

INTRODUCTION OF BILL TO REINSTATE INCENTIVE AND CAPITAL PAYMENTS TO PPS-EXEMPT HOSPITALS

**HON. RICHARD E. NEAL**

OF MASSACHUSETTS

IN THE HOUSE OF REPRESENTATIVES

*Monday, October 19, 1998*

Mr. NEAL of Massachusetts. Mr. Speaker, I rise today to introduce the Reinstatement of Medicare Bonus and Capital Payments for Rehabilitation Act of 1998. This bill would restore the full incentive payment percentages for PPS-exempt rehabilitation hospitals and units that were repealed in Section 4415 of the Balanced Budget Act of 1997 (BBA). The restored percentages would remain in effect only until the new prospective payment system (PPS) for inpatient rehabilitation services in fully phased in by October 1, 2002.

The bill would also change the provision in the BBA that reduced capital payments for PPS-exempt hospitals and units by 15 percent for FY 1999–2002.

Prior to the BBA, qualifying PPS-exempt hospitals were eligible to obtain an incentive payment for keeping their costs below their TEFRA limits. That payment was the lesser of 50 percent of the difference between their costs and the TEFRA limit, or 5 percent of the limit. This system encourages these facilities to incorporate efficiencies without compromising service or quality for their patients. The BBA reduced the applicable percentages to 15 percent and 2 percent, respectively. This modification for paying PPS-exempt (TERFA) hospitals dramatically reduces incentive payments that were designed to reward efficient facilities that are able to keep costs below their TEFRA limits.

The earlier formula actually worked as it was intended. It provided an incentive for PPS-exempt hospitals to keep costs below TEFRA limits while still retaining high quality care. This is evidenced by the fact that patient outcomes have remained the same, despite a decrease in average lengths of stay in PPS-exempt hospitals.

The BBA provision reduces incentive payments so significantly the payments are unlikely to motivate facilities to further reduce lengths of stay. And there could easily be additional negative ramifications to this misguided policy.

First, absent incentives to hold down costs, many facilities may increase lengths of stay if it is more economically feasible to do so. The end result will be increased costs to the Medicare program. In fact, a one-day increase in average Medicare length of stay in rehabilitation facilities would result in increase payments of about \$200 million. This is substantially more than the amount "saved" by the BBA's new formula.

Second, incentive payments should be retained to hold costs down and motivate efficiencies since payments under the new PPS system will be set to total 98 percent of what would have been paid absent the PPS system. That is why it is particularly important that Congress offer providers incentives to hold down costs in the interim. However, under the bill, the restored incentive payments would be retained only until the new PPS for inpatient rehabilitation services, also authorized by the BBA, is fully implemented.

Third, increased lengths of stay may negatively impact patient outcomes if providing necessary rehabilitation services is postponed to lengthen a patient's stay. This could lead to another negative—a shortage of beds. It follows that longer lengths of stay will also mean that fewer beds will be available for new patients who require access to rehabilitation services.

Fourth, a shortage of rehabilitation beds could also negatively effect hospitals' costs. Hospitals could end up keeping patients, who otherwise would have been discharged, for longer periods. This would increase their costs.

Finally, many facilities have used incentive payments in the past to help fund building programs for persons with disabilities. These programs also will likely suffer under the revised BBA incentive payment scheme.

My bill would also change the provision in the BBA which imposed a 15-percent reduction in capital payments for PPA-exempt hospitals and units for FY 1999–2002. This provision is very problematic.

Rehabilitation facilities and others are paid on a cost basis, not on a prospective payment basis as other hospitals and providers. They were exempted from capital cuts in the past because of this difference.

The argument for full reimbursement of capital is that a provider under cost reimbursement has no opportunity to make up the loss of capital payments through operating efficiencies. If operating costs go down, so does reimbursement, and the provider is stuck with payment below cost. The provider does not have any incentives to become more efficient, thus the rationale for the incentive bonus payment. This argument is still valid. However, the incentive payment has also been seriously reduced.

A 15-percent cut in capital reimbursement will cost PPS-exempt providers at least \$79 million. Total incentive payments are likely to be far less than the aggregate loss from the 15-percent cut in capital reimbursement. Few rehabilitation providers can cover capital cuts with incentive payments. This means that almost all rehabilitation providers will be paid below cost.

Compounding this situation is the fact that a rehabilitation provider does not have the same opportunity as other providers to shift costs to other payers. Because rehabilitation hospitals are heavily dependent on Medicare, they have few non-Medicare patients on whom they can shift costs. That is because 70 percent of admissions and 65 percent of days in rehabilitation are covered by Medicare fee for service. This rate of Medicare utilization is unique among provider groups.

Until the PPS system authorized by the BBA is fully implemented, capital cuts should not be imposed on PPS-exempt rehabilitation hospitals and units. Full payment of capital should continue under the cost-based system because, unlike providers in a PPS system, PPS-exempt providers have no opportunity to make up the loss of capital payments through operating efficiencies. If operating costs go down, so do reimbursements.

For the rehabilitation entities, that leaves the only other way to generate revenue from Medicare—cover the shortfall on capital reimbursement through incentive payments—which the BBA also reduced. For this reason, almost all rehabilitation providers will be paid below cost under the BBA.

That is why I am introducing my bill today. We need to enact this legislation which will repeal Section 4415 and restore the former 50/50 incentive payment formula until a PPS for inpatient rehabilitation services is fully implemented. It also removes the provision that reduces capital reimbursement for rehabilitation hospitals and units for FY 1999–2002. I appreciate your support and look forward to working with all of you on this very important issue.

DANTE B. FASCELL NORTH-SOUTH CENTER ACT OF 1991

SPEECH OF

**HON. CHRISTOPHER H. SMITH**

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

*Monday, October 12, 1998*

Mr. SMITH of New Jersey. Mr. Speaker, I rise in support of H.R. 4757, legislation renaming the North/South Center at the University of Miami after our former House colleague, the former Chairman of the Foreign Affairs Committee, the Honorable Dante B. Fascell.

Dante Fascell served in the House of Representatives, from 1954–1992; I was privileged to serve with him on the Foreign Affairs Committee and witness, first-hand, his tireless efforts on behalf of the North/South Center. Given his commitment and his role as a driving force behind the creation and development of the North/South Center, H.R. 4757 is a fitting and long-overdue tribute for Dante Fascell's great work in this regard.

Mr. Speaker, most of us know that the North/South Center is an independent research and educational organization that promotes policy initiatives aimed at resolving the most critical issues facing the nations of the Western Hemisphere. The Center's research, publications, and training efforts have focused on furthering freedom and democracy, and economic development. To date, the Center's programs have benefited citizens of the Western Hemisphere by supplying significant knowledge and expertise relevant to an inter-American agenda which has grown more complex and more critical each year.

In its first eight years, the North/South Center has embraced and fostered the ideals that Dante Fascell outlined when he first envisioned the program, especially the importance of offering academic interchanges—the free exchange of views to promote understanding and cooperation—as a means to promote democracy. The Center has also proven that it is uniquely capable of assessing the increasing interdependence of the two hemispheres, the North and the South, and developing cross border policies that stress the similarities and also bridge the gaps of the countries of the Western Hemisphere. The academic and intellectual dialogues promoted by the Center have helped advance democratic ideals especially in those Western Hemisphere countries where democracy has not yet taken hold.

The North/South Center at the University of Miami has lived up to Dante's hopes and dreams, becoming a major player in helping to determine the conduct of the U.S. in our public policy for the two hemispheres. It is well respected and provides an invaluable source of research, public outreach, cooperative study, and programs of education and training on a large variety of Western Hemisphere issues.