

**Testimony of
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Centers for Medicare & Medicaid Services
Before the
House Energy & Commerce Subcommittee on Oversight and Investigations
Hearing on
“Post Katrina Health Care in the New Orleans Region:
Progress and Continuing Concerns – Part 2”
August 1, 2007**

Mr. Chairman and Members of the Subcommittee, I am pleased to be here today to discuss post-Katrina healthcare and the actions the Centers for Medicare & Medicaid Services (CMS) have taken to help rebuild the Louisiana healthcare system. As then-Acting Administrator Norwalk testified before this Subcommittee on March 13 of this year, the public health and medical situation in greater New Orleans and throughout the Gulf Coast following Hurricanes Katrina and Rita required an immediate deployment of substantial Federal resources to prevent even further loss of life. I do not intend today to re-state all of the actions that HHS and CMS have taken to encourage and facilitate rebuilding of the healthcare infrastructure along the Gulf Coast since the hurricanes hit, but I refer you to the March 13, 2007 CMS statement before this Subcommittee, which sets forth our actions as of that date in detail. Rather, I want to focus on the two issues the subcommittee asked CMS to address, which are Graduate Medical Education (GME) payment and the Medicare area wage index.

Medicare Graduate Medical Education

Since the first days after Hurricane Katrina, CMS has worked diligently to address issues related to medical residents displaced by the disaster. In particular CMS has moved quickly to provide flexible funding as appropriate in Medicare GME payment.

Since the inception of the Medicare program, the federal government has paid its proportionate share of the direct costs associated with GME. The Medicare program makes payments to teaching hospitals for a portion of the added costs associated with medical residency training programs. Under the inpatient hospital prospective payment system, teaching hospitals also receive an add-on payment for each discharge to reflect the indirect costs of medical education. The added direct costs incurred by teaching hospitals in providing GME include both the stipends and fringe benefits of residents, the salaries and fringe benefits of faculty who supervise the residents, and other direct costs of operating the teaching program. The amounts Medicare pays are specific to the hospital in question, reflecting the costs of its program. Medicare's payment is based on the number of residents the hospital is training, the hospitals historical per resident training costs and the hospital's percent of Medicare inpatient utilization. Medicare also provides support to teaching hospitals for the indirect costs of graduate medical education (IME). The IME adjustment is made to each Medicare discharge under the inpatient prospective payment system (IPPS) to reflect the higher patient care costs of teaching hospitals relative to non-teaching hospitals. Under both direct GME and IME, the Medicare statute established a cap on the number of residents the hospital can count based on the number of residents the hospital was training in a base year, usually 1996. Residents often train at more than one hospital and in any given year may spend more time at one hospital than another depending on the year of training. To account for these annual variations in a hospital's FTE count, Medicare allows for hospitals that cross train residents that meet specific requirements to affiliate and "share" an aggregate cap. Under usual GME payment rules, the Medicare statute requires that a hospital is paid in the current year based on a three-year "rolling average" count of residents; that is, the average of the number of residents in the current year and two prior years. This is a statutory

requirement intended to distribute the impact of increasing or decreasing the number of residents at a hospital over a three-year period. Thus, if a hospital increases or decreases the number of FTE residents in a given year, the hospital counts only one third of the change in FTEs in that year, two-thirds in the second, and all of the change only in the third year.

The New Orleans hospitals asked CMS for a way in which host hospitals taking on displaced residents could receive payment for the training they were providing. In response, CMS immediately issued a document discussing a provision in the existing regulations which allows hospitals that have closed programs to temporarily transfer their allotment of full time equivalent (FTE) residents paid for under the Medicare program (referred to as the hospitals' FTE cap) to the hospitals hosting the displaced residents so that host hospitals that were already training residents at or above their cap could receive payment for training additional residents displaced by the hurricane.

Further communication with teaching hospitals in New Orleans clarified that in most cases the hospital training programs did not close entirely. In addition, hospitals in the hurricane-affected areas are in the process of reopening their residency training programs incrementally. The existing closed program regulation did not address these hospitals' issue. In order to provide relief where the programs have not or are no longer closed, the Department of Health and Human Services used the rulemaking process to publish a new regulation to allow host hospitals an adjustment to their FTE caps. The new rule allows for the host hospitals to receive financial relief for the additional medical residents they have taken on in the wake of the disaster.

Emergency Medicare GME Affiliation

CMS has revised existing regulations to address new affiliations between hospitals and nationwide affiliations in situations where a special waiver has been implemented to ensure medical care for Medicare, Medicaid or SCHIP populations in an emergency area during an emergency period. This regulation change allows Katrina-affected hospitals, as well as hospitals dealing with future national disasters or states of emergency, the flexibility to temporarily transfer residents while permitting payment for all affected hospitals. On April 12, 2006, CMS issued an interim final rule that allows hospitals to:

- Establish “emergency affiliation agreements” to allow for long distance affiliations. Under existing rules, affiliations are limited by geographical requirements or to hospitals under common ownership.
- Maintain emergency affiliations to no more than three years. During the effective period, the shared rotational arrangement requirement would also be relaxed so that residents will not be required to train in both hospitals that are members of the affiliated group.

For example, many residents of hospitals in New Orleans were moved to hospitals in Texas to continue their training and the Texas host hospitals were able to count those residents and receive increased Medicare GME payments through this emergency affiliation agreement provision.

Host Hospital Payment

Many host hospitals took in displaced residents in the belief they would be paid in full for those residents because of a special provision in the rules dealing with training residents from closed programs. Under usual GME payment rules, a hospital is paid in the current year based on a

three-year “rolling average” count of residents. However, under the new affiliation option in the interim final rule, displaced residents from August 29, 2005 to June 30, 2006 (the end of the academic year) will be excluded from the rolling average calculation and payment will be made in full in one year rather than spread over three years.

The response and revised process in the interim final rule provides hospitals with greater flexibility to transfer residents within an emergency affiliated group while ensuring payment for all the hospitals involved. It is also important to note that in the first year not only will host hospitals receive payment in full for training displaced residents, but home hospitals also receive 2/3 payment under the three-year rolling average mechanism, providing some much needed relief to the Katrina-affected hospitals.

When CMS reviewed the public comments on the April 12, 2006 interim final regulation regarding emergency affiliations, we quickly addressed a highly time-sensitive issue in the comments regarding the deadline for submission of the emergency Medicare graduate medical education (GME) affiliation agreements. The deadlines to submit the emergency Medicare GME affiliation agreements for the 2005 through 2006 and 2006 through 2007 academic years were changed in response to the comments from on or before June 30, 2006 and July 1, 2006, respectively, to on or before October 9, 2006. As a result, hospitals that accepted displaced residents but that did not complete affiliation agreements before the original deadline were able to complete their agreements and receive Medicare payments for training those residents.

CMS has been actively addressing stakeholder requests to extend the exemption of the three-year rolling average in order to provide a financial incentive for hospitals to keep training displaced residents. CMS has been advised by the Office of General Counsel that the three-year rolling average is mandated by statute, thus exhausting CMS authority within the GME rules.

CMS has authority to conduct demonstrations in cases where certain payment rules warrant study to help achieve more efficient and effective administration of Medicare. There is currently an ongoing demonstration in Utah examining the effect of managing resident slots at the State level. Under the demonstration, hospitals participating in the demonstration are allowed to form a statewide affiliated group in order to pool direct GME caps which may be redistributed at discretion of a statewide Medical Education Council. This demonstration also uses fiscal intermediaries (FIs) to calculate interim payments for direct GME due to the hospitals under the existing Medicare GME regulations; however, instead of making the payments to the hospitals, the FIs redirect the direct GME funds from each of the teaching hospitals and pay those amounts to the Council, which is an agency of the State government and reports to the governor, while the discharge-based indirect medical education payments are made to the hospitals as customary.

Area Wage Index

CMS has also been responsive to concerns about providers' requests for an increase in the area wage index to be reflective of reported increases in wage rates for health care facility staff.

Under the payment system for hospitals, the base payment rate is comprised of a standardized amount that is divided into a labor-related share and a non labor-related share. The labor-related share is adjusted by the wage index applicable to the area where the hospital is located. The

wage index is a relative value based on wage data reported from hospitals across the country. There is a uniform national process for updating the wage index that will not be based on post-storm data until FY 2010. Given the data collection, auditing, and budget neutrality requirements under the current wage index structure provides certain limitations, HHS recognized the rapid rise in wages in this affected area and thus directed approximately \$98 million of the \$160 million DRA appropriated grant toward hurricane relief efforts to compensate for higher wage costs. The funds are intended to provide an adjustment to eligible provider types that reflects higher wage costs until the wage index is based on post-storm wage data. CMS would very much like to understand the impact of the grant funds and if they are having their intended impact of mitigating the costs of higher wage index issues in Louisiana. In addition, we would like to understand how the wage issues are impacting other payers, namely Medicaid and private pay patients. Due to the nature of the data systems reported through multiple competing hospitals and the multiple payers, CMS recommends an outside entity conduct a thorough audit and evaluation on the wage issue.

Funding for Healthcare Assistance and Workforce Rebuilding

In addition to the CMS actions to provide flexible assistance through Medicare GME and wage index relief, HHS made available more than \$2.8 billion in Katrina-related funding in Fiscal Year 2006 to help respond to the health-related needs of people affected by the disaster. This included \$2 billion for federal payments to States for healthcare assistance; \$70 million in funding for healthcare related costs provided to CMS through a FEMA Interagency Agreement; a \$550 million Social Services Block Grant; a \$90 million Head Start hurricane-related Head

Start appropriation; and \$104 million in emergency Temporary Assistance for Needy Families (TANF) funding for states affected by the Hurricane.

Of the \$2.8 billion, the Deficit Reduction Act of 2005 (DRA) appropriated \$2 billion for payments to eligible States for healthcare needs of individuals affected by Hurricane Katrina. To date, payments have been made to 32 states for a range of health-care related services and administrative costs for persons made eligible under the waivers, for uncompensated care costs, and for the State share of ongoing Medicaid and SCHIP costs for the affected areas in Louisiana, Mississippi, and Alabama.

The \$2 billion DRA appropriation also enabled the Secretary to make \$160 million available in February 2007 to Louisiana, Mississippi and Alabama for payments to hospitals and skilled nursing facilities facing financial pressure because of changing wage rates not reflected in Medicare payment methodologies. Of the wage index related grants, 45 percent, or roughly \$71 million, went to Louisiana.

On March 1st, 2007, HHS provided another \$15 million DRA grant to Louisiana for professional healthcare workforce sustainability in the greater New Orleans area. These funds are for use in the four parishes that comprise Region 1, as defined by the Louisiana State Department of Health and Hospitals; namely, Orleans, Jefferson, St. Bernard, and Plaquemines parishes. The four parishes have been designated by the Secretary of HHS as Health Professional Shortage Areas.

On April 5, 2007, the Secretary visited Louisiana to determine the condition of health-care delivery in the region. Upon his arrival, it became clear that health care providers in Alabama, Louisiana and Mississippi were still experiencing difficulties. In the Greater New Orleans area, the Secretary and senior HHS officials conducted a “needs assessment” field visit with several local primary care clinics throughout the city. Almost immediately, it was determined that there was a severe shortage of access to primary care where the storms and resulting floods impacted the uninsured and those with low incomes first-hand. With these concerns in mind, the Secretary authorized an additional \$195 million in DRA grants for the Gulf Coast region with \$161 million being specifically allocated to the State of Louisiana.

This \$195 million allowed HHS to grant a supplemental award of \$35 million to the State of Louisiana’s prior workforce recruitment grant. The grant will further help recruit and retain health-care professionals in the Greater New Orleans Region. This amount, when combined with Louisiana’s original \$15 million allotment, has provided the region a total of \$50 million in workforce supply grant funds. Health care professionals that would be eligible recipients of workforce supply funds include physicians, dentists, registered nurses, nurse practitioners and physician assistants, other licensed professional health care staff. Clinical faculty for medical schools, dental schools and other health training programs are also included and targeted in these efforts.

Additionally, this included a supplemental award of \$60 million in provider stabilization grant funding was also awarded since the March hearing to Alabama, Louisiana and Mississippi, to help health-care providers meet changing wage rates not yet reflected by Medicare’s payment

policies. Roughly \$26 million, or 44 percent of the total, was allocated to providers in Louisiana, bringing the State's total provider stabilization grant funding to \$98 million.

Finally, as a result of concerns identified by the Secretary during his April, 5, 2007 visit to the Lower Ninth Ward, Covenant House and St. Cecelia clinics and based on input from local providers, State health care officials and others, HHS announced the availability of a new \$100 million Primary Care Grant to help increase access to primary care in the Greater New Orleans area. This grant that was awarded on July 23 will help the state assist New Orleans to expand primary care services in the region. Because of the unique impact on the low-income and uninsured populations of Greater New Orleans caused by the storm and its resulting floods, the state will work with a locally based partner, the Louisiana Public Health Institute, to make payments available to certain non-profit and public health care clinics to finance outpatient primary care services including medical and mental health services, substance abuse treatment, oral health care and optometric care. Of this \$100 million available, \$4 million will be made available for the exclusive use of the City of New Orleans to restore capability to its Parish Health Department for providing primary care in city neighborhoods that are not adequately served. Following the primary care, workforce recruitment, provider stabilization grant announcements, CMS and other HHS agencies (SAMSHA, HRSA) have conducted multiple technical assistance calls with the State.

We have outlined the funding breakdown in the chart below.

| Agency | Program | Emergency Funds for Hurricane Relief FY2006 in Millions |
|---|--|--|
| Administration for Children and Families (ACF) | | |
| | Head Start..... | \$ 90.0 |
| | Social Services Block Grant..... | \$ 550.0 |
| | Temporary Assistance for Needy Families -- Emergency Loan..... | \$ 68.8 |
| | Temporary Assistance for Needy Families -- Contingency Fund..... | \$ 48.4 |
| | ACF Total..... | \$ 757.2 |
| Centers for Medicare & Medicaid Services (CMS) | | |
| | Additional Federal payments for medical and child health assistance for Hurricane Katrina Relief..... | \$ 2,000.0 |
| | Funding for Katrina & Rita victim aid, provided through FEMA IAA to CMS (for emergency hospital & State uncompensated care costs)..... | \$ 70.0 |
| | CMS Total..... | \$ 2,070.0 |
| Centers for Disease Control and Prevention (CDC) | | |
| | Mosquito and other pest abatement activities..... | \$ 8.0 |
| | CDC Total..... | \$ 8.0 |
| Health Resources and Services Agency (HRSA) | | |
| | Health Centers - Emergency Communications Network..... | \$ 4.0 |
| | HRSA Total..... | \$ 4.0 |
| HHS TOTAL | | \$ 2,839.2 |

Conclusion

Since the March 13, 2007 hearing before this Subcommittee, HHS has made \$195 million in supplemental grant funding available for healthcare rebuilding and provider stabilization efforts in the Gulf Coast Region. Secretary Leavitt has made a personal investment of focus and energy in rebuilding the Louisiana healthcare systems, supported by continuous technical expertise offered by CMS and senior officials throughout HHS. The department will continue to make that expertise available to the State, as we work together toward the goal of a highly functioning, sustainable healthcare infrastructure for Greater New Orleans, which is capable of providing quality care, in the right setting, when needed.

Thank you, and I would be happy to answer any questions you might have.