United States Senate
Committee on Finance

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Floor Statement of U.S. Senator Chuck Grassley of Iowa
Ranking Member of the Committee on Finance
Medicare, Medicaid, and SCHIP Extension Act of 2007

Mr. President, as we approach the end of 2007, one cannot help but look ahead and see that there are many challenges that await us in the second session of 110th Congress. Especially in addressing issues relating to health care. In 2008, we will need to take a serious look at many issues in the Medicare program. Among them will be continuing to work on developing a solution for Medicare's flawed physician reimbursement system. As usual, I look forward to working with my partner on the Senate Finance Committee, Chairman, Senator Max Baucus, in our usual bipartisan way to address this and many other issues.

However, before we could adjourn this first session and go home to enjoy the holidays with our families, there was still urgent work to finish. That was the purpose of this exercise. In the legislation we considered today, there were several provisions that rise to the level of "Must Do's." These included ensuring that physicians do not receive a drastic cut in their Medicare reimbursement and extending a number of expiring provisions including the State Children's Health Insurance Program.

Ensuring health care access to my constituents is a top priority of mine and the possibility of a negative update for physicians was of great concern to me as well as to doctors and patients in Iowa and elsewhere. When discussions began to solve this problem I was in favor of a two year update. I know that several of my colleagues were as well. But in continuing negotiations with the House and Senate colleagues it became apparent that a two year fix was not possible.

I wanted to do more. I know Senator Baucus wanted to do more. We were unable to reach consensus even on the Republican side either and, therefore, the Finance Committee was unable to move ahead with the legislation that Senator Baucus and I had been developing. Unfortunately, for a variety of complex reasons, we are now here with a much more limited package. This is a disappointment for many of us. So the purpose of moving forward with a six month package now is to provide the opportunity for the Finance Committee to address these priorities next year.

One of my first priorities has been to ensure access to rural hospital services. Since hospitals are often not only the sole provider of health care in rural areas, but also significant

employers and purchasers in the community, it is especially important that they are able to keep their doors open. One group of hospitals that I am especially concerned about are "tweener" hospitals, which are too large to be critical access hospitals, but too small to be financially viable under the Medicare hospital prospective payment systems. The struggles these facilities face in Iowa are real and serious. I am very disappointed we were not able to help these hospitals in this package. I look forward to working with Senator Baucus and other Members to include "tweener" hospital improvements in next year's package.

Second, we must address the problem of specialty hospitals. I have been an outspoken advocate against these facilities for several years now. My primary concern with these facilities is the inherent conflict of interest that exists when physicians have an ownership interest in the facilities to which they refer patients. The best interest of the patient should always be the deciding factor when a referral for treatment is made, not the financial self interest of the doctor who is treating the patient. I strongly support a competitive marketplace and free market forces, but not at the expense of decreasing access to health care for the poor and uninsured or decreasing the quality of care for and safety of patients. I have been and remain concerned about the ability of community hospitals to provide care to ALL patients. I also look forward to working with Senator Baucus on addressing this issue in our package next year.

There are a number of other important issues that need to be addressed as well. We need to take on the reforms of the Medicare Quality Improvement Organization program, we need to inject some sunshine into the payments that drugs companies make to doctors, and we also need to make sure that Medicare is part of the solution when it comes to greater use of electronic prescribing and electronic health records.

In the meantime, we have this package with the following provisions that extend a number of Medicare, Medicaid and SCHIP provisions.

This legislation prevents the 10.1 percent cut to physician payment that would have occurred as of January 1, 2008, and instead gives a six month 0.5 percent update for physicians through June 30, 2008. In effect, this provides a 10.5 percent increase in physician fees from what they would otherwise have received beginning in January under current law. While this is not what many of us had in mind when we began this process providing an update through next June will allow more time and the opportunity for a bill to fully go through the legislative process beginning with a committee mark-up next year.

This legislation also continues to provide additional payment incentives for physicians and other health care practitioners who report quality measures in the Physician Quality Reporting System. We must ensure that health care providers can afford to continue to practice medicine. We must also ensure that beneficiaries have access to physicians and other health care providers. And we must provide incentives for quality improvement.

We also accommodate physicians ordered to active duty in the Armed Services by extending for six months a provision that permits them to engage in substitute billing arrangements for longer than the 60 days allowed under current law when they are ordered to active duty.

Our legislation also revises the Physician Assistance and Quality Initiative Fund, which is intended help stabilize physician payments and promote physician quality initiatives. This new fund will be available in 2008 to help minimize fluctuations in physician payments and promote physician quality initiatives.

The physician payment changes will be offset, in part, by an adjustment to the Medicare Advantage stabilization fund. Our legislation does not repeal the stabilization fund but rather preserves the fund for future years. We use the $1.5 billion available in 2012, while preserving the fund in 2013. Given the continued strong participation by plans in the program right now, the legislation preserves the fund so that Congress can add more funds in future years if they are needed.

The legislation extends Medicare private plan cost contracts through 2009, which, without this legislation, are due to expire at the end of 2008. These are long-standing plans that provide health care to Medicare beneficiaries in many communities but have been unable to convert to Medicare Advantage plans. In addition, the legislation includes a one-year extension to Medicare Advantage special needs plans through 2009. At the same time, the legislation puts a moratorium on new special needs plans. When Congress enacted the Medicare Modernization Act in 2003, it created a category of plans intended to provide specialized care models for certain populations, including Medicare beneficiaries who are also eligible for Medicaid, those who are chronically and severely ill or disabled, and those who are institutionalized (for example, in nursing homes). While these plans have proliferated, it is unclear how well they are meeting their mission of specialized care. The legislation freezes the program at the plans currently approved so that Congress and CMS can monitor the plans' performance and determine if any changes are needed.

In addition to reforming the manner in which Medicare pays for physician services, this legislation will extend several expiring provisions enacted in the Medicare Modernization Act to help ensure that beneficiaries will continue to have access to needed medical services. This includes provisions applicable to rural payments to physicians, extending the 1.0 floor on the work geographic adjustment, continuing direct payments to independent laboratories for physician pathology services, and continuing Medicare reasonable cost payments for lab tests in small rural hospitals.

Our legislation also provides a six-month extension of the therapy cap exceptions process that was included in the Tax Relief and Health Care Act last year to ensure that beneficiaries receive the physical, occupational, and speech language therapy services they need. It also extends the existing payment methodology for brachytherapy services and extends it to therapeutic radiopharmaceuticals through June 30, 2008.

As in previous legislation that Congress has passed, this legislation will continue to improve accountability in the Medicare program. There are situations when Medicare is not the primary payer for a beneficiary's health care, but it is currently difficult to identify these situations. This legislation will improve the Secretary's ability to identify beneficiaries for whom Medicare is the secondary payer by requiring group health plans and liability insurers to

submit data to the Secretary.

The legislation will ensure beneficiary access to long-term care hospitals. These facilities will receive regulatory relief for three years. In order to ensure patients are receiving appropriate levels of care at long-term care hospitals, facility and medical review requirements will be established, and the Secretary will be required to conduct a study on long-term care hospital facility and patient criteria. Also, there will be a limited moratorium on the development of new long-term care facilities and a freeze to the annual long-term care hospital payment update for one quarter in rate year 2008.

The legislation will also ensure beneficiary access to inpatient rehabilitation facility services by addressing the 75 percent rule. This rule has been criticized as too blunt an instrument for ensuring that appropriate patients receive care at these facilities. Under current law, a percentage of Medicare patients must have at least one of 13 listed medical conditions in order to be classified as an inpatient rehabilitation facility. This percentage or compliance threshold is currently at 65 percent. This legislation would permanently freeze the compliance threshold at 60 percent and allow comorbid conditions to count permanently toward this threshold. The Secretary will be required to study beneficiary access to inpatient rehabilitation services and care at inpatient rehabilitation facilities and to make recommendations for alternatives to the 75 percent rule. In addition, there will be a freeze to the annual inpatient rehabilitation facility payment update from April 1, 2008 through fiscal year 2009.

This legislation will also continue to promote more accurate hospital payments. One aspect of Medicare hospital payments that has been subject to much criticism is the area wage index. Many say that the current method of calculating the wage index does not reflect a hospital's actual labor costs and is instead arbitrary in nature so that similarly situated hospitals can receive significantly different wage index values. Since the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, hospitals have been able to obtain relief from this unfair situation temporarily.

The legislation also provides more accurate payment for Part B drugs. It implements recommendations of the HHS Office of Inspector General and requires CMS to adjust its Average Sales Price (ASP) calculation to use volume-weighted ASPs based on actual sales volume. It also establishes appropriate reimbursement rates for generic albuterol and for glycated hemoglobin diabetes laboratory tests.

In the Medicaid arena, the legislation extends the provision of disproportionate share hospital payments to Tennessee and Hawaii for the first three quarter of the current fiscal year. These payments were authorized for these states for the first time in last year's Tax Relief and Health Care Act and this is an extension of that policy.

The legislation also delays implementation of recently released regulations on school-based services and rehabilitation services in Medicaid so that the Finance Committee can appropriately review those regulations.

And finally, the legislation also includes an extension of the State Children's Health Insurance Program (SCHIP) through March 31, 2009. This provision makes additional funding available so that states do not have scale back SCHIP. This SCHIP extension will ensure that no state has to cut back their program due to insufficient federal funding. I remain hopeful that when the 110th Congress reconvenes next year, there will be a renewed effort to reauthorize and improve SCHIP.

The bill we considered today addressed the things Congress needed to do before going home for the holidays. I am pleased we were able to act quickly and unanimously to pass the bill. I know many of my colleagues wanted to do more. I know some of my colleagues are disappointed because their individual priorities could not be included. It is unfortunate. I do hope we can do more when we come back next year.

Next year is an election year. The caucuses in my home state of Iowa are but days away. We have important business to conclude in Medicare and Medicaid and SCHIP. We have a Democratic Congress that has to work with a slim majority in the Senate and a Republican President. At times this year, I'm not sure my colleagues on the other side of the aisle fully grasped the consequences of that reality. It certainly shows when you consider what we could have done this year and what was ultimately accomplished. I sincerely hope we do a better job of being bipartisan albeit in a political year.

Let me be clear that I stand ready to roll up my sleeves and get back to work come January. I am committed to moving ahead with the broader Medicare package when we return here next year. To make law, that package will have to be one that the President will sign. It will require bipartisan cooperation and hard work. I am ready to get the job done. There are many problems that need to be addressed, and we can address the myriad issues that we left on the table. We can review and act on the proposed Medicaid regulations that have so many people vexed. We can pass an SCHIP reauthorization that can become law. We have learned the pathway to failure this year. I stand ready to join any of my colleagues who want to join me on the path not taken in 2007 to a more productive 2008.

As we move to the end of the first session of the 110th Congress, I want to extend my grateful appreciation to my health staff and others for the work they have done in 2007. My staff director on the Finance Committee, Kolan Davis, has been with me for many, many years and provides me invaluable counsel. My chief health policy counsel, Mark Hayes, accomplishes more every day than any other hundred people on the Hill combined and for his tireless work ethic, I am truly thankful.. My Medicare Part A counsel, Mike Park, labored through the last several weeks though he was sick as a dog because it is that important. My Medicare Part B counsel, Sue Walden, ably deciphered the multiple variations we considered for providing an update to the physicians. The newest member of my team, Kristin Bass, who handles Medicare Parts C and D, helped us reach thoughtful compromises on numerous challenging issues. My Medicaid staffer, Rodney Whitlock, deftly handles the most controversial of issues day-in and day-out. I particularly want to pay tribute to my SCHIP staffer, Becky Shipp. We may have not accomplished what we hoped to do with SCHIP this year, but we wouldn't have been remotely close without Becky's expertise and effort. My team benefits from the able assistance of Sean McGuire and Shaun Freiman going above and beyond the call of duty to make sure the little

things get done. I also want to thank Senator McConnell's point person on health care, Meg Hauck, for working with us throughout the year. The Finance Committee benefits from that strong working relationship.

We work as hard as we possibly can to achieve bipartisan consensus in the Finance Committee and so I also want to pay tribute to Senator Baucus' staff: staff director Russ Sullivan, Michelle Easton, Neleen Eisinger, Billy Wynne, Shawn Bishop, David Schwartz, and Catherine Dratz.

We benefit greatly from the Congressional support staff as well. Tom Bradley, Tim Gronniger, Shinobu Suzuki, Jeanne De Sa, Eric Rollins and all of the hard working scoring gurus at CBO. Jim Fransen, John Goetcheus, Kelly Malone, and Ruth Ernst at Senate Legislative Counsel. Jennifer O'Sullivan, Rich Rimkunas, Chris Peterson, April Grady, Elicia Herz, Sybil Tyson, Mark Hamelburg, Erin Taylor and all the folks at CRS. Mark Miller and all of his staff at MedPAC. They make us look a lot more intelligent and effective than we actually are some days.

Finally, I want to thank some folks at CMS. Liz Hall, Erin Clapton, Ira Burney, Richard Strauss are people who help make sure we get things right even when we aren't in complete agreement.

In closing, I want to thank all those folks for their hard work in 2007 in service to the people of Iowa, Montana, and all of America. Thank you.