BACKUP: MEDICARE POLICIES
April 16, 1999

COMMISSION'S BBA EXTENDERS: ($51 billion over 10 years)

For 2003-2007:

- Reduce hospital market basket update by 1.1 percentage points
- Extend hospital PPS capital reduction of 2.1 percent
- Extend the 15 percent hospital PPS-exempt capital reduction
- Reduce PPS-exempt hospital update using BBA relationship between hospital's operating costs and hospital's target amount
- Reduce skilled nursing facility (SNF) update by 1 percentage point
- Reduce hospice update by 1 percentage point
- Reduce OPD update by 1 percentage point
- Reduce ambulance payment updates to CPI minus 1 percentage point
- Reduce prosthetics and orthotics updates by 1 percentage point
- Freeze lab updates, DME updates, and PEN payments
- Reduce ambulatory surgical centers update to CPI minus 2 percentage points

Potential Changes:

- Extend policies through 2009 to get additional savings
- Home health: put back update factors that were lowered in Fall 1998 home health bill
- Therapy caps: Raise from $1,500 limit to $2,000
- Hospital market basket update: From 1.1 to 1.0 for 2003-09
- Rural hospital market basket: From 1.0 to xx

DRAFT: Medicare Provider Changes

BBA Extenders included in Commission Package, except:

- Extend through 2009 (adds $7 billion in savings relative to 2007)

Hospitals

- **Updates:** Drop President's Budget proposal to reduce hospital market basket (Cost relative to PB: about $9 billion over 10)

  In extenders for 2003 - 2009,
  - General hospital market basket update reduction of 1.0 (rather than 1.1)
  - Rural hospital market update reduction of 0.5

  Cost: $12.1 billion over 10 years relative to BBA extenders through 2009

- **Indirect Medical Education:** Change the reduction in IME payments in 2000 to (a) 6.5 percent or (b) 6.25 percent (instead of 6.0 percent).

- **DSH:** Carve out full DSH payments from Medicare+Choice payments, and make full DSH payment directly to hospitals for Medicare+Choice enrollees, effective 1/1/01.

- **Hospital Outpatient**: Provide for a transitional (3 years, 6 months) add-on adjustment to Medicare OPD PPS payment amounts for the following groups of hospitals: low volume hospitals; low-volume rural; low-volume urban; teaching hospitals with more than 100 residents or with no DSH; and PPS-exempt hospitals (including cancer hospitals).

Skilled Nursing Facilities

- **Complex case adjustment.** Increase the Federal portion of per diem payments by 1 percent for approximately 9 specified RUGs with high non-therapy ancillary costs/medically complex cases. This policy would be effective until the Secretary refined RUGs to deal with non-therapy ancillary costs/medically complex cases at which time this temporary add-on policy would end.

- **Outlier policy development**. Authorize the Secretary to develop and implement a budget-neutral outlier policy for SNFs.

- **Therapy Caps:** Increase each of the two therapy caps (physical/speech therapy and occupational therapy) from $1,500 to (a) $2,200 per year, effective 1/1/00 (approximate $1 billion over 5-years); or $3,000 per year, effective 1/1/00. (approximate $2 billion over 5-years); or create a third therapy cap, separating speech and physical therapy with each having a limit of $1,500 per year.

Home Health

- **Update:** Eliminate the reductions, established by section 5105(d) of OCESA, in the home health market basket increase of 1.1 percentage points for each of fiscal years 2000, 2001, 2002 and 2003.

- **Interim payment system:** Eliminate half (i.e., 7.5 percentage points) of the scheduled 15 percent reduction in the home health per visit cost limits and per beneficiary limits in effect on 9/30/00.

- **Old agency designation** (administrative): Effective 10/1/99, allow long-existing home health agencies (i.e., those in existence since 1980) that had less than a 12 month cost reporting period ending in the FY 1994 base year because the agency changed the end date of its cost reporting period during fiscal year 1994, to choose to be treated as an "old" agency for application of the per beneficiary limits.

Managed Care:

- **Risk adjustment** (administrative actions): (a) Change the share in the risk adjustment that is based on demographics; (b) delay full phase-in of risk adjustment until 2006; (c) delay full phase-in of risk adjustment until 2007. Note: Delays in risk adjustment affect the ability to implement competitive managed care payment policies.

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Provider Type	Proposal	Supporting Organizations (1)	Legislative or Administrative	Comments
Hospitals	Repeal the Transfer Provision	AHA	Legislative	The transfer provision requires Medicare to reduce payments to hospitals that transfer patients to another hospital, or unit, skilled nursing facility, or home health agency after a shorter than average length of stay. The transfer policy applies to only ten DRGs.
Hospitals	Limit Impact of Outpatient PPS	AHA	Legislative	While HCFA is considering various proposals to limit the impact of the OPD PPS, existing authority would have this happen on a budget neutral basis. AHA is asking for new spending which they estimate will be $1.9 billion
Hospitals	Establishment of a Clinical Education Trust Fund that Both Private and Public Payers Contribute	AHA AAMC	Legislative	
Hospitals	Make Medicare+Choice Payment Rates More Uniform Nationwide	AHA	Legislative	Would like Congress to make additional dollars available so blend works as Congress intended. Note that in 2000, blend rates in effect in 63% of counties.
Hospitals	Carve-Out DSH Payments from Medicare Payments to Medicare+Choice Plans	AHA AAMC	Legislative	Would like payments to go directly to hospitals that incur the cost of caring for those who cannot pay.
Hospitals	Eliminate the Volume Expenditure Cap Included in the Proposed Outpatient Prospective Payment System Regulation	AHA	Legislative	The statue currently requires us to develop a mechanism for controlling volume. HCFA could potentially delay imposition of a volume expenditure cap for a few years.

Provider Type	Proposal	Supporting Organizations (1)	Legislative or Administrative	Comments
Hospitals	Remove the $510 Million Cut in Outpatient Reimbursement Included in the Proposed Outpatient Prospective Payment System Regulation. —Came	AHA (1.1)	Legislative ? 5.6L/5	Copayment would be calculated according to a different formula resulting in higher beneficiary copayments. Say that a technical error in the law median & Avg Charges.
Teaching Hospitals	Eliminate IME Cuts Included in the BBA Keep at 6.0 '00 5.5 '01 6-6, slower step. *	AAMC	Legislative	Included in the BBA, the IME adjustment rate was reduced from 7.0 percent to 5.5 percent over 4 years.
Teaching Hospitals	Eliminate DME and IME Caps Included in the BBA	AAMC	Legislative	
Home Health Agencies	Grant home health agencies overpayment forgiveness for payments in excess of their IPS limits.	NAHC	Legislative	$ Flexible extended repayment plan.
Home Health Agencies	Under IPS, develop outlier payments for sicker patients (or some mechanism for patient or case-mix adjustments). x	NAHC	Legislative	
Home Health Agencies	Eliminate the mandatory October 1, 2000, 15% reduction in the limits.	NAHC	Legislative (2)	$ Ease Up: ||| $1 bil.0
Home Health Agencies	Increase home health per visit cost limits to 112% of the mean, rather than 106% of the median, lift the application of the freeze to the cost limits, and require that the data used to calculate the limits be based on all types of home health agencies, including hospital-based programs.	NAHC	Legislative	

$8-10 /5

Provider Type	Proposal	Supporting Organizations (1)	Legislative or Administrative	Comments
Home Health Agencies	Reimburse agencies the full costs agencies will incur in implementing and continued management of OASIS.	NAHC	Legislative	
Home Health Agencies	Delay OASIS by requiring HHAs to begin implementing OASIS based on the amount of advance time and data actually needed for the development of a home health PPS.	NAHC	Legislative	
Home Health Agencies	Restore the full market basket update to home care payments.	NAHC	Legislative	$900 million/5
Home Health Agencies	Oppose coinsurance for Medicare and Medicaid home health services.	NAHC	Legislative	Currently, there is no copayment in Medicare home health. However, the Medicare Commission is proposing a 10 percent copayment.
Home Health Agencies	Repeal or significantly alter the surety bond requirements, applying them only to agencies with poor records of repayment to Medicare and/or Medicaid or to new agencies wishing to participate in the program(s). Requirements should be reasonable so that legitimate, reputable home care agencies can meet them.	NAHC	Legislative	The surety bond proposed rule is being developed for publication later this year. The rule will include a $50,000 bond and will not be effective until PPS begins on 10/1/00.

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Home Health Agencies	Enact homebound definition that ensures access and eligibility to the home care benefit based upon the beneficiary's functional limitations and clinical condition.	NAHC X	Legislative	Currently, eligibility requirements include physician certification that the patient is under a physician's care; a plan of care developed by a physician; physician certification that the patient is confined to the home; and need for skilled nursing care on an intermittent basis, physical therapy, speech-language pathology, or continued occupational therapy. The BBA requires the Secretary to report to Congress on the study of the homebound issue and make recommendations by 10/1/98. This report is currently under clearance in the Secretary's office. We recommend retaining the current homebound policy.
Home Health Agencies	Provide HCFA with authorization to issue emergency no-interest payments to health care providers where Medicare claims processing, payment, and payment rate updates are delayed as a result of incomplete or erroneous Y2K computer changes. Reimbursement limits should be adjusted and payments for home health agencies to allow completion of Y2K compliance efforts.	NAHC	Legislative	

Could be Differential 15% Rural

Thomas:

PT — speech separate from Occup. 4500 or 3000 can be fungible w/ Facility pre BBA $900

Provider Type	Proposal	Supporting Organizations (1)	Legislative or Administrative	Comments
Skilled Nursing Facilities	Legislate exceptions to the therapy caps	AHCA AOTA APTA ASHA AAHSA	Legislative	These groups had tried in the 105th Congress to eliminate the caps entirely, but have focused their efforts in the 106th on backing the Grassley bill which would allow exceptions to the caps. OACT scores the bill at about $2.6 billion over the 5 year period, 2000-2004.
Skilled Nursing Facilities	Outlier policy for medically complex patients	AHCA NSCA AACP NSCLC	Legislative	These groups are unhappy with the way the SNF PPS rates account for non-therapy ancillary services (including drugs) and support higher PPS payments for medically complex patients. The BBA does not specify an outlier policy for SNFs.
Skilled Nursing Facilities	Exclude non-therapy ancillary services from the PPS rates.	AHCA NASL AACP	Legislative	This is another proposal supported by industry groups to increase payments for non-therapy ancillary products and services. The BBA specifically requires that these types of services be bundled into the rates. A December GC memo states that HCFA can not do this administratively.
Skilled Nursing Facilities	Fight reductions in baseline spending	AHCA NASL NSCA	Legislative	This proposal reflects the belief that the amount of savings from the SNF PPS provision in the BBA has increased from about $9 billion to about $16 billion because CBO has adjusted their baseline. CBO has not, however, rescored the provision.

*Short-term: Pump in $ RUGS.
*Long-term: Outlier policy to develop. authorization

$2.4 = upper Band

Provider Type	Proposal	Supporting Organizations (1)	Legislative or Administrative	Comments
Managed Care Organizations	Delay implementation of M+C risk adjustment	AAHP HIAA BCBS	Legislative	In support of this proposal, AAHP and HIAA note concerns with using an in-patient based methodology and with data collection and transmission. HIAA suggests a demonstration of the methodology and capping the impact at 1% of payments. AAHP also noted the exclusion of 1-day hospital stays.
Managed Care Organizations	Implement M+C risk adjustment on a budget neutral basis	AAHP HIAA	Administrative	AAHP characterizes this as one element of a "fairness gap", indicating that relative to Medicare FFS payments, the national average 7.6% impact of implementing risk adjustment contributes to M+C payments being only 82% of FFS in 2004. The starting point for AAHP's analysis is that pre-BBA rates were 95% of fee-for-service costs. However, taking favorable selection into account, they were actually in the range of 102-110% of fee-for-service costs.
Managed Care Organizations	Modify method for updating M+C rates -- no very specific proposals o AAHP suggests linking rates more closely to local FFS spending o HIAA suggests assuring that they cover medical inflation	AAHP HIAA	Legislative	One approach to increasing payments would be to drop the 0.5% reduction in the update in 2001 and 2002. Additionally, the reductions for 1998-2000 could also be given back in 2001.

Provider Type	Proposal	Supporting Organizations (1)	Legislative or Administrative	Comments
Managed Care Organizations	Modify M+C "user fee" provisions so M+C plans are not the source for all funding for M+C information activities	AAHP HIAA	Legislative	Administration's FY2000 budget includes a proposal to increase the authorization from $100 million to $150 million for FY 2000 and beyond. Alternative funding mechanisms were considered and rejected during the FY2000 process.

(1) Organizations that have expressed support in public statements such as Congressional testimony or press releases or in meetings with HCFA. Other organizations may also support these proposals.

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