HOME HEALTH CARE PROSPECTIVE PAYMENT ACT OF 1997

Mr. HATCH. Mr. President, over the past several months, I have been developing legislation to dramatically reform the way Medicare pays for home health services. This effort builds on my work in the Finance Committee during 1995 where I strove to see a prospective payment system for home health services included in the Balanced Budget Act agreement.

The culmination of this year's efforts is a bill I introduced on June 16, the Home Health Care Prospective Payment Act of 1997 (S. 913). The Home Health Care Prospective Payment Act is intended to achieve three primary goals:

First, the bill will create incentives for providers to behave in a more cost effective manner.

Second, it will help assure that the federal government achieves the necessary savings it seeks in order to ensure the solvency of the Medicare program well into the next century.

And third, perhaps most importantly, my bill accomplishes these first two goals while protecting the quality and continuity of home health care services for beneficiaries.

As my colleagues are aware, I have been a strong supporter of home health care services ever since I came to this body. I have applauded changes that have made it easier to treat Medicare patients in the most cost-effective setting. The changes we have made to the system have benefited many patients who would otherwise have not received care. In other cases, these individuals would have had to wait until their health deteriorated to the point of having to be admitted to a hospital. This outcome was neither cost effective nor good health care policy.

We have learned a great deal about Medicare reimbursement since we passed the prospective payment system [PPS] for hospitals in 1983. We now know the value of a proper transition period so that providers will be able to manage their operations toward a permanent system.

We also know that we can model a payment system that encourages providers to manage costs and utilization better. We realize that moving to a new reimbursement system is a massive undertaking. The amount of data, time, and expense is enormous. It is especially important not to unnecessarily burden health care providers, Government, or patients with administrative requests.

My legislation proposes to begin a transition to a home health care PPS immediately, rather than waiting until fiscal year 2000. Instead of relying on cost limits, we can begin using predetermined rates in an initial PPS system during fiscal years 1998 and 1999.

The principle behind prospective payment is to shift the risk from the Government to providers. This is done by rewarding providers for keeping their costs below the rates—or having them absorb the loss if their costs are over the rates. Therefore, I propose we incorporate a limited shared savings plan during the initial 2 years of the PPS to encourage more cost effective behavior by health care providers.

In addition, there needs to be greater sensitivity to the data demands and consequences in our proposal. For example, there needs to be some discretion for the Secretary of the Department of Health and Human Services to designate a different base year for extraordinary situations that may arise in a particular case. There are other proposals that may be considered that might be good ideas in and of themselves. Some proposals, however, may impose data, time, or cost demands that are unnecessarily burdensome to providers, patients, or the Government—but may not be necessary for PPS implementation.

The changes I am proposing in my legislation are not new to the Senate, but merely reflect the information and legislative history we have gained through our consideration of Medicare payment reforms. My legislation will make home health care reform consistent with that history.

Mr. President, for the benefit of my colleagues I ask unanimous consent that a section-by-section analysis of S. 913 be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

SECTION-BY-SECTION ANALYSIS

Section 1. Provides a short title and a table of contents.

Section 2. Provides that amendments made by the Act are to the Social Security Act.

Section 3. Provides for the recapture of savings from the temporary freeze on payments for home health payments from 1994 to 1996 in updating home health costs limits for FY 1998 and subsequent years.

Section 4. Provides for the establishment of an initial prospective payment system for home health services beginning in FY 1998. Payments would be based on rates equal to the lower of—

Costs determined under the current reimbursement system (revised to limit costs to 105 percent of the median of visit costs for freestanding home health agencies and eliminating annual rate updates); or

An agency-specific per-beneficiary annual limit based on 1993 cost reports, multiplied by the agency's unduplicated patient census. Annual limits for new providers would be based on an average of limits applied to other home health agencies. Incentive payments would be available to agencies equal to 50 percent of the amount by which its year end reasonable costs are below its per-beneficiary annual limit.

Section 5. Provides for the establishment of a permanent prospective payment system for home health services beginning in FY 2000. Payments would cover all services included in the Medicare home health benefit, including medical supplies. In determining payment amounts, the Secretary of Health and Human Services would be required to determine an appropriate unit of home health service, to provide for adjustments based on variations in the mix of services provided, and to assure continued access to quality services. Payments would be subject to annual adjustments based on the home health market basket index. The Secretary would be authorized to develop a payment provision for outliers based on unusual variations in the type or amount of medically necessary services.

Initial payment rates for a permanent prospective payment system would be required to be developed in a manner that would assure the achievement of the scorable savings of the act.

Section 6. Provides for home health services to be reimbursed on the basis of the geographic location where the service is furnished.

Section 7. Provides for the elimination of periodic interim payments for home health services upon implementation of a permanent prospective payment system.

Section 8. Provides for limiting Part A coverage of home health services to the first 100 visits following a hospital stay. Clarifies coverage of intermittent and part-time nursing care. Provides for the exclusion of the costs of home health services from the calculation of Part B monthly premiums. Provides a new definition of the term ''homebound''. Authorizes the Secretary to deny coverage of home health services which are in excess of normative standards for the frequency and duration of care.

SKILLED NURSING FACILITIES PROSPECTIVE PAYMENT ACT OF 1997

Mr. HATCH. Mr. President, on June 16, 1997, I introduced legislation, S. 914, proposing to revise the present system in which the Medicare Program pays for services provided by skilled nursing facilities [SNF's]. This legislation builds on my work in the Finance Committee in 1995 when the committee included a proposal I authored to implement a prospective payment system for nursing home payments.

As currently structured under Medicare, seniors receive up to 100 days of skilled nursing facility services following a 3-day hospitalization stay. Currently, those services are reimbursed on a cost-plus basis. As Medicare has evolved, however, so have systems of cost-plus reimbursement.

For many years, I have worked with my colleagues in the Senate to provide seniors with the services they need in a skilled nursing facility setting. I have worked to modify the Medicare reimbursement methodology in order to provide economic incentives to SNF providers to provide the highest quality of care at a reasonable and affordable price to the Medicare Program.

My legislation will accomplish that goal.

Congress initially began requiring prospective payments for skilled nursing facilities in the early 1980's. However, the Health Care Financing Administration [HCFA] has not been able to identify an appropriate payment methodology, and how best to define the services provided to seniors in a comprehensive way. Nevertheless, we have come a long way since the mid 1980's in understanding the proper

structure of prospective payment systems. We are now on the verge of fundamentally revamping the current cost-plus payment system for these important services.

Let me briefly describe the key parts of my legislation.

First, during fiscal year 1998, the Health Care Financing Administration will begin phase one of a per diem, prospective payment system [PPS] for skilled nursing facilities. Such payment would be based on historical data regarding a particular facility's costs and services provided. While it is expected that the new rate is an all-inclusive rate, encompassing routine costs, ancillary services, and capital-related expenses, during the first year, HCFA is likely to adjust both the inclusion of ancillary services and capital costs only when they have sufficient data to adequately measure and quantify the level of those services.

It would be unfortunate for HCFA to put into effect a system that did not adequately account for the medical services offered to residents within a skilled nursing home. I urge HCFA to implement and include all ancillaries only when the data and the information are adequate.

Second, during the 4 four years the prospective payment system will evolve into a full PPS system where the services for an individual in a skilled nursing facility bed will be adjusted for their medical and nursing needs. This legislation calls on HCFA to develop a case-mix methodology that adequately reflects the medical needs of each patient. I have heard from many experts that the current case mix methodology does not adequately reflect certain medical needs of many skilled nursing home patients. It is my intention that the case-mix methodology be current and reflect all services provided.

And third, once this system is in place, it will provide the right kind of economic incentives so that providers will seek all services medically necessary. The Medicare Program will not be in a situation of overpaying for such services; it will provide a competitive balance so that all skilled nursing services, regardless of whether they are hospital SNF beds or freestanding SNF beds, will have comparable incentives to provide high quality services to beneficiaries.

It is extremely important that we change the existing and limited incentives in the Medicare system so that providers will offer services in the most cost-effective way. Hospitals are already under a PPS system; physicians are reimbursed on a predetermined rate as well. This approach is now the next important step in our continuing effort to ensure appropriate fiscal responsibility by the Federal Government while also ensuring that seniors have access to the important health benefits offered under the Medicare Program.

Mr. President, for the benefit of my colleagues, I have prepared a section-by-section summary of my bill and I ask unanimous consent that it be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

SECTION-BY-SECTION ANALYSIS

Establishes a prospective payment system for skilled nursing facility (SNF) services and provides for consolidated billing of Part B services provided to residents of such facilities.

Subsection (a): Provides for the establishment of a prospective payment system for services covered by the Medicare skilled nursing facility benefit, including routine service, ancillary services (except diagnostic services), and related capital costs, beginning with cost reporting periods starting on or after July 1, 1998. Payment would be based on per diem rates established by the Secretary of Health and Human Services.

Provides a four-year transition period for shifting the calculation of payments rates from facility-specific historic cost data to average national or regional costs. During the first year of the new system, payments would be based on facility-specific per diem rates. For the second through fourth years, payments would be based on a blend of facility-specific and federal rates. In the fifth year and thereafter, payments would be based exclusively on federal per diem rates.

Payments to new facilities would be based on federal per diem rates.

Federal per diem rates would be determined by the Secretary on the basis of 1995 cost data for all SNF settings and would include an estimate of amounts that would be payable under Part B for services furnished to SNF residents. Rates would be adjusted by variations in wage levels and case mix and could be computed separately for urban and rural areas based on national or regional classification. Rates would be updated annually by the skilled nursing facility market basket index.

Federal payment rates would be applied to individual facilities subject to adjustments for case mix and geographic variations in labor costs. A method of making adjustments based on case mix variations would be required to be developed by the Secretary in the form of a regulation subject to public notice and comment.

SNFs would be required to provide to the Secretary with resident assessment data as may be necessary to develop and implement per diem rates.

The Secretary would be required to develop an appropriate method of applying a prospective payment system to Medicare low volume SNFs and swing bed hospitals.

Subsection (b): Provides for consolidated billing of most Part B services furnished to residents of a skilled nursing facility, including services provided by other entities under arrangement. Claims for such services would be required to be submitted directly by the SNF and include a code or codes identifying the items or services delivered. Payment would be made to the SNF based on the Part B payment methodology (such as fee schedules) applicable to the particular item or service. Facilities would be permitted to reassign such payments when the item or service was furnished by another entity. Payments for therapy services would be required to reflect the new salary equivalency guidelines for physical, occupational, and respiratory therapy and speech-language pathology after such guidelines are finalized through the regulatory process.

The Secretary would be required to establish a medical review process to examine the effects of the changes made by the Act on the quality of skilled nursing facility furnished to Medicare beneficiaries.

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

REPORT ON FEDERAL ADVISORY COMMITTEES FOR FISCAL YEAR 1995—MESSAGE FROM THE PRESIDENT—PM 47

The PRESIDING OFFICER laid before the Senate the following message from the President of the United States, together with an accompanying report; which was referred to the Committee on Government Affairs.

To the Congress of the United States:

As provided by the Federal Advisory Committee Act, as amended (Public Law 92–463; 5 U.S.C., App. 2, 6(c)), I am submitting my third *Annual Report on Federal Advisory Committees,* covering fiscal year 1995.

Consistent with my commitment to create a more responsive government, the executive branch continues to implement my policy of maintaining the number of advisory committees within the ceiling of 534 required by Executive Order 12838 of February 10, 1993. As a result, my Administration held the number of discretionary advisory committees (established under general congressional authorizations) to 512, or 36 percent fewer than the 801 committees in existence at the time I took office.

During fiscal year 1995, executive departments and agencies expanded their efforts to coordinate the implementation of Federal programs with State, local, and tribal governments. To facilitate these important efforts, my Administration worked with the Congress to pass the ''Unfunded Mandates Reform Act of 1995'' (Public Law 104–4), which I signed into law on March 22, 1995. The Act provides for an exclusion from the Federal Advisory Committee Act (FACA) for interactions between Federal officials and their intergovernmental partners while acting in their official capacities. This action will directly support our joint efforts to strengthen accountability for program results at the local level.

Through the advisory committee planning process required by Executive Order 12838, departments and agencies have worked to minimize the number of advisory committees specifically mandated by statute. There were 407 such groups in existence at the end of fiscal year 1995, representing a 7 percent decrease over the 439 at the beginning of my Administration. However,