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Additional Medicare Savings

Hospitals

(1) Freeze PPS Update in FY 1998

Under the current proposal, PPS hospitals would receive an update of market basket minus 1 percentage point for each year between FY 1998 and FY 2002. This additional proposal would freeze the PPS hospital update for FY 1998.

PROPAC has recommended a freeze for FY 1998 for PPS hospitals. PROPAC indicates that PPS hospitals' Medicare inpatient operating costs per discharge actually decreased for 1994 and the trend has continued for 1995. PROPAC also indicates preliminary results showing PPS margins at 7.9 percent for 1995.

(2) Freeze Non-PPS Update in FY 1998

The current proposal would revise the system of cost targets for Non-PPS hospitals and reduce their update to market basket minus 1.5 percentage points for FY 1998 through FY 2002. The new proposal would freeze the Non-PPS hospital update for FY 1998.

A freeze of the FY 1998 update for Non-PPS hospitals is appropriate because Medicare expenditures for Non-PPS hospitals have been growing rapidly, more than twice as fast as expenditures for PPS hospitals.

(3) Reduce PPS Capital Payments by 5%

The current proposal is an extender which permanently captures the savings from the OBRA-1990 temporary capital reduction that expired at the end of FY 1995. As a result of the sunset of the OBRA-1990 provision, Medicare payments for capital increased beginning with FY 1996. The current proposal extends the OBRA 1990 savings by reducing current capital rates by 15.7 percent.

This additional proposal reduces PPS capital payments (federal and facility-specific) by 5 percent beginning with FY 1998 (in addition to the 15.7 percent reduction to recapture the savings from the expired OBRA-1990 provision). The additional reduction is based on the excessive growth in Medicare hospital capital payments between 1983, when the prospective payment system was implemented (except for capital), and 1991, when the prospective payment system for capital was implemented. During this period, hospital costs and Medicare payments for capital in PPS hospitals grew by 28 percent more than 1983 hospital capital costs per case, increased by inflation, case mix and intensity.

(4) Reduce IME: 6.6% in FY 1998, 5.5% in FY 1999

Under the current proposal, the Medicare indirect medical education (IME) adjustment would be reduced from 7.7 percent to 7.4 percent in FY 1998, 7.1 percent in FY 1999, 6.8 percent in FY 2000, 6.6 percent in FY 2001 and 5.5 percent beginning in FY 2002. The additional proposal would reduce IME faster, to 6.6 percent in FY 1998 and 5.5 percent beginning in FY 1999.

PROPAC recommends that the IME adjustment be reduced from 7.7 percent to 7.0 percent in FY 1998. PROPAC also notes that the IME adjustment should more closely correspond to the actual relationship between teaching intensity and costs which PROPAC estimates would be an IME

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adjustment of 4.1 percent. A reduction of the IME adjustment to 5.5 percent would be about 60 percent of the difference between the current level and the level that PROPAC estimates as the proper technical adjustment.

(5) Value of Capital When Ownership of an Institution Changes

Under current law, when a hospital or SNF changes ownership, existing statutory requirements on establishing the value of the asset have created a loophole through which some providers are able to create "losses" for which Medicare is partially liable. For example, a seller might allocate a significant portion of the purchase price of a hospital not to the value of the physical plant but to some intangible asset. If this results in the sale price for the hospital being less than its book value, current law requires Medicare to pay a share of the difference at sale.

This additional proposal would modify rules on how capital is valued when a provider changes ownership and eliminate the need for Medicare adjustments. It would also expand the statute to cover all providers.

Durable Medical Equipment

(1) Reduce Payments for Oxygen and Oxygen Equipment by 40%

Under current law, payments for oxygen and oxygen equipment and supplies are established by a statutorily prescribed methodology. However, the statutory formula results in Medicare payment levels which are far in excess of rates used by the Veterans Administration (VA), which procures oxygen and oxygen equipment using a competitive bidding system.

The additional proposal would reduce Medicare payments for oxygen and oxygen equipment by 40 percent, effective 1/1/98. The reduction is based on using the competitive market determined VA rate plus 30 percent.

(2) Effective Date for Competitive Bid

The current proposal authorizes the Secretary to set payment rates for most Part B services based on competitive bidding. Automatic reductions in rates for would be triggered for clinical laboratory services and DMEPOS (excluding oxygen services) if by 2001 a 20 percent reduction had not been achieved.

The additional proposal would advance the effective date for the automatic reductions from 2001 to 2000.

Skilled Nursing Facilities

(1) Remove New Providers from FY 1995 Base Rates

The current Administration package proposes a PPS for SNFs to be phased-in beginning in FY 1998. The PPS rates would be derived from FY 1995 cost data for all facilities, the latest available data, updated to FY 1998.

Under current law, new SNFs can receive an exemption from current routine cost limits for 3 to 4 years. The reason for the exemption is that new providers often have higher than usual costs as they increase their occupancy rates. Because no cost limit applies during the exemption period, costs

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frequently are $100 to $200 higher than the average Medicare routine cost of about $125 per day. The current proposal includes the higher costs for SNFs which in FY 1995 were new providers receiving the exemption.

The additional proposal would eliminate new providers from the FY 1995 base cost data from which the PPS rates are derived. Rates for the PPS system should not be permanently biased upward with the higher costs of SNFs which three years earlier were new and exempted from any Medicare cost limits.

(2) Eliminate New Provider Exemptions

Under the Administration's proposal, during the transition, the facility-specific rate is based on FY 1995 costs for that facility, updated to FY 1998. The current proposal would allow a SNF which was new in FY 1995 and received an exemption to retain those higher costs as its facility specific rate during the transition.

This additional proposal would establish the facility-specific rate for a SNF which was new in FY 1995 at the cost limit that would have applied in FY 1995 without the exemption, updated to FY 1998.

(3) Update SNF PPS by MB-1 for FY 1996 and FY 1997

The current proposal would update FY 1995 costs to FY 1998 by market basket for two years (FY 1996 and FY 1997) and market basket minus 1 percentage point for one year (FY 1998).

The new proposal would update the FY 1995 costs to FY 1998 by market basket minus 1 percentage point for all three years (FY 1996, FY 1997 and FY 1998). The additional reduction in updating FY 1995 costs is to recoup some of the excessive growth in SNF ancillary services which occurred prior to FY 1995. Since current cost limits apply only to routine costs, Medicare payments for SNF ancillary services grew more than 50 percent faster than payments for SNF routine costs between 1990 and 1994.

Physicians

The current package proposes to encourage physicians practicing in hospitals whose volume and intensity of physicians services per admissions was excessive to become more efficient. The additional proposal would: (a) advance the effective date of the proposal from 2000 to 1999, and (b) change the limits and withhold for urban hospitals. The new parameters would be a 20 percent withhold for physicians practicing in hospitals where the volume and intensity of physician services per admission exceeded 120 percent of the national median of urban hospitals and a 10 percent withhold where the volume and intensity of physician services was between 110 and 120 percent of the median. As under the proposal in the current package, if physicians collaborate to efficiently manage the volume and intensity of the services they provide during the year, the physicians would receive the withheld payments, plus interest, at the end of the year.

This proposal is designed to provide incentives for physicians to address the wide variation among hospitals in the volume of physician services per admission, even after adjusting for case severity, teaching hospital status and disproportionate-share status.

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Distribution of Medicare Savings by Category

	Current ($82 bil) Package	Alternative ($100 bil) Package
Hospitals	31.1%	32.3%
Physicians	7.1%	7.0%
SNFs	9.4%	10.4%
Home Health	15.7%	13.6%
Fraud and Abuse	10.3%	8.4%
Other	2.2%	3.2%
Beneficiary Premium	11.0%	8.3%
Beneficiary Improvements	-22.9%	-15.8%
Managed Care	36.4%	32.9%
Total	100.3%	100.3%

Notes:

(1) Based on CBO pricing of Administration package and guesstimates of CBO pricing for alternative.

(2) Hospitals (inpatient and outpatient) represent over 53 percent of Medicare spending.

(3) About 20 percent of the dollar savings shown for the alternative are attributable to the impact of lower fee-for-service spending on managed care. For example, 20 percent of the additional dollar savings shown for the alternative for "hospital proposals" would actually be reductions in HMO payments. The distribution figures above allocate the savings for each proposal between fee-for-service categories and managed care.