have all contributed to this phenomenon. Medical advances, for example, have expanded the range of patients who can benefit from certain therapies, and have made it possible to provide interventions (such as intravenous drug therapy) in less intensive settings. Certainly, shifts in demographics have had an immense impact on the use of post-acute and long-term care services. For example, the over 85 age group is the most likely to use nursing home services, and this age cohort has more than doubled in 5 years. Studies also show that home health care is serving many more of the older elderly population who require longer term care. Physicians and beneficiaries are increasingly showing a preference for home health care over other modalities. Finally, there has been a growth in marketing efforts toward physicians by HHAs to stimulate demand.

HCFA Administrative Efforts to Stem the Growth of Inappropriate Utilization and Costs

HCFA has closely monitored the growth in utilization of the Medicare post acute care benefits. Much of the growth in utilization and expenditures has resulted from the industry responding to incentives created by the policy changes I've described. However, some of this growth has been the result of inappropriate utilization of the Medicare post-acute benefits. I want to reassure the Congress that we have intervened where possible to stem the growth of inappropriate utilization. The following are some of the efforts we have undertaken, or are undertaking, to address this concern.

Home Health Care

Three years ago, I launched the Medicare Home Health Initiative, an agency-wide, comprehensive assessment of the home benefit. The Initiative involved consultation with representatives from consumer groups, the home health industry, professional organizations, fiscal intermediaries, and State agencies. The Initiative has spawned various efforts to make a number of improvements to the benefit and, where possible, assert greater control over its utilization.

First, we are in the process of revising the home health Conditions of Participation (CoPs) in order to hold agencies accountable for better, more accurate patient assessment, care planning, coordination of service delivery, and quality assessment and performance improvement. We hope to publish a notice of the proposed changes to the CoPs shortly. We also recently overhauled our provider manual to provide better guidance to agencies on the complex home health eligibility and coverage rules; we would expect this greater clarification to reduce the amount of inappropriately furnished services that are billed to Medicare.

We have also worked to increase physician involvement in the monitoring of home care services. Physician involvement in care plan oversight is critical to ensure that the appropriate level of care is being provided. We need to avoid situations in which physician certification is merely a rubber stamp of a plan of care that has been completed by a home health agency. To achieve this goal, HCFA is now reimbursing physicians for care plan oversight, and we hope that recent increases to the reimbursement amount will further engage physicians in the careful planning of home care services. We are also engaged in a number of efforts to educate physicians about the home care benefit.

We're also better educating beneficiaries about the benefit in an effort to help them recognize instances of inappropriate care or fraud and abuse; we have published a new home health brochure and have produced a video to be shown in hospital and office settings. Beginning early next year, we will be sending an explanation of medical benefits statement to inform beneficiaries of the services being billed on their behalf so that they can detect any aberrancies. Finally, HCFA is testing the impact of increased sharing of information between State survey agencies and regional home health intermediaries on ensuring that HCFA pays only for services that meet home health coverage requirements.

The December 31, 1995 sunset of the so-called favorable presumption provision gives us an opportunity to reduce the number of inappropriate claims that had previously been automatically paid. We support continued limitation on liability protection for a provider where it can, on a post-denial basis, demonstrate that it and the beneficiary did not know, or could not have known, that the service furnished was not covered by Medicare. However, we believe that the limitation on liability protection should not be broadened once again to shield abusive billing practices.

We will continue our diligence in attempting to stem the tide of inappropriate home health utilization. As the General Accounting Office (GAO) noted in its March 1996 report on Medicare Home Health Growth (GAO/HEHS-96-16), HCFA is striving to

gain greater control over the use of the home health benefit. We appreciate the GAO recommendation that the Congress consider providing additional resources to HCFA so that controls against abuse of the home health benefit can be better enforced.

SNF Care

For SNFs, we have considered establishing, by regulation, guidelines for payment of therapy services. Medicare has long had guidelines limiting the reasonable cost of the physical and respiratory therapy services provided by outside suppliers for clinics, rehabilitation agencies, public health agencies, or other providers of services. Under these guidelines, the reasonable cost for such services cannot exceed an amount equivalent to the salary and other costs that would have been incurred in an employment relationship, plus an allowance for costs, such as travel, that an individual not working as an employee might incur. HCFA has been working to revise the existing salary equivalency guidelines for physical and respiratory therapy, and to develop such guidelines for occupational therapy and speech language pathology. The General Accounting Office has reported that these guidelines are necessary to prevent abusive billing practices. We hope to publish proposed salary equivalency guidelines soon.

We have also enlisted the aid of physicians in curtailing the inappropriate practice of targeting a facility's entire patient population for the indiscriminate provision of therapy assessments and treatments en masse, without regard to whether each individual within the group has an actual medical need for the services. We have encouraged physicians to resist pressure to order or approve any therapy services that are not, in fact, medically necessary to improve or maintain the individual resident's functional status.

We are also using the additional funding provided through our Operation Restore Trust demonstration to compare all bills submitted for nursing home residents and to identify services billed under both Part A and Part B.

Payment Reform Legislative Proposals

Of course, control of post-acute care expenditure growth cannot be fully realized without legislation, and both the Administration and the Congress have appropriately made payment reform to the SNF and HHA benefits a top priority in Medicare reform. I will describe our payment reform proposals and will then compare and contrast them with the proposals that appeared in the Conference Agreement, where appropriate. There are important areas of common agreement and areas where our policies diverge. But I believe that we have an opportunity to strike common ground on a number of

issues, and I assume that when the Administration and Congressional leaders get back to the budget negotiating table, the areas of common agreement will be critical to a successful budget compromise.

The Broader Context for Payment Reform: A Beneficiary-Centered Delivery System and, Perhaps, an Integrated Payment System

Before I delve into specific legislative proposals, I'd like to suggest that these proposals should be viewed as means to an end, not an end in themselves. Many argue that the post-acute care payment system of the future must be one that provides comparable incentives across delivery sites. While we should not stop our efforts to develop prospective payment systems for each of the post-acute providers, we should not be permanently wedded to separate payment systems for each of the self-contained benefits. Rather, we should strive to better understand the value of each post-acute care provider type and how to better manage and coordinate care across the health care continuum.

Further, I would suggest that payment reform should support an infrastructure of post-acute and long-term care delivery systems that is better integrated and more flexible in meeting the needs of those with chronic conditions and disabilities. That is, a guiding principle in any lasting reform of the Medicare post-acute care benefits should be to make the system of services "beneficiary-centered." To be beneficiary-centered, an integrated delivery system needs a reliable and predictable stream of financing. But, it also requires a system of maintaining information on clients that is consistent and available to all service providers. This kind of information is essential as we work to target funds and determine how we go about fairly and accurately assessing what kind of care someone needs. Beneficiary-centered services also rely on inter-disciplinary case management that involves formal and informal caregivers and supports and encourages, where appropriate, beneficiaries to direct their own care. Finally, a beneficiary-centered system needs relatively standardized service packages typically provided by various health care professionals.

There is considerable overlap in the types of services provided and the types of beneficiaries that are treated in each of the post-acute settings. These distinctions are becoming increasingly blurred with the advancing technology changes. For example, physical therapy and other rehabilitation services can be provided in each of the settings. A recent HCFA analysis shows that 53 percent of beneficiaries treated in the hospital for hip fracture use SNF services, 14 percent use home health services, and 14 percent use rehabilitation hospital services. Similarly, 25 percent of patients treated in the hospital for stroke use SNF services, 26 percent use home health services, and 16

percent use rehabilitation hospital services. While there may be some clinical differences in the patients who go to each of these settings and the outcomes as a result of care provided in each of these settings, it is also likely that patient and physician preferences influence which type of post-acute service is used.

Despite the considerable overlap, Medicare's payment and coverage rules vary by setting. While I don't wish to discount the importance of beneficiary preference in making these decisions, I would like to ensure that Medicare payment is not the primary reason for care setting decisions. Medicare payment methods and amounts for similar services provided in each of the post-acute settings differ. And more expensive stays do not always imply more services or better outcomes. For example, some provocative early research findings suggest that, for some conditions, outcomes may be no better for beneficiaries treated in one setting than another, even though Medicare payment may be substantially different.

I am hopeful that further research into the characteristics of patients that use care in each of the post-acute settings, and an analysis of outcomes, can provide information about the most appropriate setting for different types of patients.

As I've suggested, any effort to control the utilization of post-acute care services and ensure equity and appropriateness of payment must involve a mechanism to track outcomes and services that address patient care needs. Such a mechanism ideally begins with a valid and reliable assessment screening instrument that would provide a preliminary assessment of the patient's needs and the types of services that would best meet desired health outcomes at the lowest possible cost. This type of instrument could also be used to assess the individual's values and preferences for continuing care, so that if two or more types of care would typically provide the desired outcomes at comparable costs, the individual could choose the type of care he or she would receive under Medicare. Such an assessment instrument should also be made of up core data elements (e.g., functional status, available care supports, etc.) that would be relevant across the care continuum and that would support case mix payment systems.

As you may be aware, HCFA has been developing assessment instruments -- the Uniform Needs Assessment Instrument (UNAI), the long-term care facility minimum data set (MDS), and the Outcomes and Assessment Information Set (OASIS), which is a core standard assessment data set for home care. The next challenge is to identify common elements among the instruments to support an integrated payment system.

Additionally, HCFA is evaluating case-mix systems to support prospective payment reforms. The Multi-State Case-Mix and Quality demonstration for SNFs has used the

MDS to classify long-term care patients according to the intensity of resource use. Additionally, we are embarking on research toward the development of a case-mix classification system for HHAs which utilizes selected OASIS items. Other work is being conducted to evaluate the feasibility of such a system for rehabilitation hospitals.

Under a possible future payment scenario, we would want to provide payments sufficient to ensure that beneficiaries receive high quality care in the appropriate settings, and that any transfers among settings occur only when medically appropriate and not in an effort to generate additional revenues.

In an effort to make payment systems "site-neutral," we might also consider splitting apart payment of the "medical" services from the room and board services. That way, payment for the "medical" services can be the same for similar patients regardless of whether they are delivered in the home or in a nursing facility. This would help address problems related to the institutional bias (a complaint many beneficiary groups have made) as well as clarify the allocation of responsibilities between Medicare and Medicaid.

This discussion addressed our general direction regarding the future of post-acute care payments. The message I mean to convey is that we are thinking more broadly about an integrated reimbursement system for post-acute care services even as we focus our attention on the reform proposals that are currently on the table. In the meantime, we will continue to develop prospective payment systems for SNF and HHA providers that will carry us through the short-term.

The prospective payment systems for SNFs and HHAs form the heart of our payment reform proposals in the President's Medicare balanced budget package. The development of PPS systems for SNFs and HHAs is proceeding well, despite delays. The delays have been largely due to the complexity in developing case mix systems.

Status of PPS Demonstrations and Studies -- What We've Learned to Date

I will now discuss the progress so far that we have made in developing PPS systems for SNFs and HHAs, and the case mix adjustment measures we are developing.

Home Health

The National Home Health Agency Prospective Payment Demonstration is testing two alternative methods of prospective payment. Phase I of the demonstration tested a per-visit prospective payment. Phase II of the demonstration, which began in June

1995, is testing a per-episode prospective payment, and will last for 2 more years.

In Phase I, we tested a per-visit payment method that established a separate payment rate for each of six types of home health visits (i.e., skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, and medical social services). Although we found that agencies being reimbursed through prospective rates were more likely than other agencies to keep their cost increases below inflation, the differences were fairly small. The demonstration had no significant effect on the number of visits provided, quality of care, access to care, and other Medicare costs. Thus, we learned that a per visit payment methodology is not effective in controlling expenditure growth.

In Phase II, participating HHAs are receiving an agency-specific episode payment based on 120 days of care and outlier payments for episodes that extend beyond 120 days. Outlier visits are reimbursed at per-visit prospective rates. A new episode of care does not begin until there has been a gap in home health services for 45 or more days after the initial 120 days. Agencies receiving per-episode payments are subject to stop-loss and profit sharing provisions.

The episode rates are based on an agency's cost experience during a base year -- the year prior to the agency entering the demonstration. Thus, the per-episode rates used during the demonstration reflect an agency's case mix during the base year period. In recognition that an agency's case mix may change during the demonstration relative to the base year period, the demonstration includes a case-mix adjuster as one of its payment adjustments. If an agency serves patients requiring relatively few services during the base year period and then serves patients requiring more resources during a demonstration year, the per-episode payment rate may not be sufficient. The case-mix adjuster would adjust payments for differences in patient characteristics.

We do not yet have results from this phase of the demonstration. Thus, we do not yet know whether the definition of an episode chosen for the demonstration (120 days) is an appropriate definition for a national payment system. This is because 120 days captures only about 60 percent of all home health visits. If 120 days were to be used as an episode, that would mean that almost 40 percent of all home health visits would fall outside the episode as outliers.

SNFs

In July of 1995 we began our Multi-state Nursing Home Case Mix and Quality Demonstration. This three-year demonstration is testing a per diem prospective payment system and a quality monitoring system for SNFs. The payment system

utilizes resident assessment data (the MDS 2.0) applied to resource utilization groupings (RUGs III) to determine case mix adjusted payments. In the first year, only routine costs were paid prospectively. Recently, we have begun incorporating payment for therapy services furnished to Medicare beneficiaries into the prospective payment. Over 500 nursing homes are participating in the demonstration.

To date, the demonstration has provided valuable insight into the proper design of a PPS system for SNFs and informed us about how best to implement such a system. We're in the process of working out many of the operational issues to make a full scale implementation easier. We've also learned that subtleties in the elements that make up the case-mix adjustor can send strong signals to providers -- that making payment contingent on patients requiring services means that many more patients will receive those services. We've learned that it is appropriate to use the same assessment instrument for both Medicare and Medicaid. We've also learned that interrupted SNF stays may be more common than previously thought (for example, one-third of stroke patients are readmitted to the hospital under a different DRG); this greatly complicates the design of a per episode PPS.

Description of Administration's Proposals for Payment Reform

I will now outline the Administration's proposals for payment reform. The information we have gained from the demonstrations thus far laid the foundation for the payment proposals that were included in the FY 1997 Budget Proposal.

Home Health Payment Reform Proposals

We proposed a number of home health payment reforms designed to achieve needed cost control, improve financial management, and control fraud and abuse. The focus is our plan to transition into a per-episode PPS in 1999. There is broad agreement among industry representatives, and many members of Congress, that a per-episode payment system is the superior way to constrain costs without sacrificing access or quality. We have sketched out in our legislation some of the features that are desirable for such a system. For example, we would anticipate that all services currently covered and paid on a reasonable costs basis under the Medicare home health benefit, including medical supplies, would be covered under the payment. The per episode payment amount would be based on the most current audited cost report data available to the Secretary. We would employ an appropriate case mix adjuster that explains a significant amount of the variation in cost. The episode payment amount would be adjusted annually by the HHA market basket index. The labor portion of the episode amount would be adjusted for geographic differences in labor-related costs based on the most current

hospital wage index. The Secretary would have the authority to designate a payment provision for outliers, recognizing the need to adjust payments due to unusual variations in the type or amount of medically necessary care. Finally, if a beneficiary elects to transfer to, or receive services from, another HHA within an episode period, the episode payment would be pro-rated between the HHAs.

While we are quite convinced of the desirability of a PPS system for home health, there is still much work to be done before we can implement such a system -- namely, the development of a case-mix adjuster that can explain a significant amount of variation in costs and the development of an appropriate definition of an episode of care. Our legislation seeks authority to request data from HHAs to support these ongoing research and development efforts. While we continue to develop these essential features of an episodic PPS system, we propose to implement an interim payment system that would allow us to achieve some cost control. The Administration's interim payment system would rely on proven techniques of current law in an effort to achieve guaranteed, up-front savings without disrupting the industry with a host of new payment methods.

The interim system would superimpose a new cost limit onto the existing cost-based reimbursement scheme. This new cost limit would build on agencies' actual experience (in a base year) in resource use per beneficiary. It would give agencies the flexibility to provide the appropriate amount of care (duration of visits, number of visits, and skill level of caregiver) within this limit, and to share in savings if agency costs fall below this limit.

To be more specific, payment to an HHA would be the lesser of: (1) the agency's actual costs, or (2) a per visit cost limit set at 105 percent of the median national cost for free-standing HHAs, or (3) the new agency-specific per beneficiary annual limit. As soon as feasible, we would modify the agency-specific per beneficiary limit to reflect regional or national variations in utilization. This proposal can be implemented immediately, with few administrative changes at negligible cost, and allow for a sensible phase-in to a prospective payment system.

We also proposed to eliminate periodic interim payments (PIP) for home health agencies simultaneous with PPS implementation in 1999. PIP was established to encourage new providers to participate in Medicare by improving cash flow -- a set amount paid on a bi-weekly basis. With about 100 new HHAs joining Medicare each month, access to home health is no longer a problem. Further, the Office of the Inspector General has found that Medicare tends to overpay providers who receive PIP, and has validated our contention that it is sometimes difficult to recover these

overpayments. We also propose to base the visit payment limitation on the location where services are rendered, not where services are billed. Many HHAs are established with a home office in an urban area and branches in rural areas. When HHAs bill Medicare, the payment limitation is based on the higher wage rate for the urban area even though the service delivery occurred in a rural area.

In comparison, the Conference Agreement proposal called for the immediate implementation of a prospective payment system for home health. Agencies would be paid a per visit prospective rate subject to an annual dollar cap that would be calculated to approximate all covered service delivered to a beneficiary during a period of 120 days. However, the payment cap would be implemented such that HHAs would be paid for providing 165 days worth of services with 120 days worth of dollars. Agencies that keep total payments for the year below the annual cap would be allowed to retain 50 percent of the savings. Numerous outliers and extended care exceptions would be paid outside of the cap on a per visit rate.

The Administration opposes the Conference Agreement proposal for the following reasons. First, savings cannot be guaranteed since the proposal relies wholly on an untested, unreliable new payment methodology that uses an inappropriate case mix adjuster and would allow about 40 percent of visits -- outliers -- to be paid a prospective rate subject to no utilization control. To the extent that savings do not reach the savings target, the Republican failsafe hammer would have come down hard on agencies.

Second, we fear that the proposal to pay 165 days of service with 120 days worth of dollars creates an incentive for agencies to avoid caring for heavy care and long-term care patients and thus would hurt access to, and continuity of care for, the sickest patients with the greatest needs.

Third, the plan is built upon the false assumption that data and systems are in place to facilitate immediate implementation. In fact, we are certain that it would take 2-3 years to develop the systems and gather the data necessary to implement the payment scheme.

Fourth, the Conference Agreement prescribes "policing" of the industry by HCFA to ensure that agencies do not circumvent the system. This policing would be burdensome, add significant additional administrative expense to HCFA, and be very intrusive to the industry.

Finally, the Conference Agreement does not provide for an eventual transition to a

comprehensive PPS that covers all HHA visits.

We understand that the industry has put forth a new proposal that may have gained some attention by lawmakers. This proposal would impose two interim reimbursement systems upon the industry until an episodic PPS can be introduced. The second phase is similar to the Conference Agreement and the concerns we had about that proposal are transferable. The first phase would entail a per visit PPS with some apparently weak utilization controls. Frankly, we have to do some more study on this new variant, but we continue to believe that our proposal is superior to the other proposals.

I know you are aware of our proposal to shift financing of a portion of the home health benefit from Part A to Part B. Under our proposal, the first 100 home health visits following a three-day hospital stay would be reimbursed under Medicare Part A. All other visits, including those not following a hospitalization, would be reimbursed under Part B. Part B visits would not be subject to the Part B coinsurance or deductible. The transfer would not impact the Part B premium. The proposal would not alter general coverage or eligibility rules and thus would have no change on access to the benefit by beneficiaries.

Clearly, by capping Part A financing of the home health benefit, we would be saving the financially vulnerable HI Trust Fund about \$5 billion dollars over 7 years. This is an important motive, and I note that Republican members once intended to achieve the same goal with an almost identical policy. But there are other sound reasons for this policy and, to explain them, I need to put this proposal into some historical context.

As I've already discussed, the home health benefit, like the SNF benefit, was originally designed to provide short-term, recuperative, post-acute care services to beneficiaries after discharge from a hospital. The benefit was only available to those beneficiaries who were discharged from a hospital following a minimum 3-day stay. The benefit provided up to 200 home health visits during a calendar year. The first 100 visits were financed under Part A of Medicare. There was no beneficiary cost-sharing during these visits. If beneficiaries exhausted all of these Part A visits and carried Part B insurance, they were then eligible to receive additional visits financed under Part B, up to a maximum of 100 visits. For these visits, beneficiaries bore some of the costs through a \$60 deductible. (Until 1973, beneficiaries also paid coinsurance for Part B visits).

The limitation on Part A and B visits restricted access to the benefit such that some beneficiaries were forced to seek institutional care. For this reason, in OBRA-1980,

Congress removed the Part A and Part B visit limits and eliminated the hospital stay requirement. Home health thus became an unlimited benefit.

An unintended consequence of the OBRA-1980 change was to burden the Part A Trust Fund with approximately 99 percent of the financing for the home health benefit, regardless of whether visits are of a post-acute care or long-term care nature. The huge shift in financing to Part A clearly was not consistent with the original intent of Part A, which was designed to finance only acute and post-acute care services that centered around a hospitalization.

The President's proposal to move a portion of the financing of home health back to Part B restores the original Part A coverage of post-acute care services and allows Part B to finance all other home health services. It maintains Congressional intent for a home health benefit that is available to all beneficiaries regardless of their Part A and Part B coverage. And it maintains Congressional intent to have a home health benefit that does not require out-of-pocket expenses borne by beneficiaries. Finally, it will allow us to better focus coverage policies for the two groups of home health users -- post-hospital and chronic users.

Let me end the home health discussion with a note of agreement. Both the Congress and the Administration wisely proposed to permanently extend the savings from the OBRA-1993 freeze on home health cost limits by not allowing for the inflation that occurred during the freeze. In the absence of this legislation, spending reverts to pre-freeze levels. Also, both the Congress and the Administration agreed that the home health re-certification survey cycle should have been increased in order to allow the Secretary greater flexibility in targeting resources toward poor performing HHAs and to give relief to the current backlog of initial certification surveys. This change became law when Congress passed our FY 1996 appropriations and we thank you for the relief it provides.

SNF Payment Reform Proposals

Now let me turn to SNF payment reform. As with home health, both the Administration and the Congress agree that the savings of the OBRA-1993 cost limit freeze should be permanently extended.

With respect to SNF reimbursement reform, we are further along with our research and demonstration efforts on SNF PPS and thus could implement a system more quickly than in the case of home health. However, like home health, we have a two-stage proposal to allow us to transition to a fully prospective PPS for SNFs.

We have a multi-part proposal for our interim system. First, we would establish an interim prospective rate for routine costs. These rates would be based on facility-specific costs, subject to regional limits. The regional limits would be based on data from freestanding SNFs only. Under current law, hospital-based SNFs are allowed a higher cost limit to reflect the higher costs in these SNFs; however, research has not substantiated a difference in the characteristics of patients treated in hospital-based and free-standing SNFs.

Second, we propose to eliminate immediately the new provider exemptions and new exceptions to the cost limits. The 3-4 year cost limit exemption for new providers under current law allows SNFs to be reimbursed for inflated costs for several years. Meanwhile, the exceptions for atypical care or extraordinary circumstances effectively allow SNFs to fully bill Medicare for more costly sub-acute care services which Medicare reimbursement would not otherwise completely cover. Under our proposal, SNFs that had exceptions in the base year would be protected under a hold harmless provision.

Third, we would require SNFs to bill Medicare for all services their residents receive (except the services of physicians, certified nurse midwives, psychologists, hospice services, and nurse anesthetists), prohibiting payment to any entity other than the SNF for services or supplies furnished to Medicare-covered SNF patients. This consolidated billing proposal is offered, in part, in response to Inspector General reports that some Part B suppliers bill Medicare for supplies that were never delivered to nursing home residents. It would also reduce beneficiary Part B copayments for services covered under Part A. To ensure that Medicare doesn't overpay for these services, we would also establish limits on ancillary services based on amounts payable for similar services provided on a fee-for-service basis under Part B. In order to implement this, we would require SNFs to include HCFA Common Procedure Codes on their bills. This would also provide the data necessary to construct a SNF PPS rate that covers ancillary services.

As an additional control on ancillary expenditure growth, we also propose to update the therapy guidelines for physical (PT) and respiratory therapy (RT), and establish similar therapy guidelines for occupational (OT) and speech-language pathology. As part of their SNF care, Medicare beneficiaries are eligible for therapy services. While some SNFs employ their own therapists, many use contractors to provide these services. Salary equivalency guidelines determine the maximum Medicare payment for the service, based upon an estimate of the costs of providing the service via a salaried employee. We discussed this effort under our administrative efforts to control costs. Because of the resource-intensive process we must go through to accomplish this

administratively, we are also proposing legislation to accomplish this more quickly.

We are committed to implementing a full PPS beginning in FY 1998, and our proposed legislation reflects this commitment. The prospective rate would be designed to cover all three SNF cost categories -- routine, ancillary, and capital-related costs.

The Conference Agreement also proposes an interim and full prospective payment systems. The interim payment system remains cost-based. Routine costs would be subject to the current limits which are separately computed for hospital-based and freestanding SNFs. However, the definition of routine costs would be expanded to include additional services. Ancillary services would be subject to a per episode limits. Capital payments would be reduced by 15 percent.

One area of difference between the Congressional and Administration provisions is the unit of payment for the prospective payment systems. The Administration's plan does not specify whether PPS payments should be made on a per episode basis, as in the Republican plan, or on a per diem basis. We have decided not to specify a unit of payment until further research and demonstration results can shed light on the appropriateness of one or the other. We are concerned that the Conference Agreement provision is based on a system that has not been appropriately informed by research. HCFA has been testing a per diem prospective payment on a demonstration basis in six states, and states have been implementing per diem prospective payment systems for years. There is no comparable information for per episode payment system. Not only do we not have sufficient information to determine the appropriate level of payment, no research has been conducted on the effects of a per-episode payment system on patient outcomes, quality, or access to care.

The incentive under a per episode prospective payment system could be for facilities to discharge patients as quickly as possible as facilities receive the same payment irrespective of how many days the beneficiary remains in the SNF. Earlier discharge may result in poor quality care and increased overall program costs as beneficiaries still needing services may return to the hospital or initiate home health visits. Furthermore, in the absence of an accurate case mix adjuster (which currently does not exist to predict per-episode costs), SNPs would have an incentive to avoid more resource intensive patients and access to SNF care for the beneficiaries that need it the most would be reduced.

Another area of significant disagreement is the Conference Agreement's provision to place limits on ancillary (non-routine) payments. We are concerned that these limits could place patients at risk of inadequate services. Facilities would have the incentive

to ensure that the cost of services their patients receive do not exceed the limit, since they would receive no additional reimbursement for any additional services. The Administration's proposal would provide some controls on expenditures for ancillary services by requiring facilities to bill for the services its patients receive, establishing therapy guidelines, and limiting payment of other ancillary services to the Part B fee schedule, without placing beneficiaries at risk of inadequate services.

Finally, the Conference Agreement would also fail to eliminate the differential in payments between freestanding and hospital-based SNFs. Research has indicated no significant differences between patients in freestanding versus hospital-based SNFs and provided no justification for the payment differential. The Administration's plan recognizes that this distinction is no longer justified and would apply the same cost limits to hospital-based and freestanding SNFs.

Conclusion

There is widespread agreement that SNF and HHA expenditures are growing rapidly, that continued growth of this magnitude is unsustainable, and that legislative efforts are needed to slow down this growth. I have laid out for you today my vision for the future of post-acute care payment. Because we do not yet have all the tools to implement this vision, this Administration has put forth concrete proposals to modify payment policies for SNFs and HHAs, and I have described these for you today. There are significant differences between the payment proposals put forth by the Administration and by Congress. However, there are many commonalities. It is my hope that we can work together to develop payment policies that provide the right incentives -- incentives to provide quality care, promote access to care, and inhibit fraud and abuse. Thank you for the opportunity to testify today.