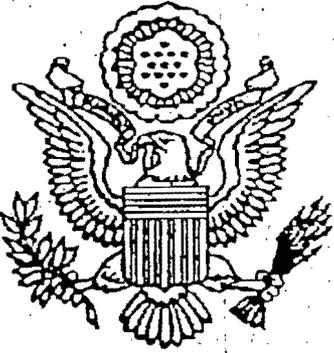


Home Health File



United States Senate  
COMMITTEE ON FINANCE

Daniel Patrick Moynihan  
Ranking Minority Member

To: Chris Jensen

From: Katie Hartman

Total Pages (including cover): 12

Fax #: 456-5557

Date: \_\_\_\_\_

Time: \_\_\_\_\_

Comments: \_\_\_\_\_

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203 HART SENATE OFFICE BUILDING  
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Senate Finance Committee  
Bipartisan Medicare Home Health Payment Reform

**Issue Summary**

Significant Medicare payment issues for home health care have emerged from analysis of the impact of multi-year BBA 97 provisions. There are severe equity issues in payment limit levels both across states and within states. These wide disparities (ex. limits on reimbursement ranging from \$760 to \$53,000 on average, per beneficiary) are exacerbated by a major distinction drawn in payment rules between so-called new vs. old agencies.

The effects are that comparable agencies providing comparable services in the same community face very different reimbursement limits, leading to highly arbitrary payment differences.

The payment limit issues deepen significantly in 1999 due to a scheduled 15% cut in already tight and severely skewed payment limit levels. Further, a case-mix adjusted prospective payment system scheduled to go on-line in October, 1999 will be delayed by several months to one year.

**Steps to an Improved Interim Payment System**

- 1) **Equity:** Reduce extreme variations in payment limits applicable to old agencies within states and across states. (*Budget-neutral blend for old agencies*)
- 2) **Fairness:** Reduce artificial payment level differences between "old" and "new" agencies. Such provider distinctions exist nowhere else in the Medicare system and contribute to the perception of arbitrariness in the home health care system. Do not create additional classes of home health agencies, such as "new-new" agencies subject to even deeper, arbitrary payment limits in the future. This is an inappropriate barrier to entry in underserved areas. (*Eliminate 2% discount applicable to new agencies. Raise the per visit limits for all agencies from 105% to 110% of the national median*)
- 3) **Accelerate PPS Implementation:** Take all feasible steps to minimize delay in implementation of the prospective payment system. (*Require HCFA to accelerate data collection efforts - based on the OASIS patient assessment instrument - necessary to develop the case-mix system at the heart of the PPS model*)
- 4) **Lengthened Transition Period for Payment Changes:** Provide all agencies a longer transition period in which to adjust to changed payment limits, and create a sustainable fiscal base for the statutorily mandated prospective payment system in 1-2 years. (*Delay the implementation of PPS and the scheduled 15% cut affecting all agencies for one year*)
- 5) **Budget Neutrality:** Include technical correction to BBA. (*Uniformly apply the BBA Medicare bad debt payment changes to all applicable providers*)

*See other page description of PPS form*

## DESCRIPTION OF PROPOSAL

Reduces state and regional differences for "old" agency payments; brings down the per beneficiary limits for the highest cost "old" agencies; raises the per beneficiary limits for the lower cost "old" agencies and eliminates current 2% discount on per beneficiary limits applicable to new agencies! Raises the separate average cost per visit limits for all agencies.

CBO ESTIMATE: budget neutral through 2003

## Per Beneficiary Limits

1. "Old" agencies: payment is 50% BBA policy + 50% (50% national mean + 50% regional mean);
2. "New" agencies: payments are increased by 2% to equal 100% of the national median (about \$3,450), (which continues to be regionally adjusted for wages); and

## Per Visit Limits

3. Increase the per visit limits from 105% to 110% of the median.

## Delay 15% across-the-board cuts

4. Delay of the 15% across-the-board cuts in payment limits and the implementation of the prospective payments system now scheduled to take effect on October 1, 1999.

## Offset

5. Include technical correction of a drafting error to BBA on Medicare bad debt payments. Uniformly apply bad debt payment policy to all applicable Medicare providers.

See other handout for pay-for explanation.

## COMPARISON OF SENATE VERSUS HOUSE HOME HEALTH POLICIES

### A. Delay 15% across-the-board cuts

#### SENATE

1. Delay of the 15% across-the-board cuts in payment limits and the implementation of the prospective payments system now scheduled to take effect on October 1, 1999.

#### HOUSE

1. No delay of the 15% cut in payment limits.

### B. Per Visit Limits

#### SENATE

1. Increase the per visit limits from 105% to 110% of the national median.

#### HOUSE

1. Increase the per visit limits from 105% to 108% of the national median.

### C. Per Beneficiary Limits

#### SENATE

1. "Old" agencies (all): payment is 50% BBA policy + 50% (50% national mean + 50% regional mean); and
2. "New" agencies: payments are increased by 2% to equal 100% of the national median, (which continues to be regionally adjusted for wages).

#### HOUSE

1. "Old" agencies (above the median per beneficiary limit): no change;
2. "Old" agencies (at or below the median per beneficiary limit): limit is increased by 50% of the difference of their BBA cap and the national median;
3. "New" agencies (opening between 10/1/94-10/1/98): payment is 50% of BBA policy + 50% (75% national median + 25% regional mean [national median and regional mean have a 2% BBA reduction]) and a hold harmless provision is instituted; and
4. "New-New" agencies (opening after 10/1/98): payment is 75% of the national median [national median has a 2% BBA reduction].

### D. Offset

#### SENATE

1. Reduce the home health care annual market basket (MB) in the following manner: for fiscal year 2000 it is MB minus 0.5 percentage point; for FY 2001 it is MB minus 0.5 percentage point; for FY 2002 and FY 2003 it is full MB; and in FY 2004 it is MB plus 1.0 percentage point. **Savings of \$300 million over 5 years.**
2. **Non-Controversial Revenue Raisers - Revenues of \$406 million over 5 years**

- a. Math Error Procedures -- This provision would clarify the math error procedures that the IRS uses.
  - b. Rotavirus Vaccine -- This provision will add an excise tax of 75 cents on a vaccine against rotavirus gastroenteritis, a highly contagious disease among young children.
  - c. Modify Net Operating Loss Carryback Rules -- Certain liability losses can be carried back over ten years. This provision would clarify the types of losses that qualify for the 10-year carry-back.
  - d. Non-Accrual Based Method -- This provision would limit the use of the non-accrual experience method of accounting to amounts received for the performance of certain professional services.
  - e. Information Reporting -- This provision requires reporting on the cancellation of indebtedness by non-bank institutions.
3. Budget Pay-Go surplus for remaining offset.

### HOUSE

1. Raise the income limit on the Roth IRA from \$100,000 to \$145,000.

### ADDITIONS TO HOUSE HOME HEALTH POLICY

- A. VA Subvention (\$500 million over 5 years, \$1.9 billion over 10)
  - a. Allows VA to establish networks to deliver care to "Category A" Medicare-eligible veterans; and
  - b. Permits "Category C" Medicare-eligible veterans to receive care at VA facilities (3-year demonstration project).
- B. Medigap Dialysis (<\$50 million over 5 and 10 years)
  - a. Allows dialysis facilities to resume subsidizing Medigap and Part B premiums for low-income patients and gives the Secretary of HHS rule making authority over this process; and
  - b. Allows dialysis providers to obtain advisory opinions from the IG to determine whether payment of Medigap and Part B premiums violates HIPAA.
- C. MedPAC Expansion (\$135,000 over 5 years, <\$1 million over 10))
  - a. Increases the number of members of MedPAC from 15 to 17.

## SUMMARY OF THE PROPOSED CHANGES TO MEDICARE HOME HEALTH PAYMENTS

### Per Beneficiary Limits

1. "Old" agency: payment is a blended formula equal to 50% BBA policy + 50% (50% national mean + 50% regional mean);
2. "New" agency: payment is increased by 2% to equal 100% of the national median, (which continues to be regionally adjusted for wages); and

### Per Visit Limits

3. Increase the per visit limits from 105% to 110% of the median.

### Delay both the 15% across-the-board cuts and the PPS

4. Delay of the 15% across-the-board cuts in payment limits and the implementation of the prospective payments system now scheduled to take effect on October 1, 1999.

### Description of Offset Policies

1. Reduce the home health care annual market basket (MB) in the following manner: for fiscal year 2000 it is MB minus 0.5 percentage point; for FY 2001 it is MB minus 0.5 percentage point; for FY 2002 and FY 2003 it is full MB; and in FY 2004 it is MB plus 1.0 percentage point. Savings of \$300 million over 5 years.
2. Non-Controversial Revenue Raisers Revenues of \$407 million over 5 years.

Math Error Procedures -- This provision would clarify the math error procedures that the IRS uses.

Rotavirus Vaccine -- This provision will add an excise tax of 75 cents on a vaccine against rotavirus gastroenteritis, a highly contagious disease among young children.

Modify Net Operating Loss Carryback Rules -- Certain liability losses can be carried back over ten years. This provision would clarify the types of losses that qualify for the 10-year carry-back.

Non-Accrual Based Method -- This provision would limit the use of the non-accrual experience method of accounting to amounts received for the performance of certain professional services.

Information Reporting -- This provision requires reporting on the cancellation of indebtedness by non-bank institutions.

3. Budget Pay-Go surplus for remaining offset.

Old Agency Per Bene Limit: 50% BBA +50% (50% national mean - 50% regional mean)  
 New Agency Per Bene Limit: 100% National Median Limit  
 Per Visit Limit: 110% Median Cost Per Visit

Percent of Agencies in Each Payment Change Group

	Number of Agencies	Lose 10%+	Lose 5%<10%	Lose up to 5%	Gain up to 5%	Gain 5%<10%	Gain 10%+
U.S.	9,891	0.05	2.69	15.14	78.55	3.34	0.23
ALABAMA	183	0.00	0.55	19.67	78.69	1.09	0.00
ALASKA	20	0.00	5.00	15.00	75.00	5.00	0.00
ARIZONA	114	0.00	3.51	15.79	78.07	2.63	0.00
ARKANSAS	202	0.00	0.99	8.42	88.61	1.98	0.00
CALIFORNIA	817	0.00	1.22	9.92	85.80	2.94	0.12
COLORADO	174	0.57	4.60	16.09	74.14	4.02	0.57
CONNECTICUT	104	0.00	2.88	32.69	53.85	10.58	0.00
DELAWARE	19	0.00	0.00	26.32	57.90	15.79	0.00
DIST. OF COL.	21	0.00	0.00	0.00	100.00	0.00	0.00
FLORIDA	378	0.00	3.71	26.72	67.99	1.32	0.27
GEORGIA	97	1.03	5.15	45.36	48.46	0.00	0.00
HAWAII	22	0.00	0.00	13.64	77.27	4.55	4.55
IDAHO	73	0.00	0.00	15.07	83.58	1.37	0.00
ILLINOIS	369	0.00	2.17	16.80	73.71	7.32	0.00
INDIANA	282	0.00	2.84	16.67	80.14	0.36	0.00
IOWA	205	0.00	2.44	4.39	82.44	9.27	1.46
KANSAS	202	0.50	1.98	12.87	80.69	3.47	0.50
KENTUCKY	112	0.00	0.90	11.61	85.72	1.78	0.00
LOUISIANA	466	0.00	11.16	24.03	64.81	0.00	0.00

Old Agency Per Bene Limit: 50% BBA +50%, (50% national mean + 50% regional mean)  
 New Agency Per Bene Limit: 100% National Median Limit  
 Per Visit Limit: 110% Median Cost Per Visit

Percent of Agencies in Each Payment Change Group

State	Number of Agencies	Lose 10%+	Lose 5%<10%	Lose up to 5%	Gain up to 5%	Gain 5%<10%	Gain 10%+
MAINE	47	0.00	0.00	10.64	85.11	4.25	0.00
MARYLAND	78	0.00	0.00	8.98	84.62	6.41	0.00
MASSACHUSETTS	192	0.52	5.21	28.65	62.50	3.13	0.00
MICHIGAN	230	0.00	0.87	14.79	77.83	6.52	0.00
MINNESOTA	261	0.00	0.38	7.28	83.52	7.28	1.53
MISSISSIPPI	69	0.00	5.80	34.78	57.97	1.45	0.00
MISSOURI	247	0.00	1.21	19.83	74.09	4.86	0.00
MONTANA	61	0.00	0.00	8.19	85.24	6.55	0.00
NEBRASKA	83	0.00	1.20	3.61	87.95	7.23	0.00
NEVADA	44	0.00	2.28	22.73	75.00	0.00	0.00
NEW HAMPSHIRE	46	0.00	0.00	6.52	82.61	10.87	0.00
NEW JERSEY	58	0.00	0.00	6.89	79.31	13.80	0.00
NEW MEXICO	102	0.00	0.98	10.78	88.24	0.00	0.00
NEW YORK	226	0.00	0.89	14.60	73.45	9.74	1.33
NORTH CAROLINA	166	0.00	0.60	20.48	71.08	7.83	0.00
NORTH DAKOTA	34	0.00	2.94	5.89	82.35	8.82	0.00
OHIO	452	0.00	1.55	9.51	83.41	4.87	0.66
OKLAHOMA	336	0.30	4.17	11.61	83.63	0.30	0.00
OREGON	80	0.00	2.50	18.75	75.00	2.50	1.25
PENNSYLVANIA	375	0.00	1.86	13.87	75.73	8.27	0.27

Old Agency Per Bene Limit: 50% BBA + 50% (50% national mean + 50% regional mean)  
 New Agency Per Bene Limit: 100% National Median Limit  
 Per Visit Limit: 110% Median Cost Per Visit

Percent of Agencies in Each Payment Change Group

State	Number of Agencies	Lose 10%+	Lose 5%<10%	Lose up to 5%	Gain up to 5%	Gain 5%<10%	Gain 10%+
RHODE ISLAND	28	0.00	3.57	17.86	75.00	3.57	0.00
SOUTH CAROLINA	80	0.00	1.25	16.25	81.25	1.25	0.00
SOUTH DAKOTA	52	0.00	1.92	3.84	88.46	3.84	1.92
TENNESSEE	222	0.00	12.61	38.73	48.20	0.45	0.00
TEXAS	1,758	0.00	2.33	11.04	86.52	0.11	0.00
UTAH	75	0.00	2.67	26.67	70.67	0.00	0.00
VERMONT	13	0.00	0.00	7.69	84.62	7.69	0.00
VIRGINIA	226	0.00	1.33	14.60	80.53	3.10	0.44
WASHINGTON	67	0.00	0.00	17.91	76.12	5.97	0.00
WEST VIRGINIA	88	0.00	1.14	5.68	88.64	4.54	0.00
WISCONSIN	176	0.00	2.27	11.37	78.98	6.82	0.57
WYOMING	59	0.00	1.69	16.95	81.36	0.00	0.00

NOTE: Payment changes reflect the difference between estimated fiscal year 1998 payments under BBA and estimated payments if the alternative policy were implemented that year.

Total agency counts reflect estimates from the Health Care Financing Administration's OSCAR system as of August 1, 1998. "Old" agency counts reflect the 5214 agencies in MedPAC's data base with cost reporting periods ending in fiscal year 1994. "New" agency counts reflect differences between OSCAR totals and MedPAC's count of "old" agencies. Total impacts are weighted to reflect the OSCAR agency counts. "Old" agencies may be overrepresented here because the model does not account for "old" agency closures. The regional portion of the per beneficiary limits does not reflect differences in wages while the regional portion of the actual limits would.

SOURCE: Medicare Payment Advisory Commission, October 6, 1998.

At the Heart of home health care



Visiting Nurse Associations of America

October 8, 1998

The Honorable Daniel P. Moynihan  
United States Senate  
Washington, D.C.

Dear Senator Moynihan:

On behalf of the Visiting Nurse Associations of America (VNAA), I want to thank you, Chairman Roth, and the entire Senate Finance Committee for the tremendous effort you have put forward during the past several days to revise the Medicare home health interim payment system (IPS).

VNAA strongly supports the Senate Finance Committee's IPS reform proposal and we have urged our members to ask their Senators to support the legislation when it is considered by the full Senate. Your proposed legislation creates a fair reimbursement system for home health care and certainly one that we can live with until the implementation of prospective payment.

During this final stage of negotiation, we urge you to add a provision that would exempt agencies on the PPS Demonstration Project from the IPS per-beneficiary limits during the fourth year of the project. These 45 agencies would still be subject to the IPS per-visit limits. This provision would make the fourth year of the demonstration consistent with the prior three years in terms of payment levels for similar services.

Thank you again for your support of this important legislation.

Sincerely,

A handwritten signature in cursive script that reads "Carolyn Markey".

Carolyn Markey  
President and CEO

At the Heart of home health care

**VNAA**

Visiting Nurse Associations of America

October 10, 1998

The Honorable Daniel Patrick Moynihan  
 United States Senate  
 Washington, D.C. 20510

Dear Senator Moynihan:

The Visiting Nurse Associations of America (VNAA) deeply appreciates your efforts to craft a solution to the problems caused by the Medicare home health interim payment system for our members and other cost effective home health agencies. Urgent action is needed before Congress adjourns to provide relief to these agencies to assure that they can continue to care for their Medicare patients.

We understand that one barrier to action has been the difficulty in finding acceptable funding offsets to the modest Medicare spending required to achieve a workable package. We have been advised that the Finance Committee is currently considering an adjustment to future home health market baskets that would generate approximately \$300 million in new Medicare savings to offset in part the cost of the one year delay in the automatic 15% reduction in home health payments now scheduled for October 1, 1999. Specifically, VNAA understands that this proposal would reduce the market basket index in 2000 and 2001 by 0.5 percentage point. In 2002 and 2003 the full market basket index would be used, and in 2004 the market basket would be increased by one percentage point.

VNAA strongly supports the delay in the 15% cut and supports the adjustment to future home health market baskets as a needed partial offset to the cost of that important action.

VNAA hopes that its support for this offset will facilitate quick action by the Senate. If there are any questions about our position, please contact our Washington Representative, Randy Fenninger, at 202-833-0007, Ext. 111.

Thank you for your continued efforts on behalf of cost effective home health agencies and their patients.

Sincerely,

*Carolyn Markey*  
 Carolyn Markey  
 President and CEO



NATIONAL ASSOCIATION FOR HOME CARE

328 Seventh Street, SE, Washington, DC 20003 • 202/547-7424 • 202/547-3540 fax

Mary Suther  
Chairman of the Board  
Val J. Halamandaris  
President

Honorable Frank E. McGuire  
Senior Counsel  
Stanley M. Brand  
General Counsel

October 7, 1998

Honorable William V. Roth, Jr.  
Chair  
Committee on Finance  
United States Senate  
Washington, D.C. 20510

Dear Senator Roth:

The National Association for Home Care (NAHC) is the largest home care organization in the nation, representing all types of home health agencies and the patients they serve. We have had continuing concerns over the past year regarding the effects of the home health provisions of the Balanced Budget Act of 1997, particularly the interim payment system (IPS).

We are pleased that you and other members of the Senate Finance Committee have shown the leadership to develop a package of IPS refinements that will help to ease some of the most pressing problems of the new payment system. We are particularly grateful for your inclusion of a one-year delay of the 15 percent reduction that is currently scheduled for October 1, 1999. While there remain a number of important issues relating to the IPS that we believe must be addressed in the 106th Congress, your proposal will make a meaningful difference in helping agencies to remain open and to serve Medicare beneficiaries throughout the nation.

Many thanks for all of your efforts. We look forward to working with you, members of the House of Representatives, and others in developing additional relief legislation early next year.

Sincerely,

Val J. Halamandaris  
President

Home Health Care

DATE: 10/8/98



**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**ROOM 405H, HUMPHREY BUILDING**  
**200 INDEPENDENCE AVE, SW**  
**WASHINGTON, D.C. 20201**

PHONE: (202)690-7450

FAX: (202)690-8425

TO: Chris Jennings  
OFFICE: \_\_\_\_\_  
ROOM: \_\_\_\_\_  
PHONE: \_\_\_\_\_  
FAX: \_\_\_\_\_

- FROM:
- JANE HORVATH
  - ANN BOWKER
  - HOLLY BODE
  - SHARON CLARKIN
  - GREGORY JONES
  - ANDREA LEVARIO
  - ROGER MCCLUNG
  - TANISHA PARKER
  - MARC SMOLONSKY
  - CARL TAYLOR
  - STEPHANIE WILSON
  -

Ways Means May. IPS Bill -  
 Stark remarks on costs.  
 There is no CBO paper (we can see why).  
 But CBO sez - \$2.4b cost/5yrs  
 ROTH IIA \$2.4b saving/5yrs  
 ROTH IIA - \$10.7b loss/10years

(INCLUDING COVER): 6

**REMARKS:**

The amendment is 44 pages. I'm sending a courier in the a.m. & will get you a copy then if you like.

**STATEMENT OF CONGRESSMAN PETE STARK  
IN THE HOUSE OF REPRESENTATIVES  
ON HOME HEALTH AND OTHER MEDICARE LEGISLATION  
October 8, 1998**

Mr. Speaker:

This bill is nothing more than a tax break for the wealthy disguised as a Medicare bill. It's a perk for Members of Congress who, along with their spouses, will now be eligible for a new tax shelter - Roth IRAs.

We have had no chance to study the home health proposal. Relative to the bill reported out of Ways and Means, it moves money toward new, for-profit agencies, who have been the cause of the home health funding crisis. Many of these agencies have been the very definition of fraud, waste, and abuse.

The health policy in this bill is not as good as the policy in the bill reported from Ways and Means—but it is not bad.

What is horrendous, what is totally unacceptable is the pay for and the budget implications! This bill loses \$10.7 billion over 10 years. It is absurd, but true that the Treasury would be better off if the Majority did NOT try to pay for the bill!

With this bill, you are spending the surplus. You are creating a tax loophole for the very upper income, that will cost billions and billions in the out-years--just when we will need the money to save Medicare and extend its life. This proposal is poor tax policy AND poor budget policy. We should be saving the surplus for Medicare—not spending it to please some for-profit home health agencies that have been abusing the program. Between now and 2008 when the Medicare Trust Fund will be exhausted, we will need about \$325 billion—yet this bill gives away billions and adds to that pending crisis.

Over the next 5 years, Medicare will spend about \$1.1 trillion. You would think that we could find zero-point-two (0.2) percent out of current Medicare spending. There is a National Bipartisan Commission on the Future of Medicare that is trying to save Medicare for future generations, but if we can't find 0.2%, and give away billions of dollars that could be saved for Medicare, what does that say about the worth of that Commission? The Majority's pay for will undoubtedly run into budget rules in the Senate, and will be opposed by the Administration. To offer such a pay for smells like a poison pill.

**SUMMARY OF HOME HEALTH POLICY**

	CURRENT LAW	NEW POLICY
CBO SCORE/ 5 YEARS:	N/A	\$2.0 BILLION
"OLD" AGENCIES ABOVE THE MEDIAN PER BENEFICIARY LIMIT	75% AGENCY + 25% REGION (minus 2% reduction)	NO CHANGE
"OLD" AGENCIES AT OR BELOW THE MEDIAN PER BENEFICIARY LIMIT	75% AGENCY + 25% REGION (minus 2% reduction)	INCREASED BY 1/2 THE DIFFERENCE OF BBA CAP AND NATIONAL MEDIAN
AGENCIES OPENING AFTER 10/1/94 AND BEFORE 10/1/98	NATIONAL MEDIAN WITH A 2% REDUCTION	HOLD HARMLESS PROVISION: GUARANTEED MINIMUM AT 100% OF NATIONAL MEDIAN  CHANGED TO 50% BBA + 50% (( 75% NATIONAL MEDIAN + 25% REGIONAL MEAN))  NOTE: National and regional amounts in the formula have the 2% BBA reduction
AGENCIES OPENING AFTER 10/1/98	NATIONAL MEDIAN WITH A 2% REDUCTION	75% OF NATIONAL MEDIAN  NOTE: National median has a 2% reduction
PER VISIT LIMITS	105% OF NATIONAL MEDIAN	108% OF NATIONAL MEDIAN
REPORTS BY HCFA, MEDPAC, AND CAO		NEW REQUIREMENT

**POLICY FOR NEW PROVIDERS (OPENED AFTER 1994 AND BEFORE 10/1/98):**

$50\% \text{ BBA} + 50\% (75\% \text{ NATIONAL MEDIAN} + 25\% \text{ REGIONAL MEAN})$

This is equal to:

$57.5\% \text{ NATIONAL MEDIAN} + 12.5\% \text{ REGIONAL MEAN}$

Both the national median and the regional mean have a 2% reduction

**STATEMENT OF CONGRESSMAN PETE STARK  
BEFORE THE RULES COMMITTEE  
ON HOME HEALTH AND OTHER MEDICARE LEGISLATION  
October 8, 1998**

Mr. Chairman, Members of the Committee:

We have had no chance to study the home health proposal. Relative to the bill reported out of the Ways and Means Committee, it moves money toward new, for-profit agencies, that have been the cause of the home health funding crisis. Many of these agencies have been the very definition of waste, fraud, and abuse.

The health policy in this bill is not as good as the policy in the bill reported from Ways and Means, but there is enough good policy in this bill for many Democrats to support it on health policy grounds.

What is horrendous and totally unacceptable, however, is the so-called pay-for. The sponsors of this bill propose to get around the House budget rules by paying for this bill with a budget trick that raises money in the short-run but loses far more money in the long-run.

This home health bill now costs \$10.7 billion over 10 years, money that is needed to save Social Security and Medicare. It is absurd, but true, that the American people would be better off if we did NOT pay for this bill at all. The health policy in this bill costs \$5.8 billion over ten years. The provision to pay for it balances the cost over five years but then starts costing the treasury money. Over ten years it would lose \$4.9 billion on top of the cost of the home health provisions for a total of \$10.7. That's because it creates a tax loophole for the highest earners that will cost billions and billions in the out-years, just when the money will be needed the most to save Medicare.

If this is the way we are going to deal with financing health care initiatives in Congress, I fear the future of Medicare is grim. If the Republicans cannot find \$1.4 billion to pay for this bill without such budgetary shenanigans, how will he ever find the \$325 billion needed over the next nine years to keep Part A of the Medicare Trust Fund solvent?

The Republicans have spent much of this last Congress claiming that if we don't get the surplus out of Washington, Democrats will find a way to spend it. Now, Republicans must feel that the people are so distracted by other matters that they themselves figure it's o.k. to use the surplus for a SPENDING bill.

The Republicans love to talk about how much waste there is in the Federal Government. But they can't find \$2.4 billion over five years — a fraction of a fraction of a percent of the total budget — to pay for this bill. Instead, they prefer to take advantage of a loophole in the rules and attach a provision that raises some money in the short run and loses \$10.7 billion in the long-run.

I can only hope that in the Senate, numerous points of order will be raised pointing out the complete fiscal irresponsibility of legislating this way. And I can not imagine that the President, who has promised the American people to preserve every penny of the projected surplus, would ever be fooled by this poorly-veiled attempt to avoid fiscal discipline.

~~Furthermore, the bill does nothing to address the major problem facing some health agencies. It does not postpone the 15% cut scheduled for next fall. That will be a killer cut to the senior citizens and sick and injured Americans who depend on home health care. We must remove the threat of that cut.~~

~~Therefore, I ask that one amendment be made in order to delay the 15% cut one year. That will cost \$1 billion. To finance that cost, the amendment would reduce the cap on the Medicare Medical Savings Account demonstration project from 390,000 to 100,000 over the short-term, and in exchange, extend the life of that demonstration, and in FY 2004 expand its size to 500,000. Although the MSA demo was to start in 1999, NO ONE has signed up to sell them yet. The program clearly will not reach the 100,000 figure in the early years, yet CBO will score us with savings if we lower the cap to a more realistic level.~~

~~I urge that this amendment — delay in the 15% cap paid for by a reduction in the MSA demo that will hurt no-one — be in order.~~

## DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Health Care Financing Administration

The Administrator  
Washington, D.C. 20201

SEP 14 1998

The Honorable Bill Thomas  
U.S. House of Representatives  
Washington, D.C. 20515

Dear Chairman Thomas:

I am responding to your August 12, 1998 and September 9, 1998 letters about the effects of the interim payment system (IPS) on home health services for Medicare beneficiaries. You requested that I provide information on the ability of the Health Care Financing Administration (HCFA) to administer several alternative proposals and any effect of these proposals on our ability to achieve our most critical short-term priority, which is to ensure that there is no disruption in Medicare payments or services to providers or beneficiaries on January 1, 2000.

In keeping with the strong interest of members of Congress in considering adjustments to the interim payment system, we have been providing technical assistance to Members and staff on an ongoing basis. We are committed to working with the Congress on any proposal that has bipartisan support, is budget-neutral or is associated with specifically defined offsets, protects vulnerable beneficiaries and is administratively feasible. I have addressed the feasibility of each of your options below as you requested.

We have worked diligently to implement the Balanced Budget Act provisions affecting home health care. On March 31, 1998, we released final regulations on the aggregate beneficiary limits (ABLs) under the interim payment system, and on August 11, 1998, we updated the limits for FY 1999. We have also worked to close loopholes that served to invite fraud in home health care. We raised the standards for enrollment in Medicare and issued guidance to help home health agencies prevent problems by establishing voluntary compliance programs. We note the recent analysis by the Congressional Budget Office (CBO) that antifraud initiatives focused on home health accounted for more than 90 percent of the drop in their home health baseline.

We are also making steady progress in developing the home health prospective payment system prescribed by the Balanced Budget Act. But, based on the recommendation of our expert Year 2000 consultants, we have determined that the implementation of this new payment system must be postponed to allow our contractors adequate time for renovating and testing the claims payment system.

Page 2:

We are monitoring a number of aspects of the home health program, including the number of agencies entering and leaving the program, claims and spending data, and the number of visits. We have provided technical assistance to Congressional staff and clarified our ability to administer a variety of different proposals. In conjunction with this effort, we have also provided information to the Medicare Payment Advisory Commission, the General Accounting Office (GAO), and the CBO. Our findings mirror the GAO's findings that, thus far, it does not appear that the changes made by the Balanced Budget Act have had a negative impact on beneficiary access to this important service. We will continue to monitor this situation.

The critical need to complete our renovation and testing of contractor payment systems for the Year 2000 does limit the range of proposals to change the interim payment system. We can make changes in the current cost limits using currently available databases. We cannot make changes to the current claims processing system, create any new databases, or undertake computer programming for a new system. For example, changing the base year from FY 1994, while seemingly simple, would require extensive data gathering and programming changes and cannot be accomplished in the next few months. We can, however, change the aggregate per-visit limit using databases currently available.

We could also change the blend of national, regional, or agency-specific rates based on the FY 1994 data used for the current aggregate beneficiary limits. The agency-specific component of the interim payment system is a rough proxy for case-mix. Therefore, reducing the portion of the limit that is based on an agency's historical costs would have both advantages and disadvantages. It would reduce the variation in ABLs among agencies in the same area, including new and old agencies. Agencies that have provided care efficiently would benefit since their historical costs would most likely be lower than the regional or national averages and thus their Medicare payments would increase. However, Medicare payments could be reduced for agencies with higher costs because the agency-specific component might currently be above the regional or national averages, due to legitimately higher case-mix.

An "outlier" system to increase payment to agencies with more costly patients has also been suggested. A case mix adjustment system is being created as part of our efforts to develop the prospective payment system. It will relate payment to the resources involved in providing care, accounting for both high and low cost cases. In the meantime, we are constrained by our systems in making outlier adjustments that would increase payment for high cost cases. We do not have the data available to make outlier adjustments for patients based on patient characteristics or diagnoses, on how many services they receive, or on how long they receive services. With sufficient policy specification in statute and

Page 3:

lead time, we could make outlier payments that adjust costs as part of the cost-report settlement process and which are based on data available on the cost report. Agencies would not have to wait until cost settlement to receive the outlier payment. The fiscal intermediaries would adjust the interim payments that they make to agencies to reflect the estimated outlier amount.

Let me comment on the specific proposals that you asked about.

(1) This proposal would repeal the aggregate beneficiary limits (ABLs) and implement a case manager review system for care for beneficiaries receiving more than 100 visits in a year. While this idea has interesting possibilities for delivering care more efficiently, we could not implement it by October 1, 1998 because a number of key features are not sufficiently specified and it would require development of a new tracking system to identify beneficiaries who have received (or are about to receive) 100 visits in a year.

Among the areas that need specification are the criteria and discretion the case managers would have to evaluate and manage care, what appeals beneficiaries would have, and how the independent contractors would be selected and paid. Once these points are specified, we would need time to promulgate regulations and then procure the necessary contracts. There could also be budget implications with a system that depends on the care evaluated and managed by a class of practitioners serving a new role in the Medicare home health benefit.

(2) This proposal would repeal the ABLs and replace them with a two-part cap. One portion would be a base amount equal to the average cost per patient in FY 1994 for the first 120 days of home health care and the other portion would be an outlier amount based on the average costs per patient in FY 1994 for home health care beyond 120 days.

We are unable to administer this proposal in the near future for two key reasons. First, we do not have the data to establish the base and outlier payment amounts. Second, we do not have the administrative system to track patients and make payments based on the days of care provided. The cost report collects aggregate costs for the agency and does not allow separation of costs for care of less than and greater than 120 days. Collection of such data would require extensive cost report modifications, and would probably require several years to implement and could impose an additional reporting burden on home health agencies. Under current law, Medicare pays for home health visits provided, rather than the number of days of care. Thus, we would need to develop a system that tracks the visits for each beneficiary from the day of the first visit to the 120th day. Development of such a system would detract from our development of the home health prospective payment system.

Page 4:

This approach creates a large "notch" whereby an agency would receive the entire outlier payment if it provided care for one day in excess of the 120 day threshold. Such a policy creates incentives for additional care to be provided for beneficiaries who are near the threshold.

(3) This proposal would repeal the ABLs and establish budgetary fail-safe targets. If our projection of home health spending in a previous year exceeded the current CBO home health baseline estimate, then ABLs would be implemented in the next year.

We may or may not be able to administer this proposal depending on how the specific details fit together. One goal of ABLs is to provide incentives for efficiency in the provision of care. Determining whether ABLs apply based on an annual trigger would create conflicting incentives for home health agencies. An argument could be made that a drop in the baseline should not be the reason to remove incentives for efficiency. I would also note that, in the past, the Administration has expressed concerns about budgetary fail-safes and triggers.

This idea could involve a significant budget cost. Regardless of CBO scoring, the Office of Management and Budget (OMB) could determine that it costs because it would be scored according to the OMB home health baseline which is lower than the CBO baseline. A budgetary cost could increase Medicare beneficiary Part B premiums as well as increase states' costs for the Part B premium they pay for beneficiaries eligible for both Medicare and Medicaid. A budgetary cost could also result in a sequester.

(4) This proposal would impose copayments. With sufficient lead time, we could implement a copayment by reducing the interim payment amount a home health agency receives when it submits a bill by the copayment amount, and then make an offset at settlement. We would not be able to verify that the agency collected the copayment amount because that would require changes to the contractor systems. We would also not be able to inform beneficiaries about their copayment liability because of the systems changes that would be needed. We could not implement such a proposal by October 1, 1998. Although your letter does not specify this, I want to point out that we would also be unable to implement a copayment that limits the annual financial outlay for a specific beneficiary because it would require a systems change that we cannot make because of our Year 2000 work.

As we have stated in the past, the Administration is concerned that copayments could potentially limit beneficiary access to the home health benefit. Medicare beneficiaries already spend a significant portion of family income on out-of-pocket health care expenses. A home health copayment would disproportionately affect poorer

Page 5:

beneficiaries, who spend an even greater proportion of their income on health care. Home health users have out-of-pocket expenditures that are generally much higher than the overall Medicare population. They are poorer, sicker, older, and more likely to live alone.

Medicaid pays coinsurance and deductibles for some low-income Medicare beneficiaries (e.g. Qualified Medicare Beneficiaries). Consequently, a copayment on Medicare home health services would increase Federal and state Medicaid expenditures.

(5) This proposal would change the ABLs so that they are based in part on FY 1994 data and the remainder on FY 1995 data. As discussed above, we could change the ABLs to any of a variety of different blends (agency-specific, regional and/or national) as long as they are based on the FY 1994 data we already have in-house and use for the current system.

We cannot implement ABLs based on FY 1995 data because collection of those data would involve the same type of extensive, lengthy effort which we undertook to obtain the FY 1994 data. The computer programming involved in such an undertaking would now conflict with our Year 2000 efforts. However, we have updated the FY 1994 data to account for inflation in the Federal Register notice published on August 11, 1998.

(6) This proposal involves two major elements: changing the ABL blends and implementing an outlier policy. There are many variations of each of these elements. This approach would also raise the per visit limits, a policy change which we could administer, as long as they are based on the data we have available.

As indicated earlier, we can implement new ABLs as long as they are based on the FY 1994 data that we developed for the existing system. We can implement new ABLs containing various proportions of national and/or regional means or medians, as well as retaining a portion of the current blend. Policies based exclusively on national and/or regional limits would eliminate the current law agency-specific component. While this eliminates any payment differences between new and old agencies, it eliminates the only crude proxy for case-mix that the agency-specific component represents.

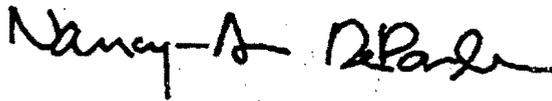
We can administer outlier payment policies that are part of the cost report settlement process and that are based on data available on the cost report. Such outlier payments could include payment of a portion of the agency's costs above their limits. Outlier payments could be based on different thresholds above an agency's limits and the Federal government could share varying portions of costs above the threshold. Likewise, we could implement an outlier approach that places floors or ceilings on the ABLs. We can

Page 6:

also implement an outlier approach that places a maximum reduction on the payments to an agency due to the effect of the limits (e.g., an agency would lose no more than 15 percent).

We understand that refining the Medicare home health interim payment system is a high priority for your Subcommittee. I appreciate the opportunity to provide you information about our views about our ability to administer the various options. We look forward to continuing to work with you on these options to reform the interim payment system.

Sincerely,



Nancy-Ann Min DeParle

Home Care PIG

BILL THOMAS, CALIFORNIA, CHAIRMAN  
SUBCOMMITTEE ON HEALTH

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U.S. HOUSE OF REPRESENTATIVES  
WASHINGTON, DC 20515

JANICE MAYS, MINORITY CHIEF COUNSEL  
BILL VAUGHAN, SUBCOMMITTEE MINORITY

SUBCOMMITTEE ON HEALTH

September 14, 1998

HCEA +

OMB have,  
all reviewing

To: Ways and Means Health Subcommittee

From: Health Staff/Bill Vaughan

Re: Home Health Mark-up Tuesday

Following is the Republican proposal. It helps the lower income agencies without giving away large amounts to the higher visit agencies.

It has a cost of about \$1.4 billion over 5 years.

There will be a Democratic Caucus in 1129 LHOB at 11 AM tomorrow (Tuesday) to discuss the proposal.

They may look  
to Buy - it  
effects for  
some -  
Another K.J.  
problem

TO CHRIS  
JEANNE

## CURRENT MEDICARE HOME HEALTH CARE PAYMENT SYSTEM

- A Prospective Payment System (PPS) was originally scheduled to be implemented on October 1, 1999. HCFA will not meet this deadline.
- Until the PPS is ready, payments will be made under the Interim Payment System (IPS).
- Under the cost-based IPS, a home health agency receives estimated payments from Medicare throughout the year. At the end of the year, the agency files a Medicare Cost Report. The agency and HCFA then "settle up."
- A home health agency is paid its own Medicare-allowed costs (for wages, rent, utilities, etc.). However, costs may not exceed two separate caps:
  - CAP 1      An aggregate cap based on the mix of services delivered (skilled nursing, therapies, social work, or aide)
  - CAP 2      An aggregate cap based on historical use per Medicare beneficiary (added in BBA 1997)
- The aggregate cap based on historical use per Medicare beneficiary (also called the "per beneficiary cap") is based on the following:
  - OLD AGENCIES:      75% agency-specific data + 25% regional average (minus 2%)
  - NEW AGENCIES      The national median (minus 2%)
- The BBA requires a 15% across-the-board reduction to the per beneficiary caps in FY 2000 if the PPS is not enacted. Given the Administration's recent admission that the PPS will not be ready, the agencies are facing this significant reduction next year.

**SUMMARY OF THE "MEDICARE HOME HEALTH CARE  
INTERIM PAYMENT SYSTEM REFINEMENT ACT OF 1998"**

	<b>CURRENT LAW</b>	<b>NEW POLICY</b>
<b>CBO SCORE/ 5 YEARS:</b>	N/A	\$1.4 BILLION
<b>"OLD" AGENCIES ABOVE THE MEDIAN PER BENEFICIARY LIMIT<sup>1</sup></b>	75% AGENCY + 25% REGION  (minus 2% reduction)	NO CHANGE
<b>"OLD" AGENCIES AT OR BELOW THE MEDIAN PER BENEFICIARY LIMIT</b>	75% AGENCY + 25% REGION  (minus 2% reduction)	INCREASED BY ½ THE DIFFERENCE OF BBA CAP AND NATIONAL MEDIAN <sup>2</sup>
<b>AGENCIES OPENING AFTER 10/1/94 AND BEFORE 10/1/98</b>	98% OF NATIONAL MEDIAN	INCREASE TO 100% OF NATIONAL MEDIAN
<b>AGENCIES OPENING AFTER 10/1/98</b>	98% OF NATIONAL MEDIAN	75% OF NATIONAL MEDIAN
<b>PER VISIT LIMITS</b>	105% OF NATIONAL MEDIAN	108% OF NATIONAL MEDIAN
<b>REPORTS BY HCFA, MEDPAC, AND GAO</b>		NEW REQUIREMENT

<sup>1</sup> BBA defines "OLD" agencies as those that opened before FY 1994 and filed a full year FY 1994 cost report.

<sup>2</sup> The unadjusted FY 1999 national median IPS limit is \$3,456.34. (This is equal to the labor share of \$2,684.47 and the non-labor share of \$771.87.) An agency with a BBA per beneficiary limit of \$2,000 and a wage index of 1.00 would have its limit increased to \$2,728.17. ( $\$3,456.34 - \$2,000 = \$1,456.34$ . Divide this by two, results in a \$728.17 increase.)

## EXAMPLES OF THE IMPACT OF THE NEW PER BENEFICIARY LIMITS

### EXAMPLE 1—The agency has a very low per beneficiary cap

FY 1999 BBA per beneficiary limit: \$2,000.00

FY 1999 national input price adjusted median limit<sup>3</sup>: \$3,456.24

NEW FY 1999 per beneficiary limit:

$$(\$3,456.34 - \$2,000) = \$1,456.24$$

$$\$1,456.34 \text{ divided in half} = \$728.17$$

NEW LIMIT: \$2000 + \$728.17 = \$2,728.17

This agency's cap is increased by 36 percent.

### EXAMPLE 2—The agency has a cap that is slightly below the national median

FY 1999 BBA per beneficiary limit: \$3,000.00

FY 1999 national input price adjusted median limit: \$3,456.24

NEW FY 1999 per beneficiary limit:

$$(\$3,456.34 - \$3,000) = \$456.24$$

$$\$456.34 \text{ divided in half} = \$228.17$$

NEW LIMIT: \$3,000 + \$228.17 = \$3,228.17

This agency's cap is increased by 7.6 percent.

<sup>3</sup>

In this example we have used the unadjusted median limit. Depending on the area in which the agency is located, the limit could be higher or lower.

105TH CONGRESS  
2D SESSION

**H. R.** \_\_\_\_\_

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IN THE HOUSE OF REPRESENTATIVES

Mr. THOMAS introduced the following bill; which was referred to the  
Committee on \_\_\_\_\_

---

**A BILL**

To amend title XVIII of the Social Security Act to make revisions in the per beneficiary and per visit payment limits on payment for health services under the medicare program.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Medicare Home Health  
5 Care Interim Payment System Refinement Act of 1998".

1 SEC. 2. INCREASE IN PER BENEFICIARY LIMITS AND PER  
2 VISIT PAYMENT LIMITS FOR PAYMENT FOR  
3 HOME HEALTH SERVICES UNDER THE MEDI-  
4 CARE PROGRAM.

5 (a) INCREASE IN PER BENEFICIARY LIMITS.—

6 (1) IN GENERAL.—Section 1861(v)(1)(L) of the  
7 Social Security Act (42 U.S.C. 1395x(v)(1)(L)) is  
8 amended—

9 (A) in the first sentence of clause (v), by  
10 inserting “subject to clause (viii)(I),” before  
11 “the Secretary”;

12 (B) in clause (vi)(I), by inserting “subject  
13 to clause (viii)(II)” after “fiscal year 1994”;  
14 and

15 (C) by adding at the end the following new  
16 clause:

17 “(viii)(I) In no case shall the limit imposed under  
18 clause (v) for cost reporting periods beginning during fis-  
19 cal year 1999 be less than the average of the limit other-  
20 wise imposed under such clause and the median described  
21 in clause (vi)(I) (but determined as if any reference in  
22 clause (v) to ‘98 percent’ were a reference to ‘100 per-  
23 cent’).

24 “(II) Subject to subclause (III), for cost reporting pe-  
25 riods beginning during or after fiscal year 1999, in no case  
26 shall the limit imposed under clause (vi)(I) be less than

1 the median described in such clause (determined as if any  
2 reference in clause (v) to '98 percent' were a reference  
3 to '100 percent'.

4 “(III) In the case of new home health agency for  
5 which the first cost reporting period begins during or after  
6 fiscal year 1999, with respect to such cost reporting period  
7 the limitation applied under clause (vi)(I) (but only with  
8 respect to such provider) shall be equal to 75 percent of  
9 the median described in subclause (II) of this clause.

10 “(IV) The limits computed under subclauses (I)  
11 through (III) are subject to adjustment under clause (iii)  
12 to reflect variations in wages among different areas.”.

13 (2) EXCLUSION OF ADDITIONAL PART B COSTS  
14 FROM DETERMINATION OF PART B MONTHLY PRE-  
15 MIUM.—Section 1839 of the Social Security Act (42  
16 U.S.C. 1395r) is amended—

17 (A) in subsection (a)(3), by striking “in  
18 subsection (e)” and inserting “in subsections  
19 (e) and (g)”, and

20 (B) by adding at the end the following new  
21 subsection:

22 “(g) In estimating the benefits and administrative  
23 costs which will be payable from the Federal Supple-  
24 mentary Medical Insurance Trust Fund for a year for pur-  
25 poses of determining the monthly premium rate under

1 subsection (a)(3), the Secretary shall exclude an estimate  
2 of any benefits and administrative costs attributable to the  
3 application of section 1861(v)(1)(L)(viii), but only to the  
4 extent payment for home health services under this title  
5 is not being made under section 1895 (relating to prospec-  
6 tive payment for home health services).”.

7 (b) REVISION OF PER VISIT LIMITS.—Section  
8 1861(v)(1)(L)(i) of such Act (42 U.S.C.  
9 1395x(v)(1)(L)(i)) is amended—

10 (1) in subclause (III), by striking “or”;

11 (2) in subclause (IV)—

12 (A) by inserting “and before October 1,  
13 1998,” after “October 1, 1997,”; and

14 (B) by striking the period at the end and  
15 inserting “, or”; and

16 (3) by adding at the end the following new sub-  
17 clause:

18 “(V) October 1, 1998, 108 percent of such me-  
19 dian.”.

20 (c) REPORTS ON SUMMARY OF RESEARCH CON-  
21 DUCTED BY THE SECRETARY ON THE SYSTEM.—By not  
22 later than January 1, 1999, the Secretary of Health and  
23 Human Services shall submit to Congress a report on the  
24 following matters:

1 (1) RESEARCH.—A description of any research  
2 paid for by the Secretary on the development of a  
3 prospective payment system for home health services  
4 furnished under the medicare care program under  
5 title XVIII of the Social Security Act, and a sum-  
6 mary of the results of such research.

7 (2) SCHEDULE FOR IMPLEMENTATION OF SYS-  
8 TEM.—The Secretary's schedule for the implementa-  
9 tion of the prospective payment system for home  
10 health services under section 1895 of the Social Se-  
11 curity Act (42 U.S.C. 1395fff).

12 (3) ALTERNATIVE TO 15 PERCENT REDUCTION  
13 IN LIMITS.—The Secretary's recommendations for  
14 one or more alternative means to provide for savings  
15 equivalent to the savings estimated to be made by  
16 the mandatory 15 percent reduction in payment lim-  
17 its for such home health services for fiscal year 2000  
18 under section 1895(b)(3)(A) of the Social Security  
19 Act (42 U.S.C. 1395fff(b)(3)(A)), or, in the case the  
20 Secretary does not establish and implement such  
21 prospective payment system, under section 4603(e)  
22 of the Balanced Budget Act of 1997. The Secretary  
23 shall include a statement from the Chief Actuary of  
24 the Health Care Financing Administration of the  
25 amount of a per visit copayment that would be re-

1       required to provide for such savings (based upon dif-  
2       ferent caps on the aggregate amount of such copay-  
3       ments for any person for a year).

4       (c) MEDPAC REPORTS.—

5           (1) REVIEW OF SECRETARY'S REPORT.—Not  
6       later than 60 days after the date the Secretary of  
7       Health and Human Services submits to Congress  
8       the report under subsection (b), the Medicare Pay-  
9       ment Advisory Commission (established under sec-  
10      tion 1805 of the Social Security Act (42 U.S.C.  
11      1395b-6)) shall submit to Congress a report describ-  
12     ing the Commission's analysis of the Secretary's re-  
13     port, and shall include the Commission's rec-  
14     ommendations with respect to the matters contained  
15     in such report.

16           (2) ANNUAL REPORT.—The Commission shall  
17     include in its annual report to Congress for June  
18     1999 an analysis of whether changes in law made by  
19     the Balanced Budget Act of 1997, as modified by  
20     the amendments made by this section, and this sec-  
21     tion with respect to payments for home health serv-  
22     ices furnished under the medicare program under  
23     title XVIII of the Social Security Act impede access  
24     to such services by individuals entitled to benefits  
25     under such program.

1 (d) GAO AUDIT OF RESEARCH EXPENDITURES.—  
2 The Comptroller General of the United States shall con-  
3 duct an audit of sums obligated or expended by the Health  
4 Care Financing Administration for the research described  
5 in subsection (b)(1), and of the data, reports, proposals,  
6 or other information provided by such research.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

Home Health File

Date:

# FACSIMILE

**PLEASE NOTIFY OR HAND-CARRY THIS TRANSMISSION TO THE FOLLOWING PERSON AS SOON AS POSSIBLE:**

Name(s): Chris Jennings

Department: \_\_\_\_\_

Phone#: \_\_\_\_\_

Fax#: \_\_\_\_\_

FROM: Gary  
*Assistant Secretary for Planning & Evaluation*

Number of pages being transmitted (including fax sheet): 3

COMMENTS: fji re home health

Department: interim payment system

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Theresa Ruster Val

Jeff Krich

Daryl Burke

Lucie Dikore

TO: Bob Williams  
Gary Claxton

(919) 681-5890

Security Fund

MAR 13 1998

FROM: Jennie Harvell

THROUGH: Mary Harahan

SUBJECT: Home Health Interim Payment System - FYI

Venopuncture only record

Barker Henry ~ Therapy

Frank on business

This is to bring to your attention anticipated agency and beneficiary impacts of the home health (HH) interim payment systems (IPS), particularly the per beneficiary cap. We are bringing these issues to your attention now because Chris Jennings is scheduled to speak at the National Association of Home Care (NAHC) conference on Monday. IPS issues will be discussed.

Health care delivery change  
- Demographics  
- Age of Biology

Background

The Balanced Budget Act (BBA) required the government implement, effective 10-1-97, an IPS, and, by 10-1-99, a case-mix adjusted PPS. Whether or not a PPS is implemented on 10-1-99, a fifteen percent reduction in Medicare HH expenditures is required. The IPS requires that home health agencies (HHAs) be paid the lower of:

Per beneficiary  
guarantee

- actual costs;
- aggregate per visit limits; or
- aggregate per beneficiary limits.

- Medicare Commission
- Implementation of BBA
- PPS - 10-1-99
- PPS
- State Bonds
- HCFA

Box IV

Quality

Tobacco  
reduc.

Children?  
cancer  
impairment

Mental  
health

The industry and advocates have expressed concern about the impact of these provisions, particularly the per beneficiary limit, on high cost beneficiaries. State Medicaid programs are being asked to finance the reductions associated with these limits. The per beneficiary limit is based on each HHA's average per beneficiary Medicare expenditures in 1993, trended forward to FY '98, multiplied by the number of beneficiaries served by the HHA in the current year (a special formula exists for new HHAs). The law does not allow for exception or outlier payments. NAHC believes that the BBA permits exceptions to the per beneficiary limit.

Anecdotes abound of agencies threatening or actually denying or reducing services to high cost beneficiaries in anticipation of the new limits. HCFA issued a letter to HHAs advising them that they can not discriminate against Medicare enrollees based on severity of condition and that to do so could jeopardize their provider agreement.

Regulatory Status

HCFA has little discretion in implementing these provisions.

- Per visit limit: A final rule was issued in January '98.
- Per beneficiary limit: A HCFA/OS regulation team has been reviewing the final rule

(with comment) on the per beneficiary limits. Receipt of this rule for formal clearance is imminent. The rule is scheduled to be published in the Federal Register April 1st. HCFA includes an analysis of the impact of this limit on HHAs.

*HCFA impact analysis* indicates that:

almost 60 percent of HHAs are expected to have costs in excess of the per beneficiary limit and that on average 10 percent of these agencies' costs are expected to exceed the limit (the percent of costs in excess of the limits was estimated after taking into account behavioral offsets that reduce the amount of savings these limits would otherwise produce. The behavioral offsets is based on an estimated 1 percent increase in volume of HH beneficiaries served).

the limits are expected to have a greater impact on freestanding HHAs than hospital-based HHAs; and

while (in general) the limits are expected to have a greater impact on older HHAs (i.e., existing in 1993) than newer HHAs, this impact varies significantly by census region. The limits are expected to have the greatest impact on old and new HHAs in the New England census region -- almost 85 percent of old and 91 percent of new HHAs in the New England Region are expected to have costs in excess of the limit.

*Beneficiary Impact.* We asked MEDSTAT to complete an analysis of the impact of the per beneficiary limit on beneficiaries. The analysis links 1994 Medicare HH expenditures with the 1994 National LTC Survey. The analysis examined the impact of the per beneficiary limit on (1) all Medicare beneficiaries, (2) Medicare home health users, and (3) Medicare home health users by disability status. The analysis was based on an estimate of what the per beneficiary limit would have been in 1994 compared to average 1994 HH expenditures. The MEDSTAT analysis indicates:

On average 34 percent of HH users across all census regions are expected to exceed the per beneficiary limit. The Pacific Region has the highest percentage of beneficiaries exceeding the cap (almost thirty-nine percent) and the South Atlantic Region has the lowest (almost thirty percent).

Sixty-six percent of those HH users with impairments in at least 3 activities of daily living would have exceeded the cap -- more than a third of all HH users who exceeded the cap.

The following types of individuals would have been more likely to exceed the limit in 1994 (had the limit been in place at that time): non-white persons, the cognitively impaired, and persons with lower incomes.

## Conclusions

HCFA anticipates that payment to 58 percent of HHAs will be limited by the per beneficiary limit, payment to an additional 35 percent of HHAs will be subject to the per visit limit, and the remaining seven percent of HHAs will be paid actual costs. We expect HCFA to include as part of the per beneficiary rule in the cover memorandum to the Secretary a statement that reductions and terminations of HH services will be monitored via the survey and certification process and through analysis of OASIS data. A rule requiring the automation of OASIS data is expected to be published in early summer '98 with an expectation that automated OASIS data will be submitted to the Federal Government by January '99. We anticipate that HCFA will also indicate that the OIG will be asked to monitor underutilization.

While the per beneficiary limit is applied in the aggregate, and, thus, is not an absolute per beneficiary cap, the MEDSTAT analysis suggests the types of beneficiaries that HHAs may target in an attempt to not exceed this limit. If Medicare HH services are either no longer available or services are reduced for severely disabled beneficiaries, given the level of disability of many of these beneficiaries, then it is reasonable to assume that alternative formal services will be required. Given that many of these individuals have limited incomes, private financing seems unlikely. Medicaid home and community based care or nursing home services seem to be likely alternatives. FYI -- We have asked MEDSTAT to look, by region and disability status, at the percentage disabled HH users who would exceed the cap and qualify for Medicaid.

## Next Steps

We are continuing our review of HH related issues to assess the feasibility of implementing a reasonable case-mix adjusted PPS by 10-1-99. We hope to report back to you by mid-April with our recommendations. If based on that review, a reasonable PPS seems unlikely by 10-1-99, an initial recommendation will likely be the need to implement a mechanism to adjust payment for high cost beneficiaries. This may require a legislative change.

cc: Christy Schmidt  
Barbara Manard  
Pam Doty

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

Date:

# FACSIMILE

**PLEASE NOTIFY OR HAND-CARRY THIS TRANSMISSION TO THE FOLLOWING PERSON AS SOON AS POSSIBLE:**

Name(s): Chris Jennings

Department: \_\_\_\_\_

Phone#: \_\_\_\_\_

Fax#: \_\_\_\_\_

FROM: Gary  
*Assistant Secretary for Planning & Evaluation*

Number of pages being transmitted (including fax sheet): 3

COMMENTS: fji - re home health  
interim payment system

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Per beneficiary limit: A HCFA/OS regulation team has been reviewing the final rule

~~limit.~~ The rule is scheduled to be published in the Federal Register April 1st. HCFA includes an analysis of the impact of this limit on HHAs.

*HCFA impact analysis* indicates that:

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- the limits are expected to have a greater impact on freestanding HHAs than hospital-based HHAs; and
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# BOOK

IDEAS FOR THE FUTURE FROM HUDSON INSTITUTE

November 1997  
Volume 1, Number 11

*Home File  
Health*

# The Cost Effectiveness of Home Health Care

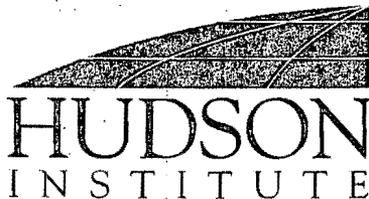
*If we continue to try to finance full nursing-home care through Medicare and Medicaid, without providing less-expensive alternatives, the system will go broke when the Baby Boomers hit retirement age a few years from now. Home health care provides a viable alternative.*

A Case Study of Indiana's In-Home/CHOICE Program

*Two of Hudson's health care reform experts*

**WILLIAM STYRING III  
AND THOMAS J. DUESTERBERG**

*discuss a home health care program that works*



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