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MEDICARE POST-ACUTE CARE

Better Information Needed Before Modifying BBA Reforms

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Summary

Providers of post-acute care services, such as home health care, skilled nursing facility (SNF) care, and rehabilitation therapy, may have to change their service delivery practices as a result of the Balanced Budget Act of 1997 (BBA) payment reforms, which seek to make Medicare a more efficient and prudent purchaser. Calls to amend or repeal these BBA changes may be premature until information is available to identify and distinguish between desirable and undesirable consequences. At the same time, imperfections in the design of BBA-mandated payment systems require attention. The design details of these systems are key to ensuring that payments are not only adequate in the aggregate but are also fairly targeted to protect individual beneficiaries and providers.

Home health care: Our prior work indicated that (1) the reductions in the number of HHAS and changes in utilization were consistent with the objectives of the interim payment system to control the rapid growth that had preceded BBA and (2) appropriate access to Medicare's home health benefit had not been impaired. The prospective payment system (PPS) is a more appropriate tool for the long term, however, because it is intended to adjust payments for differences in beneficiary needs. As we examine the challenges of designing a PPS, we are finding that the PPS will likely require further adjustments after it is implemented as more information on home health costs, utilization, and users becomes available.

SNF care: PPS was implemented beginning in July 1998 with a 3-year transition to fully prospective rates, giving providers time to adjust to the new system. Our ongoing work suggests that factors in addition to the PPS have contributed to fiscal difficulties for some SNFS. Nevertheless, certain modifications to the PPS may be appropriate to ensure that payments are targeted to patients who require costly care. The potential access problems that may result if Medicare underpays for high-cost cases could lead to beneficiaries' staying in acute care hospitals longer, rather than foregoing care altogether. HCFA is aware of this potential targeting problem and is working to develop a solution.

Caps on coverage of outpatient rehabilitation therapy: In 1999, BBA imposed an annual $1,500 per-beneficiary cap on payments for outpatient physical and speech therapy combined and a separate $1,500 cap on outpatient occupational therapy. The caps reflect a legitimate need to constrain service use. For the vast majority of outpatient therapy users, the caps are unlikely to curtail access to services. Only a small share of beneficiaries receiving therapy services are high users. Further, most of those users with greater needs will likely have access to hospital

outpatient departments, which are not subject to the $1,500 caps. In addition, owing to HCFA's partial approach to enforcing the caps, noninstitutionalized beneficiaries can avoid having the caps curtail service coverage by switching providers. Whether the caps restrict coverage for a small share of nursing home residents is less straightforward. A need-based payment system could help better target payments toward beneficiaries who genuinely require more services than allowed under the current dollar limits.

Medicare Post-Acute Care: Better Information Needed Before Modifying BBA Reforms

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you discuss the effects of the Balanced Budget Act of 1997 (BBA) on the Medicare fee-for-service program. BBA set into motion significant program changes to both modernize Medicare and rein in spending. The act's constraints on providers' fees, increases in beneficiary payments, and structural reforms together were projected to lower Medicare spending by $386 billion over the next 10 years. Because some BBA provisions have only recently been implemented or have not yet been phased in, the act's full effects on providers, beneficiaries, and taxpayers will remain unknown for some time.

BBA was enacted in response to continuing rapid growth in Medicare spending that was neither sustainable nor readily linked to demonstrated changes in beneficiary needs. The act's payment reforms represented bold steps to control Medicare spending by changing the financial incentives inherent in payment methods that, prior to BBA, did not reward providers for delivering care efficiently. To date, the Congress has remained steadfast in the face of intense pressure to roll back certain BBA payment reforms while waiting for evidence that demonstrates the need for modifications. Calls for BBA changes come at a time when federal budget surpluses and lower-than-expected growth in Medicare outlays could make it easier to accommodate higher Medicare payments. However, as the Comptroller General cautioned in July, the surpluses are merely projections and could fall short of expectations; the imperative remains to find the reforms that will make Medicare sustainable and affordable for the longer term.[1]

My comments today focus on the reforms governing payments to three providers of post-acute care services: home health agencies (HHA), skilled nursing facilities (SNF), and providers of outpatient rehabilitation therapy. Among BBA's changes affecting various providers, these reforms are farthest along in their implementation. Furthermore, it is important to consider the payment policies for these providers together because changes to payments for one of them could affect the costs and utilization of another.

In brief, providers of post-acute care services, such as home health care, SNF care, and rehabilitation therapy, may have to change their service delivery practices as a result of BBA payment reforms, which seek to make

[1]Medicare Reform: Observations on the President's July 1999 Proposal (GAO/T-AIMD/HEHS-99-236, July 22, 1999).

Medicare a more efficient and prudent purchaser. Calls to amend or repeal these BBA changes may be premature until information is available to identify and distinguish between desirable and undesirable consequences. At the same time, imperfections in the design of BBA-mandated payment systems require attention. The design details of these systems are key to ensuring that payments are not only adequate in the aggregate but are also fairly targeted to protect individual beneficiaries and providers.

With regard to home health care, the effect of the interim payment system on HHAs has raised concerns. Our May 1999 analysis indicated, however, that the reductions in the number of HHAs and changes in home health utilization were consistent with the incentives of the interim payment system to control the rapid and unexplained growth that had preceded BBA.[2] Furthermore, we found little evidence that appropriate access to Medicare's home health benefit has been impaired. The interim payment system, however, is not an appropriate payment method for the long term because it does not adjust payments for differences in beneficiary needs. Therefore, it is important to implement the BBA-mandated prospective payment system (PPS), scheduled for October 1, 2000. In ongoing work, we are examining the formidable challenges of designing a PPS with the appropriate unit of payment, level of payment, case-mix adjustment method, and risk-sharing mechanism. Our work indicates that the PPS will likely require further adjustments after it is implemented as more information on home health costs, utilization, and users becomes available.

The SNF PPS was implemented beginning July 1998 with a 3-year transition to fully prospective rates; thus, time for providers to adjust to the payment change has been built into the implementation schedule. Our ongoing work examining whether the PPS is causing financial problems for some SNFs suggests that factors in addition to the PPS have contributed to fiscal difficulties. Nevertheless, certain modifications to the PPS may be appropriate, as there is evidence that payments are not being adequately targeted to patients who require costly care. The potential access problems that may result if Medicare underpays for high-cost cases could lead to beneficiaries' staying in acute care hospitals longer, rather than foregoing care altogether. HCFA is aware of this potential targeting problem and is working to develop a solution.

[2]Medicare Home Health Agencies: Closures Continue, With Little Evidence Beneficiary Access Is Impaired (GAO/HEHS-99-120, May 26, 1999).

Beginning this year, BBA imposed an annual $1,500 per-beneficiary cap on payments for outpatient physical and speech therapy combined and a separate $1,500 cap on outpatient occupational therapy, while exempting hospital outpatient departments from these caps. The act also replaced reasonable cost reimbursement for these services with payment under a fee schedule. The caps reflect a legitimate need to constrain service use. While not calibrated to accommodate variation in beneficiary needs, the per-beneficiary caps are unlikely to curtail access to services for the vast majority of outpatient therapy users. Only a small share of beneficiaries receiving therapy services use outpatient therapy extensively. Further, most of those users with greater needs will likely have access to hospital outpatient departments, which are not subject to the $1,500 caps. In addition, owing to HCFA's partial approach to enforcing the caps while year 2000 adjustments are made to Medicare's automated systems, noninstitutionalized beneficiaries can avoid having the caps curtail service coverage by switching providers. However, the caps may restrict coverage for some nursing home residents, resulting in their having to pay out-of-pocket or seek payment from other sources, such as Medicaid, for therapy services. Studies are under way or planned to better measure the effect of the caps and how they might be adjusted. BBA also required HCFA to recommend a need-based payment system, which could help better target payments toward beneficiaries who genuinely require more services than allowed under the current dollar limits.

Background

The Medicare program consists of two parts: “hospital insurance,” or part A, which covers inpatient hospital, skilled nursing facility, hospice, and certain home health care services, and “supplementary medical insurance,” or part B, which covers physician and outpatient hospital services, outpatient rehabilitation services, home health services under certain conditions, diagnostic tests, and ambulance and other medical services and supplies.

Prior to BBA payment reforms, Medicare experienced rapid growth in the services beneficiaries receive after a hospitalization (also called post-acute-care services), primarily due to increased utilization. During much of the 1990s, home health care was one of Medicare's fastest growing benefits; between 1990 and 1997, Medicare spending for home health care rose at an annual rate of 25.2 percent. Several factors accounted for this spending growth, most notably the relaxation of coverage guidelines. In response to a 1988 court case, a change in the coverage guidelines essentially transformed the benefit from one that

focused on patients needing short-term care after hospitalization to one that serves chronic, long-term-care patients as well.[3] The loosening of coverage and eligibility criteria contributed to an increase in the number of beneficiaries receiving services and the volume of services they received. Associated with this rise in utilization was an almost doubling in the number of Medicare-certified HHAs to 10,524 by 1997.

Also contributing to the historical rise in home health care spending were a payment system that provided few incentives to control how many visits beneficiaries received and lax Medicare oversight of claims. As we noted in a previous report, even when controlling for diagnoses, substantial geographic variation existed in the provision of home health care, with little evidence that the differences were warranted by patient care needs.[4] Additional evidence indicates that at least some of the high use and the large variation in practice represented inappropriate billings and unnecessary care.[5] Medicare oversight declined at the same time that spending mounted, contributing to the likelihood that inappropriate claims would be paid. To begin to control spending, BBA implemented an interim payment system for HHAs beginning October 1, 1997. A PPS is scheduled to be implemented for all HHAs on October 1, 2000.[6]

As required by BBA, on July 1, 1998, SNFs began a 3-year transition to a PPS, under which providers are paid a prospective rate for each day of care. Previously, SNFs were paid the reasonable costs they incurred in providing Medicare-covered services. Although there were limits on the payments for the routine portion of care (that is, general nursing, room and board, and administrative overhead), payments for ancillary services, such as rehabilitative therapy, were virtually unlimited. Because higher ancillary service costs triggered higher payments, facilities had no incentive to provide these services efficiently or only when necessary. Thus, between 1992 and 1995, daily ancillary costs grew 18.5 percent a year, compared to 6.4 percent for routine service costs. Moreover, new providers were

[3]Duggan v. Bowen, 691 F. Supp. 1487 (D.D.C. 1988).

[4]Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996).

[5]Medicare: Improper Activities by Mid-Delta Home Health (GAO/T-OSI-98-6) and Office of the Inspector General, Department of Health and Human Services, Variation Among Home Health Agencies in Medicare Payment for Home Health Services (July 1995). Our 1997 analysis of a small sample of high-dollar claims found that over 40 percent of these claims should not have been paid by the program. See Medicare: Need to Hold Home Health Agencies More Accountable for Inappropriate Billings (GAO/HEHS-97-108, June 13, 1997).

[6]BBA required the HHA PPS to be in place in fiscal year 2000. Subsequent legislation delayed the implementation by 1 year and required that there be no transition to the PPS.

exempt from the caps on routine care payments for up to their first 4 years of operation, which encouraged greater participation in Medicare.

Rehabilitation therapy comprises a substantial portion of the post-acute-care services provided by SNFs and other providers, such as rehabilitation therapy agencies and comprehensive outpatient rehabilitation facilities. Under BBA, the prices of therapy services provided in outpatient settings are controlled by a fee schedule.[7] Generally, when prices are fixed, providers can compensate by increasing the volume of services delivered. To control volume, coverage for outpatient therapy is now limited to $1,500 per beneficiary for physical and speech therapy, with a separate $1,500 per-beneficiary limit for occupational therapy. Hospital outpatient departments are exempt from these coverage limits.

Little Evidence to Date of Impaired Access to Home Health Services, but Future Payment System Will Require Refinements

By October 2000, HCFA is required to establish a new PPS for home health care—with a fixed, predetermined payment per unit of service, adjusted for patient characteristics. Until that time, HHAS are paid under the BBA-mandated interim payment system. Although concerns have been raised about the effect of the interim system, our May 1999 analysis showed little evidence that appropriate access to Medicare's home health benefit had been impaired under this payment method. Nevertheless, a home health PPS is a more appropriate payment tool because it can align payments with patient needs. Designing an adequate home health care PPS, however, poses substantial challenges.

The pre-BBA payment system had controls for payments per visit but left volume unchecked. Since enactment of the BBA, home health agencies have been paid under the interim payment system, which attempts to control the costs and amount of services provided to each beneficiary. Indeed, our work indicates that overall home health utilization in the first 3 months of 1998 had declined since 1996, but utilization was about the same for a comparable period in 1994. Moreover, the sizeable variation in utilization between counties with high and low use has narrowed. Although these changes occurred at the time that about 14 percent of HHAS closed their doors to Medicare business, we found little evidence that beneficiary access to services was inappropriately curtailed.

The PPS should be a substantial improvement over the interim payment system because payments will reflect current beneficiaries and their needs

[7]Payments for inpatient rehabilitation therapy services, such as those provided by SNFs, HHAs, and rehabilitation facilities, are not subject to the fee schedule and are paid under other rules. In addition, outpatient therapy provided by critical access hospitals is not subject to the fee schedule.

rather than historical spending patterns. However, our ongoing work on this subject shows that a number of design issues remains and the payment system will likely require continued adjustments even after implementation of the PPS next year. HCFA will pay HHAS a per-episode rate for up to the first 60 days of services to a patient. Such per-episode payments are designed to balance competing goals of controlling service provision while giving HHAS flexibility to vary the intensity or mix of services delivered during the episode. Evidence indicates that HHAS do lower their costs in response to prospective payments for an episode of care. Whether they will inappropriately cut visits, which could reduce the quality of care and cause Medicare to pay for services that were not delivered, remains to be seen. Under this prospective payment approach, HHAS also have incentives to increase the number of episodes of care provided, which could escalate, rather than constrain, Medicare spending. HCFA will need to adequately monitor service provision to ensure that beneficiaries receive the care they need and the number of episodes is not inappropriately increased.

The design of the case-mix adjustment mechanism is critical to adequately pay for patients with high services need, yet not overpay for others with lower requirements. Designing this mechanism requires detailed information about services and beneficiary characteristics, and such information is currently available only for a sample of users. Furthermore, the wide geographic and agency-level variation in service use indicates that standards of care are not well-defined, nor are the criteria for who should use the benefit. As a result, the factors that will be used under PPS for grouping patients with similar resource needs may not adequately distinguish among types of home health patients, and the PPS payment adjuster that will be associated with each patient group may not reflect appropriate cost differences. Systematic errors could result in overpayments for some beneficiaries and underpayments for others. Underpayments could lead to impaired access.

Large variations in historic spending patterns mean that a PPS, which will be based on average payment amounts, may cause payment levels to rise for certain HHAS and fall for others. Although the PPS may incorporate an outlier policy—that is, extra payments for extremely costly cases—additional mechanisms to moderate payment changes may be appropriate. For example, an “inlier” policy to reduce the payment for a patient who receives few services may be warranted, particularly given the fact that multiple episode payments may be made for a single beneficiary. Policies addressing both extremes of service use could protect the access

of beneficiaries with high needs and protect Medicare from overpaying for low-cost cases. A risk-sharing method, to account for cost differences across agencies, could provide further protection against underpayments or overpayments. Given the heterogeneous use of this benefit and the unresolved PPS design issues, moderating payments through risk-sharing might be warranted, even if such a mechanism would reduce HHAS' incentives to curtail providing unneeded care.

Aggregate Payments to SNFs Are Adequate, but Refinements Needed to Help Match Payments to Patients' Service Needs

Despite industry charges to the contrary, SNF payment rates under BBA are likely to provide sufficient, or even generous, compensation for providers. Nevertheless, the distribution of these payments may be out of balance because the current case-mix adjustment method may not adequately ensure that providers serving high-cost beneficiaries are paid enough and that those serving low-cost beneficiaries are not paid too much.

Under the new PPS, SNFs receive a payment for each day of covered care provided to a Medicare-eligible beneficiary. By establishing fixed payments and including all services provided to beneficiaries under the per diem amount, the PPS attempts to provide incentives for SNFs to deliver care more efficiently. Under the PPS, SNFs that previously boosted their Medicare ancillary payments—either through higher use rates or higher costs—will need to modify their practices more than others. Scaling back the use of these services, however, may not necessarily affect the quality of care. There is little evidence to indicate that the rapid growth in Medicare spending was due to a commensurate increase in Medicare beneficiaries' need for services.

Recent industry reports have questioned the ability of some organizations that operate SNF chains to adapt to the new PPS. Indeed, pending bankruptcies have been claimed to be the results of the Medicare payment changes. Our ongoing work suggests that PPS has been only one of many factors contributing to the poor financial performance of these corporations. For one thing, Medicare patients constitute a relatively small share of the business of most SNFs and for these corporations, SNFs are only a portion of their overall revenues. Moreover, the PPS rates are being phased in to allow time for facilities to adapt to the new payment system, and most of the payments are still tied to each facility's historical costs. The reality is that some corporations invested heavily in the nursing home and ancillary service businesses in the years immediately before the enactment of the PPS, both expanding their acquisitions and upgrading facilities to provide higher-intensity services. Under tighter payment

constraints, these debt-laden enterprises are particularly challenged. Thus, while SNFs will have to adapt to the PPS constraints, the performance of some large post-acute care providers is a reflection of many Medicare payment policy changes and strategic decisions made during a period when Medicare was exercising too little control over its payments. We are gathering additional information and will report soon on the effect of the PPS on SNF solvency and beneficiary access to care.

We believe that overall payments to SNFs are adequate. In fact, we and the Department of Health and Human Services' (HHS) Inspector General (IG) are concerned that the PPS rates Medicare pays may be too generous. Most of the data used to establish these rates—from 1995 cost reports—have not been audited and are likely to include excessive ancillary costs due to the previous system's incentives and the lack of appropriate program oversight.[8]

We are concerned, however, that payments for individual beneficiaries could be inappropriately high or low because of certain PPS design problems. The first of these problems involves the patient classification system. The classification system was based on a small sample of patients and, because of the age of the data, may not reflect current treatment patterns. As a result, it may aggregate patients with widely differing needs into too few payment groups that do not distinguish adequately among patients' resource needs. In addition, the cost variation for non-therapy ancillary services may not have been adequately accounted for in the payment rates, which may inappropriately compress the range in payments. Accordingly, access problems or inadequate care could result for some high-cost beneficiaries. Hospitals have reported an increase in placement problems due to the reluctance of some facilities to admit certain beneficiaries with high expected treatment costs, which will increase hospital lengths of stay for these patients. HCFA is aware of the limitations of the case-mix adjustment method and is working to refine this system to more accurately reflect patient differences.

Another design problem is that the current case-mix adjustment method preserves the opportunity for SNFs to increase their compensation by supplying unnecessary services. A SNF can benefit by manipulating the services provided to beneficiaries, rather than increasing efficiency. For example, by providing certain patients an extra minute of therapy over a

[8]HHS' IG recently reported on the inappropriateness of the base year costs. See Office of the Inspector General, Department of Health and Human Services, Physical and Occupational Therapy in Nursing Homes: Cost of Improper Billings to Medicare (OEI-09-97-00122, Aug. 1999).

defined threshold, a facility could substantially increase its Medicare payments without a commensurate increase in its costs.

Adverse Effect of Outpatient Therapy Caps Doubtful, but Need-Adjusted Payment Limits Would Be Better

Questions have been raised about a BBA coverage restriction for a third group of post-acute-care services—outpatient rehabilitation therapy. Together with a fee schedule that replaces reasonable cost reimbursement for these services, BBA imposed an annual $1,500 per-beneficiary cap on payments for outpatient physical and speech therapy combined and a separate $1,500 per-beneficiary cap on outpatient occupational therapy.[9] Services provided by hospital outpatient departments are exempt from the per-beneficiary caps.

Rehabilitation therapy providers have raised concerns that the $1,500 limits will arbitrarily curtail necessary treatments for Medicare beneficiaries, particularly victims of stroke, hip injuries, or multiple medical incidents within a single year. These concerns have led to several legislative proposals to include various exceptions to the caps or eliminate them altogether.

Our ongoing work on this topic for Members of this Subcommittee suggests that eliminating the caps without substituting other controls could undermine BBA's comprehensive strategy for restricting payments for outpatient therapy services. Controlling the price for each unit of service—as is done with the new requirement that outpatient therapy providers bill Medicare according to the physician fee schedule—may not necessarily control Medicare expenditures if utilization rises. This is particularly likely, given the price and utilization controls imposed through PPS on other providers of rehabilitation therapy. Thus, the per-beneficiary caps serve to limit the volume of services provided.

For the vast majority of beneficiaries, the coverage caps are unlikely to curtail access to needed services. An analysis by the Medicare Payment Advisory Commission shows that, in 1996, most users (86 percent) did not exceed $1,500 in payments for physical and speech therapy or for

[9]Physical therapy includes treatments such as whirlpool baths, ultrasound, and therapeutic exercises to relieve pain, improve mobility, maintain cardiopulmonary functioning, and limit the disability from an injury or disease. Speech therapy includes the diagnosis and treatment of speech, language, and swallowing disorders. Occupational therapy helps patients learn the skills necessary to perform daily tasks, diminish or correct pathology, and promote health.

occupational therapy.[10] Moreover, if the fee schedule constrains payments as expected, the proportion of beneficiaries who are unaffected by the caps could be even higher in 1999, because beneficiaries could receive more services before reaching the per-beneficiary caps than under the former cost-based system.

Even for beneficiaries exceeding $1,500 in payments under the fee schedule, mitigating factors exist. First, under the BBA exemption, Medicare beneficiaries have no limits on coverage for rehabilitation therapy provided by hospital outpatient departments, which are widely available nationwide. In addition, the caps will initially not be applied as specified in BBA. Implementing the caps involves many programming changes to Medicare's automated information systems that HCFA is unable to undertake concurrent with its year 2000 preparation efforts. As a result, HCFA's claims processing contractors will be unable to track therapy payments on a per-beneficiary basis. Instead, effective January 1, 1999, HCFA employed a transitional approach to implementing the caps. Under this approach, each provider of therapy services is responsible for tracking its billings for each Medicare patient and stopping them at the $1,500 threshold. The consequence of this partial implementation is that noninstitutionalized beneficiaries may switch to a new provider when they have reached the $1,500 limit under the current provider.

The effect of the per-beneficiary caps on nursing home residents is less clear. The ability of beneficiaries to switch outpatient providers under HCFA's partial implementation approach is, practically speaking, not available to nursing facility residents. Under new billing requirements, the nursing facility in which the beneficiary resides is required to bill for outpatient therapy provided to the resident, regardless of the entity that actually delivered the service. Therefore, unlike their noninstitutionalized counterparts, nursing facility residents cannot switch providers to restart the $1,500 coverage allowance. Under these circumstances, some nursing home residents—like those needing extensive rehabilitation therapy resulting from conditions such as stroke or hip fractures—could be vulnerable to out-of-pocket costs for therapy.

Even the risk for these more vulnerable beneficiaries may be moderated, however, because nursing home residents seeking therapy for such conditions would likely receive a complement of rehabilitation services as a SNF inpatient—before the outpatient therapy coverage limit begins to

[10]A July 1998 report sponsored by the National Association for the Support of Long-Term Care and NovaCare, a rehabilitation services company, projects that 87 percent of beneficiaries will not exceed the per-beneficiary cap.

apply. That is, individuals suffering a stroke or undergoing hip replacement would likely spend at least 3 days in an acute care hospital, which, combined with the need for daily skilled nursing care or therapy, would make them eligible for a Medicare-covered SNF stay of up to 100 days, during which they would likely receive therapy services. After their Medicare coverage ends, a nursing facility resident can continue to receive outpatient therapy services under Medicare part B, subject to the coverage limits. BBA mandates that HCFA develop a classification system based on diagnosis to determine differences in patients' therapy needs and propose possible alternatives to the caps in a report due January 1, 2001. This report will be significant in that a need-based system could help ensure adequate coverage for those beneficiaries requiring an extraordinary level of services and prevent overprovision to those requiring only limited amounts.

Conclusion

In conclusion, the BBA payment reforms affecting providers of home health care, SNF care, and outpatient rehabilitation therapy are all intended to make these providers more efficient. As the reforms begin to have their intended effects, pressure is building to return to more generous payment policies. Evidence to date shows that BBA is moving Medicare in the right direction but that adjustments will be needed along the way. These adjustments should be based on thorough, quantitative assessments so that misdiagnosed problems do not lead to misguided solutions. With the health care of seniors and the tax dollars of all Americans at stake, policymakers must, in the face of pressure for increased payment rates, preserve new payment policies that exact efficiencies but make adaptations when substantiated evidence supports the need to do so.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or other Members of the Subcommittee might have.

GAO Contacts and Acknowledgments

For future contacts regarding this testimony, please call Laura A. Dummit at (202) 512-7119. Individuals who made key contributions to this statement include Carol L. Carter, Assistant Director; Hannah F. Fein; James E. Mathews; and Deborah Spielberg.

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