REPORT ON MEDICARE PAYMENT POLICIES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

FIRST SESSION

MARCH 2, 1999

Serial 106–15

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE
58–251 CC WASHINGTON : 1999

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REPORT ON MEDICARE PAYMENT POLICIES

TUESDAY, MARCH 2, 1999

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

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

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
February 23, 1999
No. HL–2

CONTACT: (202) 225–3943

Thomas Announces Hearing on Report on Medicare Payment Policies

Congressman Bill Thomas (R–CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on the Medicare Payment Advisory Commission's (MedPAC) recommendations on Medicare payment policies. The hearing will take place on Tuesday, March 2, 1999, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 1:00 p.m.

Oral testimony at this hearing will be from invited witnesses only. The sole invited witness will be the Honorable Gail R. Wilensky, Ph.D., Chair, Medicare Payment Advisory Commission. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Established by the Balanced Budget Act of 1997 (BBA) (P.L. 105–33), MedPAC advises Congress on Medicare payment policy. The Commission is required by law to submit annually by March 1, its advice and recommendations on Medicare payment policy in a report to the Congress. The BBA directs the Commission to review specific topics related to various aspects of the Medicare+Choice program, such as payment methodology, risk adjustment and risk selection, and quality assurance mechanisms. Additionally, the Commission is required to review payment policies under the Parts A and B fee-for-service system, particularly factors affecting program expenditures for hospitals, skilled nursing facilities, physicians and other sectors.

In announcing the hearing, Chairman Thomas stated: "The Committee continues to value MedPAC's technical advice as Congress restructures and strengthens the Medicare program for our nation's seniors. This hearing will offer the Committee an important opportunity to explore in-depth MedPAC's recommendations for improving Medicare payment policies in a variety of areas."

FOCUS OF THE HEARING:

The hearing will focus on MedPAC's March 1999 recommendations on Medicare payment policies as required by the BBA. Among the areas to be discussed will be the Medicare+Choice program and the fee-for-service components of the Medicare program.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit six (6) single-spaced copies of their statement, along with an IBM compatible 3.5-inch diskette in WordPerfect 5.1 format, with

their name, address, and hearing date noted on a label, by the close of business, Tuesday, March 16, 1999, to A.L. Singleton, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, by close of business the day before the hearing.

FORMATTING REQUIREMENTS:

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

1. All statements and any accompanying exhibits for printing must be submitted on an IBM compatible 3.5-inch diskette in WordPerfect 5.1 format, typed in single space and may not exceed a total of 10 pages including attachments. Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.

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

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

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

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

Note: All Committee advisories and news releases are available on the World Wide Web at 'HTTP://WWW.HOUSE.GOV/WAYS MEANS/'.

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

Chairman THOMAS. The Subcommittee will come to order.

Two years ago, Congress made unprecedented changes in the Medicare Program that were incorporated in the Balanced Budget Act of 1997. In strengthening Medicare for current beneficiaries and setting a direction for future generations, the Balanced Budget Act changes created the new Medicare+Choice Program that allows seniors to choose their health plans from a menu of private plan options. The Balanced Budget Act also continued the process of modernizing the fee-for-service Medicare from the sixties-style, cost-based reimbursement to prospective payment systems and simple fee schedules that are common practice in the private sector.

However, it is a far cry from Medicare's administered pricing systems to a market environment, in which competition drives the price of services. For a variety of reasons, Medicare must periodically adjust its payments rates and systems to reflect changing conditions. Up to 2 years ago, we had the occasion to host two commissions: the old Prospective Payment Assessment Commission, "ProPAC," and "PhysPRC," the Physician Payment Review Commission.

Just as the delivery of health care is being consolidated, we decided to consolidate our advisory structure. So, assisting Congress in monitoring the changes made in virtually every part of the Medicare Program, we created the Medicare Payment Advisory Commission, or "MedPAC."

MedPAC's mandated role is to provide technical advice to the Congress on all of the complex payment policies in the administered pricing system of Medicare. Congress also directed MedPAC to review, specifically, the implementation, design and development of the Medicare+Choice Program, since so much of that program was whole-cloth, or based on only a partial comfort level of information, since we had not had an adequate data collection structure in the past.

As the administration implements the BBA, the Balanced Budget Act, the Congress, and in particular, the Subcommittee is going to be looking to MedPAC for its technical advice and counsel. Contrary to our usual procedure, our only witness today is Dr. Gail Wilensky, the Chair of MedPAC, who will afford us the opportunity to explore a bit more in depth than we usually have the Commission's recommendations for fiscal year 2000 Medicare payments.

[The opening statement follows:]

Opening Statement of Hon. Bill Thomas, a Representative in Congress from the State of California

Two years ago, Congress made unprecedented, fundamental changes in the Medicare program by passing the Balanced Budget Act of 1997 (BBA). In strengthening Medicare for current beneficiaries and setting a direction for future generations, the BBA created the new Medicare+Choice program that awards our seniors the freedom to choose their health plans from a menu of private plan options.

The Balanced Budget Act also continued the process of modernizing the fee-for-service Medicare from 1960s-style cost-based reimbursement to prospective payment systems and simple fee schedules that are common practice in the private sector. However, it's a long journey from Medicare's administered pricing systems to a market environment in which competition drives the price of services. For a variety of reasons, Medicare must periodically adjust its payment rates and systems to reflect changing conditions that are not automatically addressed by the competitive market.

To assist Congress in monitoring the changes made in virtually every part of the Medicare program, the BBA created the Medicare Payment Advisory Commission, or MedPAC. MedPAC's mandated role is to provide technical advice to the Congress on the complex payment policies in Medicare's administered pricing systems. Congress also directed MedPAC to review specifically the implementation, design and development of the Medicare+Choice program.

As the Administration implements the BBA, the Congress, and in particular this Subcommittee, look to MedPAC for its technical advice and counsel. Our only witness today is Dr. Gail Wilensky, the Chair of MedPAC, which will afford us the opportunity to delve deeply into the Commission's recommendations for FY 2000 Medicare payments.

Chairman THOMAS. And with that, I recognize my friend and colleague from California, the Ranking Member, Mr. Stark.

Mr. STARK. Mr. Chairman, thank you very much. Let me first congratulate MedPAC for this year's report. It addresses many of the issues that face us in the Medicare Program and provides recommendations that Congress should consider in addressing those issues. I am particularly pleased that they recognize HCFA's resource problems. Published in the report as sort of a sidebar, is the letter published in the Journal of Health Affairs, written by Gail Wilensky and Joe Newhouse. The experts agree that we need to have additional resources to administer HCFA, and management of the plan should not be partisan. We may have partisan disagreements on what the plan should be, but once the plan is in place we should see that the government can operate as efficiently as possible to carry out our mandates. I hope we can work together as a Subcommittee to make a joint and bipartisan recommendation to the Budget Committee and the Appropriations Committee for HCFA to get the resources to carry out whatever mandate it is that Congress will give them.

We also have to find a way to make the funding a bit more stable. Perhaps through direct appropriations, the way we fund PROs or the Medical Integrity Program, would be a solution to end this annual hassle that we have to go through. I would be glad to work with the Chairman, in any way he would consider, if we could institutionalize the process in seeing that HCFA gets reasonable resources. I would like to ask that the text of the Wilensky letter be put in the record.

Chairman THOMAS. Without objection.

[The opening statement and attachment follows:]

Opening Statement of Hon. Fortney Pete Stark, a Representative in Congress from the State of California

Mr. Chairman, first, let me congratulate the Medicare Payment Assessment Commission for this year's report. It addresses many of the issues facing Medicare at this time, and it provides recommendations that the Congress should consider in addressing those issues.

I am particularly pleased that the Commission recognizes the need to address HCFA's resource problems, and has chosen to endorse and include in their Report an open letter published recently in the journal, *Health Affairs*. This letter was signed by a nonpartisan group of our Nation's leading health policy experts, including the Chair and Vice-Chair of MedPAC, Gail Wilensky and Joe Newhouse. These experts agree that HCFA must have additional resources if it is to administer the Medicare program in the way that we all agree that it should be administered.

Mr. Chairman, management of Medicare should not be a partisan issue—we all want HCFA to be well managed. As the Congress expands HCFA's responsibilities, HCFA's resources must also be increased. I hope that we can work together as a Subcommittee to make a joint, bipartisan recommendation to the Budget Committee and the Appropriations Committee for HCFA's resources for this year. We must also find a way to make HCFA's funding more stable, perhaps through a direct appropriations method similar to the way that we fund the Peer Review Organizations (PROs) and the Medicare Integrity Program (MIP).

Mr. Chairman, the Commission recommends against Congress modifying payment rates to Medicare+Choice plans at this time. In several ways, we are currently overpaying Medicare managed care plans, and I recently learned from the HCFA Administrator that, because of an error in calculating the 1997 base-year rates, the BBA actually increased payments to managed care plans, rather than reducing them.

Last year, the MedPAC Report described a technical "glitch" in the BBA in which the 1997 base year rates for calculating payments to Medicare+Choice plans are overstated by about 3 percent. CBO has estimated that the resulting overpayment to plans is $8.7 billion over 5 years and $31 billion over 10 years. I recently received a letter from the HCFA Administrator informing me that this overpayment is greater than the entire savings from managed care plans included in the BBA. The Administrator says, "the savings from the reductions (in the BBA), once fully implemented, do not even equal the increased costs due to the overstatement." Thus, the other savings in the BBA do not even correct for this mistake, let alone reduce the earlier, underlying overpayment to managed care plans. In fact, the BBA actually increased payments to managed care plans, rather than reducing them.

In addition, the HHS Inspector General reported last year that Medicare+Choice plans are paid some $1 billion annually in inappropriate payments based on their own inflated reporting to Medicare of their administrative costs. I note that the MedPAC report suggests that HCFA require separate reporting of administrative costs and profit projections, implying that these overpayments should be stopped.

I applaud the Commission for recommending that HCFA be permitted to proceed with its risk adjustment approach.. The managed care industry is saying that risk adjustment was meant to be budget neutral to the HMOs. That seems like nonsense to me; risk adjustment is meant to adjust for higher-cost or lower-cost beneficiaries throughout all of Medicare, and not just to shift money around among the HMOs. By phasing in risk adjustment, we are already giving the industry a $4.7 billion gift, and hurting the best HMOs, which would be helped by risk adjustment.

Mr. Chairman, if the Medicare+Choice program is to be effective, beneficiaries need to feel comfortable trying it out. The plan withdrawals last year legitimately scared many beneficiaries. It seems to me that there are beneficiary protections that can be added to ease some of their concerns, and I have introduced a bill (H.R.491) to address those issues.

The managed care industry has said that last year's withdrawals were just the tip of the iceberg, and that we should expect more plans to withdraw from Medicare this year. Last year, the decision for a plan to withdraw from Medicare was made easier by the fact that withdrawing plans would not face a five-year lock-out from future participation in Medicare. This year, that five-year lock out applies. I will be interested to hear what MedPAC expects to happen this year, both in plan withdrawals and in benefit reductions and premium increases.

On post-acute care, the Commission expresses concerns about the methodology that HCFA has used for the Skilled Nursing Facility (SNF) prospective payment system and is planning to use for rehabilitation facilities. The Commission prefers a discharged-based system rather than the per-diem system that HCFA is using. I, too, have expressed similar concerns, and I look forward to discussing this issue today.

This year, MedPAC goes even further than last year's report in recommending an "independent assessment of need for beneficiaries receiving extensive home health services to ensure the appropriateness of such care." I followed MedPAC's recommendations from last year and introduced legislation (H.R. 746) to establish such a system of home health case management. My bill would require long-term home health patients to have their home health care planned by an independent case manager, who would be paid by Medicare on a fee schedule, or HCFA would have the option of using competitive bidding in regions where enough competition existed to make that appropriate.

The Commission recommends that the Congress establish in law clear eligibility and coverage guidelines for home health services. We need the assistance of the Commission on this, and I also suggest that the Commission evaluate whether the home health benefit should be split into two parts, an acute care benefit and a long-term benefit, reflecting the two groupings of patients that use the program, with separate eligibility and coverage requirements.

The Commission recommends making Medicare payment methods and amounts for ambulatory services consistent across settings. I agree, and last year I introduced a bill to achieve exactly this objective. The Commission also recommends applying the physician Sustainable Growth Rate (SGR) across all ambulatory settings, and I would ask why not apply it to all of Medicare?

The Commission recommends two cost sharing issues—it recommends reducing copayments for hospital outpatient services and instituting a copayment for home health services. I agree with the recommendation to reduce cost sharing for hospital outpatient services, and I have introduced a bill (H.R. 421) to recoup for Medicare beneficiaries the savings that they lost this year when HCFA was unable to implement the BBA changes for those services. The Commission recommendations raise a larger question of whether it is time to think about restructuring all Medicare

deductibles and copayments—and Medigap insurance—so that they are more like cost sharing in managed care.

Finally, Mr. Chairman, I want to make a comment regarding conflicts of interest in accreditation organizations. The MedPAC Report cites a HCFA rule that eligible accreditation organizations for quality of care would need to operate nationwide and be free from control by the organizations that they accredit. The Report notes that this rule for managed care plans is inconsistent with Medicare accreditation rules for hospitals, and notes that this rule might create problems for NCQA, which has HMO members on its board.

It seems to me that the best way to make these Medicare rules consistent would be to apply the managed care rule throughout Medicare, to hospitals and other Medicare providers. We are constantly finding that JCAHO, which is heavily influenced by the hospitals that it regulates, is pulling punches and doing what the people who pay it want. Their quality of care work on nursing homes, for example, has been awful. I have introduced legislation calling for more public representatives on these accreditation boards. Medicare and the public are not well served and will never trust these groups until they are free of conflicts of interest.

OPEN LETTER TO CONGRESS & THE EXECUTIVE

CRISIS FACING HCFA & MILLIONS OF AMERICANS

The signatories to this statement believe that many of the difficulties that threaten to cripple the Health Care Financing Administration (HCFA) stem from an unwillingness of both Congress and the executive to provide the agency the resources and administrative flexibility necessary to carry out its mammoth assignment. This is not a partisan issue because both Democrats and Republicans are culpable for the failure to equip the HCFA with the human and financial resources it needs to address what threatens to become a management crisis for the agency and thus for millions of Americans who rely on it. This is also not an endorsement of the present or past administrative activities of the agency. Congress and the administration should insist on a HCFA that operates efficiently and in the public interest.

Over the last decade, Congress has directed the agency to implement, administer and regulate an increasing number of programs that derive from highly complex legislation. While vast new responsibilities have been added to its heavy workload, some of its most capable administrative talent has departed or retired; other employees have been reassigned as a consequence of reductions in force. At the same time, neither Democratic or Republican administrations have requested administrative budgets of a size that were in any way commensurate with the HCFA's growing challenge.

The latest report of the Medicare trustees points out that the HCFA's administrative expenses represented only one percent of the outlays of the Hospital Insurance Trust Fund and less than two percent of the Supplementary Medical Insurance Trust Fund. In part, this low percentage reflects the rapid growth of the denominator-Medicare expenditures. But, even accounting for Medicare's growth, no private health insurer, after subtracting its marketing costs and profit, would ever attempt to manage such large and complex insurance programs with so small an administrative budget. Without prompt attention to these issues, the HCFA will fall further behind in its implementation of the many significant reforms mandated by the Balance Budget Act of 1997. In the future, the agency also has to cope with a demographic revolution that it is ill-equipped to accommodate and with changes in medical technology that will increase fiscal pressures on the programs it administers.

As the Bipartisan Commission on the Future of Medicare grapples with the problem of reshaping the Medicare program for the next millennium, it would do well to consider two important reforms concerning the HCFA's administration. First, the Commission should recommend that Congress and the executive endow the agency with an administrative capacity that is similar to that found in the private sector. Second, the Commission should consider ways in which the micro-management of the agency by Congress and the Office of Management and Budget could be reduced. Congress and the public would be better served by measuring the agency's efficiency in terms of its administrative outcomes (such as accuracy and speed of reimbursement of various providers), rather than by tightly controlling its administrative processes. Only if the HCFA has more administrative resources and greater management flexibility will it be able to cope with the challenges that lie ahead of it.

The mismatch between the agency's administrative capacity and its political mandate has grown enormously over the 1990s. As the number of beneficiaries, claims,

participating provider organizations, quality and utilization review and oversight responsibilities have increased geometrically, the HCFA has been downsized. When the HCFA was created in 1977, Medicare spending totaled $21.5 billion, the number of beneficiaries served was 26 million, and the agency had a staff of about 4,000 full-time equivalent workers. By 1997, Medicare spending had increased almost tenfold to $207 billion, the number of beneficiaries served had grown to 39 million, but the agency's work force was actually smaller than it had been two decades earlier. The sheer technical complexity of its new policy directives is mind-boggling and requires the addition of a new generation of employees with the requisite skills.

HCFA's ability to provide assistance to beneficiaries, monitor the quality of provider services, and protect against fraud and abuse has been increasingly compromised by the failure to provide the agency with adequate administrative resources. Even with the addition of $154 million to its administrative budget that Congress included in its latest budget bill, the likelihood that the HCFA can effectively implement all of its varied assignments is remote. The Health Insurance Portability and Accountability Act of 1996 assigns many new regulatory responsibilities to HCFA but a far larger task is implementing the Balanced Budget Act (BBA) of 1997. The BBA has more than 300 provisions affecting HCFA programs, including the "Medicare+Choice" option, which will require complex institutional changes and ambitious efforts to educate beneficiaries.

Medicare spending accounts for over 11 percent of the U.S. budget. Workable, effective administration has to be a primary consideration in any restructuring proposal. Whether Medicare reform centers on improving the current system, designing a system that relies on market forces to promote efficiency through competition, or moving toward an even more individualized approach to paying for health insurance, Congress and the administration must re-examine the organization, funding, management and oversight of the Medicare program. Doing anything less is shortchanging the public and leaving the HCFA in a state of disrepair.

Stuart M. Butler, Heritage Foundation
Patricia M. Danzon, University of Pennsylvania
Bill Gradison, Health Insurance Association of America
Robert Helms, American Enterprise Institute
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William L. Roper, University of North Carolina at Chapel Hill
John Rother, AARP
Leonard D. Schaeffer, WellPoint Health Networks, Inc.
Gail R. Wilensky, Project Hope

Mr. STARK. I yield back. Thank you, Mr. Chairman.
Chairman THOMAS. I thank the gentleman.
[The opening statement of Mr. Ramstad follows:]

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

Mr. Chairman, thank you for calling this important hearing to review MedPAC's March 1999 Report on Medicare Payment Policies.

The opening of MedPAC's report says that "Medicare's payment policies should ensure that beneficiaries have access to medically necessary care of reasonable quality in the most appropriate setting. At the same time, the program should not spend more than is required to achieve that goal."

I couldn't agree more with this statement. But as easy as this is to say, it is much more difficult to explain and ensure. So many variables are subjective and open to interpretation by beneficiaries, doctors, nurses, hospital administrators, health plans, the Health Care Financing Administration (HCFA), the General Accounting Office (GAO), MedPAC and members of Congress.

As a new member of the Health Subcommittee, I am amazed at how many different interest groups and lobbyists are presenting me with so many explanations of what is 'medically necessary' for Medicare beneficiaries, what constitutes reasonable quality and what are the appropriate settings for providing certain treatments

or performing certain procedures. Even more so, I am hearing from everyone about "adequate reimbursement levels" and why all of them should be raised.

As Chairman Thomas has stated, MedPAC's technical advice to Congress is very important as we try to decipher all the information given us from providers and beneficiaries, especially as we and the National Bipartisan Commission on Medicare try to find ways to preserve, protect and strengthen this vital program for current and future beneficiaries.

Thank you again, Mr. Chairman, for calling this important hearing. I look forward to hearing MedPAC's recommendations for us from today's witness.

Chairman THOMAS. Now I would tell the Chairperson of MedPAC that any written testimony that she has will be made part of the record, and she can inform the Subcommittee in any manner she sees fit in the time allotted to her to begin the process.

STATEMENT OF HON. GAIL R. WILENSKY, PH.D., CHAIR, MEDICARE PAYMENT ADVISORY COMMISSION; ACCOMPANIED BY MURRAY N. ROSS, EXECUTIVE DIRECTOR, MEDICARE PAYMENT ADVISORY COMMISSION

Ms. WILENSKY. Thank you.

Chairman THOMAS. Welcome.

Ms. WILENSKY. Thank you. Good afternoon, Chairman Thomas and Members of the Subcommittee. I am here to share with you some of the recommendations that we have made from MedPAC to the Congress regarding payment policy. As you know, we will be submitting another report in June, where we take on some of the broader issues involved in Medicare.

As you are aware, the number of recommendations and the detail in the report is far greater than I can summarize during my few minutes allotted to me. So, what I thought I would do, instead, is to try to provide an overview of the areas in which we support either the BBA's specifications, and/or the specific activities HCFA has done thus far, and also indicate some of the areas where we have some concerns about something that is in the Balanced Budget Act, or something that is part of HCFA's regulations, to date.

With regard to the areas in which we have general agreement, they relate to payment in inpatient hospitals, both for capital and operating expenses. We think the amounts that were provided as part of the Balanced Budget Act are adequate and within the range of what we recommended separately. We do, however, have some concerns about further freezes, which are in effect further reductions, for hospital inpatient services, because the data that we have are sufficiently out of date. We are not able to really see the effect of the Balanced Budget Act on hospitals, to date. Therefore, to do further reductions would seem to be too risky, at this point.

Similarly, we recommend staying with the payment structure for Medicare+Choice, but we do think it is very important to monitor what happens with the plans in this next year. We are concerned about the withdrawals. We think it is important for HCFA to try to find ways to work with the plans to lower some of the costs of compliance, and to find ways to provide them with a little more flexibility than they have in the past, such as varying the benefit package. We strongly support the risk adjustment mechanism that HCFA has proposed. We think the phase-in is a good idea. Back

loading the effect is a good idea, and bringing in full-encounter data as soon as possible is a good idea. We generally support the PPS that has been proposed for the nursing homes by HCFA.

Let me indicate some areas, however, where we have some concern with either what is in the statute or the direction that we see HCFA going. Let me start with an area that goes to a general principle and that is the ambulatory care bundling that is in the HCFA outpatient PPS. We have been concerned and raised this in our last year's testimony that, whenever possible, it is desirable to have payment either the same or similar for services that occur across different settings. What we are concerned about in terms of the outpatient PPS is that payments in the outpatient will be bundled, but payments to the physician's office are typically disaggregated. That is not a good incentive system to put in place.

We are recommending that the unit of payment would better be the individual service with the ancillary services that are tied directly to that individual service, and not with the bigger aggregates that are not part of the outpatient PPS. There is concern both about the fact that you will overpay and underpay with some of the bundles that have been suggested. And the fact that you will have very different payments if the service is provided in the physician's office, as opposed to being provided in outpatient, is not a good set of incentives to have in place.

We also think that there are some changes that would be desirable with the SGR, the way we try to monitor spending in terms of softening some of the changes, and also reflecting changes in the traditional fee-for-service characteristics of the populations that are left. I see I have very little time left.

Chairman THOMAS. I'll tell the Chairwoman that she can partially ignore the light.

Ms. WILENSKY. Thank you. I will try to be sparing with my comments. With regard to postacute, we have recommendations for home care, a few recommendations for the skilled nursing facilities and some recommendations with regard to the PPS-exempt facilities. Let me try to summarize them.

With regard to home care, we think it would be very useful for the Congress to help clarify the eligibility and coverage rules. This has been an area that has caused a lot of consternation in the past, and typically has resulted in judicial decisionmaking. We think it would be better if Congress could provide clearer rules with regard to eligibility.

Second, as we indicated last year, we think it is appropriate to have a modest copayment, subject to a limit with regard to the amounts that an individual has spent for home care. We have talked about, in terms of the magnitude of the copayment, something in the neighborhood of $5, with an annual limit of about $300. We have, furthermore, suggested that there be an independent assessment of the individual's further need for home care, about the point that we would top out with regard to the copayments. In the examples that we had discussed in the Commission meeting, which was $5 a visit, we would hit the $300 limit, which was about the amount we were thinking about, at 60 visits. About at 60 visits, we would have someone come in to provide an independent assessment, both to make sure that seniors got the care

that they needed and to reduce some of the pressure that we have heard has been put on practicing physicians to continue to OK home visits out into the future.

With regard to the skilled nursing facilities, in general the resource utilization groups, or so-called RUGs, have seemed to be adequate with regard to patient classification. Concern has been raised for the so-called high acuity definitions: those cases where there are very sick patients who need ancillary services that had been previously been provided outside of the per-diem rate. There is concern that these high acuity cases are not being adequately compensated for under the existing RUG, or resource utilization group, classification system.

With regard to the rehabilitation, we believe it is desirable to move to a discharge-based rehabilitation unit. Unfortunately, it is not, we believe, possible to use the same classification systems as the resource utilization group, because it does not appear to provide as good an explanation of the variance in expenditures as an alternative. In fact, we believe that HCFA should try, on a demonstration basis, to use the suggested classification system for rehabilitation hospitals when providing rehabilitation services in a skilled nursing facility. This is consistent with the principle that we have tried to articulate where we would like to have the payment for the services the same, irrespective of where the service is provided. This would be a demonstration that would be worthwhile with regard to the rehabilitation services that are available in some skilled nursing facilities.

Finally, with regard to both the PPS-exempt services and dialysis, we think small increases in payments are needed relative to the amounts in the Balanced Budget Act. With regard to the PPS-exempt, we have recommended a four-tenths increase in per-case reimbursement, with an adjustment made for local input on the cap. With regard to dialysis, we are recommending a small increase in the composite rate in the neighborhood of 2.4 to 2.9 percent. We are concerned that the fixed rate that has occurred over so many years is beginning to have a deleterious effect on quality and, therefore, are making this increase in payment.

That summarizes the recommendations. Again, the philosophical position has been that wherever possible, we think payment should be the same or similar for services that are provided in different settings. This is particularly true of services in postacute, where a similar service may be provided in rehabilitation, or the skilled nursing facility, or in home care. It is also true in the ambulatory setting, where the same service may now be, or will be in the future, provided in an outpatient and ambulatory surgery center or in the physician's office. Wherever possible, we think those payments should be similar or consistent. Thank you for your time and I would be glad to answer any more questions.

[The prepared statement follows:]

Statement of Hon. Gail R. Wilensky, Ph.D., Chair, Medicare Payment Advisory Commission

Good morning Chairman Thomas, and members of the Subcommittee. I am Gail Wilensky, Chair of the Medicare Payment Advisory Commission (MedPAC). I am pleased to be here this morning to discuss MedPAC's second annual report to the Congress on Medicare Payment Policy. This report contains the Commission's recommendations on Medicare payment policy issues for fiscal year 2000. We will de-

liver another report in June that addresses other Medicare policy issues. These reports fulfill the legislative mandate we were given in the Balanced Budget Act (BBA) of 1997 to consider, develop, review, and advise the Congress on improvements to the program.

The Commission's recommendations represent the collective judgement of MedPAC's 15 commissioners, based on qualitative and quantitative analyses of the relevant issues, discussion of the findings and implications, and deliberations as to the appropriate policy responses. All of the recommendations were discussed at meetings open to the general public.

CONTEXT FOR THE RECOMMENDATIONS

The Balanced Budget Act (BBA) of 1997 made wide-reaching changes to the Medicare program. The BBA established the Medicare+Choice program, which will allow new types of private health plans to offer new options for Medicare beneficiaries. It modified payment updates and mechanisms for Medicare+Choice plans, hospitals, and physicians, with the intent of slowing the rate of growth of Medicare spending and making payments more equitable among providers and across geographic areas. The BBA also directed the Health Care Financing Administration (HCFA) to establish new prospective payment systems for skilled nursing facilities, hospital outpatient departments, rehabilitation hospitals, and home health agencies.

Broadly speaking, the Commission's recommendations address four topics: adequacy of payment updates, equity of payments, technical and regulatory components of new payment mechanisms, and other issues related to payment concerning coverage and beneficiary cost-sharing.

For certain services whose payment updates are set in law—such as those provided by Medicare+Choice plans, inpatient hospitals under the prospective payment system, and physicians—MedPAC's recommendations address whether the statutory updates are appropriate. In general, the Commission finds the updates to be appropriate and does not recommend changes to the law. In the case of payment for physicians' services, however, the Commission recommends changing the sustainable growth rate mechanism to accommodate changes in the characteristics of beneficiaries enrolled in traditional Medicare, such as their distribution across age groups, and changes in medical technology. The Commission also recommends making technical changes to the mechanism to avoid large swings in payment updates.

MedPAC addresses issues of payment equity in a number of ways. The Commission supports the introduction of a new risk adjustment system for Medicare+Choice plans. We recommend a new method of making payments to hospitals that treat a disproportionate share of low-income beneficiaries. We also recommend changing payment methods for hospital outpatient and physicians' services to account for cost differences that are due to variations in the health status among patients.

For services that the BBA directed to be paid under new payment systems, MedPAC's recommendations are addressed to the Secretary of Health and Human Services (the Secretary) and to the Congress, as appropriate, given the stage of development of the new system. We recommend technical changes in regulations that would make payments more equitable within provider groups and more consistent across types of providers. For example, the Commission supports the Secretary's efforts to develop a case-mix system for skilled nursing facilities that better accounts for use of services other than rehabilitation therapy. The Commission also supports developing a common unit of payment—a facility discharge where possible—across providers of post-acute care.

With respect to other issues, MedPAC's key recommendations concern services provided in outpatient hospital departments and by home health agencies. For the former, MedPAC recommends accelerating the so-called coinsurance buydown provided for in the BBA. For the latter, we recommend clarifying eligibility guidelines for receiving home health services and instituting modest cost-sharing.

SUMMARY OF KEY RECOMMENDATIONS

MedPAC's recommendations are based on the principle that Medicare's payment policies should ensure that beneficiaries have access to medically necessary care in an appropriate setting. At the same time, the program should not spend more than is required to achieve that goal. This principle implies that payment rates must be consistent with the costs of efficiently providing the necessary level of care, offering fair payment to providers while not interfering with clinical decisions as to the amount of care or the setting in which it is provided.

The Commission's recommendations address the following areas:

- the Medicare+Choice program;
- the acute care hospital inpatient prospective payment system;

- payments for facilities exempt from the acute care prospective payment system;
- developing new payment systems for post-acute care providers;
- modifying payment for services provided in ambulatory care facilities;
- continuing reform of the Medicare Fee Schedule for physicians; and
- the composite rate for outpatient dialysis services.

The Medicare+Choice program

One of the major initiatives of the BBA was to make a wider variety of private health care coverage options available to Medicare beneficiaries by expanding the previous risk contracting program into Medicare+Choice. However, changes in how payment rates are determined, the establishment of new regulations in implementing the program, and concurrent trends in the health insurance environment appear to have contributed to few new options becoming available and, in fact, fewer Medicare risk plans participating.

It is too soon to tell whether the recent departures from Medicare stem from systematic problems with the level or distribution of payment, but we plan to monitor this situation further in the next year. In the meantime, however, HCFA should continue to work with the relevant parties to identify changes in specific regulations or other policies that would reduce the burden of compliance without compromising the objectives of the program. Two such changes include moving the deadline by which Medicare+Choice organizations must file their premium and benefit proposals and allowing them to vary their benefit packages by county within their service areas.

The Commission supports the Secretary's plan to phase in, beginning in 2000, HCFA's interim risk adjustment mechanism for Medicare+Choice payments. In this mechanism, differences in expected costliness among enrollees will be based on health status, as measured by diagnoses from hospital stays in the previous year, prior entitlement to Medicare benefits based on disability and eligibility for Medicaid benefits during the previous year. As quickly as feasible, however, the risk adjustment mechanism should be refined to incorporate diagnosis data from all sites of care. These changes should improve the correlation between payments to Medicare+Choice organizations and the costliness of their enrollees.

The acute care hospital inpatient prospective payment system

Although the annual updates to the operating payment rate under the Medicare hospital inpatient prospective payment system (PPS) are already set in law, MedPAC each year provides guidance to the Congress on the appropriate update for the upcoming fiscal year. Based on our ongoing analyses of the factors that determine year-to-year changes in hospital costs, we believe that the operating update for fiscal year 2000 that was enacted in the BBA—1.8 percentage points less than the increase in HCFA's hospital operating market basket index—will provide reasonable payment rates. If the current market basket forecast holds, the update would be 0.7 percent.

The PPS capital payment rate update is set by the Secretary each year. The Commission's recommendation on the PPS capital update for fiscal year 2000 is a range between 3.0 percentage points and 0.1 percentage points below the increase in HCFA's hospital capital market basket index. Under the current market basket forecast, an update of between −1.1 percent and 1.8 percent would be adequate.

These recommendations are made in the context of evidence that the hospital industry has thus far successfully adapted to a more competitive market by changing its practice patterns and reducing its costs, but also out of concern that many of the major effects of the BBA are not yet fully evident. Therefore, reducing payment rates below the level prescribed in the BBA would not be prudent, at least for this year.

MedPAC is also recommending a revision in the method of providing extra payments to hospitals that care for a disproportionate share of low-income patients. These disproportionate share payments are made through a complex formula that determines a percentage add-on to each hospital's PPS payments based on its location, size, certain other characteristics, and a measure of care to low-income people. The measure of care to low-income people, however, excludes uncompensated care and local indigent care programs, which represent a large share of the burden faced by many hospitals that treat low-income patients. Moreover, under the current formula, rural and small urban hospitals that treat a disproportionate share of low-income patients receive a much smaller adjustment (if any) than large urban hospitals with the same share. Our recommendations are intended to eliminate these flaws.

Payments for facilities exempt from the acute care prospective payment system

Certain types of hospitals and distinct part units of hospitals are exempt from the acute care PPS. These so-called PPS-exempt facilities are a diverse group that share a common Medicare payment method established by the Tax Equity and Fiscal Responsibility Act of 1982. They include rehabilitation, long-term, psychiatric, children's, and cancer hospitals, and rehabilitation and psychiatric units in acute care hospitals. Each of these facilities is paid an amount based on its own costs in the payment year relative to a per-case target that depends on its costs in a base year, updated to the payment year.

MedPAC's analysis of the factors that determine year-to-year cost increases for PPS-exempt facilities indicates that the update factor applied to the per-case targets in fiscal year 2000 should be increased by 0.4 percentage points more than in the formula prescribed in the BBA. The BBA also established a category-specific cap on the per-case targets for rehabilitation and psychiatric facilities and long-term hospitals but did not provide that these nationwide caps be adjusted for differences in input prices across areas. We recommend correcting that technical oversight.

The BBA required that Medicare implement a new payment system for rehabilitation facilities, and that the Secretary develop a proposal for long-term hospitals. It did not mention psychiatric facilities, however. MedPAC encourages additional research in case-mix classification for payments to psychiatric facilities, with an eye toward developing a PPS for them in the future.

Developing new payment systems for post-acute care providers

The BBA mandated substantial changes in Medicare payment policy for providers of post-acute care. In addition to the work on new payment systems for rehabilitation facilities and long-term hospitals discussed above, a PPS for skilled nursing facilities (SNFs) was implemented in July 1998 and an interim payment system for home health agencies was put in place in October 1997 until a PPS can be developed. To guide the development of consistent payment policies across post-acute care settings, MedPAC recommends that common data elements be collected to help identify and quantify the overlap of patients treated and services provided. Further, it is important to put in place quality monitoring systems in each setting to ensure that adequate care is provided in the appropriate site. We also support research and demonstrations to assess the potential of alternative classification systems for use across settings to make payments for like services more comparable.

The Commission has several recommendations intended to improve the PPS for skilled nursing facilities. More work is needed to refine the classification system used in the PPS for skilled nursing facilities, particularly in its ability to predict the costs of nontherapy ancillary services. Alternative ways of grouping rehabilitation services provided in SNFs may also be called for to reduce reliance on measurements of rehabilitation time. A method for updating the relative weights that determine how much facilities are paid for each type of patient is crucial as the system and the types of services that are provided change over time. In general, as better data become available with the new system, distortions in the base payment rates due to imperfections in the initial data and measures used should be detected and corrected. To avoid future problems, facilities must be accountable for accurately assessing patients' needs and reporting the data used to determine payment for each case. Finally, payments should be adjusted for geographic differences in labor prices using wage data from SNFs, rather than hospitals, to make them more equitable among providers.

As systems for rehabilitation facilities and long-term hospitals are developed, a number of crucial decisions must be made. Among them is the unit of payment. MedPAC recommends that a per-discharge mechanism be adopted for rehabilitation services. A system currently exists that could serve as a basis for such an approach, perhaps with some modifications. We also recommend that, in choosing a patient classification methodology for a long-term hospital PPS, HCFA consider not only per diem but also existing and potential per-discharge approaches.

The interim payment system for home health agencies that was created in the BBA was the subject of a great deal of controversy in the year following its enactment. This controversy stemmed, in part, from the use of payment policy as a vehicle for curbing the rapidly rising cost of a benefit that was poorly defined. Although the debate appears to have subsided at least temporarily with recent changes in the system, MedPAC believes that more fundamental changes are necessary even as a new payment system is being developed. We urge the Congress, in consultation with the Secretary, to enact clearer eligibility and coverage guidelines for Medicare home health services. To understand better the content of home health visits, agencies' bills should describe the specific services provided. Moreover, we recommend that

an independent assessment of need be conducted for Medicare beneficiaries who receive extensive home health care to ensure that care is appropriately coordinated and suits the needs of the patient. Finally, modest beneficiary cost-sharing should be introduced for home health services; copayments should be subject to an annual limit, and low-income beneficiaries should be exempt from this requirement.

Modifying payment for services provided in ambulatory care facilities

Spending for facility-based ambulatory care services has grown substantially since the early 1980s, in part because a combination of financial incentives and technological advances encouraged shifting of services that once were provided exclusively in the inpatient setting to hospital outpatient departments (OPDs), ambulatory surgical centers (ASCs), and physicians' offices. Medicare pays for many of these services differently according to where they are provided. MedPAC offers several recommendations on making payments more equitable across settings and services.

The Commission makes several recommendations that apply to payment for ambulatory care in general. Consistent with the way that Medicare pays for physicians' services, the unit of payment should be the individual service—that is, the primary service and the ancillary supplies and services integral to it—rather than a larger bundle of services. Accordingly, the relative cost of the individual service should determine payment, rather than costs for groups of services taken together. In setting payment rates, the pattern of services and costs across ambulatory settings should be taken into account. Moreover, a single update mechanism, linking updates to spending growth across all ambulatory care settings, should be applied to the payment rates for each type of provider.

As required by the BBA, HCFA has proposed a new payment system for hospital outpatient services and major modifications to the payment system for ambulatory surgical centers. MedPAC recommends these changes be closely monitored to ensure that beneficiary access to appropriate care is not compromised in the face of substantial reductions in payments to hospital OPDs. In addition, payments should reflect the higher costs of treating certain types of patients. In the absence of adequate patient-level indicators, facility-level adjustments may be required for the time being. We are also concerned that loosening guidelines for determining whether a procedure is eligible for coverage in an ASC may lead to inappropriate changes in the pattern of service provision across ambulatory settings.

Although the BBA provided for a gradual reduction in the amount of beneficiary coinsurance for services provided in hospital outpatient departments, it will be years before that amount is reduced to a level comparable with that for similar Medicare-covered services furnished in ASCs or physicians' offices. MedPAC recommends accelerating the reduction in the outpatient coinsurance, with increased program spending being used to avoid further reductions in hospital payments.

Continuing reform of the Medicare Fee Schedule for physicians

The BBA mandated a number of changes in the Medicare Fee Schedule for physicians. To update payment rates for physicians' services, a sustainable growth rate system was established to replace volume performance standards. To make the fee schedule fully resource-based, HCFA recently began a phase-in of a new resource-based methodology for the practice expense component (which it intends to refine as it is used) and is developing revisions to the professional liability component.

MedPAC recommends several modifications to the sustainable growth rate (SGR) system. These include revising the SGR to account for changes in the composition of Medicare fee-for-service enrollment, cost increases that reflect desirable improvements in medical capabilities and technology, and inaccuracies in the forecasts used in estimating the SGR each year. We also call for technical changes that would make the timing of SGR components more consistent, and the earlier availability of estimated updates for each upcoming year.

With respect to practice expense payments, MedPAC agrees that, for some services, it is appropriate to pay a lower practice expense amount when physicians perform the service in facility-based settings outside the office. MedPAC recommends, however, that a service-by-service approach be used to decide which services are subject to this site-of-service differential, rather than applying the same decision to entire groups of services. Payments for services generally recognized as inappropriate to perform in a physician's office should also be reduced by the site-of-service differential. In developing further refinements to the practice expense component of the fee schedule, participants with a wide variety of relevant expertise should be included in the process.

To make the professional liability component of the fee schedule resource-based, payments should reflect the risk of a professional liability claim in providing each service.

The composite rate for outpatient dialysis services

MedPAC is required to recommend an appropriate update to the composite rate for outpatient dialysis services each year. The dialysis industry has been profitable and firms continue to enter the market despite the lack of a significant update in the composite rate since it was established in 1983. The Commission's analysis indicates, however, that costs have been approaching payments in recent years. We are concerned that further increases in dialysis costs relative to the payment rate may cause quality to deteriorate and, therefore, recommend an update of 2.4 percent to 2.9 percent. We also urge that the increasing emphasis on the quality of care received by dialysis patients continue, and efforts to collect and evaluate information on patient care and treatment patterns proceed.

CONCLUSION

In just over a decade, the first members of the so-called baby-boom generation will become eligible for Medicare. Policymakers have appropriately focused significant attention on how to address Medicare's future fiscal pressures. But Medicare also faces challenges in the short run as HCFA continues to implement the BBA, as developments unfold in the market for health care, and as new technologies and treatments emerge.

These short run challenges are inevitable because Medicare is an extraordinarily complex program. The program has 40 million beneficiaries, and it makes payments to hundreds of thousands of providers who deliver tens of thousands of different kinds of health care services and supplies. Therefore, the program's payment policies must continue evolving to ensure that Medicare's aged and disabled beneficiaries have access to high quality, medically necessary care across the country.

To assist the Congress and HCFA in meeting this objective, MedPAC will continue to monitor Medicare beneficiaries' access to health care and will examine what can be done to improve quality not only in Medicare+Choice, but also in the traditional fee-for-service program. The Commission will track developments as the Medicare+Choice program matures, looking at the availability of plans, the impact of risk adjustment, and other payment policies. MedPAC will continue to analyze fee-for-service payment policies in a broad context that takes into account that health care services can increasingly be provided in different settings. This work will look not only at what constitutes an appropriate unit of payment, but how payments are currently updated using quite different methods. Finally, the Commission will continue to study the delivery of services in the broader health care market to determine whether strategies that have evolved in private markets can be used to improve Medicare policy.

Chairman THOMAS. Thank you, Doctor. I do want to say that I want to ask you some questions in a general sense, in relation to the larger Medicare question and the future of Medicare. I do not want to detract from the initial questioning that the Members may have focused on this particular report, so I will save those for the second round.

In a general sense, one of the things that has been focused on is what I guess we would call"flat growth," or relative "no growth," in the Medicare payment structure. It is just a couple of months old, but if you start extrapolating that out, the world looks different. Do you have any general statement you might want to make about this recent phenomenon? Do you think it is going to continue? Do we have an explanation for it? Was it really anticipated?

Ms. WILENSKY. The answers, in summary and then I will elaborate in a moment are, no, we did not anticipate that. No, I do not think it is going to continue and I am not sure we understand exactly what is going on.

Let me explain, a little bit, those statements.

Chairman THOMAS. You will be pleased to know that you have given me as much information as anybody else can on this. It is interesting.

Ms. WILENSKY. It is an issue that I have discussed to some degree with Bob Reischauer and others who have poured over the numbers, so it represents at least something about this issue. Thank you.

We did not expect the drop that has been reported in the cash receipts. However, we did see a somewhat similar phenomenon in 1983–84 after the introduction of the DRGs, when there was a sudden drop in the first year, then followed by a little bit of catch-up and more spending than was in the projected pattern. I believe that we are seeing something like the "deer in the headlights" phenomenon going on right now: a sudden response to a lot of changes that are affecting hospitals, not only directly, but through home care and skilled nursing facilities and rehabilitation facilities. It has accentuated the response. I would be very surprised if the type of the response, the level or magnitude of the decline we see, continues and I would expect it to go back up to the 5- to 6-percent increase that was in the projections.

Chairman THOMAS. I have a hunch. Again, it is just a hunch. Perhaps, not like 1983–84, we saw the phenomenon with HCFA having to take a step back. Reassessed on the Y2K question, this may, in fact, also be a phenomenon that is out there in private sector with billing and the rest. It may simply be a slow-down of the process, making sure that the information and the data are correct and then going forward. Is that a reasonable assumption, although no one has verified that?

Ms. WILENSKY. I think that is a reasonable assumption. I also believe that the current emphasis on fraud and abuse makes institutions very reticent to send forward bills that they are not convinced are accurate.

Chairman THOMAS. Not bad up to a point. Let me, very quickly, go through some questions that I have. I would prefer shorter answers rather than longer. It focuses on the concerns I have about discussions with the press. Notwithstanding the embargo on the Commission's report until today, in which statements were printed in the press, my reaction was that there was a statement that I had some concern about. Then, in turning to the report, I could not find specific verification for the statement. So, I need some dots connected, if you will.

For example, on February 25, the press reported that you said that hospital margins had taken "a big hit in the last 6 months." And yet, in looking at the Commission's report, I could not find any acknowledgement of potential hospital financial problems. In fact, on page 59, the report says, "Hospitals generally appear to be in good financial shape, overall, with PPS margins likely to remain relatively high," and so on. Is this data that have arrived after the Commission report was written? Is this anecdotal? Where does it come from?

Ms. WILENSKY. No. It was a statement I never made. I will explain the statement I did make, however. What I said was that, in traveling around the country I had been hearing that in the last 6 months hospitals are reporting problems and hits on their mar-

gins that they had not felt before. I was impressed with the fact that institutions that did not know each other, were not related to each other, were making similar comments. I very specifically indicated that it was only anecdotal. I had no way of knowing if it was true, but I was impressed that I was hearing it in different parts of the country.

Chairman THOMAS. Good. In the report, on page 20, it states that skilled nursing facilities have developed specialized rehabilitation units to which they admit patients needing intensive therapy. In the report it goes on to say, "Often these units have been developed because local hospitals do not provide sufficient rehabilitation capacity." In reflecting on that phrase, my immediate reaction was that we are moving from the old cost-based reimbursement structure to a prospective system. In the old days, any of the therapy and ancillary services were paid whatever the costs were. It would seem to me that an enterprising skilled nursing facility could see this as a potential money-maker. You could also argue that they were developed because local hospitals did not provide a sufficient rehabilitation capacity. How were you able to discern that it was not an activity that could be an income producer for a SNF, rather than the failure to have sufficient rehabilitation capacity?

Ms. WILENSKY. We can provide you additional information. My interpretation of the statement was more of a statement of fact. In some hospitals there were not specific rehabilitation units that were present. In those areas, that led to the development of specific rehabilitation hospitals.

Chairman THOMAS. That could be a statement of fact in particular instances. But then, did that support a generality, in terms of a reference to the fact that that was the reason they produced these?

Ms. WILENSKY. I will find out. I do not recall.

[The following was subsequently received:]

In its March 1999 Report to the Congress, the Commission notes both of the above as factors likely associated with growth in SNF payments. Pointing to the availability of inpatient rehabilitation facilities, page 20 of the Report notes that some skilled nursing facilities "have developed specialized rehabilitation units to which they admit patients. Often, these units have been developed because local hospitals do not provide sufficient rehabilitation capacity." Also noting the cost-based ancillary payment structure for skilled nursing facilities, page 82 of the Report notes that "differences between SNF and rehabilitation facility services diminished partly because until last year, Medicare reimbursed SNFs their full costs of furnishing rehabilitation services."

The Commission believes that both factors likely contributed to the growth in SNF ancillary payments and specialized payments, although the Report does not posit that one factor is more predictive than the other regarding the presence of a rehabilitation unit or therapy-ancillary spending in SNFs.

Chairman THOMAS. Good. It is significant if you could analyze that that was actually the reason they did it, rather than the other. You mentioned, in your initial statements, the home health care cost sharing concept. You said, "We have talked about it." On page 95, which describes that general area, there was no $5 copayment mentioned, or a $300 out-of-pocket limit mentioned. Who is the "we" and where have you talked about it?

Ms. WILENSKY. We can provide you, if you would like, the transcript from the Commission's meeting. These numbers were specifically discussed in our public Commission meeting to give some indication about what we meant when we talked about "modest stop loss," and we specifically used the numbers of about $5 a visit, for about 60 visits that they would be subjected to. That meant a stop loss of about $300, exempting low-income people, and at that point, moving to an independent assessment. So, those were the numbers that were specifically used in our public hearing.

Chairman THOMAS. What was the rationale for not including them in the report as an example of what you meant by the general statement, "Congress should require modest cost sharing for home health services"?

Ms. WILENSKY. I do not recall, this year, that we actually discussed that point. Last year, we had not included the specific number, because we had not spent enough time. We felt deciding whether $5, $4, $7 was a right amount. But there actually would have been, I believe, no objection to using the four examples in the text. We just did not. As I said, if you would like, we would be glad to provide you with a transcript that indicates the discussion of those specific dollar amounts.

Chairman THOMAS. My concern is that when I read something in the paper and I turn to the document to find verification for it; it is not in there. As you indicated, you may not have been accurately quoted in the press, and I have already received letters signed by Members based upon those press reports. They had the weekend to write the letter, because the information was presented, notwithstanding the embargo of the report until Monday.

Last question, for now, also involves a specific date. If this was discussed in the Commission, I would very much like knowing that. Our concern, of course, in the adjustments for the Medicare+Choice sector is some of the timing is simply not workable. The one that is being focused on, most recently, is the May 1 reporting date, which we believe, having pursued it with attorneys both in the executive branch and here, that we are probably going to have to change it by statute. It can't be done administratively.

I noted that in the report, it was recommended moving it to later in the year. I believe the press has reported that you, or the Commission, has said July 1, but I do not know where July 1 came from because I do not believe it is in the report, is it?

Ms. WILENSKY. I believe, again, that our discussion was either July or August, depending on what HCFA thought it could live with.

Chairman THOMAS. OK. The basic operating statement should be, I think, isn't it, "as late as we can get it"?

Ms. WILENSKY. Right. Exactly.

Chairman THOMAS. Because the only criterion would be getting the material out for the educational purposes. So rather than some arbitrary fixed date, if it is too early, let us get it as late as we possibly can to make sure that people have the maximum amount of time to come with a decision commensurate with HCFA's ability to get the information out.

Ms. WILENSKY. That was one of the reasons we did not want to specify, exactly, which later date we meant, because we did not know that.

Chairman THOMAS. The statement in the Commission report, later in the year, does not necessarily specify July 1, although that date has been used.

Ms. WILENSKY. It does not, although that has been used. In fact, usually what I have said is July or August to try to get into that second quarter.

Chairman THOMAS. Good. Thank you. As I said, I will have some additional questions, but I wanted to make sure the rest of the Members have time to respond. Gentleman from California.

Mr. STARK. Thank you, Mr. Chairman. Gail, I have got a whole host of questions. Just let me pick out a couple here, at random. The risk adjustment issue is being debated. The managed-care folks are saying that it should be revenue neutral just among the people they have signed up. I would contend that it should be revenue neutral across the whole Medicare population. What we are concerned about is the fact that they are getting paid too much for cherry picking. So, if you only take the cherries they picked and assumed they were all healthy, there is nothing to adjust. Is it not the idea that we should risk adjust within the entire Medicare population?

Ms. WILENSKY. I believe that we should risk adjust within and between.

Mr. STARK. Thank you. I have a concern regarding DSH payments and you made some recommendations about what we should do about changing the DSH payments. You did not give us some of the detail that is required. There are about 1500 major hospitals that get all of the DSH payments, out of 6000. We have always used DSH as a proxy. We never have, in the past, gone through and evaluated whether a hospital really did, in fact, deliver the services for which we were then giving extra money, because of their higher cost. Have you considered whether we could somehow do so on a hospital-specific basis? I know we have never been able to define "charity care," but maybe the time has come. I know in my county they have lumped the children's health care, the indigent care and the Medicaid all into one package. They have got their own county managed care operation. In Tennessee, by definition, every hospital is a DSH hospital, because they all have to share. Now is there a possibility that we just have to redesign that?

Ms. WILENSKY. I think we definitely have to redesign it. What we have tried to suggest in the approach that we have recommended, is that because of the changes, like in TennCare and other places, we need to have a broader definition of what we are talking about. It needs to include indigent care in addition to Medicaid and any local indigent care programs. Our concern has been that while DSH should be focused on a relatively small proportion, or at least not all of the hospitals, that the barriers and the distributions are unfair between urban and rural. The distribution is too focused to urban hospitals in the sense of the amount.

Mr. STARK. That is easy, because the rural hospitals do not amount to much money.

Ms. WILENSKY. Right. It is easy to fix in terms of the dollars. It is just unfair. Yes, we ought to redefine how we are doing it and we ought to include all indigent care that is provided. That would make a much fairer program.

Mr. STARK. Are you going to do something about it? We ought to do it.

Ms. WILENSKY. We had recommendations from last year and some discussion. We would certainly be very pleased to work with the Subcommittee to try to operationalize what we have.

Mr. STARK. I was hoping you were going to do it.

Ms. WILENSKY. Well, we have some work done on it. We have some distributions that result from the recommendations that we made. We feel like what we did last year did not quite hit, exactly, what we intended. It is definitely in the right direction and better than what we have now.

Mr. STARK. I have always felt, and I think you have touched on this before, that we should pay for a procedure at the lowest price that the procedure is available. In other words, if a physician could do a procedure in his office or her office, we should not pay him the hospital-based rate for that procedure. Even if they do it in the hospital, they should receive the lowest rate that is in the market. Is that a fair assessment?

Ms. WILENSKY. It is subject to making sure that the patient characteristics are really comparable. One of the problems that we are concerned about is that the person who has a procedure in the hospital may not be the person who has it in the doctor's office. Jack Rowe, our geriatrician, reminds us that when somebody comes in his hospital, they frequently have three or four different morbidities. They may have some senility or dementia. Having any procedure done becomes far more expensive. So, either we have to have good patient characteristics or make some allowance for that. Notwithstanding that, yes, we agree.

Mr. STARK. Finally, oncologists are saying that the reason they have got to charge a whole lot for the drugs they sell, which we pay for, is that we are not giving them enough in their practice expense payment. I do not think that quite washes. It is my understanding that under the Physician Reimbursement Plan, which you wrote, we pay physicians for their services, not the products that they sell and the mark-up of those products. Now, there is nothing illegal about a physician, in most states, being in the pharmacy business. They can buy the drugs wholesale and sell them. But, ought we to put some limit on that? Ought we to say, "No more than what the VA pays?" I think it is becoming a very expensive issue. It probably could lend itself to some overutilization where there is a tremendous mark-up in these drug prices. Are you prepared to bring us any recommendations?

Ms. WILENSKY. This is not an issue that the Commission has formally taken up. I believe, last year, we responded to you that we think that reimbursement ought be what is justified for the drug, per se, and should not be used as a justification to cross-subsidize the physician. If the oncologist believes there is something wrong with their payment, then they need to make that argument directly to HCFA during the review period.

Mr. STARK. What about limiting what we pay for the drugs?

Ms. WILENSKY. You should. You have to decide what that limit is; whether it is the supply price of the AWP minus 5, or whatever. Yes, there ought to be some decision as to how to reimburse.

Mr. STARK. Thank you. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you. Gentlewoman from Connecticut, do you wish to inquire?

Mrs. JOHNSON of Connecticut. Thank you, Mr. Chairman. Just to follow-up on the preceding question: one of the problems has been that the RBRVS, resource-based relative value scale, did not take into account the cost of delivering oncology drugs. So, we put that into the medication costs. We want to be sure that in looking at what we are going to reimburse for drugs, we do not to compare them to what we pay the VA for those same drugs. Wouldn't you agree?

Ms. WILENSKY. I was not suggesting the VA supply price as the price that I would use.

Mrs. JOHNSON of Connecticut. I appreciate the good work of the Commission. I am terribly disappointed in your recommendations, because I think that your data are too old for the urgency of the problems we face. I do not see recommendations that go to the heart of what I am seeing out there. I see institutions at peril of going under. They are at peril because of some of the irrational aspects of our payment system. The fact that medically complex patients are not properly reimbursed under the skilled nursing facilities' PPS is sufficiently recognized by HCFA that they have contracted for a study. But the study will not report until 2001. I can tell you that in the small nursing homes out there, our failure to reimburse correctly for the medically complex patients is now a very serious issue.

It has become extremely burdensome and problematical, because we are now requiring those nursing homes to pay for ambulance rides, which they never used to have to pay for before, and prosthetic devices. So, has the Commission given any thought to restructuring the payment system for nursing homes to exclude things, like ambulance charges, over which they have very little control? The two are related. If they have high costs for the medically complex patient and that patient has to go a hospital in my district, the ride is $700. The reimbursement rate is $200. You are automatically out 3½ days' worth of reimbursement rate if you have to take a patient to a hospital. I would like your comments on whether the Commission believes that HCFA should be making some interim effort to address the medically complex reimbursement rate. Also, would you be able to work with me on evaluating the possibility of excluding ambulance charges from the PPS?

Ms. WILENSKY. With regard to the first issue, the medically complex patient, the Commission agrees with you. One of the areas where we thought there is a problem with the existing classification system is the high-acuity patient. I think the question is going to be whether there is additional money put into the system to provide better for the high-acuity patients, or whether it is going to be a fight over redistributing the existing dollars. That is obviously something that Congress will have to determine: whether or not there are additional moneys, as were put up last year for home care, to try to ease this problem. We do think there is a problem

with the high-acuity patients. We don't have a response to hurrying up HCFA's study in order to try to redesign that. We believe HCFA also recognizes the high-acuity patient problem.

The issue with regard to ambulances is different. We have not, to the best of my knowledge, specifically looked at that issue. In general, the Congress was concerned about the cost pass-through of ancillary services. In general, I don't know if in the deliberations of the nursing home PPS requirement any thought was given as to whether ambulance costs, per se, particularly if not owned—if the ambulance company had no financial relationship to the nursing home—whether there was ever any consideration given to having that be outside the PPS. I agree with you. It seems to be somewhat different in nature than, say, IV or ventilator or other services that are in the ancillary service. So, it may be possible to construct a payment that would differentiate between ambulance services that have financial relationships and those that do not. I do not know what it would cost and I do not know whether that was considered when the BBA was passed.

Mrs. JOHNSON of Connecticut. Well, my understanding was that it was not. In modeling the PPS for nursing homes on the hospital thing, the only thing that was excluded was the hospital. I do think there is a real urgency about looking at that kind of cost because it is completely out of their control. It is very large compared to their reimbursement rates. You get a run of difficult patients and you will no longer be financially sound. I do not believe we can wait 2 years to address this. I will be hoping that the Commission can work with me on that.

My light has gone on, so I will come back to my other questions on a successive round. Thank you.

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

Mr. MCCRERY. Thank you, Mr. Chairman. Ms. Wilensky, I want you to expound for just a minute on your remarks regarding specialty hospitals, rehabilitation hospitals, long-term care hospitals and a prospective payment system that might be devised for those hospitals. You indicated, I think, in your testimony that your Commission was opposed to simply extending the payment system devised by HCFA for SNFs to rehabilitation and long-term care hospitals. Is that correct? If so, would you explain a little bit more why that system is not suitable for those specialty hospitals?

Ms. WILENSKY. This is an area in which I have not personally done research, but I will report, as accurately as I can, the sense of the Commissioners in this area. Ideally, we would prefer if we could have a single medical classification system that would cover skilled nursing facilities and rehabilitation hospitals. Unfortunately, the researchers who have done work in this area have concluded that there isn't a system that explains the variations in both of these areas, and that one medical classification system, the so-called RUG, or resource utilization group, seems to do a pretty good job in skilled nursing facilities, but there is a different system that has an acronym called FIM–FRG. It has a rather long functional measurement component to it. It describes the better medical classification system for rehabilitation hospitals.

And, therefore, our position has been that, while we would prefer if a single classification existed, it doesn't. And, therefore, our recommendation is we should go with what describes skilled nursing facilities for skilled nursing facilities and use the system, the per-discharge system, that is more appropriate for the rehabilitation hospital for those services.

In order to try to keep that same sense of paying for the service, irrespective of where it is provided, we have suggested that HCFA try a demonstration where, when a rehabilitation service is provided in a skilled nursing facility—which sometimes it is—that that reimbursement for the rehabilitation service be made as though it were being provided in a rehabilitation facility. So you would have the same payment even though the site of care differed. That is how strongly we think that the resource utilization group classification system doesn't seem to fit the rehabilitation world.

So, if we could, we would rather have one system. But we have recognized the reality that one system just doesn't seem to work and, therefore, we recommend two different systems and to get consistency where you can by focusing on the service itself, not the site.

Mr. MCCRERY. In fact, it seems to me that, if we went to the per-diem basis for rehabilitations, that there would be a reverse incentive there for them to game the system and just keep the patient as long as possible to get the maximum reimbursement, which has a number of adverse consequences.

Ms. WILENSKY. Yes.

Mr. MCCRERY. Is that your fear also?

Ms. WILENSKY. That is true. I was surprised. I happened to speak to a few heads of rehabilitation hospitals. I assumed they would prefer the per diem because it would put more demands on them to go to a per-case. They actually indicated they think they can do a better job getting the right rehabilitation to the patient as they need it without all the artificial constraints that is in a per diem. So we think, intellectually, it makes more sense and I was pleasantly surprised that the people who actually run them think it makes more sense.

Mr. MCCRERY. Thank you.

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

Mrs. THURMAN. I thank you, Mr. Chairman. I have got a couple of questions and I am going to preface with this. Yesterday I was at a Rotary Club in Crystal River and I had a gentleman who said to me: I have lived in a lot of places in this country and I feel like I am a second-class citizen here in Citrus County because I can't get HMOs Medicare. It was really kind of a sad state of how he was feeling about himself.

So my issues are really going to be based on some of the reimbursement issues, particularly to rural areas and I know you have got some stuff on the blended formula in here. But let me ask you, do you believe that the fiscal year 2000 reimbursement rates will have any kind of an effect on this issue?

Ms. WILENSKY. I think there is so much turmoil going on now that if it has any effect, it will be very modest. There will be some kicking in of the blended rate, which will help rural counties a year

sooner than we initially thought. And the so-called floor counties, the counties that had been paid less than $367 per person, per senior, per month are already being helped.

But I would be surprised if there is a big change right away. There are enough issues outstanding for the HMOs about the service delivery requirements across counties in a single service area, about the timing, about when they have to have their premium benefit combinations into HCFA, about how much information they have to provide HCFA, and how much that will cost that I suspect a number of groups that might be at the edge of coming in might well wait a year before they come in. So I don't know that we will have a fair chance to see how much effect the increased reimbursement in rural areas is going to provide in this next year, although I would be very pleased if I was wrong.

Mrs. THURMAN. Well, what would you recommend? I mean, I have to tell you, the letters that are going out for those people that are losing their coverage. I mean, basically what the letter is saying is Congress did it because of the reimbursement issues. I mean, what would you suggest we do? I mean, these are very important issues to these folks because they can't make up the benefit of pharmaceutical issues. I mean, I need some help.

Ms. WILENSKY. I think in this case, HCFA did it, honestly. Because last fall, they could have provided a little more flexibility, acting more like insurance commissioners when the plans approached them in August and September and said, we missed the mark. They could have allowed them to come in, beaten them up, given them 10 or 15 percent of the difference they were asking for, and maybe kept some of those HMOs in the counties for another year.

I think the issues that Congress needs to push HCFA to work on are some of the flexibility issues. The date, although this is going to be a statutory question. This issue of can they go until July or August before they have to get the premium benefit combination in. That is a big question about how much uncertainty you are going to face in the coming year.

The issue about the service package difference. Up until this last year, HCFA allowed an HMO to have a different benefit package across different counties in a service area if HCFA paid those counties different amounts, basically reflecting, in fact, different spending patterns. That has now changed and that is going to cause some people, some plans that have rural counties in bigger service areas, to be concerned about whether they can differentiate it. And if they can't, to give them one more reason not to go in.

So I think right now, it is to push HCFA to find ways to lighten the burden since I don't think it is so likely that you are going to increase directly the payment rates. But if you can decrease some of the extra costs that have been put on the plans, that might be just as well to try to get them to come in.

Mrs. THURMAN. Do you think that the 5-year rule issue has had any effect on this as well, where people may have pulled out this year?

Ms. WILENSKY. Yes, I do. I mean, it was raising the ante to pulling out and it meant that some plans that might have stuck

around for another year wanted to get out before they got swept up into that.

Mrs. THURMAN. Mr. Chairman, I hope we are doing another round, because I have a whole bunch of other questions. But thank you.

Chairman THOMAS. Well, the Chairman certainly is going to do it and if you want to stick around for it, you can. I just want to, prior to recognizing the gentleman from Texas for his questioning, indicate that I took a look at Citrus County. It is $488 on the new blend rate. The gentleman from Minnesota, who has extensive managed care at very tight dollars, for example, hunt up and Minnesota's $457 rim—see, Minnesota's $470 dollars—I have a county in California, Fresno County, which is $438 and they are able to bring in managed care. But it is oftentimes in context with roughly where they are geographically, since California's a high-penetration State and Fresno is only two counties over from the Bay area.

And all of the points that the Chairman made about the decisions that now have to be made to make it work are exactly why—and my questions are going to go to the larger question of the future of Medicare—but the Medicare Commission is looking at a premium support model, which would negate the need to try to make all of those decisions administratively and incorporate it into the plans making those decisions in the price that they offer to the new board.

For example, you are very familiar with the politics of producing this blend structure. It slows the growth up top, whether they need it or not they get 2 percent, it speeds up the bottom. But the critical point is those middle dollars that make the difference between attracting a plan or not. And that area is going to grow slower than it probably needs to because it doesn't get 13 percent at the bottom, but it doesn't get the 7 percent that it needs, it gets the 3.2 percent. And that I don't know that we can wait the time for that change to occur.

Ms. WILENSKY. And, Mr. Chairman, I would have to say too, though, I think because we have such a large veterans population which is not included in some of these issues, have something to do with it. Getting doctors to participate because there is a smaller number of doctors in these areas that we are talking about, the surrounding areas are anywhere between a population of 100,000. So we just don't have the population figures and we have doctors that will just lock us out.

Chairman THOMAS. And the gentleman from Washington has that problem with bases as well. And those are now irrelevant to HCFA's pricing of the product, but certainly not irrelevant to the health care delivery structure in the area. That, in part, would be incorporated under a premium support model as the prices are determined relatively automatically and that is one of the primary attractions and the reason we have come so close to the statutory 11 votes to present that to the Congress. But I am going to have some questions about that later. The gentleman from Texas.

Mr. JOHNSON of Texas. Thank you, Mr. Chairman. Well, I would like to continue with that a little bit. You know, I know you are recommending that Medicare choice have the flexibility to tailor their benefit packages with their service areas and we seem to

think that flexibility is needed because of the way that formulas do vary by county. And I wonder if you would comment some more on that.

In particular, Waco down in Texas is a low area, by county. And they have all left there. There is nothing left there except fee-for-service. And, you know, how do we entice these people back into the system? And, I grant it, Waco is fairly close to some high-level metropolitan areas where people could go, I suppose. But, still, it is not there for them when they need it. Can you comment?

And let me ask one more follow-up on that while you are talking. Are we trying to develop another system of figuring out how to make the payments, over and above what we already have established? Or are we refining it? Or are we initiating a new system? What is your recommendation?

Ms. WILENSKY. What we are trying to help the Congress with now is to refine the existing system that was put in place with the Balanced Budget Act. The commission that Chairman Thomas referenced, a bipartisan commission, is looking at the much bigger picture of what Medicare in the future might look like. But, of course, there are times in which these two start to have some overlap because some of the decisions that you get asked to look at from the Medicare+Choice provisions in the Balanced Budget Act raise the same kind of questions that a long-term Medicare commission would look at.

This issue about the difference in payment across geographic areas has been looked at a little in the Balanced Budget Act. But I believe that as many problems have been created as have been solved. What the Congress correctly noted is that there was a big spread in payments across counties under risk contracts, from a low of $225 or $230 in Nebraska to a high of $780. And they put a floor on to make sure the very lowest counties didn't go below $367. And they financed it by having very slow growth in the high counties, 2-percent growth in the high counties, where many of the HMOs were in the higher paid counties.

But the problem is that spending under traditional Medicare in those higher paid counties is going to continue at whatever rate and that—I think Chairman Thomas referenced this fact—that 2-percent growth, the minimum growth rate—is a very small, very low growth rate. Especially when other Medicare spending in the same area is going to grow at a faster rate.

It raises the question that the Congress hasn't taken on yet, but will have to at some point, which is how much variation should occur across the country in terms of what Medicare pays. Sometimes the variation occurs because people have differing health status or they are more likely to die in a year. But a lot of the difference occurs because of the way medicine is practiced in different parts of the country; much more aggressively in some parts, much more conservatively in other parts. And whether the Federal Government ought to pay for that is an issue that the Congress hasn't dealt with.

I think the variations that exist now are still too great, even though they are less than they used to be. And I think the different payments in the same geographic area that was introduced in the Balanced Budget Act is asking for trouble and sooner, rather than

later, that Congress is going to have to do something about that problem.

Mr. JOHNSON of Texas. Yes, but what are we going to do? Did you make a recommendation about that?

Ms. WILENSKY. We have not made a recommendation because it really goes to the big issue of what you want to do about Medicare for the 21st century.

Mr. JOHNSON of Texas. I hear you. So you are waiting for the commission.

Ms. WILENSKY. And then we will gladly try to help you with the policy questions that fall from that.

Mr. JOHNSON of Texas. OK. Thank you very much. Thank you, Mr. Chairman.

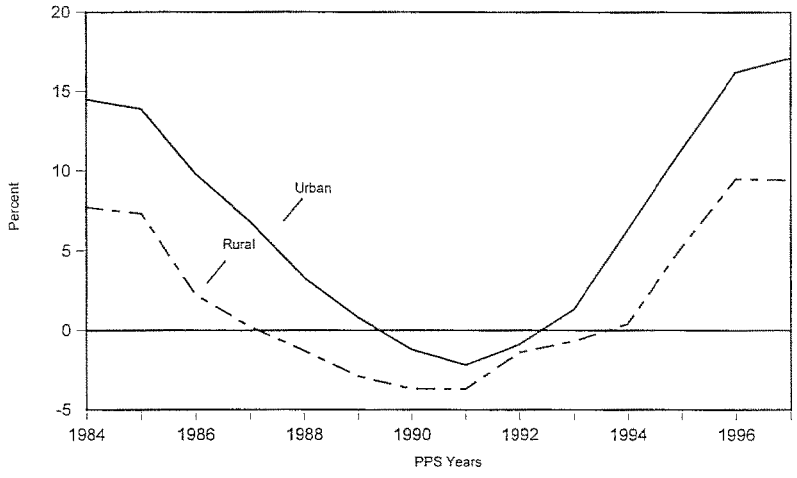
Chairman THOMAS. I thank the gentleman. The gentleman from Michigan to inquire.

Mr. CAMP. Thank you, Mr. Chairman. We have had some discussion over the profitability of hospitals and I know that your report seems to use national data. And I just want to say that—and it is anecdotal as well—but the information I get from the hospitals in mid and northern Michigan are that their margins aren't as rosy a picture as maybe the national pictures might suggest they should be. And I just wondered if MedPAC has any data that show any significant difference in the operating margins of rural versus urban hospitals?

Ms. WILENSKY. We can, Mr. Camp, get you information that will show you the margins for both Medicare and total hospital expenses for rural as well as urban and other classifications.

[The following was subsequently received:]

Medicare Hospital Inpatient PPS Margin, Urban vs. Rural Hospitals, 1984-1997



NOTE: Data for 1997 are estimated.

SOURCE: Medicare Payment Advisory Commission analysis of Medicare Cost Report data from the Health Care Financing Administration.

Ms. WILENSKY. As it happens in MedPAC, we have a representative from the hospitals in Michigan.

Mr. CAMP. Yes. Right.

Ms. WILENSKY. So I think that we have tried to be cognizant of the fact that there is a distribution in terms of margins. We have pointed out in the chart books that we have put out that even in 1996, which in general was a very positive year for hospitals, there were some 23 or 22 percent of hospitals that were reporting negative margins and that, while it is lower than it had been in previous year, it was still almost one in four that had this difficulty. So we do try to look at the issue.

And we also are extremely concerned about the fact that our latest information goes through the summer of 1997, in response to both your comment and Mrs. Johnson's comment. We keep trying to find ways—I have had discussions with various groups about whether there might be ways to get more timely data. It is why we have recommended no further reductions in payment, because we know we can't see what is going on now. But it is hard for us to make a positive recommendation, because we also don't know what is going on and only have anecdotal data. So we are concerned about what we can't see right now.

Mr. CAMP. Well, I appreciate that answer. I have another question about Medicare choice. You know, it is difficult in rural areas and I think there is a struggle to try to increase the health choices for seniors there. And I wondered if the recommendation for updating the government's plan so that the treatment of sicker or healthier patients will be taken into account. Do you, in your opinion or experience, do you believe that that risk adjustor will result in lower or higher reimbursement levels in rural areas?

Ms. WILENSKY. I have not seen the distribution so I honestly don't know what it will do in rural areas. What risk adjustors attempt to do is to get the relative price right. If there are reasons to believe that the absolute price might be too low because of changes that have gone on in the Balanced Budget Act to the base price, that is a legitimate question to ask. It is legitimate to ask, after you have introduced risk adjustment, whether 95 percent still is justified as opposed to 100 percent, since, in some ways, that was a crude way to try to approximate some selection.

But what risk adjustment attempts to do—and I think HCFA has done as good a job as they could have, given the data and the time constraints placed on them—is to try to get the relative prices between different HMOs and between the risk contracts and traditional Medicare right. And they ought to do it, because it is the correct way to make adjustments.

Mr. CAMP. Sure. Just, quickly, you recommend or the report recommends a copay with an annual cap on home health services.

Ms. WILENSKY. Right.

Mr. CAMP. And you mentioned a $300 cap. But that low-income individuals would be exempt from this copayment.

Ms. WILENSKY. Exactly.

Mr. CAMP. At what level would you define low income?

Ms. WILENSKY. We thought, for administrative ease, anybody who has Medicaid, QMB, or SLMB, that is, anybody who is already under some kind of a Federal program so we wouldn't have to income test someone for this provision.

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

Chairman THOMAS. I thank the gentleman. The gentleman from Washington wishes to inquire.

Mr. MCDERMOTT. Thank you, Mr. Chairman. Interesting report and I read a lot of chapter two. Karen Ignani says that what is happening this year is simply a tip of the iceberg. What is your anticipation for July 1, when we get the bids for next year?

Ms. WILENSKY. I am worried. I am worried that there may be additional withdrawals, partly because there is so much uncertainty.

Mr. MCDERMOTT. So much uncertainty?

Ms. WILENSKY. Uncertainty in terms of how the regulatory structure will play itself out, with regard to risk adjustment when some of the full encounter information will be available, the requirements in terms of information reporting, the timing issue. So I am concerned that, in some areas, we will see further withdrawals.

However, the plans are in there to provide services to seniors and seniors use a lot of health care services. And there have been a number of plans that say they are interested in stepping up to the plate. So I believe it would be helpful if HCFA tried to come up with ways to lower some of the regulatory burdens in appropriate ways, so that you are not risking bad outcomes or not collecting appropriate information. Because I think there are some administrative procedures HCFA puts in place that worsen the problem.

Mr. MCDERMOTT. Specifically?

Ms. WILENSKY. Well, as I indicated, I thought last year not allowing for some renegotiation later in the year pushed out plans that might not have left. Not making any allowance for the fact that plans were asked to come in in May where, up until then, they had had until November to come in.

The second issue has to do with this service flexibility. Up until this year, HCFA has allowed for a different benefit package. If HCFA pays counties different rates within their general service area and has now come out with a rule that will prohibit any such variation, even though it is making different payments in some of these different counties.

Mr. MCDERMOTT. Does that mean they will go up to the highest payment in the service area?

Ms. WILENSKY. They can only do one. And anyway they do it, they will have to give any difference in payments, between payments and benefit, as extra payments. Probably if there is a lot of variation they will leave.

Mr. MCDERMOTT. Do you think the 5-year lock out provision that comes into effect this year will make a difference in what people decide to do in July?

Ms. WILENSKY. I think if they are not in and they have any question, they may wait a year or two.

Mr. MCDERMOTT. Rather than get in and then have to get out and be under a 5-year lock out.

Ms. WILENSKY. And be out for 5 years. Right.

Mr. MCDERMOTT. OK, let me move to one other issue, because I——

Ms. WILENSKY. And another one is, on the other hand, for the people who are in, this isn't quite the atom bomb strategy, but it is raising the stakes high.

Mr. MCDERMOTT. Yes. I kind of wonder if it is going to survive this session of Congress, frankly.

Ms. WILENSKY. I think it might be appropriate to think whether a similar but somewhat lower bar wouldn't do, wouldn't have some of the same effect without having it be quite as harsh. But, I mean, I understand why you wanted to do that and the idea seems a reasonable one.

Mr. MCDERMOTT. Let me just move to another issue—geographic disparity—because I come from the area where we believe that no good deed goes unpunished. Minnesota, Washington, Oregon—our AAPCC, everything is lower than the national average, but the particular issue I want to raise is home health care. Our average visits are 34 per year. Louisiana is 170. Now, whatever you want to say about people in Louisiana, I don't think they are sicker than people in Washington State. There is something different about the way the plan is being run. And it seems to me that you have to evaluate acute and chronic cases separately.

We took the provisions of last year's Medipac report and put a piece of legislation in—it was H.R. 746—in order to try and set up a mechanism by which you could case-by-case evaluate the long-term cases. Where are you on the commission, in terms of this whole issue of how we sort out what we do in home health care? Because Washington State is getting punished with a 10-percent penalty when we are so far below the national average that it is not fair. And I think something has got to be done about it. So I am interested in how we work this out.

Ms. WILENSKY. I am concerned about the variation in Medicare payments across the country. I think that it is not fair to the conservatively practicing States.

What we have suggested—because we agree, there do seem to be two different populations in home care—is that after about 60 visits, there ought to be an independent assessment about the care needs of the individual with regard to future home care. So that you both try to tackle the cases where there may be inappropriate care—because we did not want to have any additional copayments beyond 60 visits—so that you both have appropriate care for those who, in fact, have more chronic care needs, as provided for under Medicare coverage, but you don't prolong what will then be home care with zero copayment because of how care tends to be delivered in a particular place. We think this idea of having a geriatrically trained individual do an independent case assessment around 60 visits—although we are not stuck on that—but that seemed to pick up the two distributions that we were observing, would help try to deal with this, both for the appropriate and inappropriate users.

Mr. MCDERMOTT. Do you think the $5 copay that you have suggested is fair? Is that going to get the desired result or does that fall more heavily on the low-income people?

Ms. WILENSKY. Well, what we have suggested is that we exempt anybody who qualifies for any of the Federal designations. So Med-

icaid, QMB, SLMB, those people not be subject to the $5 copayment off the top. The second provision is, we want to put a stop-loss provision so that, at some relatively low level—although it obviously depends on who you are—but something like $300, there are no further payments.

We use that $5 a visit, $300, as a ceiling to say around the 60th visit where we are no longer going to use copayments, we ought to have an independent assessment of the health care needs of the individual, both to make sure the people who needed it continue to get care at zero copayment and that the people who are either pressuring physicians unreasonably to sign-off on home care or for whatever reason were having long streams of home care thereafter would have an independent assessment of that need. So it was a way to try to deal with both issues.

Mr. MCDERMOTT. I would like you to take a look at our legislation and give us your comments. Because we tried to set up a mechanism by which that could be evaluated and I appreciate your looking at it. Thank you.

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

Mr. ENGLISH. Yes. Thank you, Mr. Chairman. Dr. Wilensky, this may be faintly redundant, but in your testimony, you stated with regard to the hospital industry, that quote, "Reducing payment rates below the level prescribed in the BBA would not be prudent, at least for this year." I wonder if you could amplify on this statement and, specifically, give me your thoughts on the administration's budget proposals that would reduce payments to hospitals this year.

Ms. WILENSKY. Our concern, as several of the Members have raised, is that our data are not as timely as we would like. The last good data we have are from the summer of 1997, just prior to the implementation or the enactment of the Balanced Budget Act. While at that time it looked like hospital margins in general were strong, even so there were about 22 or 23 percent of hospitals with negative margins. In general, hospital margins were strong, but we have just gone through a very active period of change. We cannot see the effects of that change. We have cut out the maneuverability of many hospitals because change is occurring in the outpatient area, home care, skilled nursing facilities, as well as the reduced payments to hospitals. We, therefore, think it is unwise to have further reductions when we know we can't see what is going.

Furthermore, as I indicated in my comments to the Chairman, I am impressed that, going around the country, I am hearing hospital administrators say they feel something very different has been happening in the last 6 months. They are not even sure themselves, but they are having enormous pressure on their margins and that the squeeze is much greater than they are used to. I understand and they understand that this is anecdotal information, but given that we know how out-of-date our data are, that supports the notion of not doing further reductions.

Mr. ENGLISH. I am getting the same anecdotal information so, for what that is worth, I think you are on to something. Let me, maybe, narrow my inquiry a little bit. Bad debt payments to hospitals, obviously, are designed to compensate hospitals for the cost

of treating indigent patients who can't afford to pay their bills. We are going into a period where there may be a fair amount of pressure in some areas, particularly with the new implementation of welfare reform. And I wonder, can you give us any greater detail with regard to the effect the administration's proposed 10-percent reduction on bad debt payments might have to hospitals?

Ms. WILENSKY. I don't have at my fingertips any analysis. I will see whether there is any information that MedPAC has available.

[The following was subsequently received:]

First, we need to clarify that Medicare's bad debt payments to hospitals cover only the bad debts of Medicare patients in the fee-for-service sector. These bad debts result from hospitals' inability to collect (after reasonable collection effort) the deductible and copayment amounts beneficiaries owe. Medicare does not pay for any of the bad debts that hospitals incur in treating non-Medicare patients, although MedPAC has recommended that Medicare' disproportionate share adjustment be modified to reflect the uncompensated care (sum of charity care and bad debts) that hospitals provide to all patients.[1]

The Balanced Budget Act of 1997 cut payments for Medicare bad debts by 45 percent over the course of three years (25 percent in fiscal year 1998, 40 percent in 1999, and 45 percent in 2000). The President, in his budget for fiscal year 2000 published earlier in the year, proposed to extend the reduction to 55 percent for hospitals and to apply the 55 percent cut to all other providers of services entitled to claim bad debt reimbursement. The Congressional Budget Office scored the overall proposal as producing savings of $400 million in fiscal year 2000. We estimate that approximately one-third of these savings result from the impact of the proposal on the hospitals covered by Medicare's inpatient prospective payment system.

Mr. ENGLISH. Could you give us your thoughts, then, on the benefits or drawbacks that you foresee with regard to skilled nursing facilities using an episodic payment method?

Ms. WILENSKY. The biggest question with regard to an episodic payment is whether or not you can predict the episodes. I think there is some difficulty in going to a per-case, which is why we have had the existing per-diem system. I mean, if you could do it and explain the variation, that is frequently desirable. The question is, is there a mechanism that allows you to explain the variation across different illness patterns. And my sense is that that remains problematic.

Mr. ENGLISH. My final question: Do you have any further comment on the current HCFA implementation of the SNF perspective payment system?

Ms. WILENSKY. As we discussed earlier, there appears to be concern that the sickest patients, the high acuity patients, do not have adequate reimbursement under the existing system. Mrs. Johnson raised the concern that waiting until 2001 and the results of a HCFA study is a long time to wait, and I agree. It seems to be generally believed that there is inadequate reimbursement for high acuity patients. I doubt you will have the luxury of waiting two more years.

Mr. ENGLISH. Thank you for your testimony. Thank you, Mr. Chairman.

Chairman THOMAS. I thank the gentleman from Pennsylvania. The gentleman from Minnesota wishes to inquire?

Mr. RAMSTAD. Thank you, Mr. Chairman. Dr. Wilensky, good to see you again and I applaud the outstanding job you have done in

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[1] Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, March 1, 1999, pages 60–65.

chairing the commission. I appreciate also the exchange you had with my good friend from Florida, Mrs. Thurman, as well as the recognition of the Chairman and Mr. McDermott of the problems we have in Minnesota with the Medicare+Choice payments.

I know your commission is not recommending any changes at this time to the methodology by which Medicare+Choice payments are calculated and I certainly agree with your report that we must consider the various factors influencing plans to reduce their number of service areas. Payment is not the only reason, but certainly payment levels are very important.

Blue Cross-Blue Shield Minnesota, for example, just pulled out of Minnesota completely and it is of concern to many in my State, obviously. I haven't seen the numbers for next year yet, Dr. Wilensky, but I understand we will finally see the blend funded for most counties. This is certainly good news, but, again, many in Minnesota still aren't confident that the blend will be funded beyond next year. Is there anything you can recommend to help us ensure that the changes in the Balanced Budget amendment are able to operate fully and the blend is there for more than 1 year?

Ms. WILENSKY. Well, the first is that I think the fact that it is coming in a year earlier than we thought it might is good news. The second issue—and this is really one for me to give back to you, because it is a statute issue, legislative issue—is that a level of blend was specified in the Balanced Budget Act. At some point, the Congress will need to consider whether that is the right blend level or not.

It goes back to the question that we talked about earlier, which is it will still allow for substantial variation in spending across the country and whether or not that is regarded as appropriate or inappropriate is an issue that the Congress is going to have to decide. How much to peg at a national level and how much to allow for local variation, remembering that the people who are above the average are probably going to be unhappy when they are pulled down toward the average, as well as those coming up. But this is an issue, ultimately, I think that Congress is going to have to take another look at.

Mr. RAMSTAD. In your judgment, Dr. Wilensky, wouldn't a better way to do it be by regions, rather than nationally?

Ms. WILENSKY. I think I would have to look at that to decide, if not the local level, how best to do it. I would prefer, rather than having a specific geographic area, think about how medicine is best practiced, to set the parameters and then to make adjustments for illness levels in the community and cost of living. I actually am not that keen about using means or medians or some other average measure because we really don't have a good sense. It may well be that the conservative practice used in Oregon or in parts of Utah or in the State of Washington or in Minnesota is the model that would be best and we ought to allow deviations from that only because we think there is some reason to do so. So I am a little reluctant to specify a particular geographic area.

Mr. RAMSTAD. Let me shift gears—and I certainly appreciate your responses—to graduate medical education. Certainly, like most of my colleagues, I am concerned about GME, graduate medical education, payments. I didn't see much reference to such pay-

ments in the report, either on how the funding be handled or if changes to the payment levels are appropriate. Now I know the bipartisan commission is looking at new ways to fund GME, do you have any recommendations on such funding or on these issues?

Ms. WILENSKY. No, but we will in August. We owe you a report on graduate medical education in August 1999. Normally, you are correct, you would see in our March report our payment recommendations. But because we had a specific stand-alone report due in August, we have chosen to postpone that, but we will back in a few months.

Mr. RAMSTAD. I appreciate that assurance and your recognition of the importance of this issue. Mr. Chairman, I yield back.

Chairman THOMAS. I thank the gentleman from Minnesota. Does the gentleman from Georgia wish to inquire?

Mr. LEWIS of Georgia. Thank you very much, Mr. Chairman. Dr. Wilensky, in your written testimony, you speak of the need to increase Medicare payment for outpatient dialysis services. As you know, many African-Americans, especially the elderly, suffer from diabetes and depend on dialysis treatment. Would you please explain to the Subcommittee in greater detail why HCFA should increase the compensation for dialysis treatment.

Ms. WILENSKY. We will have additional information in our June report on quality issues, but our concern is that the payment has been kept at the same amount, the so-called composite rate, for so long that the costs are going to exceed the payment rate. We already have had raised some issues about mortality and outcomes data in the United States versus other countries.

Now that is a complicated issue, but we think, even at the preliminary stage of our analysis, that it is too low a rate or that it has been frozen at too long a level. While we anticipate providing more information on access and quality issues in our June report and, I hope, in our next year's report as well, even at this early stage we thought it was inappropriate to say nothing because our sense is that saying nothing means a continued freeze. Of course it may be a continued freeze in any case, but we wanted to be on record as indicating that some at least modest increase was appropriate.

Mr. LEWIS of Georgia. Thank you, Dr. Wilensky. I have another question. It is a little long and if you could be patient with me for a moment. The New England Journal of Medicine recently released a study which concluded that doctors are significantly less likely to recommend cardiac catheterization for blacks and women then for white men with identical complaints of chest pain. As you know, this is the best tool for diagnosing heart disease and all doctors were 40 percent less likely to recommend this diagnostic treatment for blacks and women than for whites and men. This study is just one in a long history of evidence showing that minorities and women do not receive the same level of treatment as their white male counterparts, despite having identical insurance coverage. This is unacceptable and maybe we should find a way to do something about it.

I believe that monitoring hospitals and requiring that they report how their procedures vary by race and sex might help close this gap. Identifying and educating doctors about the bias is the best

way to help eliminate it. And I want you to respond, Dr. Wilensky, if you can, what type of monitoring and public disclosure might be useful in making health care providers more conscious of biases in treatment and health providers and help us close this growing gap between minorities and women and white men in America when it comes to health care?

Ms. WILENSKY. Well, as a middle-aged white woman, I actually took a lot of notice of that report. It is, I think, a concern to all of us to read that people with similar, identical symptoms were provided with very different treatment. And I think there are several ways to try to respond to this. To the extent that we can make sure there are guidelines and protocols, good scientifically available guidelines and protocols, we can help provide at least a scientific basis for making decisions.

The second thing we can do is to require outcomes and reports, particularly in areas where we think variations may exist, so that the public and the professionals can see the kinds of variations that exist.

Finally, it may be that, because of the substantial increase in at least women—our success rate for African-Americans has not been as good—going into medical schools, may have a greater sensitivity to the medical needs of women and minorities then we have seen to date. Maybe, I guess, it is an issue that we can hope that the State medical societies and the national medical associations would regard as sufficiently serious that they also attempt to reach out to their membership. It was a very distressing report.

Mr. LEWIS of Georgia. Thank you very much, Dr. Wilensky. I yield back my time, Mr. Chairman.

Chairman THOMAS. I thank the gentleman for yielding. We do have a vote on. There will be two consecutive votes. But the gentleman from California, Mr. Becerra, who is no longer a Member of this Subcommittee, has sat through the entire process and wishes to ask one question.

Mr. BECERRA. Thank you, Mr. Chairman. Yes, one question with three parts, right. [Laughter.]

No, let me thank the Chairman for giving me the opportunity to be here and to ask these questions. Ms. Wilensky, thank you very much for being here. I wish I could say I am still sitting on the Subcommittee, but we don't have those kinds of choices sometimes.

The financing issue with HCFA. I know it has become more difficult. Let me ask you—and there may be a subpart, a real quick subpart on this—we have been talking a lot about Social Security these days. Social Security has administration just the way Medicare has administration. HCFA does it for Medicare. Social Security has its administration off-budget; it is not a part of the appropriations process. Social Security gets to determine its administration. We don't have that for Medicare and HCFA, we are finding, is underfunded. We have got to do something quickly, otherwise we are going to find it is going to be very difficult to administer the program well. What are your thoughts about doing something similar to, say, Social Security where the administration, the costs of administration, are done separately.

And then, if you can, within that question, answer the following. The whole issue of using software for your billing purposes—and

I think you may have instituted this when you were the HCFA administrator—if people use computer technology to submit their claims rather than do paper claims, we can save some money. I am being told it is about $1 per claim that we save. The number I have is that there are 800 million claims submitted; 20 percent are still done by paper. There is $160 million at a $1 a claim that is additional cost to HCFA by not having more of our providers using the new technologies.

So, again, administration should be done more like Social Security and, two, how can we provide an incentive for providers to go more toward technology in the submission of claims?

Ms. WILENSKY. Let me do the second first and then I will go to the first.

Mr. BECERRA. Very quickly.

Ms. WILENSKY. I think that you ought to phase in the requirement, but it ought to be time-specific and tell physicians that if they are not reimbursed, then they will have to pay the additional costs. Institutions do it and I think if you had a 2- or 3-year period or some period of phase-in, as long as it was a date certain at that time, we would be done with it. If we had started that when I was there, we would be done for sure by now.

I am concerned about the administrative budget. I am a little nervous about putting more into entitlements. That seems to be the wrong direction to go. I don't know whether the HCFA legislation offers any type of road map where, as I understand it, there is some special funds because they are collected from fraud and abuse, but they are appropriated. I don't want to get away from the appropriation. I want to have Congress make a distinct decision, but if there is a way to have it not necessarily come out of the very limited discretionary moneys, there may be a way to respond to both areas.

Social Security, as I understand it, is a fixed percentage of the expenditures. That is too much of one more entitlement to make me comfortable. But there may be a way that was a direct appropriation, but being able to tap into the entitlement fund that would allow for the discipline of direct decisionmaking by the Congress, but without quite the competitive pressure that happens when you are fighting against vaccine money for low-income children or LIHEAP or any of the other discretionary programs that you have to deal with.

So I would like to explore that to try to respond to both issues.

Chairman THOMAS. I thank the gentleman for his question. I want to compliment him. Although his rules would have allowed him to stay here, he chose to go someplace better. But the commitment is appreciated, because you are still coming back although you are not on the roster.

Very quickly, how unfairly this may be, kind of yeses and noes, because I want to lay the groundwork as we go forward. You are on record, for example, in the February Health Affairs edition about Medicare, what is right and what is wrong and what is next. The commission has been focusing on a premium support model. Do you believe, if structured properly, that is an appropriate way to go?

Ms. WILENSKY. I personally, yes. The commission, MedPAC, has not taken a position.

Chairman THOMAS. While you have mentioned that you think that major reform in Medicare probably will not occur until 2005 or 2009, is that a fairly accurate representation of some of your predictions?

Ms. WILENSKY. I think that Congress is more likely to act in the year after a Presidential election and when the fiscal pressures mount. You are the gentlemen who are going to be voting, so I would be very happy to have you contradict that. But as——

Chairman THOMAS. Well often voting occurs in a climate and, depending upon the climate, it either has a chance for a greater success or less success. And, to the degree that people who are recognized as experts say it is 2005, it makes it a slightly more difficult environment.

When you take a look at the problems in terms of out years, it is fairly obvious one of the reasons is that, notwithstanding the better efficiency, effectiveness, getting value to beneficiaries, that the premium support model might save some money, if done correctly. And, if that is the case, isn't it better to start it sooner rather than later because of the impact on out years?

Ms. WILENSKY. My preference is that the decisionmaking be made sooner rather than later.

Chairman THOMAS. Thank you. One of the challenges is the question of transition. Do you have any thoughts—and I know you cannot now expound them—and I would very much like any discussion or presentation of transition questions, not tied to any specific plan, but moving from our current structure to a premium support model, because of the difficulty that we have had with the Medicare+Choice within HCFA and if, as per our dialog with the gentlewoman from Florida, my follow-up, that a number of those questions would be negated and, therefore, they would not be of concern in a transition discussion, between the current structure and a premium support model, in a general sense. And I would very much like—has the commission done any thinking on this?

Ms. WILENSKY. No.

Chairman THOMAS. Well, it has been fairly evident since the summer that we had maybe 10 and close to 11 votes and you would be the people we would be relying on, so I would like to put you on notice that, even if we don't get 11 votes, I believe Senator Breaux has indicated we are going to be talking about it legislatively. So on your August graduate medical exam report, we may be asking you to look at some of those questions. So if you think about them in general, you can plug in the specifics as we move forward.

With that, thank you very much. The Subcommittee stands adjourned.

[Whereupon, at 2:46 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of American College of Surgeons

The American College of Surgeons is pleased to submit this statement to the Ways and Means Health Subcommittee for the record of its hearing on the Medicare Payment Advisory Commission's (MedPAC's) 1999 report to Congress, which was held on March 2, 1999. The College's comments focus on Chapter 7 of that report,

which addresses the continuing reform of Medicare physician payments. Specifically, we have concerns about the report's discussion and recommendations regarding three key issues: resource-based practice expense relative value units (RVUs); professional liability insurance (PLI) expense RVUs; and the sustainable growth rate (SGR) system.

PRACTICE EXPENSE RVUS

The College is very concerned and, frankly, somewhat confused about the set of issues that the Commission chose to highlight for Congress in the section of Chapter 7 that addresses the transition to resource-based practice expense RVUs. In particular, we believe the Commission devoted an inordinate amount of space in that chapter to issues of concern to comparatively few physicians, while completely ignoring many issues that have been identified by the Health Care Financing Administration (HCFA) and others as having a significant impact on the distribution of payments among various physician specialties and services.

For example, the list included in the report of technical and methodological matters that will be considered during the transition to new practice expense RVUs contains no mention of the following refinement issues, many of which were identified by HCFA in its preamble to the final rule published on November 2, 1998:

- revisions of the practice expense per hour data;
- the accuracy and consistency of physician time data;
- the effect of rounding the amount of physician time assigned to high volume services of relatively short duration;
- the impact of averaging the clinical practice expert panel (CPEP) inputs for codes reviewed by more than one CPEP;
- the effect of mid-level practitioners on the calculation of practice expenses per hour; and
- the relevance of Y2K problems.

Further, MedPAC fails to note that none of the issues identified in the 14,000 public comments submitted on the proposed rule issued last June were ever addressed, including those involving more than 3,000 codes that were identified as misvalued. We are now in the first year of the transition to resource-based practice expense RVUs, and the amount of work that needs to be done by HCFA and the American Medical Association/Specialty Society RVS Update Committee is extraordinary. In fact, the publication schedule for the proposed rule that must be issued on the 2000 Medicare fee schedule effectively guarantees that the first two years of the three-year transition period will pass before any significant refinements can be made-even those that would address the most obvious data errors.

We agree with a recommendation made last month by the General Accounting Office (GAO) in its report, Medicare physician payments: need to refine practice expense values during transition and long-term, which advised HCFA to conduct sensitivity analyses to determine which issues have the greatest impact on Medicare payments and then prioritize its refinement efforts accordingly. We also believe that MedPAC and Congress should monitor HCFA's refinement activities closely. If the key issues that affect the distribution of practice expense payments in a substantial way are not resolved, we believe Congress should consider delaying the transition to fully resource-based practice expense RVUs for at least another year. In other words, the 50–50 blend of new and old RVUs would take effect on January 1, 2001, and the 75–25 RVU blend would begin on January 1, 2002—with full implementation of the new, refined practice expense RVUs beginning January 1, 2003.

We also noted that, unlike the recent GAO report, MedPAC did not express concern about the potential impact of cumulative Medicare payment reductions on beneficiary access to care. The transition to resource-based practice expense RVUs is causing many major surgical procedures to experience substantial Medicare payment reductions in addition to other payment cuts that occurred in prior years. Like GAO, we believe HCFA should be directed to monitor particularly hard-hit services closely for signs of impaired access.

We also believe that these cumulative payment reductions may more severely affect some practices than others. For example, practices that specialize in complex procedures are likely to experience aggregate payment reductions much more severe than the specialty level impacts published by HCFA in the final rule. We recommend that practice level impacts be estimated for different types of physician practices, such as those located in urban and rural areas, teaching hospitals, and those that focus largely on specific procedures such as major joint replacement. These additional impact analyses could serve as a critical first step for directing surveillance of possible access problems.

PLI EXPENSE RVUs

The implementation of resource-based RVUs for PLI costs is of considerable interest to the College. We are very concerned about the factual accuracy of many points raised by MedPAC in this section of the chapter, as well as the commission's sharp departure from previous recommendations on this issue.

The College disagrees with MedPAC's conclusion that the specifications set forth in the statement of work issued to the HCFA contractor do not describe RVUs that are fully resource-based. While we have some specific concerns and unanswered questions about the details of HCFA's proposal, we believe it is generally consistent with previous recommendations made by the Physician Payment Review Commission (PPRC) for a "risk-of-service" approach to developing resource-based RVUs. Interestingly, MedPAC offers no explanation of why that approach is no longer favored or how it is being modified by the current recommendation.

Further, it is unclear how RVUs for over 7,000 physicians' services can be developed with "the frequency of closed malpractice claims with payment, by service, as the basis for the RVUs," as now recommended by MedPAC. We are unaware of any nationally representative source of data that could be used by HCFA to comply with this recommendation. Even if such data were available, they are not likely to be useful in establishing RVUs for the thousands of services for which malpractice claims have never been filed. Additionally, the new approach being proposed by MedPAC seems unnecessarily complex, given the relatively straightforward nature of PLI costs.

We also are very concerned about the limited time available for HCFA to develop the new PLI expense RVUs and about the relatively limited information HCFA has shared with physician organizations about how it plans to do so. We understand that HCFA's contractor did not meet its due date of January 31, 1999, for submitting its first draft report. Thus, the agency is already behind schedule.

Finally, we would note that whatever method HCFA eventually uses to develop the RVUs should result in total payments to physicians that actually cover the cost of their PLI premiums. We made this point many times to HCFA with regard to the practice expense issue, and so far the agency has not provided any impact analyses to the public that are adequate for determining how the new practice expense payments compare with physicians' actual practice costs.

SGR LIMITS

As you know, the American College of Surgeons was an early supporter of the expenditure target concept as one means of addressing unnecessary increases in the utilization of physicians' services. We believe, however, that Medicare's SGR system and annual update calculation need to be revised.

We were very pleased, therefore, that the Commission recommended that Congress revise the SGR formula to include measures of changes in the demographic composition of Medicare fee-for-service enrollment. Such an adjustment is essential to recognizing the effect on physician expenditures of changes like the aging of the Medicare population and the continuing growth of managed care enrollment (which could leave relatively old and sick patients in the fee-for-service program).

We also are pleased the Commission recognizes that the SGR does not include an appropriate adjustment factor to represent improvements in medical technology and advancements in scientific technology. Currently, the SGR includes only a factor representing growth in the general economy, as measured by changes in the real gross domestic product (GDP) per capita.

We disagree, however, with MedPAC's conclusion that GDP growth is an appropriate indicator of the ability of the economy to finance health care services—called "affordability" in the report. We are not aware of studies showing that the economy suffers as the mix of economic activity shifts to more health care services. The College believes that targets setting limits on acceptable increases in physician expenditures should be based on the need for healthcare services-which bears no relationship to general economic growth.

The report also recommends that the Secretary of Health and Human Services correct estimates of various factors included in the SGR when more accurate data become available. The College strongly agrees with the Commission's recommendation, but we are somewhat puzzled by its statement that HCFA lacks the authority to make this change under current law. In last year's proposed regulation on the 1999 Medicare fee schedule, HCFA invited comments on the issue. We are not aware that the agency has concluded it lacks the authority under current law to correct estimates but, if that is indeed the case, Congress certainly must provide that authority if there is to be any logic behind the SGR system.

The College believes Congress should also consider several other shortcomings of the SGR system. These issues involve:

- Shifts in patient care settings. As services move from the inpatient hospital setting to various ambulatory settings, increased physician spending can result. The SGR, however, is not adjusted for these effects.
- Cumulative SGR formula. The current SGR is endlessly cumulative back to April 1, 1997. Under this formulation, physician spending that occurred years ago could result in inappropriate adjustments to the update for current years.
- Service-specific policy and volume changes. The lack of targeting in the SGR could result in services with relatively stable volume growth being subjected to payment reductions to compensate for volume and intensity increases in particular services. For example, some have expressed concern that revision in evaluation and management documentation guidelines may result in a substantially larger number of claims for high-level visit services.

CONCLUSION

Once again, the College appreciates this opportunity to present its views and looks forward to working with members of the subcommittee as they continue to review these and other issues affecting physician payments under Medicare.

Statement of American Medical Association

The American Medical Association (AMA) appreciates the opportunity to submit this written testimony for consideration by the Ways and Means Subcommittee on Health and requests that it be included in the printed record. Our statement will focus on the comments the AMA provided to the Medicare Payment Advisory Commission (MedPAC) regarding MedPAC's March 1999 report.

With the enactment of the Balanced Budget Act of 1997 (BBA), Congress opened a broad array of new private plans to Medicare patients and began the work that will be necessary to preserve the program for future generations. As with any new endeavor, careful monitoring is required to ensure that Medicare patients are protected as the new Medicare+Choice program is fully implemented. At the same time, we must all remember that most Medicare patients have decided to remain in Medicare's fee-for-service program, at least for now.

It is therefore important that Congress and MedPAC not lose sight of the potential problems that could arise in fee-for-service Medicare as payments are subjected to tighter and tighter constraints in the future. For this reason, the AMA is pleased that MedPAC has focused on both the Medicare+Choice and fee-for-service components of the Medicare program and we hope the subcommittee will follow this example.

The AMA finds much to like in the Commission's report. We have previously argued that Congress should modify the Sustainable Growth Rate (SGR) expenditure target established in the BBA and we are pleased that MedPAC is echoing many of our suggestions in this area. We also hope that Congress will follow the Commission's recommendation to reinstate the requirement that the Health Care Financing Administration (HCFA) report each spring on projected physician payment updates for the following year. We are supportive of the report's general conclusions on the Medicare+Choice program. However, we do not believe that MedPAC has provided sufficient analysis to justify its recommendation that Congress create a single expenditure target that would apply to all outpatient services.

SUSTAINABLE GROWTH RATE

Under the BBA, the SGR is based on projected changes in the Gross Domestic Product (GDP), Medicare payment rates, fee-for-service enrollment, and law and regulations. If Medicare expenditures grow by more or less than the SGR, physicians' payment updates the following year are reduced or increased by enough to offset the difference between actual spending and the target. However, increases above the normal inflation update cannot exceed 3% and reductions from the inflation update cannot exceed 7%.

Absent significant modifications in the SGR, physicians face payment constraints that are far more severe than Congress has imposed on any other sector of the health industry. According to HCFA and MedPAC, updates will ping pong between the MEI+3 and MEI–7 floor and ceiling. Overall, however, rates will fall. In fact, shortly before enactment of the BBA, the Congressional Budget Office (CBO) pre-

dicted that between 1998 and 2002, physician payments under the SGR would decline by 11% before adjustment for inflation and by 19% after adjustment for inflation.

No other health group has been asked to absorb this sort of across-the-board decrease in payments. In fact, the many managed care plans that are withdrawing from Medicare had been guaranteed a 2% per year pay raise under the BBA. This inequity is particularly ironic in view of the fact that physicians' track record in controlling the growth of their services has been far better in recent years than that of most other members of the health industry.

The underlying problem with the SGR is that it assumes that there is—or should be—some magic relationship between health costs and national productivity. In fact, however, growth in health spending typically exceeds growth in the GDP, and there is no reason to expect health expenditures and the GDP to rise at the same rate. If there were a serious economic downturn with negative GDP growth at the same time that a serious epidemic struck large number of Medicare patients, would Congress really want to hold physicians to a target that called upon them to reduce their services to the elderly?

Put another way, the SGR essentially decrees that no matter what happens, the use of physicians' services by fee-for-service Medicare patients cannot increase by any more than growth in the GDP. There is no attempt to adjust for technological advances, emerging medical needs, or changes in medical practice. As a result, the AMA is concerned that the current formula effectively puts the brakes on technological innovation and improvements in the medical care and health status of Medicare patients.

Congress has demonstrated its interest in fostering advances in medical technology and making these advances available to Medicare patients through FDA modernization, increases in the National Institutes of Health budget, and efforts to improve Medicare's coverage policy decision process. But the benefits of these efforts could be seriously curtailed if physicians face disincentives to adopt available new technologies into their practices because of inadequate expenditure targets.

The Physician Payment Review Commission had originally recommended a 1 to 2 percentage point add-on to the SGR to account for technology changes and MedPAC is repeating the call for a technology add-on. The AMA believes it is imperative that Congress modify the SGR to include a technology add-on of at least GDP+2. However, MedPAC has not identified a specific percentage so we suggest that in determining what the add-on should be, Congress should consult further with both the Commission and the Agency for Health Care Policy and Research.

Moreover, we urge Congress to consider other adjustments as well. As MedPAC points out in its report, fee-for-service patients in 1997 were somewhat older and sicker than in 1993 and physician payments per patient increased slightly as a result. The Commission is therefore calling for an SGR adjustment to reflect changes in the composition of Medicare fee-for-service enrollment. The AMA heartily endorses that recommendation and urges Congress to adopt language requiring adjustments for changes in the composition of the fee-for-service population. We note that HCFA recently observed in its proposed payment system for hospital outpatient departments that it is likely that Medicare patients who choose managed care will be healthier than those who stay in fee-for-service so that over time the intensity of services provided to the fee-for-service patients could rise.

As MedPAC has also pointed out, hospitals are reducing costs by trimming lengths of stay and scaling back on staff. As a result, physicians are performing some additional services in their offices and part of the hospital savings has translated to increased costs for doctors. Since the SGR penalizes physicians if growth in their services exceeds growth in the GDP, doctors' ability to recoup these increased costs is severely limited and the AMA is concerned about their ability to continue absorbing the increases without deleterious effects on care of their disabled and elderly patients.

The Commission has not yet addressed this issue. In the AMA's view, however, this is a critical flaw in the SGR. We ask that Congress direct MedPAC and HCFA to study the impact of this phenomenon and recommend an additional adjustment to account for the cost-shift from inpatient to outpatient settings.

While these adjustments would greatly improve the SGR, calculation of the target still will involve a series of difficult and sometimes subjective projections that may prove unreliable in the long run. In 1998, for example, actual GDP growth was nearly three times as high as HCFA's 1.1% projection. As a result, the 1998 SGR and the 1999 physician update were about 1.5 percentage points lower than they should have been. This mistake cost physicians some $645 million in 1999 and if not corrected will lead to additional losses in the future under the SGR's cumulative baseline.

As HCFA acknowledged in its November 2 announcement of the 1999 SGR, there is a good chance that this year's −0.3% target could be wrong as well. This negative target—which increases the likelihood that physicians will exceed the SGR and trigger payment reductions in future years—is due partly to the fact that first quarter data suggest that GDP growth will exceed HCFA's estimates again in 1999. However, the negative target results primarily from HCFA's totally unrealistic projection that in 1999, enrollment in fee-for-service would decline by 4.3% in fee-for-service and rise by 29% in managed care.

When HCFA published the SGR last November, the rate of growth in Medicare managed care enrollment had been declining each month since July, numerous managed care plans had withdrawn from Medicare, HCFA had curtailed its own informational campaign on Medicare+Choice and considerable publicity had been generated about the Medicare patient confusion surrounding the new options. HCFA did concede in the announcement of the SGR that "differences between its initial estimate and a later estimate could ... affect the SGR by as much as 1 percentage point" or $400 million in either direction. However, even this concession is based on an assumption that enrollment will grow by about 23%, which seems highly unlikely when enrollment growth has continued to decline and in January of 1999 was just 11% higher than in January of 1998. Notably, enrollment actually fell between December of 1998 and January of 1999.

To make matters worse, it appears that HCFA's forecast of growth in the GDP may be understated again in 1999. Hence it is possible that the projection error could be three to four times what HCFA concedes is possible.

The Physician Payment Review Commission recommended retroactive adjustments for projection errors, and a year ago HCFA indicated that it would make such adjustments. Medicare officials now say that even though they don't think "Congress contemplated such significant variations" between projected and actual elements of the SGR formula, the law may not give them the authority to make retroactive corrections. MedPAC has recommended that Congress require HCFA to correct the estimates used in the SGR calculations each year. The AMA concurs and believes that Congress should move immediately to rectify the injustice that was done to physicians this year.

Both HCFA and MedPAC have also pointed to a technical problem having to do with the varying time periods used in the SGR. A mismatch of the time periods is expected to trigger extreme oscillations with payments ping-ponging between positive and negative updates each year. HCFA has proposed a non-specific legislative fix and MedPAC has offered a more detailed proposal that would use the calendar year for both the period covered by the expenditure target and the period for which actual spending is compared to the target.

The AMA agrees that the oscillation problem needs to be addressed. However, we do not have enough information to evaluate HCFA's solution and we have some concerns that MedPAC's approach could exacerbate projection error. We would like to work with Congress as well as HCFA and MedPAC in designing a solution to this problem. In addition, we believe the SGR should be modified so that payment reductions of inflation–7 are never possible.

Finally, we want to make it possible for Congress and MedPAC to exercise more oversight of the SGR and the payment updates that it produces. Under the previous expenditure target, HCFA was required to provide projections of actual spending compared to the SGR each spring and to calculate the updates that would occur if Congress adhered to the expenditure target formula. The agency could recommend changes from the formula updates as could the Physician Payment Review Commission, which evaluated the HCFA report and offered its own independent advice to Congress. Sometimes Congress let the formula updates take effect. In other instances, it increased or reduced the formula rates.

When the old target was replaced with the SGR, Congress replaced the language requiring the spring reports with a provision requiring HCFA to report on the next year's SGR by August 1. Neither physicians nor policy-makers have any inkling of what the payment updates will be until they are announced in November. To make matters worse, the Administration was three months overdue in announcing that the 1999 SGR would be negative.

The current timing of the announcements precludes Congress or MedPAC from examining the data and determining if it will produce a reasonable effect. As a result MedPAC, as mandated by Congress, spends hours pouring over hospital financial data and evaluating the adequacy of projected hospital rate hikes. Ironically, however, neither Congress nor MedPAC even know what the physician update will be.

MedPAC has proposed to correct this disparity by requiring HCFA to publish the update report each year by March 31. The AMA believes that oversight of the physi-

cian update must be restored before physician payment rates fall to such low levels as to jeopardize physicians' ability to continue providing high quality care to Medicare patients. We therefore urge Congress to follow MedPAC's advice and to require that HCFA provide quarterly expenditure data as well so that both MedPAC and the physician community can compare actual spending against the target even if HCFA fails to produce its report in a timely fashion.

PRACTICE EXPENSE PAYMENTS

Another important physician issue is the practice expense changes that are now being refined by HCFA. We have some reservations about the Commission's suggestion that third-party payers other than Medicare be involved in future discussions of practice expense methodology. However, we believe the Commission has come up with a reasonable set of recommendations for dealing with HCFA's decision to create a separate and higher practice expense value for any service performed in a physicians' office rather than a facility.

We do not disagree with HCFA's basic premise that providing a service in the office generally costs physicians more than if they deliver the same service in a facility. However, HCFA has applied the policy even to procedures that are only rarely done in the office and a number of specialties have pointed to potential quality problems with this approach. We would therefore endorse MedPAC's solution to examine these differentials on a service-by-service basis and to apply the facility-based practice expense value in both the office and the facility unless there is clinical consensus that the procedure can be safely performed in the office.

PAYMENTS IN OTHER OUTPATIENT SETTINGS

In its most recent report, MedPAC is repeating a previous recommendation that prospective payments for hospital outpatient departments and ambulatory surgical centers should be based on individual services, not groups of services. The AMA agrees. Physicians examining the proposed system have found it replete with problems that threaten Medicare patients' access to certain services such as the newest and most appropriate cancer drugs. In addition, we do not believe it will ever be possible to extend a system that calls for so much averaging into physicians' offices. HCFA has persisted in the grouping approach despite MedPAC's recommendations, however, so we believe Congress should now direct HCFA to develop a new methodology that is based on individual services rather than ambulatory patient classifications.

While we share MedPAC's skepticism about the payment system that HCFA is developing to pay for hospital outpatient and ambulatory surgical center care, the AMA does not understand the Commission's enthusiasm for creating a new expenditure target that would include all outpatient services in a single target. In the BBA, Congress directed the Administration to develop a "method for controlling unnecessary increases in the volume of covered" services in hospital outpatient departments. We believe that this emphasis on the control of unnecessary services was wise and would like to remind the subcommittee that expenditure targets do not distinguish between necessary and unnecessary services. Rather the target applies across the board, including all services in its scope and then reducing payments for all services, not just those that are believed to be unnecessary, if the target is exceeded.

In addition, the Commission has spent very little time examining the details of how an expenditure target for other outpatient services might work. MedPAC members have never been presented with alternative designs. Nor have they seen comparative data on the impact of all-encompassing targets versus sector-by-sector targets where physicians and hospital outpatient departments each would have their own separate targets. The AMA therefore urges Congress to reject MedPAC's recommendation that Congress should direct HCFA to "develop and implement a single update mechanism that would link conversion factor updates to volume growth across all ambulatory care services."

MEDICARE+CHOICE

On another issue of great importance to Medicare patients, the AMA appreciates MedPAC's efforts to ensure a smooth implementation of the new Medicare+Choice program created by the BBA. While we endorse the expansion of private options to the traditional Medicare program, we believe that success will depend upon the development of a fair and equitable payment method that does not encourage biased selection. The AMA therefore supports the Commission's recommendation that a new risk-adjuster begin on schedule in January of 2000. We also concur with HCFA's and MedPAC's call for a five-year phase-in of the new adjuster.

Like the Commission and Congress, the AMA is worried about the impact of managed care plan withdrawals on Medicare patients. We would not like to see a repeat of the massive exodus that occurred last fall. We note, however, that managed care plans are guaranteed a 2% increase in payments every year while fee-for-service physicians face potential cuts in their payments. We therefore agree with MedPAC that Congress should adopt a wait-and-see approach before taking any drastic steps to encourage the managed care industry to continue to serve Medicare patients.