June 1, 1999

Mr. Chris Jennings
Deputy Assistant to the President
for Health Policy Development
Old Executive Office Building, Room 216
17th Street & Pennsylvania Avenue, NW
Washington, D.C. 20503

Dear Chris:

Per your conversation with Rick Pollack, enclosed please find several of our BBA fixes including proposals to: 1) assure adequate payments under outpatient PPS; 2) improve the skilled nursing facility PPS; and 3) repeal the transfer provision. In addition, we wanted to share with you MedPAC's recommendation for a .5% increase in the inpatient PPS update for fiscal year 2000.

Thank you for your attention to the enclosed.

Sincerely,

Mary Beth Savary Taylor

Mary Beth Savary Taylor
Director
Executive Branch Relations

FYI
Jeanne
Dan
Mike
Bonnie

Enclosures

Washington, DC Center for Government and Public Affairs
Chicago, Illinois Center for Health Care Leadership

Liberty Place, Suite 700
325 Seventh Street, N.W.
Washington, DC 20004-2802
(202) 638-1100

AHA PROPOSAL TO ASSURE ADEQUATE PAYMENTS UNDER MEDICARE'S OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (PPS)

PROBLEM:

According to a recent Medicare Payment Advisory Commission (MedPAC) report, Medicare pays hospitals only 90 cents for each dollar of outpatient care provided prior to enactment of the BBA. Today, as a result of the BBA, hospitals are paid only 82 cents on the dollar. And, once the new outpatient PPS is implemented, HCFA will reduce hospital outpatient payments by another 3.8 percent. Many hospitals, however, will lose much more than 3.8 percent, according to HCFA's estimates.

√ More than half of the nation's major teaching hospitals would lose more than 10 percent and nearly one-half of rural hospitals also would more than 10 percent.

√ Catastrophic losses would be experienced by some individual hospitals. For example, large hospitals in Iowa and New Hampshire will immediately lose almost 14 to 15 percent of their Medicare outpatient revenue. Other large urban hospitals in Missouri, Massachusetts, Wisconsin, Florida, and California lost 20 percent to 40 percent. Some New York City hospitals would lose more than 40 percent. Some small rural hospitals in Arkansas, Kansas, Mississippi, Washington, and Texas will lose more than 50 percent of their revenue.

SOLUTION:

To prevent these precipitous drops in Medicare revenues from doing additional harm to hospitals and the Medicare beneficiaries who rely on them, legislation should be enacted that limits payment losses created by the move to outpatient PPS. However, the costs of financing this proposal should not be paid by the remaining hospitals, because most of them are also expected to lose under the outpatient PPS. Moreover, large new losses would have to be incurred by those hospitals, ranging from 8 to 3 percent, to protect other hospitals from losses of 5 to 15 percent. Instead, this change needs to be funded by additional Medicare program spending. **Beneficiary spending would be unaffected.**

- Until January 2002, each hospital's Medicare payments for outpatient PPS services would be adjusted so that the hospital's losses are limited to 5 percent of what the hospital would have been paid by Medicare under the current system.

- For CY 2002, the payment losses would be limited to 10 percent.

- For CY 2003, the payment losses would be limited to 15 percent. No limit is set after 2003.

If HCFA does not change its interpretation that unfairly shifts the 3.8 percent reduction in beneficiary copayments from the Medicare program to hospitals, this proposal will require roughly $1.9 billion over 5 years in new funding.

3/15/99

SEC. __. LIMITING REDUCTIONS IN FEDERAL PAYMENTS UNDER PPS FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) IN GENERAL.–Section 4523 of the Balanced Budget Act of 1997 is amended by adding at the end the following:

"(e) TEMPORARY LIMIT ON REDUCTIONS IN FEDERAL PAYMENTS.–

"(1) IN GENERAL.–Notwithstanding section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)), as added by subsection (a), the amount that is paid from the Federal Supplementary Medical Insurance Trust Fund for covered OPD services furnished by a hospital during a calendar year (or portion thereof) specified in paragraph (2)(A) may not be less than the applicable percentage of the case mix adjusted average amount that would have been payable to such hospital for such services (including cost sharing) if the prospective payment system established under such section did not apply. Such average amount may be determined on a prospective basis using the Secretary's best estimate of the reasonable costs incurred in furnishing covered OPD services or on a retrospective basis using cost reports submitted by a hospital.

"(2) DEFINITIONS.–For purposes of paragraph (1)–

"(A) subject to paragraph (3), the term 'applicable percentage' means–

"(i) with respect to covered OPD services furnished during the first full calendar year (and any portion of the immediately preceding calendar year) for which the prospective payment system established under section 1833(t) of such Act is in effect, 95 percent,

"(ii) with respect to the second full calendar year for which such system is in effect, 90 percent, and

"(iii) with respect to the third full calendar year for which such system is in effect, 85 percent; and

"(B) the term 'covered OPD services' has the meaning given to such term in section 1833(t)(1)(B) of such Act.

"(3) APPLICATION TO CERTAIN HOSPITALS.--In the case of hospitals described in section 1833(t)(8) of such Act, the 'applicable percentage' for a calendar year (or portion thereof) shall be the same applicable percentage that applies to covered OPD services furnished by hospitals that are not described in such section during such calendar year (or portion thereof).

"(4) RULE OF CONSTRUCTION.--Nothing in this subsection shall be construed as affecting the amount of cost sharing paid by individuals enrolled under part B of title XVIII of the Social Security Act for covered OPD services.".

(b) CONFORMING AMENDMENT.--Section 1833(t)(1)(A) of the Social Security Act (42 U.S.C. 1395l(t)(1)(A)) is amended by inserting "except as provided in section 4523(e) of the Balanced Budget Act of 1997," after "1999,".

(c) EFFECTIVE DATE.--The amendments made by this section shall become effective as if included in the enactment of the Balanced Budget Act of 1997.

AMERICAN HOSPITAL ASSOCIATION and AMERICAN ASSOCIATION OF HOMES AND SERVICES FOR THE AGING PROPOSAL TO IMPROVE THE SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM

Problem

The Balanced Budget Act of 1997 (BBA) reduced skilled nursing facility (SNF) payments by $9 billion over five years. At the same time, it required the Health Care Financing Administration (HCFA) to implement a prospective payment system (PPS) for these services. The new PPS is not refined enough, however, and therefore fails to adequately account for differences in costs associated with the care of medically complex patients. In addition, the exception payments which covered the cost of care for these patients prior to the PPS were not included in the PPS federal rates, and only partially included in the facility-specific rate used in the transition to PPS.

For example:

- ✓ An amputee is placed in a SNF for rehabilitative services. The SNF must pay for the prosthesis, which could cost up to $5,000. The SNF, however, receives only a $200 to $300 per diem for treatment and must pay for the prosthesis from the per diem.

- ✓ A cancer patient breaks his hip and is hospitalized. He is placed in a SNF for therapy and nursing services. His chemotherapy treatment for prostate cancer is $2,000. Costs for chemotherapy must be paid for from the $200 to $300 SNF per diem.

- ✓ An AIDS patient is admitted to a SNF. The costs of drugs for treatment can be hundreds of dollars per week. Costs for drug therapy must come from SNF's per diem payment.

Proposed Solution

Both HCFA and providers believe these issues can be addressed by revising current case-mix (Resource Utilization Groups) categories used in the new SNF PPS to reflect these types of patients. However, HCFA cannot make any changes to case-mix until after 2000 due to the year 2000 computer problems. HCFA has also not completed its research on how to improve case-mix. Moreover, without any of the lost exception payments, improving case-mix would only come at the expense of the funding necessary to care for other patients.

AHA and AAHSA propose that an adjustment to the SNF PPS be created for patients with high cost "non-therapy ancillaries" like chemotherapy and prostheses. The adjustment is modeled on the existing outlier adjustment in the PPS for acute care. Thus, the proposal would minimize the financial risks associated with caring for certain kinds of patients and compensate for higher costs for the non-therapy ancillaries. It would be established with additional monies of about one percent of annual SNF payments -- $140 million in the first year and up to $1 billion over 5 years. The adjustment will no longer be necessary once the Secretary addresses these case-mix concerns and the funding is then used to pay for the care of these medically complex patients. If the outlier provision is delayed due to year 2000 computer problems, HCFA would be expected to make appropriate adjustments for claims already submitted as the agency did after the initial 3 to 6 month delay of the implementation of PPS.

SEC.__. OUTLIER PAYMENTS FOR CERTAIN ANCILLARY SERVICES UNDER SNF PPS SYSTEM.

(a) IN GENERAL.--Section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)) is amended by adding at the end the following:

"(11) OUTLIER PAYMENTS FOR CERTAIN ANCILLARY SERVICES.--

"(A) IN GENERAL.--The Secretary shall provide for an additional payment to a skilled nursing facility for any month (or portion thereof) of covered skilled nursing facility services for which the average per diem non-therapy ancillary costs of the facility exceed--

"(i) a fixed multiple of the non-therapy ancillary component of the applicable adjusted Federal per diem rate, or

"(ii) such other fixed dollar amount as the Secretary designates,

whichever is greater.

"(B) AMOUNT OF PAYMENT.--The Secretary shall determine the amount of the additional payment to a facility under subparagraph (A). Such amount--

"(i) shall approximate the additional cost of non-therapy ancillary services beyond the cutoff point applicable under such subparagraph, and

(ii) shall not exceed an amount that is equal to ten times the non-therapy ancillary component of the applicable adjusted Federal per diem rate.

"(C) AMOUNT OF AGGREGATE PAYMENTS.--The total amount of the additional payments made under this paragraph for a fiscal year shall equal 1 percent of the total payments projected or estimated to be made under this subsection for the fiscal year.

"(D) DEFINITIONS.--For purposes of this paragraph--

"(i) the term 'non-therapy ancillary costs' means the allowable costs of ancillary services (other than therapy services described in the second sentence of paragraph (2)(A)(ii)) furnished to an individual who is a resident of a skilled nursing facility during the period in which the individual is provided with covered skilled nursing facility services, and

"(ii) in determining the average per diem of such costs for a facility for a month (or portion thereof) of covered skilled nursing services for purposes of comparison with the applicable cutoff point under subparagraph (A), the Secretary shall—

"(I) adjust the charges of the facility for such services by the cost-to-charge ratio of the facility for covered post-hospital extended care services, and

"(II) divide the total of such costs for such period by the number of days of covered skilled nursing facility services that are included in such period.

"(E) LIMITATION ON ADJUSTMENTS.--The Secretary is not authorized to reduce each of the facility-specific or Federal per diem rates determined under this paragraph by a factor equal to the proportion of payments under this section that are additional payments under this paragraph.".

(b) CONFORMING CHANGE.--Section 1888(e)(8) of the Social Security Act (42 U.S.C. 1395yy(e)(8)) is amended--

(1) by striking "and" at the end of subparagraph (B),

(2) by striking the period at the end of subparagraph (C) and inserting a semicolon and "and", and

(3) by adding at the end the following:

"(D) the establishment of cutoff points and payment amounts under

paragraph (11).".

(c) EFFECTIVE DATE.--

(1) IN GENERAL.--The amendments made by this section shall apply to days of covered skilled nursing facility services occurring on or after October 1, 1999, and before the first day of the first fiscal year to begin on or after the date on which the Secretary of Health and Human Services (in this subsection referred to as the "Secretary") determines that the case mix adjustment authorized by section 1888(e)(4)(G)(i) of the Social Security Act (42 U.S.C. 1395yy(e)(4)(G)(i)) adequately compensates skilled nursing facilities for non-therapy ancillary costs of covered skilled nursing facility services.

(2) ADJUSTMENT OF FEDERAL PER DIEM RATES.--Notwithstanding any other provision of law, the Secretary shall increase each of the Federal per diem rates determined under section 1888(e)(4) of the Social Security Act (42 U.S.C. 1395yy(e)(4)) for the first fiscal year beginning after the close of the period described in paragraph (1) by 1 percentage point. Such increase shall be in addition to any other increase required by law and shall continue to be reflected in the Federal per diem rates for succeeding fiscal years.

WHY THE TRANSFER PROVISION SHOULD BE REPEALED

Background Medicare patients who are sent from one acute care hospital to another acute care hospital are defined as **transfer cases**. These cases are paid less than the full PPS rate if the patient had a shorter inpatient stay than average. Medicare patients who are sent after their inpatient hospital stay to a rehabilitation or a skilled nursing facility or a home health agency are defined as discharges from the acute-care hospital. For a discharge, acute care hospitals are paid the full Medicare prospective payment (PPS) rate.

The BBA expanded the definition of a transfer to include patients sent from an acute care hospital to **any** post acute setting--rehabilitation, psychiatric, or skilled nursing facility, or a home health agency-- for up to 10 DRGs as of October 1, 1998. Again, the hospital is paid only part of the PPS rate if the patient had a shorter inpatient stay than average.

Transfer cases are paid a per-diem rate up to the full PPS rate which is based on the average stay. The hospital gets paid twice the per-diem for the first day. Thus, full payment is not achieved until the stay is one day less than average. For example, if a patient stayed 6 days where the average stay was 10 days, the hospital would receive 70 percent of the PPS rate. But if the patient stayed 14 days where the average stay was 10 days, no additional payments would be made above the PPS rate.

This provision does not change payment rates for post-acute facilities. Only the acute care hospital payment is changed.

AHA View This provision hurts vulnerable hospitals and does not make sense for the Medicare program.

- ✔ **Inequitable** -- After this policy is implemented, hospitals will be paid less for cases that stay two days less than average. But hospitals are not paid more overall for cases that stay longer -- **any** outlier payments are funded by reducing payments for the less costly cases. Thus the transfer policy reduces payments for shorter stay cases where the payment was **already reduced** to fund outlier payments.

- ✔ **Unfair to Rural Hospitals** -- The transfer provision penalizes hospitals with shorter than the national average length of stay. Rural hospitals have <u>always</u> had shorter lengths of stay than urban hospitals.

- ✔ **Cuts Hospitals Twice** -- The overall reduction in hospital length of stay (referred to as a "change in hospital product") is explicitly addressed in the Medicare Payment Advisory Commission's update recommendation. In fiscal 1998, MedPAC recommended no update based in part on prior changes in length of stay. Congress acknowledged MedPAC's recommendation, giving hospitals received no update in FY 1998. To further penalize hospitals under the transfer policy is a **double hit**.

106TH CONGRESS
1ST SESSION

H. R. 405

To amend title XVIII of the Social Security Act to repeal the restriction on payment for certain hospital discharges to post-acute care imposed by section 4407 of the Balanced Budget Act of 1997.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 19, 1999

Mr. NUSSLE (for himself, Mr. EWING, Mr. BOEHLERT, Ms. SANCHEZ, Mr. CONDIT, Mr. OBERSTAR, Mr. SANDERS, Mr. PETERSON of Minnesota, Mr. MASCARA, Mr. SERRANO, Mr. PRICE of North Carolina, and Mr. MEEHAN), introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend title XVIII of the Social Security Act to repeal the restriction on payment for certain hospital discharges to post-acute care imposed by section 4407 of the Balanced Budget Act of 1997.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicare Common Sense Hospital Payment Act of 1999".

SEC. 2. REPEAL OF RESTRICTION ON MEDICARE PAYMENT FOR CERTAIN HOSPITAL DISCHARGES TO POST-ACUTE CARE.

(a) IN GENERAL.—Section 1886(d)(5) of the Social Security Act (42 U.S.C. 1395ww(d)(5)), as amended by section 4407 of the Balanced Budget Act of 1997 (Public Law 105–33), is amended—

(1) in subparagraph (I)(ii), by striking "not taking in account the effect of subparagraph (J),", and

(2) by striking subparagraph (J).

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to discharges occurring on or after October 1, 1999.

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between MedPAC's and HCFA's construction of the market basket index. We weight expected growth in employee compensation in the hospital industry and the general economy equally, while HCFA gives less weight to the hospital industry projections. Because wage growth in the hospital industry has trailed that of the broader economy in recent years, MedPAC's market basket is forecast to increase more slowly than HCFA's. Correspondingly, we are making a −0.2 percentage point adjustment.

The second input price adjustment addresses errors in previous market basket forecasts. Because the annual updates are based on the forecasts available prior to the beginning of the payment year, they are subject to errors that can result in inappropriately high or low payment rates. MedPAC corrects these errors when actual data become available, two years after they are applied to payments. Because the update in fiscal year 1998 was zero and not based on the market basket forecast, however, any error in the forecast did not affect the payment rates in that year. Therefore, we are making no adjustment for market basket forecast error for fiscal year 2000.

Scientific and technological advances

MedPAC's review of hospital technology suggests there will be no significant changes in the overall rate at which hospitals adopt quality-enhancing but cost-increasing technologies in fiscal year 2000, with the exception of the need to address year 2000 computer problems. (See Appendix C for a more detailed description of the technologies considered in this analysis.) We believe that hospitals will incur significant operating and capital costs in becoming year 2000 compliant and that these improvements will be completed during fiscal years 2000 and 2001.

The improvements to hospital systems and medical devices to fix year 2000 problems differ from the other technologies included in the allowance for scientific and technological advances in that they are not new advances or new applications of existing technologies (one of the criteria used to identify technologies for the allowance). Rather, the year 2000 improvements will maintain the current operation of information systems and medical devices, resulting in limited changes in their functions and capabilities. Nonetheless, we believe these improvements to hospital systems and devices fall under the rubric of our allowance for scientific and technological advances.

Therefore, we are explicitly increasing the allowance for scientific and technological advances by 0.5 percent from that used in our recommendation for fiscal year 1999 to account for year 2000 computer improvements. However, this increase is not considered a permanent part of the allowance, and we will reconsider the level of this adjustment in subsequent fiscal year analyses. For fiscal year 2000, MedPAC recommends an allowance for scientific and technological advances of 0.5 percent to 1.0 percent.

Productivity improvement

We make a downward adjustment in the framework to reflect expected improvements in hospital productivity. This adjustment is a policy target, reflecting our position that Medicare should require hospitals to reduce their inputs relative to output by at least a modest amount each year. Hospitals that can surpass this target will be able to keep the additional gains they achieve in the next year.

Our analysis of factors related to hospital productivity suggests that annual improvements of about 3 percent in inputs used per discharge, exclusive of the impact of site-of-care substitution, have been achieved in 1997 and 1998.[8] Although gains have been registered each year from 1992, those in the last two years appear to have been by far the largest.

However, the change in real costs per discharge in these years was well below the rate of inflati and services hospitals u inpatient care, despite si stay declines than in pre doubt that this rate of in sustainable. Moreover, c adjustment is intended t level of improvement th achieved without advers quality, and yet it is not for changes in quality wi the productivity trend. W that requiring efficiency measured in recent years serious threat to maintai Therefore, we set a rang percent for the productiv adjustment in fiscal year

Site-of-care sub

The average length of Me stays declined 5.4 percent 1991 and 1996, and we es led to per discharge cost s percent a year. We believe these savings reflect a shi other settings, as care in t substituted for the latter d stays. A variety of substitu can be involved, including inpatient and outpatient re physicians' services in an setting, and home health c Medicare automatically pa in the new settings, the sit substitution adjustment is funding along with the ass

When care in an amb acute setting replaces acu days, there may be a syste reduction in costs. If a ski substitutes for an acute ca example, the hospital's va (like daily food, housekee and nursing care) may be more than the amount of r costs in the skilled nursing Assuming no change in cl we would consider this ne productivity gain, which s

8 Because of lags in the availability of Medicare Cost Report data, our 1997 and 1998 est to more recent data available from the American Hospital Association. The estimate cited in case mix), exclusive of the net cost impact of length of stay reductions. This estimate m of stay may be attributable to site-of-care substitution. See Appendix D for additional info

9 Appendix D shows the trend in length of stay and cost per discharge, for all patients and of length of stay reductions.

1994 Report. pg. 57

SEC. ___. INCREASING MEDICARE UPDATE FOR INPATIENT HOSPITAL SERVICES TO ACCOMMODATE Y2K COMPLIANCE COSTS.

Section 1886(b)(3)(B)(i)(XV) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)(XV)) is amended by striking "minus 1.8 percentage points" and inserting "minus 1.3 percentage points".

May 28, 1999

Mr. Daniel N. Mendelson, Associate Director
Health and Personnel
Office of Management and Budget
Old Executive Office Building, Room 238
17th Street & Pennsylvania Avenue, NW
Washington, D.C. 20503

CC: JENNINGS
LAMBREW
MILLER

WE WILL SET UP A MEETING ON THIS. THANKS.

Dear Dan:

Enclosed please find a copy of a letter we sent to HCFA Administrator Nancy-Ann DeParle on the outpatient PPS issue strongly objecting to HCFA's interpretation of the 1997 Balanced Budget Act requiring hospitals to fund a portion of reduced beneficiary coinsurance costs. In addition, we have also enclosed for your review a legal analysis reinforcing our position and urging HCFA to follow congressional intent by having Medicare program funds offset reductions in beneficiary coinsurance.

We are requesting a meeting with you so that this inequity can be fixed administratively in an expeditious manner. We will follow-up with you within the next several days to determine a mutually agreeable time. Thank you for your prompt attention to this critical issue for our members.

Sincerely,

Mary Beth Savary Taylor

Mary Beth Savary Taylor
Director
Executive Branch Relations

Enclosure

Washington, DC Center for Government and Public Affairs
Chicago, Illinois Center for Health Care Leadership

Liberty Place, Suite 700
325 Seventh Street, N.W.
Washington, DC 20004-2802
(202) 638-1100

May 21, 1999

Nancy-Ann DeParle
Administrator
Health Care Financing Administration
200 Independence Ave S.W. – Room 314-G
Washington, D.C. 20201

Dear Ms. DeParle:

On behalf of our 5,000 member hospitals, health systems and other providers of care, the American Hospital Association (AHA) is growing increasingly concerned about the outpatient prospective payment system (PPS). During the development of the Balanced Budget Act, Congress, HCFA, seniors and hospitals agreed that beneficiaries were paying too high a share of the payments hospitals receive for providing outpatient care. All parties also agreed that the program should shoulder the financial burden of reducing beneficiaries' liability to 20 percent of total payments. Thus, program payments were set by the BBA to gradually increase to 80 percent of total payments for outpatient care.

We believe HCFA has misinterpreted the intent of Congress by reducing hospital payments to offset reduced beneficiary coinsurance. The language of the House and Senate bills clearly placed the financial burden of this change on the Medicare program. The conference report clearly states that the PPS "would be required to equal the total amounts estimated by the Secretary that would be paid for OPD services in 1999." A legal analysis of the statute supporting our view is attached to this letter.

Moreover, we were informed last week by HCFA that the offset -- 5.7% or $4.3 billion over five years -- is now almost twice as large as previously estimated. Part of the revision is because HCFA failed to include in the initial estimates the impact of discounting payments for multiple surgeries performed on the same day. This policy is not required by statute.

These policies endanger the delivery of emergency and outpatient care to America's seniors. According to the Medicare Payment Advisory Commission, Medicare only covers 82 cents of every dollar in Medicare outpatient care costs today and further reductions in the level of payment are clearly untenable. We urge you to correct this inequity, as Congress intended, by having program funds offset reductions in beneficiary coinsurance.

Washington, DC Center for Public Affairs
Chicago, Illinois Center for Health Care Leadership

Liberty Place, Suite 700
325 Seventh Street, N.W.
Washington, DC 20004-2802
(202) 638-1100

Should you have any questions about these issues, please contact me, Carmela Coyle, senior vice president for policy (202) 626-2266, or Deborah Williams (202) 626-2340. We look forward to meeting with you soon.

Sincerely,

Rick Pollack

Rick Pollack
Executive Vice President

Attachment

AMERICAN HOSPITAL ASSOCIATION WHITE PAPER

HCFA's Authority to Develop a Budget Neutral Conversion Factor Under the Hospital Outpatient Department Prospective Payment System

By

Darrel J. Grinstead
Hogan & Hartson, L.L.P.

Background. The Balanced Budget Act of 1997 ("BBA") establishes a Medicare hospital outpatient department ("OPD") prospective payment system ("PPS") to determine both the amount of Medicare payments for outpatient department services and the amount of beneficiary copayments for those services. The new system is intended to be implemented in a budget-neutral way. While budget savings were achieved in the BBA through several OPD-related provisions (extension of current law payment reductions, elimination of formula-driven overpayments, and limitations on market basket rates of increase), there is no indication that Congress intended to achieve additional savings through the PPS formula itself. However, the proposed regulations published by the Health Care Financing Administration to implement this provision result in an additional reduction of 5.7% or $900 million per year in Medicare payments to hospitals for OPD services. This results from an interpretation by HCFA of a provision of the BBA that was not intended by the Congress nor required by the language of the statute. The following analysis supports this conclusion.

The Statutory Formula. Analysis of this problem requires an initial understanding of the basic formula that Congress devised for determining Medicare payments and beneficiary copayments for OPD services. The statute requires relative payment weights to be determined for each OPD service or group of services. Based on those weights and the frequencies of each service or group, a conversion factor is calculated so that the sum of the Medicare fee schedule amounts (conversion factor times relative weight) multiplied by the frequencies for each service or group equals the projected amount that would have been payable under the old system. The fee schedule amount is composed of both the Medicare payment amount and the beneficiary copayment. In order to correct a problem in the current statute that results in excessive copayment amounts, the statute requires the determination of an "unadjusted copayment amount" (20 percent of the

national median of the charges for each service or group). The formula for determining the amount of actual copayments for each year is designed to reduce copayments gradually until they reach that target amount.

HCFA's Proposed Process for Calculating the Conversion Factor. The problem with HCFA's interpretation of this statutory formula derives from the manner in which it proposes to determine the conversion factor. In calculating the conversion factor, rather than utilizing data that will result in payments under the new system in the first year equaling what would have been paid under the old system, HCFA proposes to build into the conversion factor a significant reduction in its estimate of beneficiary copayments. The ultimate result of this interpretation is a lower conversion factor and a permanent and unintended reduction in payments to hospitals for OPD services.

Under section 1833(t)(3)(A) of the statute, the Secretary's estimation of the conversion factor must begin with the calculation of base amounts (i.e., a hypothetical calculation such as that previously used in converting several other Medicare payment systems to fee schedules or prospective payment systems). These amounts traditionally have been based on assumptions of the amounts that would have been paid in the initial year under the old system and were intended to ensure budget neutrality in "converting" from one system to another. However, in this case, the statute specifies that, in calculating the total amount that hospitals would have received for an OPD service, **Medicare** payments in the base year will be based on an estimate of Trust Fund payments for OPD services in 1999 "without regard to this section," while beneficiary **copayments** will be based on the amounts "estimated to be paid under this subsection" in 1999. § 1833(t)(3)(A)(ii).

There is one critical problem with this statutory instruction. The statute and HCFA's proposed regulation would require the Secretary, in solving for an unknown (the conversion factor), to use as one of the components of the formula (the copayment base amount) an amount that can only be determined after the conversion factor has been calculated. On its face this instruction seems circular because the Secretary cannot know what amounts would be paid "under this subsection" until she can apply to the formula the conversion factor that is the subject of this calculation.

In its proposed regulation implementing this formula, HCFA states that it is following this statutory instruction. While HCFA does not expressly state that it is doing so, the only figure that would be immediately available for estimating copayment amounts "under this subsection" would be the "unadjusted copayment amount" that the Secretary is required to calculate for purposes of

determining the beneficiary copayment amounts under the formula, as discussed above. 1/

Under section 1883(t)(3)(B), the unadjusted copayment amount for each service or group is set at 20 percent of the national median of the charges for that service or group in 1996, updated to 1999 by the Secretary's estimate of the growth in charges during that period. However, the unadjusted copayment amount is not calculated for the purpose of establishing the amount of copayments to be paid by beneficiaries in any year. The sole purpose for calculating that figure is to determine the program payment percentage, which determines the proportion of the total fee schedule amount to be paid by both Medicare and beneficiaries. Nowhere in the statute is there an instruction to determine actual or estimated copayment amounts based on the unadjusted copayment amount. It is merely a fixed proxy amount which, when applied in the formula for each year, results in a gradual decrease over time in the relative share of the full fee schedule amount that is paid by Medicare beneficiaries as a copayment. 2/

There are a number of problems with using the unadjusted copayment amount as a proxy for total 1999 beneficiary copayment amounts in the calculation of the base amount under section 1833(t)(3)(A). First, it is merely a fictitious amount based on the national median of the charges for a service in 1996, updated to 1999 to reflect increases in charges over that period. It does not in fact reflect current payment levels. Because the median amount for these charges is less than the mean, we understand from HCFA's actuaries that the aggregate amount of this unadjusted copayment amount will be more than 10 percent less than current levels of beneficiary copayments. There is no indication in the legislative history or elsewhere that Congress intended this result

Second, as noted above, Congress did not instruct the Secretary to use that figure in that manner. If Congress had intended the "unadjusted copayment amount" calculated under section 1883(t)(3)(B) of the statute to be used as the Secretary's estimate of the total amount of copayments for 1999 for purposes of the conversion factor, it would have referred to that specific provision in the statute, rather than requiring, as section 1883(t)(3)(A) does, that the Secretary "estimate" that amount. It would be illogical to require the Secretary to estimate a payment amount if Congress intended to Secretary to use an amount that is specifically calculated under the statutory provision immediately following the provision requiring the estimation.

1/ See discussion in section V.C.2.b. of the preamble to the proposed regulation, 63 FR 173. Sept. 8, 1998, p. 47573.

2/ Under the statute, when the program payment percentage for a service or group reaches 80 percent, it then permanently remains at that amount, the gradual reduction in copayment percentage having been fully achieved. § 1833(t)(3)(B)(ii).

Legislative History. Thus, there is considerable ambiguity in the statute as to how the Secretary is instructed to calculate the total amount of beneficiary copayments for the purposes of determining the base amounts and the resulting conversion factor. We do not believe, however, that there is any ambiguity in the congressional intent that the conversion factor should be calculated in such a manner that the fee schedule amounts determined under the PPS "would be required to equal the total amounts estimated by the Secretary that would be paid for OPD services in 1999." That precise language appears as a statement of congressional intent in both the House and Senate reports on the OPD PPS provisions, and in the Conference Report. 3/ The use of the subjunctive "would be paid" in this phrase seems clearly to indicate Congress' intent to refer to amounts payable in other circumstances, i.e., had Congress not changed the formula.

Both the House and Senate versions of the bill that went to Conference on the Balanced Budget Act contained almost identical versions of an OPD prospective payment system. Both of those bills required a determination of base amounts (for purposes of determining the conversion factor) derived from an estimate of the amounts that would be payable by Medicare for OPD services under the old law and as though the required coinsurance, as in effect prior to enactment of the new PPS, continued to apply. However, in the final drafting of the Conference language, technical changes were made to the entire OPD PPS provision, apparently to correct drafting flaws, without any change being intended to the actual determination of payment amounts. 4/ The Conference Report states that it adopts the House bill with amendments to define covered OPD services and to provide market basket minus one percent updates to the fee schedule amount for the years 2000 through 2002, with full market basket percentage increases thereafter.5/ No mention is made in the Conference Report of any intention to reduce the copayment portion of the base amount in order to achieve additional savings. In fact, such savings are nowhere mentioned in the legislative history or in the budget analyses of this provision. Therefore, it seems probable that any change in the language of this provision made by the Conference Committee was intended only to correct the drafting problems and not to require a $900 million annual reduction in Medicare payments for OPD services.

3/ H.R. Rep. No 105-149, 105th Cong., 724 (1997); S. Rep No. 105-29, 105th Cong., 53 (1997); H.R. Rep. No. 105-217, 105th Cong., 784 (1997).

4/ The conversion factor that would have been used in the House and Senate bills would have used as an aggregate base amount Trust Fund payments only, calculated without regard to the PPS amendments, and calculated as though the coinsurance provisions in effect prior to enactment continued to apply. However, the conversion factor established in the Conference report is based on the sum of both Medicare Trust Fund payments and beneficiary copayment amounts.

5/ H.R. Rep. No. 105-217, 105th Cong., 785 (1997).

The legislative history does not explain why the Conference Committee adopted language for calculating base amounts that referred to copayment amounts "estimated to be paid under this section" rather than assuming that copayments would be calculated under the old system, as both the House and Senate bills did. Perhaps the drafters assumed, without being aware of the effect of using median charge levels rather than the mean for calculating unadjusted copayment amounts, that either method would produce the same result. Or perhaps the drafters simply failed to recognize that copayment amounts "under this subsection" would be something entirely different from the amount of copayments that should be taken into account in order to achieve the stated budget neutrality purpose of the conversion factor. In any event, there is no discernible logic in the use of base amounts derived from the former system for establishing the Medicare portion of the conversion factor base, while using amounts that are somehow to be determined under the new system for establishing the beneficiary copayment portion of that factor.

If HCFA's proposed rule is adopted, the amount of copayments estimated to be paid by beneficiaries for purposes of determining the conversion factor will be arbitrarily reduced by 6.9 percent. That downward adjustment will permanently reduce the fee schedule amounts and the amounts paid to hospitals by Medicare in a manner that is totally inconsistent with the clearly stated congressional intent indicated above.

Although courts and administering agencies are under an obligation in most cases to follow statutory language that is clear and unambiguous, in some "rare and exceptional circumstances," this presumption can be rebutted. *Ardestani v. INS*, 502 U.S. 129, 135-36 (1991). Even if the language in question here were unambiguous (which we have demonstrated is not the case), it is a well-established canon of statutory construction that "a court should go beyond the literal language of a statute if reliance on that language would defeat the plain purpose of the statute." *Bob Jones University v. United States*, 461 U.S. 574, 586 (1983). This directive is particularly appropriate when construing a complex statute that produces an unexpected result. *DeJesus v. Perales*, 770 F.2d 316, 321 (2d. Cir. 1985), cert. denied, 478 U.S. 1007, (1986) (interpreting conditions a state Medicaid plan must meet in order to qualify for federal matching funds, which the court describes as "a statute of unparalleled complexity").

This is not the first time HCFA has been faced with implementing changes in Medicare payment policy where the language of the statute was inconsistent with Congress' actual intention. HCFA had a similar problem when Congress enacted the Omnibus Budget Reconciliation Act of 1990 6/ which required

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6/ OBRA 90, Pub. L. No. 101-508, 104 Stat. 1388 (1990).

HCFA to create national payment limits for durable medical equipment. 7/ The payment system was to be phased in over three years, starting in 1991, and payment rates were to be updated annually based on a "covered item update." 8/ The update for both 1991 and 1992, as it was enacted and signed into law, was a "reduction of 1 percentage point." 9/ What Congress had intended, however, was not a reduction in payments of one percent but an *increase* based on the Consumer Price Index for all urban consumers ("CPI-U") for the previous year reduced by one percentage point. Congress corrected this error, four years later, by a technical correction included in the Social Security Act Amendments of 1994. 10/

In the meantime, however, HCFA had no difficulty in implementing the statute as it had been intended rather than as it plainly read. Although the correction to the statutory provision was not made until 1994, HCFA promulgated regulations in 1992 that interpreted the covered item update for 1991 and 1992 to be based on the CPI-U, reduced by one percent. 11/ In short, the regulation assumed that the statutory provision as enacted was incorrect and read into the provision a payment update based on congressional intent.

Similarly, we do not believe HCFA is obliged to interpret the OPD provisions discussed above by following blindly a narrow reading of the language of the statute itself. This is especially true given that to do so would deprive hospitals of $900 million in annual revenues in a manner that was not intended by the Congress and not reflected in any of the agreements, discussions or analyses of the budget impact of this legislation. Moreover, as noted above, the language of the statute has an unusual circularity that renders it infeasible to be implemented literally. The courts have recognized the leeway that administrative agencies must be given in interpreting complex and ambiguous statutory language (see *Perales, supra*), in order to ensure that congressional intent is achieved.

Conclusion. In light of the complexity of this statutory scheme and the ambiguity in the statutory language, HCFA should interpret the statute in a manner that will achieve the stated objectives of the Congress and that will make sense in terms of calculating a conversion factor that will ensure that the fee

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7/ *Id.* at § 4152(b).

8/ *Id.* at § 4152(b)(4) (prior to 1994 amendment).

9/ *Id.*

10/ Social Security Act Amendments of 1994, Pub. L. No. 103-432, § 135, 108 Stat. 4398, 4422 (1994).

11/ Payment for Durable Medical Equipment and Orthotic and Prosthetic Devices, 57 Fed. Reg. 57678 (1992).

schedule amounts determined under the PPS will "equal the total amounts estimated by the Secretary that would be paid for OPD services in 1999." 12/ HCFA's regulations should provide for a budget neutral conversion factor that will provide for the conversion of payments from the former system to the new without extracting $900 million annually in unjustified and unintended hospital payment reductions.

12/ H.R. Rep. No 105-149, 105th Cong., 724 (1997); S. Rep No. 105-29, 105th Cong., 53 (1997); H.R. Rep. No. 105-217, 105th Cong., 784 (1997).

POWERS
PYLES
SUTTER &
VERVILLE PC
ATTORNEYS AT LAW

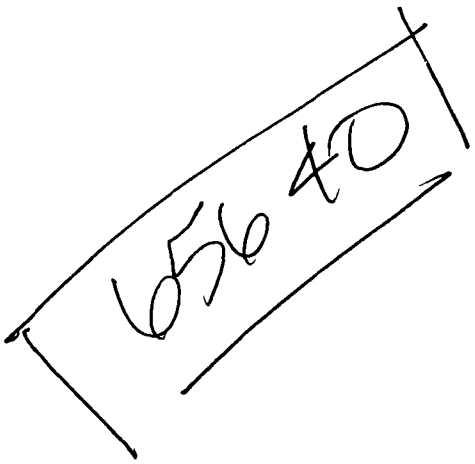
FILE ID:

TWELFTH FLOOR
1875 EYE STREET, NW
WASHINGTON, DC 20006-5409
PHONE: (202) 466-6550 FAX: (202) 785-1756

FAX COVER SHEET

To:	Chris Jennings c/o Barbara Wooley	**From:**	Jim Pyles
Fax:	456-5557	**Pages:**	3
Phone:	456-5594	**Date:**	June 2, 1999
Re:	Administration's Potential Plan for Home Health Copayment		

☐ Urgent ✓ **For Review** ☐ Please Comment ☐ Please Reply



POWERS PYLES SUTTER & VERVILLE PC
ATTORNEYS AT LAW

DAVID C. BECK
REBECCA L. BURKE
HAROLD DAMELIN
ARTHUR S. DIDIO, M.D.*
MARK R. FITZGERALD
STANLEY A. FREEMAN
JOEL M. HAMME
THOMAS HYLDEN
MARIE C. INFANTE
CHRISTOPHER L. KEOUGH
KAREN S. LOVITCH
ANA-MARIA McKESSY
MARY SUSAN PHILP
GALEN D. POWERS
JAMES C. PYLES
JOEL M. RUDNICK
ROBERT J. SANER II
MARLA P. SPINDEL
RONALD N. SUTTER
D. BENSON TESDAHL
PETER W. THOMAS
RICHARD E. VERVILLE

J. MICHAEL HALL, GOVERNMENT RELATIONS

DIRECTOR OF PUBLIC POLICY AND LEGISLATION
JUDITH A. BUCKALEW

LEGISLATIVE AFFAIRS
AMY E. BACON
JOHN L. BUDETTI

OF COUNSEL
DONALD W. AARONSON, M.D.
CHICAGO, ILLINOIS

*Member Virginia Bar Only

MEMORANDUM

To: Chris Jennings

From: Jim Pyles
Home Health Services and Staffing Association

Date: June 2, 1999

Re: Administration's Potential Plan for Home Health Copayment

We are concerned that the Administration is contemplating imposing a copayment on home health services covered under Medicare, and believe that such a decision would be bad public policy and bad political strategy.

As the attached chart of CBO projections shows, home health expenditures had a negative rate of growth in FY '98 of **minus 15%**. (The rate of growth actually dropped 20% from a positive growth rate of 5% in FY 1997.) The cuts in home health expenditures for FY '98 were more than six times higher than projected when BBA '97 was passed. Finally, the average rate of expenditure growth for home health over five years is approximately 0% and is lower than the rate projected for any other service covered by Medicare. All these reductions are occurring during a period when the need for home health services by Medicare beneficiaries will be increasing.

As further shown by the attached information, Medicare claims for home health services are down by 20%, at least 2,195 Medicare-certified agencies have been forced to close, the value of home health company stocks has dropped by 45% to 55% in one year, at least one major home health company has had to seek bankruptcy protection, at least 61,000 home health jobs have been lost, the wages of home health workers have not kept pace with inflation, and agencies are having to discharge patients who need the most expensive care.

Also, HCFA is seeking to impose the OASIS data reporting system which will add $45 million in costs in the current year and $110 million in costs over the next five years. HCFA estimates that 70% of home health agencies will not receive any Medicare reimbursement for these additional costs because their cost of services per beneficiary

will be over the new, lower per beneficiary limits established by BBA '97. A copayment in any amount would simply add more administrative costs and divert additional dollars away from services to patients.

In short, Medicare funding is already insufficient to permit home health agencies to provide the services to patients that are covered under Medicare. Copayments will simply make home health care inaccessible for even more of the sickest patients.

Attachment

HOME HEALTH "SAVINGS" UNDER BBA '97

CBO Estimates of Impact of BBA '97

Home Health Outlays in Billions

Fiscal Year	1998	1999	2000	2001	2002
Jan. 1997 Baseline	$21.1	$23.1	$25.3	$27.5	$29.9
Post BBA '97 Baseline	$20.0	$21.1	$21.2	$23.3	$25.2
Cum. Savings from BBA'97	$1.1	$3.1	$7.2	$11.4	$16.1
March 1999 Baseline	$14.9	$15.0	$16.5	$15.6	$17.1
Revised Cum. Savings	$6.2	$14.3	$23.1	$35.0	$48.8

5 year savings projected at time BBA'97 passed = $16.1
5 year savings projected in March 1999 = $48.8
5 year savings from BBA'97 are 300% higher than projected

Rate of Growth in Home Health Expenditures Compared to Other Services (March 1999)

Fiscal Year	1998	1999	2000	2001	2002	5yr Average
Hosp.	-2.5%	-1.5%	5.7%	4.7%	4.5%	2.2%
SNF's	8.9%	-3.8%	1.7%	5.3%	5.1%	3.4%
Phys.	3%	.6%	4.2%	2.3%	2.4%	2.5%
HHA's	-14.9%	.8%	10.3%	-5.3%	10.1%	.2%

Average growth rate for other services = 2.7%
Average growth rate for Home Health = .2%

Home Health services have been subjected to far greater cuts than any other service covered by Medicare, and home health expenditures have a far lower growth rate than any other Medicare service.

The Crisis in Home Health Care

1. **According to HCFA's most recent utilization data for home health, the total number of claims received in fiscal year 1997 was 20,959,349 and the total number of claims received in fiscal year 1998 was 16,880,856 – about a 20% decrease in the number of claims received.** (HCFA Contractor Reporting of Workload Data, February 1, 1999)

2. **2,195 Medicare-certified home health agency offices have closed since January 1998, according to a survey of state health licensure departments. Hardest hit was Texas, where 352 agencies and another 438 branch offices closed. Other States with large numbers of closures: Louisiana 250, California 153, Florida 97, Missouri 91, Oklahoma 87, Tennessee 67, and Indiana 60.** (Eli's Home Care Week, Volume VIII, Number 6, February 8, 1999)

3. **Home care stocks dropped 43.8 percent in 1998 according to an annual survey by Hilton Head, South Carolina-based HealthCare Markets Group, Inc.** (Eli's Home Care Week, Volume VIII, Number 2, January 11, 1999)

4. **Home care stocks dropped 55.8 percent between April 1, 1998 and March 31, 1999 according to a financial analysis of home care public companies by Houlihan, Lokey, Howard & Zukin Investment Bankers.** (March 31, 1999)

5. **Home Health Corporation of America filed for Chapter 11 bankruptcy protection February 18, citing Medicare cutbacks as one cause of its mounting debt. HHCA will not go out of business, but will downsize by releasing 300, or about 10 percent of its employees.** (HomeCare Monday, February 22, 1999)

6. **Employment at freestanding home health agencies declined by 7,000 jobs in January 1999. Since September 1997, freestanding HHAs have lost 61,000 – or 8.5%, according to the Bureau of Labor Statistics.** (Eli's Home Care Week, Volume VIII, Number 7, February 15, 1999)

7. **In Home Health Inc. reported a loss of $132,000 on revenue of $18.6 million in the quarter ended December 31. That compares with net income of $186,000 on revenue of $27.9 million during the same period the year before.** (...home health line, February 15, 1999)

8. **Home care workers received only a .7 percent wage increase in 1997, while Americans as a whole saw a 3.4 percent increase, according to new Labor Department statistics.** (The Washington Times, Eli's Home Care Week, Volume VIII, Number 6, February 8, 1999)

9. **A Visiting Nurses Association branch in Illinois found that Medicare payments are now so low that it made the painful decision to abandon 25 patients who needed the most expensive care, rather than face the possibility of having to go out of business in a few months and strand some 300 patients.** (The Washington Post, A1, May 10, 1999)

June 1, 1999

Mr. Chris Jennings
Deputy Assistant to the President
for Health Policy Development
Old Executive Office Building, Room 216
17th Street & Pennsylvania Avenue, NW
Washington, D.C. 20503

Dear Chris:

Per your conversation with Rick Pollack, enclosed please find several of our BBA fixes including proposals to: 1) assure adequate payments under outpatient PPS; 2) improve the skilled nursing facility PPS; and 3) repeal the transfer provision. In addition, we wanted to share with you MedPAC's recommendation for a .5% increase in the inpatient PPS update for fiscal year 2000.

Thank you for your attention to the enclosed.

Sincerely,

Mary Beth Savary Taylor

Mary Beth Savary Taylor
Director
Executive Branch Relations

Enclosures

A H A 100 Y E A R S

Washington, DC Center for Government and Public Affairs
Chicago, Illinois Center for Health Care Leadership

Liberty Place, Suite 700
325 Seventh Street, N.W.
Washington, DC 20004-2802
(202) 638-1100

AHA PROPOSAL TO ASSURE ADEQUATE PAYMENTS UNDER MEDICARE'S OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (PPS)

PROBLEM:

According to a recent Medicare Payment Advisory Commission (MedPAC) report, Medicare pays hospitals only 90 cents for each dollar of outpatient care provided prior to enactment of the BBA. Today, as a result of the BBA, hospitals are paid only 82 cents on the dollar. And, once the new outpatient PPS is implemented, HCFA will reduce hospital outpatient payments by another 3.8 percent. Many hospitals, however, will lose much more than 3.8 percent, according to HCFA's estimates.

- √ More than half of the nation's major teaching hospitals would lose more than 10 percent and nearly one-half of rural hospitals also would more than 10 percent.

- √ Catastrophic losses would be experienced by some individual hospitals. For example, large hospitals in Iowa and New Hampshire will immediately lose almost 14 to 15 percent of their Medicare outpatient revenue. Other large urban hospitals in Missouri, Massachusetts, Wisconsin, Florida, and California lost 20 percent to 40 percent. Some New York City hospitals would lose more than 40 percent. Some small rural hospitals in Arkansas, Kansas, Mississippi, Washington, and Texas will lose more than 50 percent of their revenue.

SOLUTION:

To prevent these precipitous drops in Medicare revenues from doing additional harm to hospitals and the Medicare beneficiaries who rely on them, legislation should be enacted that limits payment losses created by the move to outpatient PPS. However, the costs of financing this proposal should not be paid by the remaining hospitals, because most of them are also expected to lose under the outpatient PPS. Moreover, large new losses would have to be incurred by those hospitals, ranging from 8 to 3 percent, to protect other hospitals from losses of 5 to 15 percent. Instead, this change needs to be funded by additional Medicare program spending. **Beneficiary spending would be unaffected.**

- Until January 2002, each hospital's Medicare payments for outpatient PPS services would be adjusted so that the hospital's losses are limited to 5 percent of what the hospital would have been paid by Medicare under the current system.

- For CY 2002, the payment losses would be limited to 10 percent.

- For CY 2003, the payment losses would be limited to 15 percent. No limit is set after 2003.

If HCFA does not change its interpretation that unfairly shifts the 3.8 percent reduction in beneficiary copayments from the Medicare program to hospitals, this proposal will require roughly $1.9 billion over 5 years in new funding.

3/15/99

SEC. LIMITING REDUCTIONS IN FEDERAL PAYMENTS UNDER PPS FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) IN GENERAL.–Section 4523 of the Balanced Budget Act of 1997 is amended by adding at the end the following:

"(e) TEMPORARY LIMIT ON REDUCTIONS IN FEDERAL PAYMENTS.–

"(1) IN GENERAL.–Notwithstanding section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)), as added by subsection (a), the amount that is paid from the Federal Supplementary Medical Insurance Trust Fund for covered OPD services furnished by a hospital during a calendar year (or portion thereof) specified in paragraph (2)(A) may not be less than the applicable percentage of the case mix adjusted average amount that would have been payable to such hospital for such services (including cost sharing) if the prospective payment system established under such section did not apply. Such average amount may be determined on a prospective basis using the Secretary's best estimate of the reasonable costs incurred in furnishing covered OPD services or on a retrospective basis using cost reports submitted by a hospital.

"(2) DEFINITIONS.–For purposes of paragraph (1)–

"(A) subject to paragraph (3), the term 'applicable percentage' means–

"(i) with respect to covered OPD services furnished during the first full calendar year (and any portion of the immediately preceding calendar year) for which the prospective payment system established under section 1833(t) of such Act is in effect, 95 percent,

"(ii) with respect to the second full calendar year for which such system is in effect, 90 percent, and

"(iii) with respect to the third full calendar year for which such system is in effect, 85 percent; and

"(B) the term 'covered OPD services' has the meaning given to such term in section 1833(t)(1)(B) of such Act.

"(3) APPLICATION TO CERTAIN HOSPITALS.--In the case of hospitals described in section 1833(t)(8) of such Act, the 'applicable percentage' for a calendar year (or portion thereof) shall be the same applicable percentage that applies to covered OPD services furnished by hospitals that are not described in such section during such calendar year (or portion thereof).

"(4) RULE OF CONSTRUCTION.--Nothing in this subsection shall be construed as affecting the amount of cost sharing paid by individuals enrolled under part B of title XVIII of the Social Security Act for covered OPD services.".

(b) CONFORMING AMENDMENT.--Section 1833(t)(1)(A) of the Social Security Act (42 U.S.C. 1395l(t)(1)(A)) is amended by inserting "except as provided in section 4523(e) of the Balanced Budget Act of 1997," after "1999,".

(c) EFFECTIVE DATE.--The amendments made by this section shall become effective as if included in the enactment of the Balanced Budget Act of 1997.

AMERICAN HOSPITAL ASSOCIATION and AMERICAN ASSOCIATION OF HOMES AND SERVICES FOR THE AGING PROPOSAL TO IMPROVE THE SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM

Problem

The Balanced Budget Act of 1997 (BBA) reduced skilled nursing facility (SNF) payments by $9 billion over five years. At the same time, it required the Health Care Financing Administration (HCFA) to implement a prospective payment system (PPS) for these services. The new PPS is not refined enough, however, and therefore fails to adequately account for differences in costs associated with the care of medically complex patients. In addition, the exception payments which covered the cost of care for these patients prior to the PPS were not included in the PPS federal rates, and only partially included in the facility-specific rate used in the transition to PPS.

For example:

- ✓ An amputee is placed in a SNF for rehabilitative services. The SNF must pay for the prosthesis, which could cost up to $5,000. The SNF, however, receives only a $200 to $300 per diem for treatment and must pay for the prosthesis from the per diem.

- ✓ A cancer patient breaks his hip and is hospitalized. He is placed in a SNF for therapy and nursing services. His chemotherapy treatment for prostate cancer is $2,000. Costs for chemotherapy must be paid for from the $200 to $300 SNF per diem.

- ✓ An AIDS patient is admitted to a SNF. The costs of drugs for treatment can be hundreds of dollars per week. Costs for drug therapy must come from SNF's per diem payment.

Proposed Solution

Both HCFA and providers believe these issues can be addressed by revising current case-mix (Resource Utilization Groups) categories used in the new SNF PPS to reflect these types of patients. However, HCFA cannot make any changes to case-mix until after 2000 due to the year 2000 computer problems. HCFA has also not completed its research on how to improve case-mix. Moreover, without any of the lost exception payments, improving case-mix would only come at the expense of the funding necessary to care for other patients.

AHA and AAHSA propose that an adjustment to the SNF PPS be created for patients with high cost "non-therapy ancillaries" like chemotherapy and prostheses. The adjustment is modeled on the existing outlier adjustment in the PPS for acute care. Thus, the proposal would minimize the financial risks associated with caring for certain kinds of patients and compensate for higher costs for the non-therapy ancillaries. It would be established with additional monies of about one percent of annual SNF payments -- $140 million in the first year and up to $1 billion over 5 years. The adjustment will no longer be necessary once the Secretary addresses these case-mix concerns and the funding is then used to pay for the care of these medically complex patients. If the outlier provision is delayed due to year 2000 computer problems, HCFA would be expected to make appropriate adjustments for claims already submitted as the agency did after the initial 3 to 6 month delay of the implementation of PPS.

SEC. . OUTLIER PAYMENTS FOR CERTAIN ANCILLARY SERVICES UNDER SNF PPS SYSTEM.

(a) IN GENERAL.--Section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)) is amended by adding at the end the following:

"(11) OUTLIER PAYMENTS FOR CERTAIN ANCILLARY SERVICES.--

"(A) IN GENERAL.--The Secretary shall provide for an additional payment to a skilled nursing facility for any month (or portion thereof) of covered skilled nursing facility services for which the average per diem non-therapy ancillary costs of the facility exceed--

"(i) a fixed multiple of the non-therapy ancillary component of the applicable adjusted Federal per diem rate, or

"(ii) such other fixed dollar amount as the Secretary designates,

whichever is greater.

"(B) AMOUNT OF PAYMENT.--The Secretary shall determine the amount of the additional payment to a facility under subparagraph (A). Such amount--

"(i) shall approximate the additional cost of non-therapy ancillary services beyond the cutoff point applicable under such subparagraph, and

(ii) shall not exceed an amount that is equal to ten times the non-therapy ancillary component of the applicable adjusted Federal per diem rate.

"(C) AMOUNT OF AGGREGATE PAYMENTS.--The total amount of the additional payments made under this paragraph for a fiscal year shall equal 1 percent of the total payments projected or estimated to be made under this subsection for the fiscal year.

"(D) DEFINITIONS.--For purposes of this paragraph--

"(i) the term 'non-therapy ancillary costs' means the allowable costs of ancillary services (other than therapy services described in the second sentence of paragraph (2)(A)(ii)) furnished to an individual who is a resident of a skilled nursing facility during the period in which the individual is provided with covered skilled nursing facility services, and

"(ii) in determining the average per diem of such costs for a facility for a month (or portion thereof) of covered skilled nursing services for purposes of comparison with the applicable cutoff point under subparagraph (A), the Secretary shall—

"(I) adjust the charges of the facility for such services by the cost-to-charge ratio of the facility for covered post-hospital extended care services, and

"(II) divide the total of such costs for such period by the number of days of covered skilled nursing facility services that are included in such period.

"(E) LIMITATION ON ADJUSTMENTS.--The Secretary is not authorized to reduce each of the facility-specific or Federal per diem rates determined under this paragraph by a factor equal to the proportion of payments under this section that are additional payments under this paragraph.".

(b) CONFORMING CHANGE.--Section 1888(e)(8) of the Social Security Act (42 U.S.C. 1395yy(e)(8)) is amended--

(1) by striking "and" at the end of subparagraph (B),

(2) by striking the period at the end of subparagraph (C) and inserting a semicolon and "and", and

(3) by adding at the end the following:

"(D) the establishment of cutoff points and payment amounts under

paragraph (11).".

(c) EFFECTIVE DATE.--

(1) IN GENERAL.--The amendments made by this section shall apply to days of covered skilled nursing facility services occurring on or after October 1, 1999, and before the first day of the first fiscal year to begin on or after the date on which the Secretary of Health and Human Services (in this subsection referred to as the "Secretary") determines that the case mix adjustment authorized by section 1888(e)(4)(G)(i) of the Social Security Act (42 U.S.C. 1395yy(e)(4)(G)(i)) adequately compensates skilled nursing facilities for non-therapy ancillary costs of covered skilled nursing facility services.

(2) ADJUSTMENT OF FEDERAL PER DIEM RATES.--Notwithstanding any other provision of law, the Secretary shall increase each of the Federal per diem rates determined under section 1888(e)(4) of the Social Security Act (42 U.S.C. 1395yy(e)(4)) for the first fiscal year beginning after the close of the period described in paragraph (1) by 1 percentage point. Such increase shall be in addition to any other increase required by law and shall continue to be reflected in the Federal per diem rates for succeeding fiscal years.

WHY THE TRANSFER PROVISION SHOULD BE REPEALED

Background Medicare patients who are sent from one acute care hospital to another acute care hospital are defined as **transfer cases**. These cases are paid less than the full PPS rate if the patient had a shorter inpatient stay than average. Medicare patients who are sent after their inpatient hospital stay to a rehabilitation or a skilled nursing facility or a home health agency are defined as discharges from the acute-care hospital. For a discharge, acute care hospitals are paid the full Medicare prospective payment (PPS) rate.

The BBA expanded the definition of a transfer to include patients sent from an acute care hospital to **any** post acute setting--rehabilitation, psychiatric, or skilled nursing facility, or a home health agency-- for up to 10 DRGs as of October 1, 1998. Again, the hospital is paid only part of the PPS rate if the patient had a shorter inpatient stay than average.

Transfer cases are paid a per-diem rate up to the full PPS rate which is based on the average stay. The hospital gets paid twice the per-diem for the first day. Thus, full payment is not achieved until the stay is one day less than average. For example, if a patient stayed 6 days where the average stay was 10 days, the hospital would receive 70 percent of the PPS rate. But if the patient stayed 14 days where the average stay was 10 days, no additional payments would be made above the PPS rate.

This provision does not change payment rates for post-acute facilities. Only the acute care hospital payment is changed.

AHA View This provision hurts vulnerable hospitals and does not make sense for the Medicare program.

- ✔ **Inequitable** -- After this policy is implemented, hospitals will be paid less for cases that stay two days less than average. But hospitals are not paid more overall for cases that stay longer -- **any** outlier payments are funded by reducing payments for the less costly cases. Thus the transfer policy reduces payments for shorter stay cases where the payment was **already reduced** to fund outlier payments.

- ✔ **Unfair to Rural Hospitals** -- The transfer provision penalizes hospitals with shorter than the national average length of stay. Rural hospitals have <u>always</u> had shorter lengths of stay than urban hospitals.

- ✔ **Cuts Hospitals Twice** -- The overall reduction in hospital length of stay (referred to as a "change in hospital product") is explicitly addressed in the Medicare Payment Advisory Commission's update recommendation. In fiscal 1998, MedPAC recommended no update based in part on prior changes in length of stay. Congress acknowledged MedPAC's recommendation, giving hospitals received no update in FY 1998. To further penalize hospitals under the transfer policy is a **double hit**.

106TH CONGRESS
1ST SESSION

H. R. 405

To amend title XVIII of the Social Security Act to repeal the restriction on payment for certain hospital discharges to post-acute care imposed by section 4407 of the Balanced Budget Act of 1997.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 19, 1999

Mr. NUSSLE (for himself, Mr. EWING, Mr. BOEHLERT, Ms. SANCHEZ, Mr. CONDIT, Mr. OBERSTAR, Mr. SANDERS, Mr. PETERSON of Minnesota, Mr. MASCARA, Mr. SERRANO, Mr. PRICE of North Carolina, and Mr. MEEHAN), introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend title XVIII of the Social Security Act to repeal the restriction on payment for certain hospital discharges to post-acute care imposed by section 4407 of the Balanced Budget Act of 1997.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicare Common Sense Hospital Payment Act of 1999".

SEC. 2. REPEAL OF RESTRICTION ON MEDICARE PAYMENT FOR CERTAIN HOSPITAL DISCHARGES TO POST-ACUTE CARE.

(a) IN GENERAL.—Section 1886(d)(5) of the Social Security Act (42 U.S.C. 1395ww(d)(5)), as amended by section 4407 of the Balanced Budget Act of 1997 (Public Law 105–33), is amended—

(1) in subparagraph (I)(ii), by striking "not taking in account the effect of subparagraph (J),", and

(2) by striking subparagraph (J).

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to discharges occurring on or after October 1, 1999.

○

between MedPAC's and HCFA's construction of the market basket index. We weight expected growth in employee compensation in the hospital industry and the general economy equally, while HCFA gives less weight to the hospital industry projections. Because wage growth in the hospital industry has trailed that of the broader economy in recent years, MedPAC's market basket is forecast to increase more slowly than HCFA's. Correspondingly, we are making a −0.2 percentage point adjustment.

The second input price adjustment addresses errors in previous market basket forecasts. Because the annual updates are based on the forecasts available prior to the beginning of the payment year, they are subject to errors that can result in inappropriately high or low payment rates. MedPAC corrects these errors when actual data become available, two years after they are applied to payments. Because the update in fiscal year 1998 was zero and not based on the market basket forecast, however, any error in the forecast did not affect the payment rates in that year. Therefore, we are making no adjustment for market basket forecast error for fiscal year 2000.

Scientific and technological advances

MedPAC's review of hospital technology suggests there will be no significant changes in the overall rate at which hospitals adopt quality-enhancing but cost-increasing technologies in fiscal year 2000, with the exception of the need to address year 2000 computer problems. (See Appendix C for a more detailed description of the technologies considered in this analysis.) We believe that hospitals will incur significant operating and capital costs in becoming year 2000 compliant and that these improvements will be completed during fiscal years 2000 and 2001.

The improvements to hospital systems and medical devices to fix year 2000 problems differ from the other technologies included in the allowance for scientific and technological advances in that they are not new advances or new applications of existing technologies (one of the criteria used to identify technologies for the allowance). Rather, the year 2000 improvements will maintain the current operation of information systems and medical devices, resulting in limited changes in their functions and capabilities. Nonetheless, we believe these improvements to hospital systems and devices fall under the rubric of our allowance for scientific and technological advances.

Therefore, we are explicitly increasing the allowance for scientific and technological advances by 0.5 percent from that used in our recommendation for fiscal year 1999 to account for year 2000 computer improvements. However, this increase is not considered a permanent part of the allowance, and we will reconsider the level of this adjustment in subsequent fiscal year analyses. For fiscal year 2000, MedPAC recommends an allowance for scientific and technological advances of 0.5 percent to 1.0 percent.

Productivity improvement

We make a downward adjustment in the framework to reflect expected improvements in hospital productivity. This adjustment is a policy target, reflecting our position that Medicare should require hospitals to reduce their inputs relative to output by at least a modest amount each year. Hospitals that can surpass this target will be able to keep the additional gains they achieve in the next year.

Our analysis of factors related to hospital productivity suggests that annual improvements of about 3 percent in inputs used per discharge, exclusive of the impact of site-of-care substitution, have been achieved in 1997 and 1998.[8] Although gains have been registered each year from 1992, those in the last two years appear to have been by far the largest.

However, the change in real costs per discharge in these years was well below the rate of inflation and services hospitals use inpatient care, despite sm stay declines than in previ doubt that this rate of imp sustainable. Moreover, ou adjustment is intended to level of improvement that achieved without adversel quality, and yet it is not pc for changes in quality whe the productivity trend. We that requiring efficiency g measured in recent years r serious threat to maintaini Therefore, we set a range percent for the productivit adjustment in fiscal year 2

Site-of-care subs

The average length of Med stays declined 5.4 percent a 1991 and 1996, and we est led to per discharge cost sa percent a year. We believe these savings reflect a shift other settings, as care in th substituted for the latter da stays. A variety of substitut can be involved, including inpatient and outpatient reh physicians' services in an o setting, and home health ca Medicare automatically pa in the new settings, the site substitution adjustment is d funding along with the ass

When care in an ambu acute setting replaces acut days, there may be a syste reduction in costs. If a skil substitutes for an acute car example, the hospital's var (like daily food, housekeep and nursing care) may be r more than the amount of n costs in the skilled nursing Assuming no change in cli we would consider this net productivity gain, which sh

8 Because of lags in the availability of Medicare Cost Report data, our 1997 and 1998 esti to more recent data available from the American Hospital Association. The estimate cited in case mix), exclusive of the net cost impact of length of stay reductions. This estimate ma of stay may be attributable to site-of-care substitution. See Appendix D for additional info

9 Appendix D shows the trend in length of stay and cost per discharge, for all patients and of length of stay reductions.

SEC. ___. INCREASING MEDICARE UPDATE FOR INPATIENT HOSPITAL SERVICES TO ACCOMMODATE Y2K COMPLIANCE COSTS.

Section 1886(b)(3)(B)(i)(XV) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)(XV)) is amended by striking "minus 1.8 percentage points" and inserting "minus 1.3 percentage points".

Office of Legislation

HCFA MEDICARE • MEDICAID

Number of Pages:_____

Date: 6/10/99

To:	From:
Chris Jennings Caroline Steves	Bonnie Washington
Fax: _____	Fax: _____
Phone: _____	Phone: _____

REMARKS: _____

HEALTH CARE FINANCING ADMINISTRATION
200 Independence Ave., SW
Room 341-H, Humphrey Building
Washington, DC 20201

United States General Accounting Office
Testimony

Before the Committee on Finance, U.S. Senate

GAO

For Release on Delivery
Expected at 10:00 a.m.
Thursday, June 10, 1999

Pls fax these 2 testimonies to Caroline Davis + Chris Jennings

BALANCED BUDGET ACT

Any Proposed Fee-for-Service Payment Modifications Need Thorough Evaluation

Statement of William J. Scanlon, Director
Health Financing and Public Health Issues
Health, Education, and Human Services Division

GAO/T-HEHS-99-139

Mr. Chairman and Members of the Committee:

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

My comments focus on the payment reforms for providers under the fee-for-service portion of the program. I will concentrate on the changes made to skilled nursing facility (SNF) and home health agency (HHA) payment policies. Although the BBA mandated similar reforms for other types of providers, the SNF and HHA changes are, at this time, farthest along in their implementation. These provisions were enacted in response to continuing rapid growth in Medicare spending that was neither sustainable nor readily linked to demonstrated changes in beneficiary needs. These provisions represented bold steps to control Medicare spending by changing the financial incentives inherent in provider payment methods to promote more efficient service delivery. Yet the Congress is coming under increasing pressure from providers to revisit these reforms. As additional BBA provisions are implemented, and other providers feel the effects of the mandated changes, calls for modifications may continue or even intensify. How responsibilities to current and future seniors, the American taxpayer, and the health care provider community are balanced will shape the resulting responses. Achieving the appropriate balance will require recognition of legitimate concerns about beneficiary access and the ability of providers to adjust to the new payment methods.

Calls by providers to moderate the effect of BBA changes come at a time when federal budget surpluses and smaller-than-expected increases in Medicare outlays may make it easier to accommodate higher Medicare payments. Indeed, many provider groups contend that BBA changes produced more savings than originally intended. The Congressional Budget Office has revisited and lowered its estimates of Medicare spending since BBA enactment. As a result of the lower projected spending, the estimated savings from the BBA provisions will represent a proportionately larger share of Medicare expenditures. Lower projected Medicare spending, however, does not necessarily mean that the effect of the BBA changes was greater than intended. Rather, it merely raises again issues of how much the federal government should pay for health care for the elderly and what payment levels are appropriate for the various provider groups.

The BBA mandated the continued movement of fee-for-service Medicare away from cost-based reimbursement methods and toward prospective payment systems (PPS). The goal is to foster more efficient provision and use of services to lower spending growth rates, replicating the experience of acute care hospitals after a PPS was implemented, beginning in the mid-1980s. The BBA mandated such payment systems for SNFs, HHAs, hospital outpatient services, and certain hospitals. On July 1, 1998, SNFs began a 3-year transition to a PPS.[1] An interim payment system (IPS) for HHAs was phased in beginning on October 1, 1997, and a PPS is scheduled to be implemented for all HHAs on October 1, 2001.[2]

In brief, both SNFs and HHAs have felt the effect of the BBA provisions, and both industries will need time to adapt, but the calls to amend or repeal the new payment systems are, in our view, premature. The SNF PPS was implemented with a 3-year transition to the fully prospective rates, and facilities are phased into this transition schedule according to their fiscal year; thus, the adjustment time has been built into the PPS schedule. Current concerns that the PPS is causing extreme financial pressures for some SNFs need to be systematically evaluated on the basis of additional evidence. Several factors suggest that the problem may be less severe than is being claimed by providers. Nevertheless, certain other modifications to the PPS may be appropriate because there is evidence that payments are not being appropriately targeted to patients who require costly care. The potential access problems that may result from underpaying for high-cost cases will likely result in beneficiaries' staying in acute care hospitals longer, rather than forgoing care. This is a safety net for beneficiaries while modifications are made. The Health Care Financing Administration (HCFA), which has responsibility for managing the Medicare program, is aware that payments may not be adequately targeted to high-cost beneficiaries and is working to address this problem.

As a result of the swift implementation of the home health IPS and the lack of a transition period, the BBA's impact on home health agencies has been more noticeable. The number of participating agencies declined by 14 percent between October 1997 and January 1999, and utilization has dropped to 1994 levels, the base year for the IPS. However, since the number of HHAs and utilization had both grown considerably throughout most of the decade, beneficiaries are still served by over 9,000 HHAs—approximately the same number that were available just prior to the

[1]The SNF PPS will be phased in on the basis of facility cost-reporting years. During the transition, payment rates will be a blend of a declining portion of a facility-specific historical amount and an increasing portion of the national prospective rate.

[2]The BBA required the HHA PPS to be in place in fiscal year 2000. Subsequent legislation delayed the implementation by 1 year and eliminated the phasing in of the system.

recent declines. Our interviews with HHAs, advocacy groups, and others in rural areas that lost a significant number of agencies indicated that the recent decline in HHAs has not impaired beneficiary access. While the drop in utilization does not appear to be related to HHA closures, it is consistent with IPS incentives to control the volume of services provided to beneficiaries. In short, after years of substantial increases in home health visits, the IPS has curbed the growth in home health spending. Some of the decline in utilization appears to involve greater sensitivity to who qualifies for the home health care benefit, with some who do not qualify, but who may have been previously served, not receiving services now. There are indications, however, that beneficiaries who are likely to be costlier to serve than the average may have more difficulty than before in obtaining home health services because the revenue caps imposed by the IPS are not adjusted to reflect variations in patient needs. This problem should be ameliorated with the implementation of the PPS. In designing the PPS, it will be essential that HCFA adequately adjust payments to account for the wide differences in patient needs.

To date, the principal lessons to be drawn from the SNF and HHA payment reforms and their implementation are that

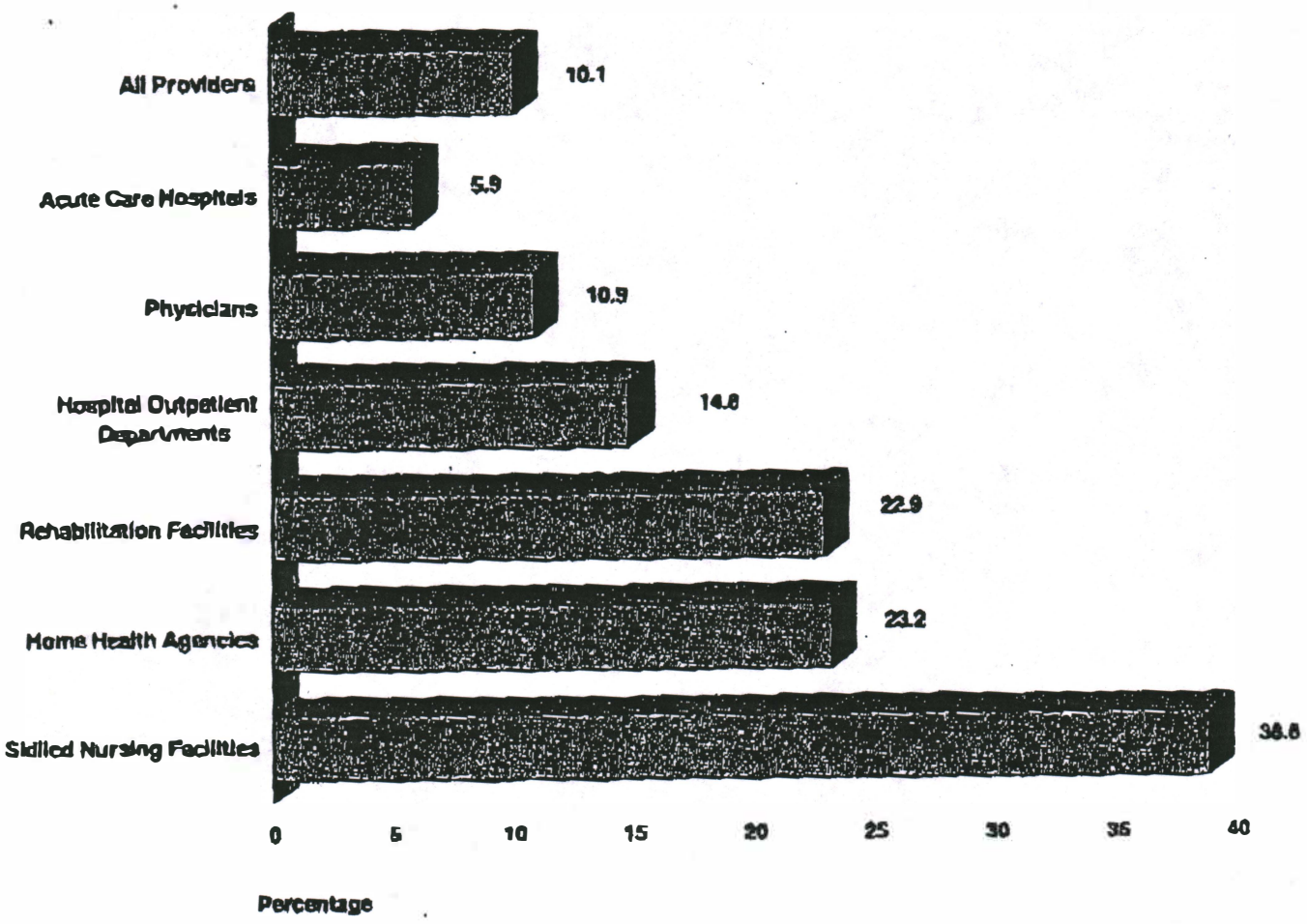
- the particulars of payment mechanisms largely determine the extent to which a reform option can control excess government spending while protecting beneficiary access to care and

- revisions to newly implemented policies should be based on a thorough assessment of their effects so that, at one extreme, policies are not unduly affected by external pressures and premature conclusions and, at the other extreme, policies do not remain static when change is clearly warranted.

BACKGROUND

Medicare is the nation's largest health insurance program, covering about 39 million elderly and disabled beneficiaries at a cost of more than $193 billion a year. The sheer size of this program during a period of particular concern over government spending made it the target of spending reforms. That Medicare was growing faster than the overall economy and the Medicare Hospital Insurance Trust Fund was facing imminent depletion only heightened attention on this program. Medicare expenditures had been rising at an average annual rate of 10.1 percent between 1985 and 1995 (see fig. 1). While the outlook for the federal budget has changed, with projected surpluses replacing deficits, the importance of ensuring that Medicare is an efficient purchaser of health services remains.

Figure 1: Average Annual Rate of Growth in Medicare Expenditures, 1985-95, by Type of Provider

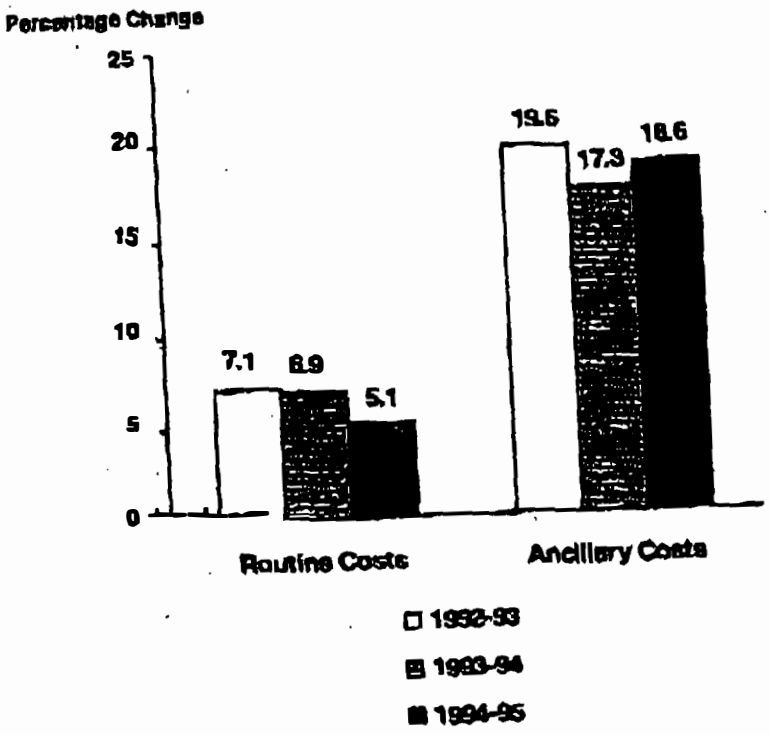


Despite significantly lower projected spending due to BBA reforms, there is a growing consensus among experts, including the trustees of the Medicare Hospital Insurance Trust Fund, that additional reforms are needed. As the baby boomers reach retirement age, the pressures on Medicare program spending will intensity. Fueled by medical technology advancements that allow more and better treatments for a larger portion of the elderly, Medicare spending growth will continue to be an important budgetary issue. The Congressional Budget Office projects that by 2009 Medicare's expenditures as a portion of the gross domestic product will rise almost one-third.

INDUSTRY AND OTHER CONCERNS ABOUT SNF PPS REQUIRE THOROUGH ANALYSIS

Prior to the PPS, SNFs were paid the reasonable costs they incurred in providing Medicare-allowed 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 other costs—primarily 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, growth in ancillary costs far outpaced the growth in routine service costs between 1992 and 1995 and drove up overall Medicare payments to SNFs (see fig. 2). Moreover, new providers were exempt from even the routine caps for their first 4 years of operation, which encouraged expansion of the industry.

Figure 2: Percentage Growth in SNF Routine and Ancillary Costs per Day, 1992-95



Under the new PPS, facilities receive a payment for each day of care provided to a Medicare-eligible beneficiary. This per diem rate is based on the average daily cost of providing all Medicare-covered services, as reflected in facilities' 1995 costs, adjusted to take into account the nature of each patient's condition and expected care needs. 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 and judiciously.

The PPS represents a major change to the previous incentives of cost-based reimbursement and, as a result, Medicare treatment patterns that were influenced by the previous payment method will need to be modified. Previously, SNFs benefited from providing more ancillary services, without regard to the price paid for those services, since Medicare's payment was based on each facility's actual costs. SNFs that boosted their Medicare ancillary costs–either through higher use rates or higher prices–will need to make more modifications than those that did not. Scaling back these services, however, will 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' needs. Further, practice pattern changes may not be very disruptive because Medicare patients constitute a small share of most SNFs' business. And, blending facility-specific costs with the national PPS rates during the transition will ease the adjustments for facilities that have a history of providing many ancillary services.

Recent industry reports, however, have questioned the ability of some organizations operating SNF chains to adapt to the new PPS. Indeed, claims of pending bankruptcies have been linked to the Medicare payment changes. It is likely, however, that a combination of factors has contributed to the poor financial performance of these businesses. For example, many of the organizations have other lines of post-acute-care services–including the provision of outpatient rehabilitation therapy and ancillary services to affiliated SNFs as well as independent SNFs. The PPS may have affected the demand for these services, but other BBA provisions likely have had an effect as well.[8] In addition, some of these organizations invested heavily in the nursing home and ancillary service businesses not long before the enactment of the PPS, both expanding their acquisitions and upgrading facilities to provide higher-

[8]The BBA applied a per beneficiary payment cap of $1,500 for outpatient physical and speech therapy and a $1,500 cap for outpatient occupational therapy, although neither cap is applicable to services provided through a hospital outpatient department. These limits will not apply to Medicare beneficiaries during a Medicare-covered SNF stay, but could affect Medicare SNF residents if their stay is not covered by Medicare. This provision, in combination with consolidated billing for all services under the PPS, could limit some providers' ability to sell therapy and other ancillary services to other SNFs.

intensity services. Yet HCFA had been developing a PPS for some time that would curtail unnecessary growth in ancillary payments. We are studying these issues and will provide more details later this year on the effect of the PPS on solvency and beneficiary care.

While we think that industry concerns about the financial viability of SNFs operating under PPS have not been substantiated and may be premature, we have identified three key PPS design issues that may affect Medicare's ability to realize program savings and may limit beneficiaries' access to care. First, we are concerned about the SNF case-mix adjusters, which are needed to ensure that facilities serving patients with more intensive care needs receive adequate payments and, conversely, that SNFs are not overcompensated for patients with lower care needs. The current case-mix adjusters preserve the opportunity for SNFs to increase their compensation by supplying potentially unnecessary services. A SNF can benefit by manipulating the services provided to beneficiaries, rather than increasing efficiency. For example, the payment for a patient who requires 143 minutes of therapy care daily is $286 per day, compared with $346 for a patient who requires 144 minutes (see table 1). Thus, by providing an extra few minutes of therapy to certain patients, a facility could increase its Medicare payments without a commensurate increase in its costs. Rather than improving efficiency and patient care, this might only raise Medicare outlays. We believe that HCFA needs to continue its research into a classification system that is less dependent on service use and more closely tied to patient characteristics and needs. It also must provide adequate oversight to ensure that providers properly classify patients and do not manipulate service provision to take advantage of the classification system.

Table 1: Comparison of Length of Average Daily Therapy and per Diem SNF Payments for Different Rehabilitation Case-Mix Groups

Rehabilitation case-mix groups	Length of average daily therapy (for 5 days per week)	Per diem payment (federal unadjusted rate for urban facilities)
Ultra high	144+ minutes	$346
Very high	100 to 143 minutes	286
High	65 to 99 minutes	250
Medium	30 to 64 minutes	239

Our second concern is whether the system adequately identifies the most expensive patients and adjusts payment rates accordingly. This concern emanates from limitations in the data HCFA had available to establish the case-mix groups and the rates. 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, the classification system may aggregate expensive patients with widely differing needs into too few groups to distinguish adequately among patients' resource needs. In addition, the classification system does not take into account varying nontherapy ancillary service needs and is likely to overpay SNFs for treating patients with low service needs and underpay those SNFs treating patients with high service requirements. These design weaknesses could result in access problems or inadequate care 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 adjusters and is working to refine these measures to more accurately reflect patient differences.

Finally, we are concerned that the cost reports submitted to Medicare for the year on which payments are based (1995) include unreasonable costs and may establish payments levels that are too high. Most of the data used to establish these rates have not been audited and are likely to include excessive ancillary costs, because the prior system had no incentives to constrain such costs. Moreover, it is likely that the base year includes too many services and that the costs per service were inappropriately high.

HHA CLOSURES AND DECLINING UTILIZATION SIGNAL IPS IMPACT, BUT THERE IS LITTLE EVIDENCE OF IMPAIRED ACCESS

Medicare spending for home health care rose at an annual rate of 25.2 percent between 1990 and 1997. Several factors accounted for this spending growth, most notably the relaxation of coverage guidelines. In response to a 1988 court case, the benefit was essentially transformed from one that focused on patients needing short-term care after hospitalization to one that serves chronic, long-term-care patients as well.[4] Thus, Medicare may now be covering services that would previously have been paid for by Medicaid or by beneficiaries themselves. The loosening of coverage and eligibility criteria contributed to an increase in the number of beneficiaries receiving services. Between 1990 and 1997, the number of Medicare home health users per 1,000 beneficiaries increased from 57 to 109.[5] Associated with the increase in

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

[5]These numbers reflect Medicare fee-for-service beneficiaries only.

beneficiaries being served over this period was the near doubling of Medicare-certified HHAs to 10,524 by 1997.

Also contributing to the historical rise in spending were a payment system that provided few incentives to control how many visits beneficiaries received and lax Medicare oversight of claims. Between 1990 and 1997, the average number of visits per user climbed from 36 to 73. HHAs could boost revenues by providing more services to more beneficiaries, a strategy that could actually help HHAs avoid being constrained by Medicare's limits on payments per visit.[6] There is evidence that some HHAs provided visits of marginal value. For example, as we noted in a previous report, even when controlling for diagnoses, substantial geographic variation exists in the provision of home health care.[7] In 1996, the average number of visits per user in the West South Central region (Arkansas, Louisiana, Oklahoma, and Texas) was 129, compared with 47 in the Middle Atlantic region (New York, New Jersey, and Pennsylvania). While the precise reasons for this variation are not known, there is no reason to assume that it was warranted by patient care needs. Evidence indicates that at least some of the high use and the large variation in practice represented inappropriate care.[8] Medicare oversight declined at the same time that spending mounted, contributing to the likelihood that inappropriate claims would be paid. The proportion of claims that were reviewed dropped sharply, from about 12 percent in 1989 to 2 percent in 1995, while the volume of claims almost tripled.

To control spending while ensuring the appropriate provision of services, the BBA mandated expeditious implementation of the IPS while the PPS was under development. Prior to BBA, HHAs were paid on the basis of their costs, up to preestablished limits. The limits were set for each type of visit but were applied in the aggregate for each agency; that is, costs above the limit for one type of visit could still be paid if costs were sufficiently below the limit for other types of visits. The IPS lowered the visit payment limits and subjected HHAs to an aggregate Medicare

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[6]Agencies could avoid the payment limits by lowering their per visit costs in two ways: by serving less expensive patients with shorter visits and by providing more visits and thereby spreading fixed costs over more visits.

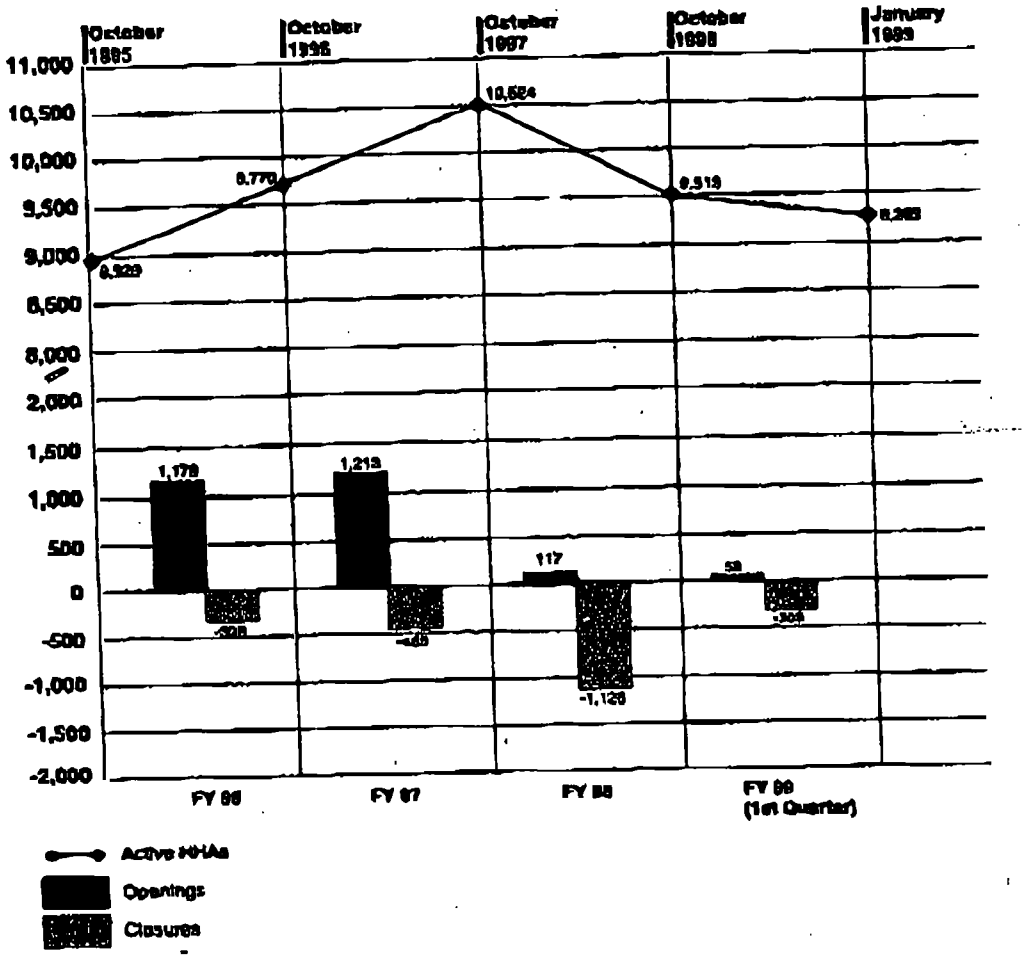
[7]Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996).

[8]Medicare: Improper Activities by Mid-Delta Home Health (GAO/T-OSI-98-6, Mar. 19, 1998) and Department of Health and Human Services, OIG, Variation Among Home Health Agencies in Medicare Payment for Home Health Services (Washington, D.C.: HHS, 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).

revenue cap based on a historical per beneficiary amount that factors in both agency-specific and regional average per beneficiary payments. The purpose of the cap is to control the number of services provided to users. The blending of agency-specific and regional amounts accounts for the significant differences in service use across agencies and geographic areas. For new HHAs, without historical cost data, the caps are based solely on the national median. Because per beneficiary limits are tied to fiscal year 1994 payments, the new payment limits will be more stringent for agencies and areas that experienced significant growth in the number of visits per user between 1994 and 1997. Notably, the growth in Louisiana, Oklahoma, and Texas, where 1994 utilization levels were approximately twice the national average, greatly exceeded the average increase nationally. By comparison, utilization levels declined in one-fifth of the states with utilization levels below the national average in 1994, making it easier for HHAs in those states to cope with the cap.

In contrast to the SNF PPS, the IPS had a more immediate effect on the operation of providers because there was no gradual transition to imposition of the revenue cap. The IPS was phased in according to an HHA's cost reporting year–61 percent of agencies came under the IPS by January 1, 1998, and the remainder by September 30, 1998. Moreover, unlike the situation with SNFs, Medicare beneficiaries represent a substantial proportion of the patients served by HHAs. The closure of a significant number of HHAs occurred after the IPS was implemented. Between October 1, 1997, and January 1, 1999, 1,436 Medicare-certified HHAs stopped serving Medicare beneficiaries. However, because of the growth in the industry since 1990, there were still 9,263 Medicare certified HHAs in January 1999–only 500 fewer than in October 1996. (See fig. 3.)

Figure 3: Change in Number of Medicare-Certified HHAs, October 1, 1995, Through January 1, 1999



Forty percent of the closures were concentrated in three states that had experienced considerable growth in the number of HHAs and had utilization rates (visits per user as well as users per thousand fee-for-service beneficiaries) well above the national average (see table 2). Furthermore, the majority of closures occurred in urban areas that still have a large number of HHAs to provide services. The pattern of HHA closures suggests a response to the IPS. The IPS revenue caps would prove particularly stringent for HHAs that provided more visits per user, for smaller agencies, for those with less ability to recruit low-cost patients, and for newer agencies. In fact, HHAs that closed had provided over 40 percent more services per

user than agencies that remained open. Closing HHAs were also about half the size of those that remained open, and they had been losing patients before the implementation of IPS.

Table 2: Decline in HHAs and Changes in Utilization Nationally and in Three High-Use States

	HHA closures as a percentage of active agencies, Oct. 1, 1997	Number of Medicare-certified HHAs, Jan. 1, 1999	People served per 1,000 Medicare fee-for-service enrollees			Visits per user		
			1994	1997	Percentage change	1994	1997	Percentage change
Nationwide	-14.0	9,269	94.2	109.2	15.9	66.0	72.9	10.6
Louisiana	-21.6	407	138.6	157.3	13.5	125.8	161.0	28.0
Oklahoma	-23.2	299	108.9	131.9	21.1	105.7	147.0	39.1
Texas	-20.1	1,680	106.9	133.7	25.1	97.4	141.0	44.8

Despite the widespread attention focused on closures, the critical issue is whether beneficiaries who are eligible to receive services are still able to do so. Utilization rates during the first 3 months of 1998 are consistent with IPS incentives to control costs. Home health utilization in the first quarter of 1998 was lower than during a comparable period in 1996 but was about the same as during a comparable period in 1994–the base year for the IPS. Moreover, the sizeable variation in utilization between counties with high and low use has narrowed. In counties without an HHA, both the proportion of beneficiaries served and the visits per user declined slightly during the first 3 months of 1998, compared with a similar period in 1994, but these counties' levels of utilization remained above the national average. Our February 1999 interviews with officials at HHAs, hospital discharge planners, advocacy groups, and others in 34 primarily rural counties with significant closures indicated that beneficiaries continue to have access to services. Some of the decline in utilization appears to be for beneficiaries who no longer qualify for the home health care benefit. However, these interviews also suggested that as HHAs change their

operations in response to the IPS, beneficiaries who are expected to be costlier than average to treat may have increased difficulty obtaining home health care. The pending implementation of the PPS, which will adjust payments to account for costlier patients, has the potential to ameliorate future access problems.[9]

CONCLUSION

The BBA made necessary and fundamental changes to Medicare's payment methods for SNFs and HHAs to slow spending growth while promoting more appropriate beneficiary care. Further refinements are required to make these systems more effective. However, the intentional design of these systems is to require inefficient providers to adjust their practice patterns to remain viable.

The very boldness of these changes has generated pressure to reverse course. In the current environment, the Congress will face difficult decisions that could pit particular interests against a more global interest in preserving Medicare for the long term. As PPSs are implemented for rehabilitation facilities and hospital outpatient services, and as SNFs continue their transition to full PPS rates, provider complaints about tight payment rates and impaired beneficiary access will continue to be heard. It is important that the implementation of these new payment mechanisms is monitored to ensure that the correct balance between appropriate beneficiary access and holding the line on Medicare spending is being achieved. Our work suggests that it would be premature at this juncture, however, to significantly modify the BBA's provisions without thorough analysis or a fair trial of the provisions over a reasonable period of time.

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

GAO CONTACT AND ACKNOWLEDGMENTS

For future contacts regarding this testimony, please call William J. Scanlon at (202) 512-7114. Individuals who made key contributions to this statement include Carol Carter and Walter Ochinko.

(101855)

[9]For additional information on the impact of the home health IPS on beneficiary access, see Medicare Home Health Agencies: Closures Continue With Little Evidence Beneficiary Access Is Impaired (GAO/HEHS-99-120, May 26, 1999).

HOGAN & HARTSON L.L.P.

MEMORANDUM

June 7, 1999

TO: David Seckman, President
American Health Care Association

FROM: Darrel J. Grinstead

RE: HCFA's Authority to Develop An Alternative Skilled Nursing Facility Market Basket Index and to Make Other Changes Affecting SNF Medicare Payment Rates

You have asked for an analysis of the authority of the Secretary of Health and Human Services (the "Secretary") to adopt a skilled nursing facility ("SNF") market basket index to be used for annual rate updates for the recently-implemented SNF prospective payment system under Medicare. Specifically, you have asked whether the Secretary has the discretion to establish or use a market basket index different from the one discussed in the interim final rule with comment published on May 12, 1998 (63 Fed. Reg. 26252). We also agreed to identify other aspects of the SNF prospective payment system ("PPS") on which the Secretary would have discretion to make changes that might affect payment rates.

Summary

The Medicare statute gives the Secretary broad discretion to establish an appropriate SNF market basket index. Her authority in that regard is not limited to the use of a pre-existing index. Nor does the legislative history of the statute indicate that any specific market basket index was intended. In short, we see no legal impediment to the Secretary adopting or establishing a different SNF market basket index from that described in the May 1998 interim final rule with comment. Likewise there are other analyses, assumptions, and estimates that the Health Care Financing Administration ("HCFA") made in its PPS implementing regulations that can be examined and revised to ensure that the amount actually paid for Medicare SNF services approximates the amount that Congress intended.

Background: Statutory Mandate for a SNF Prospective Payment System

The Balanced Budget Act of 1997 ("BBA") established a new prospective payment system for determining payment rates for skilled nursing facilities under Medicare. 1/ For the first three years of the new system, beginning with the cost reporting period starting on or after July 1, 1998, the per diem payment rate for SNF services is a blend of a facility-specific rate and a federal rate. Thereafter, all payments are based on the federal rate which is adjusted for factors such as case mix and wage differences. Both the facility-specific per diem rates and the federal per diem rates are established on the basis of the allowable costs of extended care services for cost reporting periods beginning in fiscal year 1995 (with certain adjustments) and an estimate of the corresponding amounts payable under Part B. These bases are updated to the first year of the PPS by the percentage change in the SNF market basket index minus one percent. Thereafter, the per diem rates are adjusted annually by the percentage change in the SNF market basket index, reduced by one percent each year through fiscal year 2002.

Thus, the SNF market basket index is an important factor in determining both the initial rates that SNFs will be paid under the new PPS, and in determining annual adjustments to account for the increased costs (presumably) of providing services. With respect to the setting of the initial PPS rates, the market basket index has a compounded effect on those rates because it is applied to base period amounts over a three year period, from 1995 to 1998. Stated simply, if the market basket index fails by one percent to reflect the actual percentage increase in prices of the goods and services included in covered SNF services in each of those years, it would result in more than a three percent underpayment by Medicare for those services in the first year of the PPS. The greater any underestimation of true market basket percentage, the more drastic will be the impact of that calculation on initial SNF payment rates. Moreover, that negative impact on payment rates would continue for each subsequent year for the duration of the PPS.

Analysis of the Secretary's Authority to Determine the SNF Market Basket Index

Section 1888(e)(5) of the Social Security Act, as added by the BBA, provides as follows with respect to the establishment of the SNF market basket index and percentage:

1/ Pub. L. No. 105-33, § 4432; Social Security Act ("SSA") § 1888(e).

> (A) SKILLED NURSING FACILITY MARKET BASKET INDEX.--The Secretary shall establish a skilled nursing facility market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered skilled nursing facility services.

Subparagraph (B) goes on to define the SNF market basket percentage as the percentage change in the SNF market basket index from the midpoint of one year to the midpoint of the following year.

The statute merely requires the Secretary to "establish" a SNF market basket index. It makes no reference to an existing index, and provides no guidance as to what should be included in the index other than that it must reflect changes over time in the "prices" of an "appropriate" mix of goods and services included in covered SNF services. 2/ Thus, the Secretary has substantial discretion to determine what should be used as or included in the SNF market basket index, so long as it reflects changes over time in the prices of an appropriate mix of goods and services.

In the May 1998 interim final rule with comment implementing the SNF PPS, HCFA chose to adopt an existing SNF market basket index that had been used since 1979 to make annual adjustments to the SNF cost limits. 3/ However, HCFA recognized the inadequacy of the existing index. Because it was a "fixed-weight index" HCFA observed that the index did not consider, and was not designed to consider "[t]he effects on total expenditures resulting from changes in the mix of goods and services purchased subsequent or prior to the base period...." 4/ For that reason, HCFA explained that it was necessary to "rebase" the index, by moving the base year for the input prices from 1977 to 1992 and to "revise" the index, by including data sources and categories that are needed to reflect the current mix of goods and services but that were not included in the previous index (*e.g.*, ancillary services and capital costs). 5/ HCFA's interim final rule discusses

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2/ The legislative history of the BBA sheds no light on Congressional intent in this regard. The Conference Report simply refers to the updates being based on the SNF market basket, which the Senate amendment substituted for a "SNF historical trend factor" that had been used in the House bill. H.R. Rep 105-217, 105th Cong., pp. 756-57.

3/ 63 Fed. Reg. at 26289.

4/ Id. at 26290.

5/ Id.

in detail the complex changes that it believed were required to make the pre-existing index usable for the new SNF PPS. Interestingly, no effort seems to have been made to revise the index to account for the estimated Part B base year costs, which also need to be adjusted from 1995 to 1998. Moreover, the interim final rule contained no discussion of alternative approaches that HCFA might have considered to the use of that index or of the availability of other indices that might be suitable for the purpose.

HCFA acknowledges in the interim final rule with comment that the market basket index that it has chosen to use is an "input" price index. Such an index works in a two step process: (1) the inputs needed to provide a mix of goods and services are identified as of some point in the past for which data are available, and (2) subsequently, the average rate of change in those prices is measured from year to year to determine a percentage increase. It has been suggested that an "output" price index might be more appropriate for this purpose because it is a more dynamic measure of changes in prices and would take into account, on a more timely basis, changes in the intensity of the inputs necessary to provide a new mix of goods and services. 6/

While the interim final rule with comment did not discuss the economic merit of these approaches, it is clear from the language of the statute that the Secretary would be free to chose either approach. The only issue in this regard raised by the statutory language is whether the index chosen reflects changes over time in the prices of an appropriate mix of goods and services.

Further, we believe that such a change could be adopted in the SNF PPS final rule without requiring a new notice and comment period. Given that HCFA chose to utilize its own index, after making certain revisions, in an interim final rule with comment, a strong argument can be made that a different index can be adopted at this time without the prior issuance of a formal proposed rule. If HCFA had the authority to adopt the current index without undertaking notice and comment rulemaking, it should be able to revisit its choice without undertaking notice and comment rulemaking.

6/ The Bureau of Labor Statistics has recently developed two such indices that reflect the average annual change in nursing facility outputs. The CPI component for Nursing Homes and Adult Day Care measures the rate of change of private sector output prices for those facilities, and the Producer Price Index for Skilled and Intermediate Care Facilities measures the average rate of change of private and public sector prices paid for the outputs of those facilities. We believe the change from the HCFA market basket to either of these indices could be made under existing law.

Finally, it has been suggested that adopting an index such as one of those discussed above would establish a precedent that such indices should be adopted for other Medicare benefits involving a market basket update. However, the other Medicare benefits that utilize a market basket update are given less statutory latitude than SNF PPS. For example, in the PPS for inpatient hospital services, the market basket index that is utilized is defined in SSA § 1886(b)(3)(B)(iii) in a more precise manner than the SNF index. The hospital market basket definition sets forth a specific methodology and specific components that the Secretary is required to use for purposes of that index. 7/ Similarly, the current home health agency payment system requires HCFA to utilize "the home health market basket index." 8/ Rather than afford the Secretary discretion to establish an index, Congress appears to have directed the Secretary to continue to use the existing home health agency market basket index. That Congress, in the same legislation, vested the Secretary with discretion to establish an index for SNF PPS, but did not do so for home health agencies, further demonstrates the wide latitude provided the Secretary in creating an index for SNF PPS.

In any event, the decision of the Secretary to use a particular index that she determines is most appropriate for SNF services should in no way require or even suggest that the inpatient hospital market basket index, which has been in place and has been the subject of annual Congressional review for over 15 years, should or even could be scrapped because the Secretary made a particular decision on what appropriate index to use to update Medicare covered SNF rates.

Additional Areas of HCFA Flexibility to Address SNF PPS Underpayments

The Congressional Budget Office ("CBO") report that accompanied the Balanced Budget Act of 1997 indicated that the impact of the SNF PPS would be a reduction in Medicare SNF payments of approximately $9.5 billion over 5 years. However, current projections are that the SNF PPS as implemented by HCFA will result in expenditure reductions of between $3.5 billion and $6.5 billion greater

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7/ SSA §1886(b)(3)(B)(iii) defines the inpatient hospital market basket percentage increase to be "the percentage, estimated by the Secretary before the beginning of the period or fiscal year, by which the cost of the mix of goods and services (including personnel costs but excluding nonoperating costs) comprising routine, ancillary, and special care unit inpatient hospital services, based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such inpatient hospital services, for the period or fiscal year will exceed the cost of such mix of goods and services for the preceding 12-month cost reporting period or fiscal year."

8/ SSA § 1861(v)(1)(L(v).

than those initially projected by CBO. 9/ The reason for the difference between the initial CBO estimates and the actual payment reductions is probably unknown at this time, but the result is that SNFs are being required to provide a given level of services to Medicare beneficiaries for a substantially lower amount of payment than Congress contemplated. Given the substantial amount of discretion provided to HCFA in implementing the new system, it seems incumbent upon HCFA carefully to assess each analysis and estimate that it used in implementing the system to ensure that payment rates match what Congress intended.

As discussed above, there are numerous features of the PPS that require HCFA to establish indices (such as the market basket index) or determine data elements (such as 1995 base year allowable costs) where the source of data is either left to HCFA's discretion or requires HCFA to make estimates or adjustments. We will discuss some of those areas briefly below and suggest elements that HCFA could examine to determine whether changes in its assumptions or estimates might result in more appropriate payment rates.

1. Determination of base year payments

Just as the selection and accuracy of the market basket index will have a permanent impact on SNF payment rates, the determination of the base year allowable amounts will have a continuing effect on total SNF payments under Medicare. In the case of the facility-specific rates, the effect will be for a three year period, while the effect on the federal rate will be permanent. There are a number of aspect of the base rate determinations that should be examined for their impact on current rates.

a. Adjustments for non-settled cost reports

HCFA has the discretion to modify (and make more generous) the adjustment for non-settled cost reports. 10/ To the extent that reductions in allowable costs have been attributed to audit adjustments and other disallowances taken when cost reports are

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9/ HCFA's interim final rule indicated that the PPS as implemented by that rule would result in savings of $12.9 billion. 63 Fed. Reg. at 26302. At HCFA's April 23, 1999, SNF PPS Town Hall Meeting, Congressman Benjamin J. Cardin (D-Maryland) indicated that CBO is projecting savings of approximately $16 billion.

10/ To account for the fact that some 1995 cost reports may not have been settled at the time the allowable costs for that year were determined, the statute authorizes the Secretary to adjust non-settled cost reports. SSA § 1888(e)(3)(A)(i) and (4)(A)(i). The final rule indicates that, based on the experience of prior years, routine costs in non-settled reports were reduced by 1.31 percent and ancillary costs were reduced by 3.26 percent.

finalized at the fiscal intermediary level, HCFA could adjust such reductions upward in light of the fact that disputes over many such disallowances may still be on appeal and ultimately will be decided in favor of the provider.

b. Estimate of Part B payments

HCFA has broad discretion to revise its estimate of the amount of Part B payments that should be included in the per diem rates. It should reexamine the assumptions regarding those estimates to ensure that all Part B costs have been captured and are reflected in the rates.

c. Inclusion of all Allowable Costs

HCFA could determine, on a basis other than the successful appeal of an issue by a provider, that additional allowable costs should have been included in the base year and adjust the rates accordingly.

2. Case Mix Adjustments

HCFA has wide authority to revise the case-mix index that is intended to measure intensity of care and translate that into an appropriate payment level. HCFA's use of data from many sources makes this index more susceptible to revision.

HCFA is developing a methodology for an adjustment to the unadjusted Federal rates because of changes in the aggregate case mix ("case mix creep"). Although HCFA likely envisions this as a means to reduce payments, current low payment rates, especially for high intensity cases, may justify a determination that payments for some categories should be increased.

Conclusion

HCFA has significant discretion in a number of areas to revisit and revise upward its initial determination of payment rates for the SNF PPS. Changes that impact base year costs could prove significantly beneficial in the same way that a revision to the market basket index would have a compounded effect. It is unclear whether HCFA would be more willing to make the base year and other changes in areas listed above than to adopt a different market basket index.

However, pursuing a single change to the market basket index may be the most effective means of significantly impacting SNF PPS rates and is squarely within the agency's discretionary authority.

ccs: Bruce A. Yarwood
Robert Deane
Elise Smith, Esq.

AHA

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NOTES/COMMENTS:

The attached is from Rick Pollack. Enjoy your Memorial Day Weekend!!

325 SEVENTH STREET NW
WASHINGTON, DC 20004
202/626-2311
202/626-2955 FAX

May 21, 1999

Nancy-Ann DeParle
Administrator
Health Care Financing Administration
200 Independence Ave S.W. – Room 314-G
Washington, D.C. 20201

Dear Ms. DeParle:

On behalf of our 5,000 member hospitals, health systems and other providers of care, the American Hospital Association (AHA) is growing increasingly concerned about the outpatient prospective payment system (PPS). During the development of the Balanced Budget Act, Congress, HCFA, seniors and hospitals agreed that beneficiaries were paying too high a share of the payments hospitals receive for providing outpatient care. All parties also agreed that the program should shoulder the financial burden of reducing beneficiaries' liability to 20 percent of total payments. Thus, program payments were set by the BBA to gradually increase to 80 percent of total payments for outpatient care.

We believe HCFA has misinterpreted the intent of Congress by reducing hospital payments to offset reduced beneficiary coinsurance. The language of the House and Senate bills clearly placed the financial burden of this change on the Medicare program. The conference report clearly states that the PPS "would be required to equal the total amounts estimated by the Secretary that would be paid for OPD services in 1999." A legal analysis of the statute supporting our view is attached to this letter.

Moreover, we were informed last week by HCFA that the offset – 5.7% or $4.3 billion over five years -- is now almost twice as large as previously estimated. Part of the revision is because HCFA failed to include in the initial estimates the impact of discounting payments for multiple surgeries performed on the same day. This policy is not required by statute.

These policies endanger the delivery of emergency and outpatient care to America's seniors. According to the Medicare Payment Advisory Commission, Medicare only covers 82 cents of every dollar in Medicare outpatient care costs today and further reductions in the level of payment are clearly untenable. We urge you to correct this inequity, as Congress intended, by having program funds offset reductions in beneficiary coinsurance.

Washington, DC Center for Public Affairs
Chicago, Illinois Center for Health Care Leadership

Liberty Place, Suite 700
325 Seventh Street, N.W.
Washington, DC 20004-2802
(202) 638-1100

Should you have any questions about these issues, please contact me, Carmela Coyle, senior vice president for policy (202) 626-2266, or Deborah Williams (202) 626-2340. We look forward to meeting with you soon.

Sincerely,

Rick Pollack

Rick Pollack
Executive Vice President

Attachment

AMERICAN HOSPITAL ASSOCIATION WHITE PAPER

HCFA's Authority to Develop a Budget Neutral Conversion Factor Under the Hospital Outpatient Department Prospective Payment System

By

Darrel J. Grinstead
Hogan & Hartson, L.L.P.

Background. The Balanced Budget Act of 1997 ("BBA") establishes a Medicare hospital outpatient department ("OPD") prospective payment system ("PPS") to determine both the amount of Medicare payments for outpatient department services and the amount of beneficiary copayments for those services. The new system is intended to be implemented in a budget-neutral way. While budget savings were achieved in the BBA through several OPD-related provisions (extension of current law payment reductions, elimination of formula-driven overpayments, and limitations on market basket rates of increase), there is no indication that Congress intended to achieve additional savings through the PPS formula itself. However, the proposed regulations published by the Health Care Financing Administration to implement this provision result in an additional reduction of 5.7% or $900 million per year in Medicare payments to hospitals for OPD services. This results from an interpretation by HCFA of a provision of the BBA that was not intended by the Congress nor required by the language of the statute. The following analysis supports this conclusion.

The Statutory Formula. Analysis of this problem requires an initial understanding of the basic formula that Congress devised for determining Medicare payments and beneficiary copayments for OPD services. The statute requires relative payment weights to be determined for each OPD service or group of services. Based on those weights and the frequencies of each service or group, a conversion factor is calculated so that the sum of the Medicare fee schedule amounts (conversion factor times relative weight) multiplied by the frequencies for each service or group equals the projected amount that would have been payable under the old system. The fee schedule amount is composed of both the Medicare payment amount and the beneficiary copayment. In order to correct a problem in the current statute that results in excessive copayment amounts, the statute requires the determination of an "unadjusted copayment amount" (20 percent of the

national median of the charges for each service or group). The formula for determining the amount of actual copayments for each year is designed to reduce copayments gradually until they reach that target amount.

HCFA's Proposed Process for Calculating the Conversion Factor. The problem with HCFA's interpretation of this statutory formula derives from the manner in which it proposes to determine the conversion factor. In calculating the conversion factor, rather than utilizing data that will result in payments under the new system in the first year equaling what would have been paid under the old system, HCFA proposes to build into the conversion factor a significant reduction in its estimate of beneficiary copayments. The ultimate result of this interpretation is a lower conversion factor and a permanent and unintended reduction in payments to hospitals for OPD services.

Under section 1833(t)(3)(A) of the statute, the Secretary's estimation of the conversion factor must begin with the calculation of base amounts (i.e., a hypothetical calculation such as that previously used in converting several other Medicare payment systems to fee schedules or prospective payment systems). These amounts traditionally have been based on assumptions of the amounts that would have been paid in the initial year under the old system and were intended to ensure budget neutrality in "converting" from one system to another. However, in this case, the statute specifies that, in calculating the total amount that hospitals would have received for an OPD service, Medicare payments in the base year will be based on an estimate of Trust Fund payments for OPD services in 1999 "without regard to this section," while beneficiary copayments will be based on the amounts "estimated to be paid under this subsection" in 1999. § 1833(t)(3)(A)(ii).

There is one critical problem with this statutory instruction. The statute and HCFA's proposed regulation would require the Secretary, in solving for an unknown (the conversion factor), to use as one of the components of the formula (the copayment base amount) an amount that can only be determined after the conversion factor has been calculated. On its face this instruction seems circular because the Secretary cannot know what amounts would be paid "under this subsection" until she can apply to the formula the conversion factor that is the subject of this calculation.

In its proposed regulation implementing this formula, HCFA states that it is following this statutory instruction. While HCFA does not expressly state that it is doing so, the only figure that would be immediately available for estimating copayment amounts "under this subsection" would be the "unadjusted copayment amount" that the Secretary is required to calculate for purposes of

determining the beneficiary copayment amounts under the formula, as discussed above. 1/

Under section 1833(t)(3)(B), the unadjusted copayment amount for each service or group is set at 20 percent of the national median of the charges for that service or group in 1996, updated to 1999 by the Secretary's estimate of the growth in charges during that period. However, the unadjusted copayment amount is not calculated for the purpose of establishing the amount of copayments to be paid by beneficiaries in any year. The sole purpose for calculating that figure is to determine the program payment percentage, which determines the proportion of the total fee schedule amount to be paid by both Medicare and beneficiaries. Nowhere in the statute is there an instruction to determine actual or estimated copayment amounts based on the unadjusted copayment amount. It is merely a fixed proxy amount which, when applied in the formula for each year, results in a gradual decrease over time in the relative share of the full fee schedule amount that is paid by Medicare beneficiaries as a copayment. 2/

There are a number of problems with using the unadjusted copayment amount as a proxy for total 1999 beneficiary copayment amounts in the calculation of the base amount under section 1833(t)(3)(A). First, it is merely a fictitious amount based on the national median of the charges for a service in 1996, updated to 1999 to reflect increases in charges over that period. It does not in fact reflect current payment levels. Because the median amount for these charges is less than the mean, we understand from HCFA's actuaries that the aggregate amount of this unadjusted copayment amount will be more than 10 percent less than current levels of beneficiary copayments. There is no indication in the legislative history or elsewhere that Congress intended this result

Second, as noted above, Congress did not instruct the Secretary to use that figure in that manner. If Congress had intended the "unadjusted copayment amount" calculated under section 1833(t)(3)(B) of the statute to be used as the Secretary's estimate of the total amount of copayments for 1999 for purposes of the conversion factor, it would have referred to that specific provision in the statute, rather than requiring, as section 1833(t)(3)(A) does, that the Secretary "estimate" that amount. It would be illogical to require the Secretary to estimate a payment amount if Congress intended to Secretary to use an amount that is specifically calculated under the statutory provision immediately following the provision requiring the estimation.

1/ See discussion in section V.C.2.b. of the preamble to the proposed regulation, 63 FR 173. Sept. 8, 1998, p. 47573.

2/ Under the statute, when the program payment percentage for a service or group reaches 80 percent, it then permanently remains at that amount, the gradual reduction in copayment percentage having been fully achieved. § 1833(t)(3)(B)(ii).

Legislative History. Thus, there is considerable ambiguity in the statute as to how the Secretary is instructed to calculate the total amount of beneficiary copayments for the purposes of determining the base amounts and the resulting conversion factor. We do not believe, however, that there is any ambiguity in the congressional intent that the conversion factor should be calculated in such a manner that the fee schedule amounts determined under the PPS "would be required to equal the total amounts estimated by the Secretary that would be paid for OPD services in 1999." That precise language appears as a statement of congressional intent in both the House and Senate reports on the OPD PPS provisions, and in the Conference Report. 3/ The use of the subjunctive "would be paid" in this phrase seems clearly to indicate Congress' intent to refer to amounts payable in other circumstances, i.e., had Congress not changed the formula.

Both the House and Senate versions of the bill that went to Conference on the Balanced Budget Act contained almost identical versions of an OPD prospective payment system. Both of those bills required a determination of base amounts (for purposes of determining the conversion factor) derived from an estimate of the amounts that would be payable by Medicare for OPD services under the old law and as though the required coinsurance, as in effect prior to enactment of the new PPS, continued to apply. However, in the final drafting of the Conference language, technical changes were made to the entire OPD PPS provision, apparently to correct drafting flaws, without any change being intended to the actual determination of payment amounts. 4/ The Conference Report states that it adopts the House bill with amendments to define covered OPD services and to provide market basket minus one percent updates to the fee schedule amount for the years 2000 through 2002, with full market basket percentage increases thereafter.5/ No mention is made in the Conference Report of any intention to reduce the copayment portion of the base amount in order to achieve additional savings. In fact, such savings are nowhere mentioned in the legislative history or in the budget analyses of this provision. Therefore, it seems probable that any change in the language of this provision made by the Conference Committee was intended only to correct the drafting problems and not to require a $900 million annual reduction in Medicare payments for OPD services.

3/ H.R. Rep. No 105-149, 105th Cong., 724 (1997); S. Rep No. 105-29, 105th Cong., 58 (1997); H.R. Rep. No. 105-217, 105th Cong., 784 (1997).

4/ The conversion factor that would have been used in the House and Senate bills would have used as an aggregate base amount Trust Fund payments only, calculated without regard to the PPS amendments, and calculated as though the coinsurance provisions in effect prior to enactment continued to apply. However, the conversion factor established in the Conference report is based on the sum of both Medicare Trust Fund payments and beneficiary copayment amounts.

5/ H.R. Rep. No. 105-217, 105th Cong., 785 (1997).

The legislative history does not explain why the Conference Committee adopted language for calculating base amounts that referred to copayment amounts "estimated to be paid under this section" rather than assuming that copayments would be calculated under the old system, as both the House and Senate bills did. Perhaps the drafters assumed, without being aware of the effect of using median charge levels rather than the mean for calculating unadjusted copayment amounts, that either method would produce the same result. Or perhaps the drafters simply failed to recognize that copayment amounts "under this subsection" would be something entirely different from the amount of copayments that should be taken into account in order to achieve the stated budget neutrality purpose of the conversion factor. In any event, there is no discernible logic in the use of base amounts derived from the former system for establishing the Medicare portion of the conversion factor base, while using amounts that are somehow to be determined under the new system for establishing the beneficiary copayment portion of that factor.

If HCFA's proposed rule is adopted, the amount of copayments estimated to be paid by beneficiaries for purposes of determining the conversion factor will be arbitrarily reduced by 6.9 percent. That downward adjustment will permanently reduce the fee schedule amounts and the amounts paid to hospitals by Medicare in a manner that is totally inconsistent with the clearly stated congressional intent indicated above.

Although courts and administering agencies are under an obligation in most cases to follow statutory language that is clear and unambiguous, in some "rare and exceptional circumstances," this presumption can be rebutted. *Ardestani v. INS*, 502 U.S. 129, 135-36 (1991). Even if the language in question here were unambiguous (which we have demonstrated is not the case), it is a well-established canon of statutory construction that "a court should go beyond the literal language of a statute if reliance on that language would defeat the plain purpose of the statute." *Bob Jones University v. United States*, 461 U.S. 574, 586 (1983). This directive is particularly appropriate when construing a complex statute that produces an unexpected result. *DeJesus v. Perales*, 770 F.2d 316, 321 (2d. Cir. 1985), cert. denied, 478 U.S. 1007, (1986) (interpreting conditions a state Medicaid plan must meet in order to qualify for federal matching funds, which the court describes as "a statute of unparalleled complexity").

This is not the first time HCFA has been faced with implementing changes in Medicare payment policy where the language of the statute was inconsistent with Congress' actual intention. HCFA had a similar problem when Congress enacted the Omnibus Budget Reconciliation Act of 1990 6/ which required

6/ OBRA 90, Pub. L. No. 101-508, 104 Stat. 1388 (1990).

HCFA to create national payment limits for durable medical equipment. 7/ The payment system was to be phased in over three years, starting in 1991, and payment rates were to be updated annually based on a "covered item update." 8/ The update for both 1991 and 1992, as it was enacted and signed into law, was a "reduction of 1 percentage point." 9/ What Congress had intended, however, was not a reduction in payments of one percent but an *increase* based on the Consumer Price Index for all urban consumers ("CPI-U") for the previous year reduced by one percentage point. Congress corrected this error, four years later, by a technical correction included in the Social Security Act Amendments of 1994. 10/

In the meantime, however, HCFA had no difficulty in implementing the statute as it had been intended rather than as it plainly read. Although the correction to the statutory provision was not made until 1994, HCFA promulgated regulations in 1992 that interpreted the covered item update for 1991 and 1992 to be based on the CPI-U, reduced by one percent. 11/ In short, the regulation assumed that the statutory provision as enacted was incorrect and read into the provision a payment update based on congressional intent.

Similarly, we do not believe HCFA is obliged to interpret the OPD provisions discussed above by following blindly a narrow reading of the language of the statute itself. This is especially true given that to do so would deprive hospitals of $900 million in annual revenues in a manner that was not intended by the Congress and not reflected in any of the agreements, discussions or analyses of the budget impact of this legislation. Moreover, as noted above, the language of the statute has an unusual circularity that renders it infeasible to be implemented literally. The courts have recognized the leeway that administrative agencies must be given in interpreting complex and ambiguous statutory language (see *Perales, supra*), in order to ensure that congressional intent is achieved.

Conclusion. In light of the complexity of this statutory scheme and the ambiguity in the statutory language, HCFA should interpret the statute in a manner that will achieve the stated objectives of the Congress and that will make sense in terms of calculating a conversion factor that will ensure that the fee

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7/ *Id.* at § 4152(b).

8/ *Id.* at § 4152(b)(4) (prior to 1994 amendment).

9/ *Id.*

10/ Social Security Act Amendments of 1994, Pub. L. No. 103-432, § 135, 108 Stat. 4398, 4422 (1994).

11/ Payment for Durable Medical Equipment and Orthotic and Prosthetic Devices, 57 Fed. Reg. 57678 (1992).

schedule amounts determined under the PPS will "equal the total amounts estimated by the Secretary that would be paid for OPD services in 1999." 12/ HCFA's regulations should provide for a budget neutral conversion factor that will provide for the conversion of payments from the former system to the new without extracting $900 million annually in unjustified and unintended hospital payment reductions.

12/ H.R. Rep. No 105-149, 105th Cong., 724 (1997); S. Rep No. 105-29, 105th Cong., 58 (1997); H.R. Rep. No. 105-217, 105th Cong., 784 (1997).

ROBERT G. TORRICELLI
NEW JERSEY

COMMITTEES:

GOVERNMENT AFFAIRS

JUDICIARY

RULES AND ADMINISTRATION

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United States Senate

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(202) 224-3224

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(973) 624-5555

420 BENIGNO BLVD.
KORMAN INTERSTATE BUSINESS PARK
SUITE A-1
BELLMAWR, NEW JERSEY 08031
(609) 933-2245
http://torricelli.senate.gov/
Senator_Torricelli@Torricelli.Senate.Gov

June 3, 1999

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The Honorable William J. Clinton
The White House
Washington, DC 20500

Dear Mr. President:

Once again, I would like to alert you to some issues which are of particular concern to health care providers in my home State of New Jersey.

The Balanced Budget Act of 1997 was an important step toward ensuring the long-term strength of the Medicare program; however, the unintended consequences of reimbursement reductions included in the BBA have been economically devastating to skilled nursing facilities (SNFs) in my state. Thus, I want to share with you some potential administrative options which the Health Care Financing Administration (HCFA) may choose to implement to help preserve access to community-based skilled care services.

First, the market basket update index currently used by HCFA understates the annual change in the costs of providing an appropriate mix of goods and services taking place in a SNF. For this reason, the BBA specifically instructs the Secretary to establish a SNF market basket index that "reflects changes over time in the prices of an appropriate mix of goods and services included" in a SNF. Therefore, HCFA may choose to replace the current market basket index with an index that reflects the average annual change in the prices of SNF outputs. Currently, the Bureau of Labor Statistics has such an index, which, if used, could provide immediate relief to providers and beneficiaries.

A second possible solution would be to give facilities the option of continuing to be reimbursed under the current transition rate or to be reimbursed the full federal rate. As you know, SNFs are being transitioned to a 100 percent federal rate over three years which are a blend of 1995 facility specific historical costs and a federal rate. Facilities that changed the type and volume of services after 1995 are disadvantaged by the transition rate and would be better served under the federal rate.

As you continue to pursue proposals to ensure the long-term solvency of the Medicare, I encourage you to carefully consider these administrative options that could bring immediate relief to health care providers in my state. Thank you for your leadership with this important issue, and I look forward to working with you.

Sincerely,

ROBERT G. TORRICELLI
United States Senator

NEC

cc: DPC

RGT:km

HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515
(202) 225–2601

218–14 NORTHERN BOULEVARD
BAYSIDE, NY 11361
(718) 423–2154

229 MAIN STREET
HUNTINGTON, NY 11743
(516) 423–2154
http://www.house.gov/ackerman

Gary L. Ackerman
Congress of the United States
5th District, New York

COMMITTEE ON INTERNATIONAL RELATIONS
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CAUCUS ON INDIA AND INDIAN-AMERICAN ISSUES
CHAIRMAN

June 3, 1999

President Bill Clinton
The White House
1600 Pennsylvania Ave.
Washington, DC 20500

Dear Mr. President:

As you prepare the Administration's Medicare reform proposal, I ask you to resist further cuts in payments to our nation's hospitals and health care providers.

Throughout the past several years, you have demonstrated your leadership on this issue by fighting attempts to either privatize or dramatically scale back the program. It is my hope that you will continue your commitment to our nation's seniors by approaching Medicare reform in the most balanced and responsible manner possible.

New York hospitals are already under significant financial pressure, due to cuts that were contained in the Balanced Budget Act (BBA) of 1997. Moreover, most of the cuts mandated under the BBA have not yet been implemented. In fact, New York hospitals are expected to experience an additional $3.9 billion in payment reductions with the full implementation of the BBA.

The BBA has also had a dramatic impact upon home health care agencies throughout the nation, enduring approximately $49 billion in payment reductions. The changes contained in the BBA have saved more than double the funding that was originally projected by the Congress. Even worse, these cuts are being felt the greatest in the poorest and most destitute of communities.

I believe that we have a unique opportunity to protect and preserve the Medicare program. However, we need to view Medicare reform in the context of payment reductions that are already in the process of being implemented. Most importantly, I hope you will oppose any new cuts to providers and hospitals.

Once again, thank you for your continued commitment to our nation's frail and elderly. I look forward to working with you in the near future.

Sincerely,

Gary L. Ackerman

GARY L. ACKERMAN
Member of Congress

NEC

CC: DPC

CC: Chris Jennings
Donna Shalala

Office of Legislation

HCFA MEDICARE • MEDICAID

Number of Pages:_____ Date: 6/10/99

To:	From:
Chris Jennings Caroline Davis	Bonnie Washington
Fax: _____	Fax: _____
Phone: _____	Phone: _____

REMARKS:_____

HEALTH CARE FINANCING ADMINISTRATION
200 Independence Ave., SW
Room 341-H, Humphrey Building
Washington, DC 20201

United States General Accounting Office

GAO

Testimony

Before the Committee on Finance, U.S. Senate

For Release on Delivery
Expected at 10:00 a.m.
Thursday, June 10, 1999

Pls fax these 2 testimonies to Caroline Davis + Chris Jennings

BALANCED BUDGET ACT

Any Proposed Fee-for-Service Payment Modifications Need Thorough Evaluation

Statement of William J. Scanlon, Director
Health Financing and Public Health Issues
Health, Education, and Human Services Division

GAO/T-HEHS-99-139

Mr. Chairman and Members of the Committee:

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

My comments focus on the payment reforms for providers under the fee-for-service portion of the program. I will concentrate on the changes made to skilled nursing facility (SNF) and home health agency (HHA) payment policies. Although the BBA mandated similar reforms for other types of providers, the SNF and HHA changes are, at this time, farthest along in their implementation. These provisions were enacted in response to continuing rapid growth in Medicare spending that was neither sustainable nor readily linked to demonstrated changes in beneficiary needs. These provisions represented bold steps to control Medicare spending by changing the financial incentives inherent in provider payment methods to promote more efficient service delivery. Yet the Congress is coming under increasing pressure from providers to revisit these reforms. As additional BBA provisions are implemented, and other providers feel the effects of the mandated changes, calls for modifications may continue or even intensify. How responsibilities to current and future seniors, the American taxpayer, and the health care provider community are balanced will shape the resulting responses. Achieving the appropriate balance will require recognition of legitimate concerns about beneficiary access and the ability of providers to adjust to the new payment methods.

Calls by providers to moderate the effect of BBA changes come at a time when federal budget surpluses and smaller-than-expected increases in Medicare outlays may make it easier to accommodate higher Medicare payments. Indeed, many provider groups contend that BBA changes produced more savings than originally intended. The Congressional Budget Office has revisited and lowered its estimates of Medicare spending since BBA enactment. As a result of the lower projected spending, the estimated savings from the BBA provisions will represent a proportionately larger share of Medicare expenditures. Lower projected Medicare spending, however, does not necessarily mean that the effect of the BBA changes was greater than intended. Rather, it merely raises again issues of how much the federal government should pay for health care for the elderly and what payment levels are appropriate for the various provider groups.

The BBA mandated the continued movement of fee-for-service Medicare away from cost-based reimbursement methods and toward prospective payment systems (PPS). The goal is to foster more efficient provision and use of services to lower spending growth rates, replicating the experience of acute care hospitals after a PPS was implemented, beginning in the mid-1980s. The BBA mandated such payment systems for SNFs, HHAs, hospital outpatient services, and certain hospitals. On July 1, 1998, SNFs began a 3-year transition to a PPS.[1] An interim payment system (IPS) for HHAs was phased in beginning on October 1, 1997, and a PPS is scheduled to be implemented for all HHAs on October 1, 2001.[2]

In brief, both SNFs and HHAs have felt the effect of the BBA provisions, and both industries will need time to adapt, but the calls to amend or repeal the new payment systems are, in our view, premature. The SNF PPS was implemented with a 3-year transition to the fully prospective rates, and facilities are phased into this transition schedule according to their fiscal year; thus, the adjustment time has been built into the PPS schedule. Current concerns that the PPS is causing extreme financial pressures for some SNFs need to be systematically evaluated on the basis of additional evidence. Several factors suggest that the problem may be less severe than is being claimed by providers. Nevertheless, certain other modifications to the PPS may be appropriate because there is evidence that payments are not being appropriately targeted to patients who require costly care. The potential access problems that may result from underpaying for high-cost cases will likely result in beneficiaries' staying in acute care hospitals longer, rather than forgoing care. This is a safety net for beneficiaries while modifications are made. The Health Care Financing Administration (HCFA), which has responsibility for managing the Medicare program, is aware that payments may not be adequately targeted to high-cost beneficiaries and is working to address this problem.

As a result of the swift implementation of the home health IPS and the lack of a transition period, the BBA's impact on home health agencies has been more noticeable. The number of participating agencies declined by 14 percent between October 1997 and January 1999, and utilization has dropped to 1994 levels, the base year for the IPS. However, since the number of HHAs and utilization had both grown considerably throughout most of the decade, beneficiaries are still served by over 9,000 HHAs—approximately the same number that were available just prior to the

[1]The SNF PPS will be phased in on the basis of facility cost-reporting years. During the transition, payment rates will be a blend of a declining portion of a facility-specific historical amount and an increasing portion of the national prospective rate.

[2]The BBA required the HHA PPS to be in place in fiscal year 2000. Subsequent legislation delayed the implementation by 1 year and eliminated the phasing in of the system.

recent declines. Our interviews with HHAs, advocacy groups, and others in rural areas that lost a significant number of agencies indicated that the recent decline in HHAs has not impaired beneficiary access. While the drop in utilization does not appear to be related to HHA closures, it is consistent with IPS incentives to control the volume of services provided to beneficiaries. In short, after years of substantial increases in home health visits, the IPS has curbed the growth in home health spending. Some of the decline in utilization appears to involve greater sensitivity to who qualifies for the home health care benefit, with some who do not qualify, but who may have been previously served, not receiving services now. There are indications, however, that beneficiaries who are likely to be costlier to serve than the average may have more difficulty than before in obtaining home health services because the revenue caps imposed by the IPS are not adjusted to reflect variations in patient needs. This problem should be ameliorated with the implementation of the PPS. In designing the PPS, it will be essential that HCFA adequately adjust payments to account for the wide differences in patient needs.

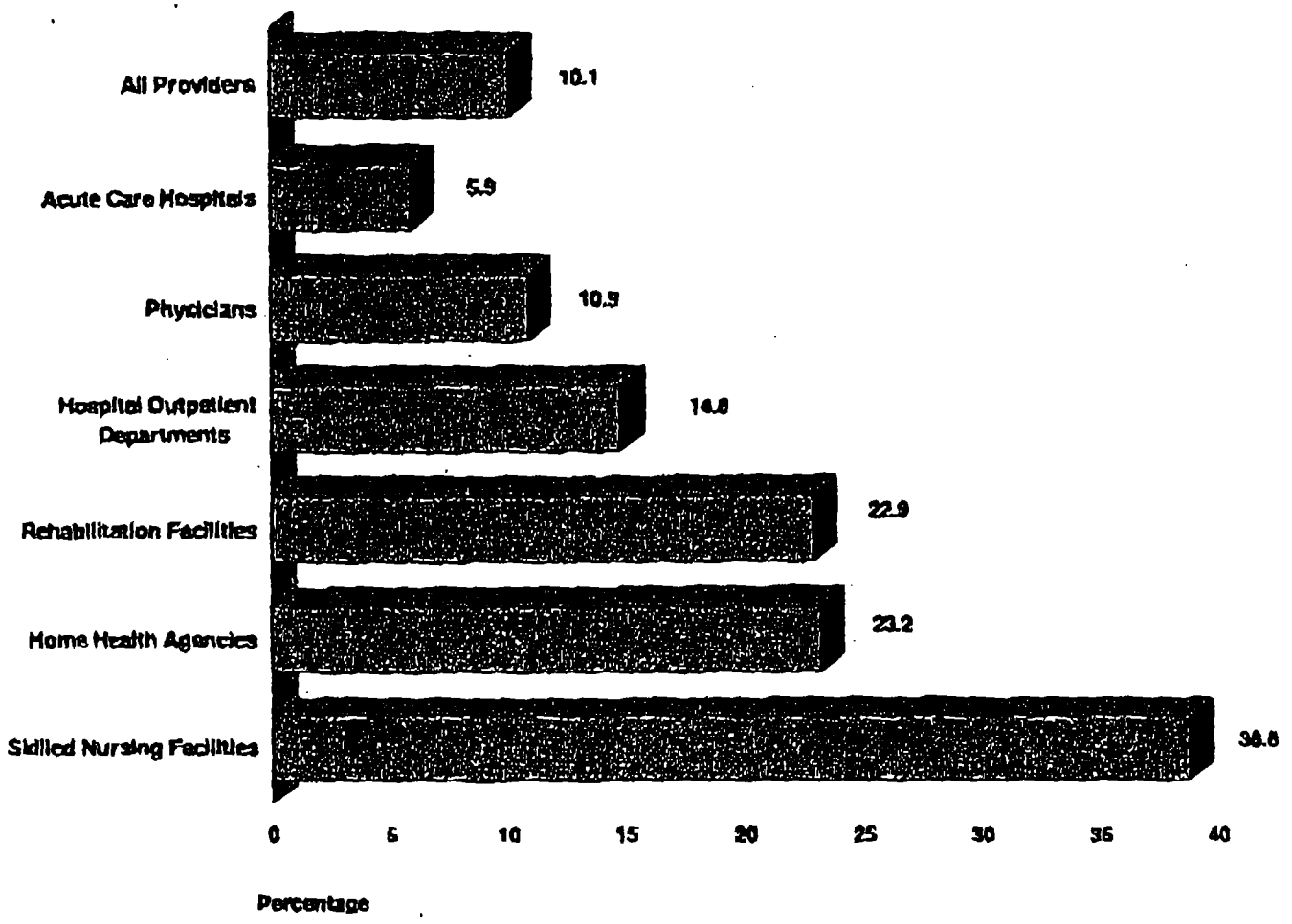
To date, the principal lessons to be drawn from the SNF and HHA payment reforms and their implementation are that

- the particulars of payment mechanisms largely determine the extent to which a reform option can control excess government spending while protecting beneficiary access to care and
- revisions to newly implemented policies should be based on a thorough assessment of their effects so that, at one extreme, policies are not unduly affected by external pressures and premature conclusions and, at the other extreme, policies do not remain static when change is clearly warranted.

BACKGROUND

Medicare is the nation's largest health insurance program, covering about 39 million elderly and disabled beneficiaries at a cost of more than $193 billion a year. The sheer size of this program during a period of particular concern over government spending made it the target of spending reforms. That Medicare was growing faster than the overall economy and the Medicare Hospital Insurance Trust Fund was facing imminent depletion only heightened attention on this program. Medicare expenditures had been rising at an average annual rate of 10.1 percent between 1985 and 1995 (see fig. 1). While the outlook for the federal budget has changed, with projected surpluses replacing deficits, the importance of ensuring that Medicare is an efficient purchaser of health services remains.

Figure 1: Average Annual Rate of Growth in Medicare Expenditures, 1986-95, by Type of Provider

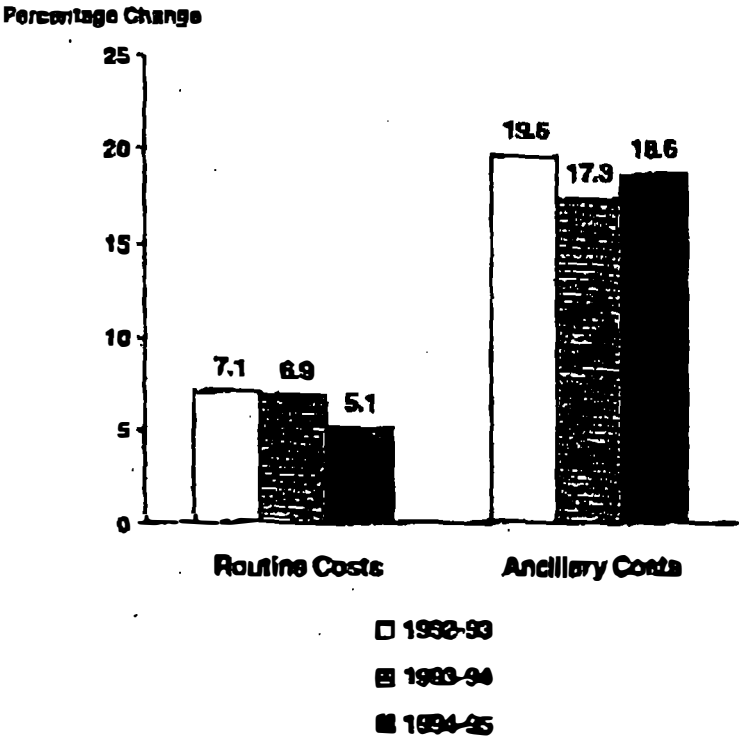


Despite significantly lower projected spending due to BBA reforms, there is a growing consensus among experts, including the trustees of the Medicare Hospital Insurance Trust Fund, that additional reforms are needed. As the baby boomers reach retirement age, the pressures on Medicare program spending will intensity. Fueled by medical technology advancements that allow more and better treatments for a larger portion of the elderly, Medicare spending growth will continue to be an important budgetary issue. The Congressional Budget Office projects that by 2009 Medicare's expenditures as a portion of the gross domestic product will rise almost one-third.

INDUSTRY AND OTHER CONCERNS ABOUT SNF PPS REQUIRE THOROUGH ANALYSIS

Prior to the PPS, SNFs were paid the reasonable costs they incurred in providing Medicare-allowed 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 other costs—primarily 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, growth in ancillary costs far outpaced the growth in routine service costs between 1992 and 1995 and drove up overall Medicare payments to SNFs (see fig. 2). Moreover, new providers were exempt from even the routine caps for their first 4 years of operation, which encouraged expansion of the industry.

Figure 2: Percentage Growth in SNF Routine and Ancillary Costs per Day, 1992-95



Under the new PPS, facilities receive a payment for each day of care provided to a Medicare-eligible beneficiary. This per diem rate is based on the average daily cost of providing all Medicare-covered services, as reflected in facilities' 1995 costs, adjusted to take into account the nature of each patient's condition and expected care needs. 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 and judiciously.

The PPS represents a major change to the previous incentives of cost-based reimbursement and, as a result, Medicare treatment patterns that were influenced by the previous payment method will need to be modified. Previously, SNFs benefited from providing more ancillary services, without regard to the price paid for those services, since Medicare's payment was based on each facility's actual costs. SNFs that boosted their Medicare ancillary costs–either through higher use rates or higher prices–will need to make more modifications than those that did not. Scaling back these services, however, will 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' needs. Further, practice pattern changes may not be very disruptive because Medicare patients constitute a small share of most SNFs' business. And, blending facility-specific costs with the national PPS rates during the transition will ease the adjustments for facilities that have a history of providing many ancillary services.

Recent industry reports, however, have questioned the ability of some organizations operating SNF chains to adapt to the new PPS. Indeed, claims of pending bankruptcies have been linked to the Medicare payment changes. It is likely, however, that a combination of factors has contributed to the poor financial performance of these businesses. For example, many of the organizations have other lines of post-acute-care services–including the provision of outpatient rehabilitation therapy and ancillary services to affiliated SNFs as well as independent SNFs. The PPS may have affected the demand for these services, but other BBA provisions likely have had an effect as well.[3] In addition, some of these organizations invested heavily in the nursing home and ancillary service businesses not long before the enactment of the PPS, both expanding their acquisitions and upgrading facilities to provide higher-

[3]The BBA applied a per beneficiary payment cap of $1,500 for outpatient physical and speech therapy and a $1,500 cap for outpatient occupational therapy, although neither cap is applicable to services provided through a hospital outpatient department. These limits will not apply to Medicare beneficiaries during a Medicare-covered SNF stay, but could affect Medicare SNF residents if their stay is not covered by Medicare. This provision, in combination with consolidated billing for all services under the PPS, could limit some providers' ability to sell therapy and other ancillary services to other SNFs.

intensity services. Yet HCFA had been developing a PPS for some time that would curtail unnecessary growth in ancillary payments. We are studying these issues and will provide more details later this year on the effect of the PPS on solvency and beneficiary care.

While we think that industry concerns about the financial viability of SNFs operating under PPS have not been substantiated and may be premature, we have identified three key PPS design issues that may affect Medicare's ability to realize program savings and may limit beneficiaries' access to care. First, we are concerned about the SNF case-mix adjusters, which are needed to ensure that facilities serving patients with more intensive care needs receive adequate payments and, conversely, that SNFs are not overcompensated for patients with lower care needs. The current case-mix adjusters preserve the opportunity for SNFs to increase their compensation by supplying potentially unnecessary services. A SNF can benefit by manipulating the services provided to beneficiaries, rather than increasing efficiency. For example, the payment for a patient who requires 143 minutes of therapy care daily is $286 per day, compared with $346 for a patient who requires 144 minutes (see table 1). Thus, by providing an extra few minutes of therapy to certain patients, a facility could increase its Medicare payments without a commensurate increase in its costs. Rather than improving efficiency and patient care, this might only raise Medicare outlays. We believe that HCFA needs to continue its research into a classification system that is less dependent on service use and more closely tied to patient characteristics and needs. It also must provide adequate oversight to ensure that providers properly classify patients and do not manipulate service provision to take advantage of the classification system.

Table 1: Comparison of Length of Average Daily Therapy and per Diem SNF Payments for Different Rehabilitation Case-Mix Groups

Rehabilitation case-mix groups	Length of average daily therapy (for 5 days per week)	Per diem payment (federal unadjusted rate for urban facilities)
Ultra high	144+ minutes	$346
Very high	100 to 143 minutes	286
High	65 to 99 minutes	250
Medium	30 to 64 minutes	239

Our second concern is whether the system adequately identifies the most expensive patients and adjusts payment rates accordingly. This concern emanates from limitations in the data HCFA had available to establish the case-mix groups and the rates. 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, the classification system may aggregate expensive patients with widely differing needs into too few groups to distinguish adequately among patients' resource needs. In addition, the classification system does not take into account varying nontherapy ancillary service needs and is likely to overpay SNFs for treating patients with low service needs and underpay those SNFs treating patients with high service requirements. These design weaknesses could result in access problems or inadequate care 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 adjusters and is working to refine these measures to more accurately reflect patient differences.

Finally, we are concerned that the cost reports submitted to Medicare for the year on which payments are based (1995) include unreasonable costs and may establish payments levels that are too high. Most of the data used to establish these rates have not been audited and are likely to include excessive ancillary costs, because the prior system had no incentives to constrain such costs. Moreover, it is likely that the base year includes too many services and that the costs per service were inappropriately high.

HHA CLOSURES AND DECLINING UTILIZATION SIGNAL IPS IMPACT, BUT THERE IS LITTLE EVIDENCE OF IMPAIRED ACCESS

Medicare spending for home health care rose at an annual rate of 25.2 percent between 1990 and 1997. Several factors accounted for this spending growth, most notably the relaxation of coverage guidelines. In response to a 1988 court case, the benefit was essentially transformed from one that focused on patients needing short-term care after hospitalization to one that serves chronic, long-term-care patients as well.[4] Thus, Medicare may now be covering services that would previously have been paid for by Medicaid or by beneficiaries themselves. The loosening of coverage and eligibility criteria contributed to an increase in the number of beneficiaries receiving services. Between 1990 and 1997, the number of Medicare home health users per 1,000 beneficiaries increased from 57 to 109.[5] Associated with the increase in

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

[5]These numbers reflect Medicare fee-for-service beneficiaries only.

beneficiaries being served over this period was the near doubling of Medicare-certified HHAs to 10,524 by 1997.

Also contributing to the historical rise in spending were a payment system that provided few incentives to control how many visits beneficiaries received and lax Medicare oversight of claims. Between 1990 and 1997, the average number of visits per user climbed from 36 to 73. HHAs could boost revenues by providing more services to more beneficiaries, a strategy that could actually help HHAs avoid being constrained by Medicare's limits on payments per visit.[6] There is evidence that some HHAs provided visits of marginal value. For example, as we noted in a previous report, even when controlling for diagnoses, substantial geographic variation exists in the provision of home health care.[7] In 1996, the average number of visits per user in the West South Central region (Arkansas, Louisiana, Oklahoma, and Texas) was 129, compared with 47 in the Middle Atlantic region (New York, New Jersey, and Pennsylvania). While the precise reasons for this variation are not known, there is no reason to assume that it was warranted by patient care needs. Evidence indicates that at least some of the high use and the large variation in practice represented inappropriate care.[8] Medicare oversight declined at the same time that spending mounted, contributing to the likelihood that inappropriate claims would be paid. The proportion of claims that were reviewed dropped sharply, from about 12 percent in 1989 to 2 percent in 1995, while the volume of claims almost tripled.

To control spending while ensuring the appropriate provision of services, the BBA mandated expeditious implementation of the IPS while the PPS was under development. Prior to BBA, HHAs were paid on the basis of their costs, up to preestablished limits. The limits were set for each type of visit but were applied in the aggregate for each agency; that is, costs above the limit for one type of visit could still be paid if costs were sufficiently below the limit for other types of visits. The IPS lowered the visit payment limits and subjected HHAs to an aggregate Medicare

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[6]Agencies could avoid the payment limits by lowering their per visit costs in two ways: by serving less expensive patients with shorter visits and by providing more visits and thereby spreading fixed costs over more visits.

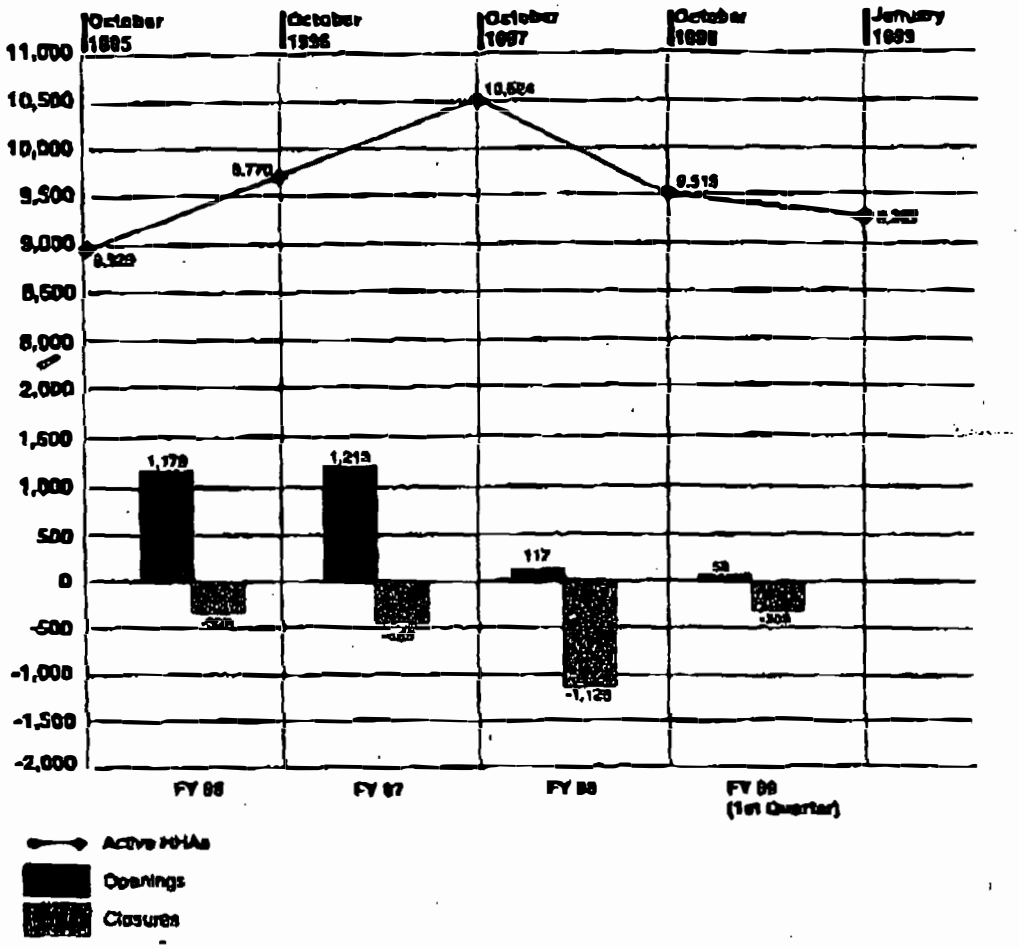
[7]Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996).

[8]Medicare: Improper Activities by Mid-Delta Home Health (GAO/T-OSI-98-6, Mar. 19, 1998) and Department of Health and Human Services, OIG, Variation Among Home Health Agencies in Medicare Payment for Home Health Services (Washington, D.C.: HHS, 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).

revenue cap based on a historical per beneficiary amount that factors in both agency-specific and regional average per beneficiary payments. The purpose of the cap is to control the number of services provided to users. The blending of agency-specific and regional amounts accounts for the significant differences in service use across agencies and geographic areas. For new HHAs, without historical cost data, the caps are based solely on the national median. Because per beneficiary limits are tied to fiscal year 1994 payments, the new payment limits will be more stringent for agencies and areas that experienced significant growth in the number of visits per user between 1994 and 1997. Notably, the growth in Louisiana, Oklahoma, and Texas, where 1994 utilization levels were approximately twice the national average, greatly exceeded the average increase nationally. By comparison, utilization levels declined in one-fifth of the states with utilization levels below the national average in 1994, making it easier for HHAs in those states to cope with the cap.

In contrast to the SNF PPS, the IPS had a more immediate effect on the operation of providers because there was no gradual transition to imposition of the revenue cap. The IPS was phased in according to an HHA's cost reporting year–61 percent of agencies came under the IPS by January 1, 1998, and the remainder by September 30, 1998. Moreover, unlike the situation with SNFs, Medicare beneficiaries represent a substantial proportion of the patients served by HHAs. The closure of a significant number of HHAs occurred after the IPS was implemented. Between October 1, 1997, and January 1, 1999, 1,436 Medicare-certified HHAs stopped serving Medicare beneficiaries. However, because of the growth in the industry since 1990, there were still 9,263 Medicare certified HHAs in January 1999–only 500 fewer than in October 1996. (See fig. 3.)

Figure 3: Change in Number of Medicare-Certified HHAs, October 1, 1995, Through January 1, 1999



Forty percent of the closures were concentrated in three states that had experienced considerable growth in the number of HHAs and had utilization rates (visits per user as well as users per thousand fee-for-service beneficiaries) well above the national average (see table 2). Furthermore, the majority of closures occurred in urban areas that still have a large number of HHAs to provide services. The pattern of HHA closures suggests a response to the IPS. The IPS revenue caps would prove particularly stringent for HHAs that provided more visits per user, for smaller agencies, for those with less ability to recruit low-cost patients, and for newer agencies. In fact, HHAs that closed had provided over 40 percent more services per

user than agencies that remained open. Closing HHAs were also about half the size of those that remained open, and they had been losing patients before the implementation of IPS.

Table 2: Decline in HHAs and Changes in Utilization Nationally and in Three High-Use States

	HHA closures as a percentage of active agencies, Oct. 1, 1997	Number of Medicare-certified HHAs, Jan. 1, 1999	People served per 1,000 Medicare fee-for-service enrollees			Visits per user		
			1994	1997	Percentage change	1994	1997	Percentage change
Nationwide	-14.0	9,269	94.2	109.2	15.9	66.0	72.9	10.5
Louisiana	-21.6	407	138.6	157.3	13.5	125.8	161.0	28.0
Oklahoma	-23.2	299	108.9	131.9	21.1	105.7	147.0	39.1
Texas	-20.1	1,680	106.9	133.7	25.1	97.4	141.0	44.8

Despite the widespread attention focused on closures, the critical issue is whether beneficiaries who are eligible to receive services are still able to do so. Utilization rates during the first 3 months of 1998 are consistent with IPS incentives to control costs. Home health utilization in the first quarter of 1998 was lower than during a comparable period in 1996 but was about the same as during a comparable period in 1994–the base year for the IPS. Moreover, the sizeable variation in utilization between counties with high and low use has narrowed. In counties without an HHA, both the proportion of beneficiaries served and the visits per user declined slightly during the first 3 months of 1998, compared with a similar period in 1994, but these counties' levels of utilization remained above the national average. Our February 1999 interviews with officials at HHAs, hospital discharge planners, advocacy groups, and others in 34 primarily rural counties with significant closures indicated that beneficiaries continue to have access to services. Some of the decline in utilization appears to be for beneficiaries who no longer qualify for the home health care benefit. However, these interviews also suggested that as HHAs change their

operations in response to the IPS, beneficiaries who are expected to be costlier than average to treat may have increased difficulty obtaining home health care. The pending implementation of the PPS, which will adjust payments to account for costlier patients, has the potential to ameliorate future access problems.[9]

CONCLUSION

The BBA made necessary and fundamental changes to Medicare's payment methods for SNFs and HHAs to slow spending growth while promoting more appropriate beneficiary care. Further refinements are required to make these systems more effective. However, the intentional design of these systems is to require inefficient providers to adjust their practice patterns to remain viable.

The very boldness of these changes has generated pressure to reverse course. In the current environment, the Congress will face difficult decisions that could pit particular interests against a more global interest in preserving Medicare for the long term. As PPSs are implemented for rehabilitation facilities and hospital outpatient services, and as SNFs continue their transition to full PPS rates, provider complaints about tight payment rates and impaired beneficiary access will continue to be heard. It is important that the implementation of these new payment mechanisms is monitored to ensure that the correct balance between appropriate beneficiary access and holding the line on Medicare spending is being achieved. Our work suggests that it would be premature at this juncture, however, to significantly modify the BBA's provisions without thorough analysis or a fair trial of the provisions over a reasonable period of time.

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

GAO CONTACT AND ACKNOWLEDGMENTS

For future contacts regarding this testimony, please call William J. Scanlon at (202) 512-7114. Individuals who made key contributions to this statement include Carol Carter and Walter Ochinko.

(101855)

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[9]For additional information on the impact of the home health IPS on beneficiary access, see Medicare Home Health Agencies: Closures Continue With Little Evidence Beneficiary Access Is Impaired (GAO/HEHS-99-120, May 26, 1999).

CBO TESTIMONY

Statement of
Paul N. Van de Water
Assistant Director
for Budget Analysis
Congressional Budget Office

on
the Impact of the Balanced Budget Act
on the Medicare Fee-for-Service Program

before the
Committee on Finance
United States Senate

June 10, 1999

NOTICE

This statement is not available for public release until it is delivered at 10:00 a.m. (EDT), Thursday, June 10, 1999.

CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

Mr. Chairman and Members of the Committee, I am pleased to represent the Congressional Budget Office (CBO) at this hearing on the fee-for-service portion of the Medicare program. After many years of rapid increases, the growth of Medicare spending has slowed sharply in the past two years. My statement discusses the reasons for that slowdown and presents CBO's assessment of future trends. I will make three main points:

- The greater-than-expected slowdown in the growth of Medicare spending stems mainly from successful efforts to combat fraud and from delays in payments to health care providers.

- With one exception, CBO's estimates of the effects of the Medicare provisions of the Balanced Budget Act (BBA) of 1997 still appear reasonable. CBO did not anticipate how home health agencies would implement the interim payment system for home health services, however, and may therefore have underestimated its savings.

- The factors that are holding down the growth of Medicare spending will be played out in the next few years, and more rapid growth will then resume.

TRENDS IN MEDICARE SPENDING

Between 1980 and 1997, Medicare spending increased at an average rate of 11 percent a year and expanded from 5 percent to 12 percent of the federal budget. Total outlays for Medicare rose by only 1.5 percent in 1998, however, and may decline in 1999. Part of that slowdown was anticipated; the Balanced Budget Act lowered the projected growth of Medicare spending by an estimated 4 percentage points in 1998. The BBA reduced payment rates for many services and restrained the update factors for payments through 2002. Both fee-for-service providers and Medicare+Choice plans are experiencing lower increases in payments as a result.

But the actual rate of spending growth is considerably slower than the BBA provisions alone were expected to produce. Other factors appear to have contributed to the sudden flattening of Medicare expenditures, including greater compliance with Medicare payment rules and a longer time for processing claims.

Widely publicized efforts to clamp down on fraud and abuse in the program have resulted in greater compliance by providers with Medicare's payment rules. Those efforts include more rigorous screening of claims by Medicare contractors and tougher enforcement of Medicare laws by the Departments of Justice and Health and Human Services. Through investigations and lawsuits, those agencies have pursued a wide range of providers—including hospitals, teaching physicians, home health

agencies, clinical laboratories, and providers of durable medical equipment—as well as Medicare contractors themselves. Although the total reduction in spending growth attributable to the improved compliance cannot be quantified, CBO estimates that one response alone to recent enforcement efforts—less aggressive billing by hospitals—lowered growth in Medicare spending by 0.75 percentage points in 1998.

The average time for processing Medicare claims rose dramatically in 1998. Expanded compliance activities, combined with major efforts to prepare computer systems for 2000, contributed to longer payment lags, which can have a substantial effect on Medicare outlays. An increase of one week, for example, in the average time for processing claims reduces Medicare outlays for the fiscal year by 2.3 percent. But that reduction is only temporary because the delay merely moves outlays into the next fiscal year.

CBO expects that improved compliance with payment rules and longer claims-processing times will have little or no effect on the rate of growth of Medicare spending in the longer run. Our projections assume that payment lags will begin to return to more typical levels late in 2000, with a catch-up in spending and a resumption of normal spending growth in 2001 and 2002 (see Table 1). Most of the projected increase over the next few years reflects rising expenditures per enrollee. The leading edge of the postwar baby boom will not reach age 65 until after 2010.

TABLE 1. MEDICARE OUTLAYS (By selected fiscal year)

	1990	1998	1999	2004	2009
In Billions of Dollars					
Gross Mandatory Outlays					
Benefits	107	210	212	298	443
Mandatory administration and grants[a]	b	1	1	1	1
Total	107	211	213	300	444
Premiums	-12	-21	-21	-34	-53
Mandatory Outlays Net of Premiums	96	190	192	266	391
Discretionary Outlays for Administration	2	3	3	4	4
All Medicare Outlays Net of Premiums	98	193	195	269	396
Average Annual Growth Rate from Previous Year Shown (Percent)					
Gross Mandatory Outlays		8.8	1.1	7.1	8.2
Premiums		7.5	3.4	9.7	9.3
Mandatory Outlays Net of Premiums		9.0	0.8	6.7	8.0
Discretionary Outlays for Administration		1.5	7.4	4.7	4.0
All Medicare Outlays Net of Premiums		8.8	0.9	6.7	8.0

SOURCE: Congressional Budget Office.

a. Mandatory outlays for administration support peer review organizations, certain activities against fraud and abuse, and grants to states for premium assistance.

b. Less than $500 million.

Projections of Spending and Enrollment in Medicare+Choice

Payments for Medicare+Choice plans in CBO's baseline soar from $37 billion in 1999 to $141 billion in 2009 as enrollment in those plans continues to expand. The spending increase also reflects the expected growth in expenditures per enrollee. CBO projects that risk-based plans will account for 16 percent of Medicare enrollees in 1999, 22 percent in 2004, and 31 percent in 2009, assuming that the second phase of risk adjustment is implemented on a budget-neutral basis.

Projections of Spending and Enrollment in the Medicare Fee-for-Service Program

CBO projects that spending in Medicare's fee-for-service program will increase from $175 billion in 1999 to $302 billion in 2009 (see Table 2). That growth will occur despite shrinkage in fee-for-service enrollment, which will decline by 1.5 million over the next decade, and cuts in the growth of payment rates for many services.

Spending growth for different services will vary considerably over the same period. The extent of the recent slowdown in spending has also varied by type of service, although spending for all services has been affected by the 1.9 percent drop in fee-for-service enrollment that occurred in 1998 and the further 0.8 percent decline expected in 1999.

TABLE 2. OUTLAYS FOR MEDICARE BENEFITS, BY SECTOR (By fiscal year)

Sector	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
					In Billions of Dollars							
Medicare+Choice[a]	32	37	41	49	48	60	70	88	88	108	124	141
Fee-for-Service												
Skilled nursing facilities	13	13	13	14	14	15	16	17	18	19	21	22
Home health	15	15	17	16	17	18	20	21	25	24	26	28
Hospice	2	2	2	2	3	3	3	3	3	3	4	4
Hospital inpatient[b]	87	86	91	95	99	104	108	112	117	123	129	135
Physicians' services	32	32	33	34	35	36	37	38	39	40	41	43
Outpatient facilities	17	16	17	18	20	21	23	25	26	28	30	33
Other professional and outpatient ancillary services	12	12	14	15	17	20	22	25	28	31	34	38
Subtotal	178	175	186	194	205	217	228	241	255	269	285	302
Total	210	212	228	243	253	277	298	328	343	378	409	443
					Annual Growth Rate (Percent)							
Medicare+Choice[a]	26.3	14.0	11.7	18.0	-1.3	25.0	16.7	24.7	0.8	22.8	14.6	13.4
Fee-for-Service												
Skilled nursing facilities	8.9	-3.8	1.7	5.3	5.1	6.4	6.0	6.4	6.5	6.4	6.4	6.4
Home health	-14.9	0.8	10.5	-5.8	10.1	6.6	7.2	7.9	7.8	7.4	6.8	6.6
Hospice	1.0	2.5	8.6	6.3	4.6	5.7	5.3	5.7	5.8	5.7	5.8	5.8
Hospital inpatient[b]	-2.5	-1.5	5.7	4.7	4.5	4.7	3.9	4.1	4.5	4.6	4.9	4.8
Physicians' services	3.0	0.6	4.2	2.3	2.4	3.4	2.6	2.8	3.0	3.0	3.3	3.5
Outpatient facilities	-5.5	-6.6	8.4	8.5	7.1	7.7	7.2	7.4	7.3	7.3	7.6	7.9
Other professional and outpatient ancillary services	0.7	0.6	14.0	13.0	12.5	13.2	12.3	12.3	12.1	11.0	10.7	10.2
All Fee-for-Service	-2.1	-1.4	6.4	4.4	5.5	5.8	5.2	5.5	5.8	5.8	5.9	5.9
All Medicare Benefits	1.4	1.0	7.3	6.8	4.1	9.5	7.7	10.0	4.4	10.1	8.4	8.2

SOURCE: Congressional Budget Office.

a. Includes spending for health maintenance organizations paid on a cost basis, certain demonstrations, and health care prepayment plans, which are paid on a cost basis for Part B services.

b. Includes subsidies for medical education that are paid to hospitals that treat patients enrolled in Medicare+Choice plans.

Postacute Care Services. Growth in payments for skilled nursing facility (SNF) and home health services—the fastest-growing areas of fee-for-service spending in Medicare during the decade preceding passage of the Balanced Budget Act—slowed significantly in 1998. The most dramatic change was in spending for home health care, which actually fell by 14.9 percent in 1998. SNF expenditures, by contrast, continued to rise but at less than half the rate of growth in 1997—8.9 percent compared with 21.1 percent. The slowdown in spending reflects the implementation of new prospective payment systems and increases in the time for processing claims.

The transition to prospective payment systems is expected to hold down the average annual rate of growth in these categories of spending through 2001. Spending is then projected to increase through 2009 at an average annual rate of 6.2 percent for SNF services and 7.5 percent for home health services.

Inpatient Hospital Services. Medicare payments for inpatient hospital services fell 2.5 percent in 1998, to $87 billion. The factors contributing to that drop include a decline in the volume of services provided (reflecting the drop in fee-for-service enrollment) and several provisions in the BBA that froze payment rates for most operating costs, reduced capital-related payment rates by 17.8 percent, and cut subsidies for medical education. In addition, the case-mix index—a measure of the relative costliness of the cases treated in hospitals paid under the prospective payment system—fell 0.5 percent in 1998. Much of that unprecedented drop in the

index is probably attributable to widespread adoption by hospitals of less aggressive billing practices following antifraud initiatives that focused on those practices.

For most hospitals, the BBA limits cumulative increases in payment rates for operating costs to about 6 percentage points below inflation over the 1999-2002 period. CBO projects that the limit on rate increases, in combination with declining fee-for-service enrollment, will result in a 1.5 percent drop in payments for hospital inpatient services in 1999. Those payments are projected to begin rising in 2000, with annual growth rates averaging 4.5 percent from 2000 through 2009.

Physicians' Services. Medicare payments for physicians' services rose 3.0 percent in 1998, to $32 billion. Payments are projected to remain flat in 1999 and to grow at an average annual rate of 2.8 percent over the next decade, reaching $43 billion in 2009. That growth rate is a result of payment formulas enacted in the BBA that tie the growth of per-enrollee expenditures for physicians' services to the growth of gross domestic product per capita. Those formulas generate annual rate changes that oscillate widely around a smooth trend. CBO projects stable growth rates, however, because the timing of those oscillations is impossible to predict.

Outpatient Services. Payments to outpatient facilities—such as hospital outpatient departments, dialysis facilities, and rural health clinics—fell by 5.5 percent in 1998 and are projected to decline another 6.6 percent in 1999. Those reductions result

largely from lower payment rates accompanying the transition to a prospective payment system for hospital outpatient services. Outpatient payments are projected to rebound in 2000 and grow at annual rates of 7 percent or more for the rest of the decade.

Spending for outpatient therapy services and other outpatient ancillary services—including pharmaceuticals, durable medical equipment, and chiropractic care—rose only 0.7 percent in 1998 as a result of reductions in payment rates and a cap on payments for therapy services performed outside hospitals. Projected payments for nonphysician professional services and outpatient ancillary services will grow only slightly in 1999 before taking off again in 2000. Annual spending growth is expected to average 11.3 percent from 1999 through 2009.

EFFECTS OF THE BALANCED BUDGET ACT

In January 1997, CBO projected that net mandatory outlays for Medicare would grow from $189 billion in 1997 to $288 billion in 2002. That January 1997 baseline was the basis for CBO's estimate of the savings from the BBA. CBO estimated that the BBA would reduce net mandatory spending for Medicare by $6 billion in 1998, $41 billion in 2002, and $112 billion over the 1998-2002 period. As a result, in its August 1997 analysis of the BBA, CBO projected that net mandatory outlays for

Why the Projections Have Changed

Each year CBO updates its budget projections to account for legislative changes, updated economic assumptions, and other new information. Since the enactment of the BBA, the only noticeable legislative effect on Medicare spending has been the modification of home health payment rates included in last year's omnibus appropriation bill (Public Law 105-277). CBO estimated that legislation will increase Medicare outlays by $2 billion in 2000 and reduce them by $1 billion in 2001. CBO's current projections of inflation rates are slightly lower than they were in January 1997. Those lower inflation rates account for about $3 billion of the annual differences between the August 1997 and March 1999 projections.

Most of the difference between the two sets of projections is attributable to new information—most notably the unanticipated slowing of spending growth in 1997 and 1998 resulting from improved compliance with Medicare payment rules. In essence, the 1997 projections were too high because CBO did not anticipate the full effects of Operation Restore Trust—Medicare's program to combat fraud. CBO also did not foresee the increasing lag in 1998 and 1999 between when services are furnished and when payment is made and implementation of adjustments to payments to Medicare+Choice plans on the basis of risk in a manner that will reduce spending.

Medicare would grow to $247 billion in 2002, rather than the $288 billion projected the previous January (see Table 3).

CBO's current baseline, prepared in March 1999, projects that net mandatory Medicare spending will grow from $192 billion in 1999 to $227 billion in 2002. Those figures are $18 billion and $20 billion, respectively, below the levels projected in August 1997.

TABLE 3. COMPARISON OF AUGUST 1997 AND MARCH 1999 PROJECTIONS OF NET MANDATORY OUTLAYS FOR MEDICARE (By fiscal year, in billions of dollars)

	1997	1998	1999	2000	2001	2002
January 1997 Projection	189	206	226	250	261	288
Minus Effects of Balanced Budget Act	0	-6	-16	-29	-20	-41
August 1997 Projection	189	200	210	220	241	247
March 1999 Projection	187	190	192	206	219	227
March 1999 Projection Minus August 1997 Projection	-1	-9	-18	-15	-22	-20

SOURCE: Congressional Budget Office.

NOTE: Numbers may not add up to totals because of rounding.

CBO has not revised its estimates of the effect of the BBA on Medicare spending. With one possible exception, CBO believes that its estimates of the Balanced Budget Act were reasonable.

Spending for Home Health Services

The one policy for which CBO may have significantly underestimated savings is the interim payment system for home health agencies. CBO's current projection of outlays for home health services is much lower than projected in August 1997. Those lower projections are largely attributable to new information about the effects of Operation Restore Trust and other antifraud initiatives and to increases in the lag between when services are furnished and when payment is made; they do not fully incorporate our revised assessment of the effects of the interim payment system.

Lower payments for home health services also explain most of the shortfall in Medicare spending so far this year. Some of the drop in home health spending stems from longer payment lags resulting from a new method of processing claims known as sequential billing, in which a claim is paid only if all prior claims have been processed. Medicare will suspend that billing process in July, which should increase spending during the last quarter of the fiscal year. In addition, the use of home health services seems to have dropped substantially, probably as a result of

both antifraud activities and an unexpectedly cautious response by home health agencies to the per-beneficiary limit under the interim payment system. That limit applies to aggregate payments: payments for individual beneficiaries may exceed the limit as long as the average payment for all beneficiaries served by an agency does not exceed the per-beneficiary limit. Some agencies, however, apparently believe that the limit applies to each beneficiary and are cutting off services to patients who have reached the per-beneficiary limit. Thus, the average payment per beneficiary is well below the allowable amount.

CONCLUSION

CBO is currently updating its projections of Medicare spending and will release them on July 1, as called for in the budget resolution. Because the rate of Medicare spending through May of this year has been lower than CBO estimated in March (and about 2½ percent below the rate for the first eight months of last year), the July projections of Medicare spending in 1999 and 2000 will probably be several billion dollars lower than the March estimates.

Medicare will replace the interim payment system for home health services with a prospective payment system in 2001. Because that system will remove much of the uncertainty about payments that has contributed to the current apparent drop in utilization, spending for home health services could rebound in 2001 and

subsequent years. Therefore, CBO does not now anticipate significantly revising its projections of spending on home health services—or other categories of services—beyond 2000. CBO expects that total Medicare spending will resume growing at an average rate of 7 percent to 8 percent a year in the decade after 2000.