

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