



# Medicare Provisions in the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33)

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## Summary

Medicare is a nationwide health insurance program now covering 38 million aged and disabled persons. Total program outlays in FY1998 are estimated at \$230.1 billion; net Medicare outlays (after deduction of beneficiary premiums) are estimated at \$208.6 billion. Medicare consists of two parts. The Part A program covers hospital services, skilled nursing facility (SNF) services and home health care. Part B covers physicians services, laboratory tests, durable medical equipment, outpatient hospital services, and other medical services.

The ability of Medicare's current financing structure to adequately fund program growth has been of concern for many years. The Part A trust fund had been projected to become insolvent in 2001. In that year, revenues coming into the trust fund (primarily payroll taxes), together with any balance carried over from prior years, would have been insufficient to cover the payment for Part A benefits in that year. Unlike Part A, because of the way it is financed, Medicare Part B has not faced insolvency. However, policymakers have also been concerned with the rapid growth in Part B payments and the impact of this growth on general revenue spending and the federal budget deficit. Further compounding the funding problems is the fact that the large babyboom population will start to become eligible for Medicare in 2011.

On May 15, 1997, the President and congressional leaders agreed to a Bipartisan Budget Agreement designed to reduce the budget deficit to zero by 2002. The agreement, subsequently included in the FY1998 Budget Resolution, provided for Medicare savings of \$115 billion over the FY1998-FY2002 period. On June 25, 1997, the House and Senate each passed bills (the Balanced Budget Act of 1997, BBA 97) which included these savings. The conference agreement passed the House July 30, 1997, and the Senate July 31, 1997. It was signed into law as P.L. 105-33 on August 5, 1997.

The BBA 97 achieves the target savings by slowing the rate of growth in payments to hospitals, physicians, and other providers; and by establishing new payment methodologies for skilled nursing facilities, home health agencies, and other service categories. These savings reduce the average annual rate of growth in net Medicare spending from 8.8% to 5.5% for the period FY1997-FY2002. The measure also provides coverage for additional preventive benefits. It further extends the solvency of the Part A trust fund through FY2009. The proposed Senate plans to introduce means testing into the Part B program and to increase the eligibility age were not included in the final package.

The BBA 1997 establishes the Medicare+Choice program which expands private plan options to include preferred provider organizations (PPOs), provider sponsored organizations (PSOs), and private fee-for-service plans. It modifies the way payments are made to health maintenance organizations (HMOs). Further, under a demonstration program, a limited number of beneficiaries would also be able to establish medical savings accounts (MSAs) in conjunction with a high deductible plan.

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## **Introduction: Overview of Medicare**

### **Coverage**

Medicare is the nation's health insurance program for the elderly and disabled. It is a non-means tested program; there are no income or assets tests for coverage. Medicare consists of two parts—Part A (Hospital Insurance) program and Part B (Supplementary Medical Insurance) program. Almost all persons over age 65 are automatically entitled to Medicare Part A. Part A also provides coverage, after a 24-month waiting period, for persons under age 65 who are receiving Social Security cash benefits on the basis of disability. Most persons who need a kidney transplant or renal dialysis may also be covered, regardless of age. In FY1997, Part A will cover an estimated 38.1 million aged and disabled persons (including those with chronic kidney disease).

Medicare Part B is voluntary. All persons over age 65 and all persons enrolled in Part A may enroll in Part B by paying a monthly premium—\$43.80 in 1997. In FY1997, Part B will cover an estimated 36.6 million aged and disabled persons.

### **Benefits**

Part A provides coverage for inpatient hospital services, up to 100 days of post-hospital skilled nursing facility (SNF) care, home health services and hospice care. Patients must pay a deductible (\$760 in 1997) each time their hospital admission begins a benefit period. (A benefit period begins when a patient enters a hospital and ends when he or she has not been in a hospital or SNF for 60 days.) Medicare pays the remaining costs for the first 60 days of hospital care. The limited number of beneficiaries requiring care beyond 60 days are subject to additional charges. Patients requiring SNF care are subject to a daily coinsurance charge for the 21<sup>st</sup> through the 100<sup>th</sup> day (\$95 in 1997). There are no cost-sharing charges for home health care and limited charges for hospice care.

Part B provides coverage for a complimentary set of health services including physicians' services, laboratory services, durable medical equipment, outpatient hospital services and other medical services. The program generally pays 80% of Medicare's fee schedule or other approved payment amount after the beneficiary has met the annual \$100 deductible. The beneficiary is liable for the remaining 20%.

### **Payments for Services**

The majority of Medicare enrollees obtain services under a fee-for-service system. Under fee-for-service, beneficiaries obtain covered services through providers of their choice and Medicare makes payments for each service rendered. The amount of payment per service is generally subject to certain limits.

Taken together, spending for inpatient hospital and physicians' services account for close to 70% of Medicare benefit payments. Medicare makes payments for inpatient hospital services under a prospective payment system (PPS); a predetermined rate is paid for each inpatient stay based on

the patient's admitting diagnosis. Payments for physicians' services are made on the basis of a fee schedule. Specific payment rules are also used for other services.<sup>1</sup>

## **Medicare and Managed Care**

Managed care encompasses a wide variety of arrangements, including health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Typically managed care plans control costs by restricting an enrollee's choice of provider or by giving enrollees strong financial incentives to choose particular providers. They also reduce costs by managing enrollees' use of services. They may reduce unnecessary hospitalizations, diagnostic tests, or specialty referrals, either by giving participating physicians a financial stake in the cost of the services they order or through programs that review the use of services. Managed care plans may also select low-cost providers of services or negotiate discounted rates from providers.

HMOs are the oldest type of managed care organization. Like traditional insurers, an HMO accepts financial responsibility for a defined set of health care benefits in return for a fixed monthly per capita premium paid by or on behalf of each enrolled member. Unlike other insurers, an HMO directly provides or arranges for services through affiliated physicians, hospitals, and other network providers, instead of simply paying bills. Generally, an HMO controls access to covered benefits through a primary care gatekeeper.

Medicare has been authorized to contract with HMOs since 1972, but the major managed care program, the Medicare risk contract program, dates to 1982 with the passage of the Tax Equity and Fiscal Responsibility Act (TEFRA). This is why risk contracts are also known as TEFRA risk contracts. The intent of TEFRA was to enable beneficiaries to enroll in managed care organizations as an alternative to traditional fee-for-service Medicare, and also to capture efficiencies of HMOs and thus save Medicare money.

Enrollment of beneficiaries in Medicare managed care has grown significantly, from about 4% in 1985 to over 13% of Medicare beneficiaries by the end of 1996. Most Medicare managed care enrollment is in risk contract plans. The remainder are enrolled in HMOs that are paid on the basis of actual costs or are in HMOs or other types of managed care organization participating in Medicare demonstration programs.

Each risk HMO is paid a predetermined monthly amount (called the adjusted average per capita cost or AAPCC) for each Medicare enrollee regardless of the amount of Medicare covered services the enrollee uses. The HMO is at risk for providing any necessary services to the enrollee which may exceed the Medicare payment.

With certain exceptions, a Medicare beneficiary who enrolls in a risk contract plan must obtain all Medicare covered services through that plan. The beneficiary may be charged the usual cost-sharing charges or pay the equivalent in the form of a monthly premium to the organization. Beneficiaries share in any projected savings to the risk contract HMO through the provision of benefits in addition to those included in the Medicare benefit package.

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<sup>1</sup> For additional information on these rules see U.S. Library of Congress. Congressional Research Service. *Medicare Reimbursement Policies*. CRS Report 97-602, by Celinda Franco, et al, May 28, 1997. Washington, 1997.

## **Administration**

Medicare is administered by the Health Care Financing Administration (HCFA) within the Department of Health and Human Services (HHS). Much of the day-to-day work of reviewing claims and making payments is done by intermediaries (for Part A) and carriers (for Part B). These are commercial insurers or Blue Cross and Blue Shield Plans.

## **Financing**

Medicare Part A is financed primarily through a payroll tax levied on current workers and their employers. In 1997, employers and employees each pay a tax of 1.45% on all earnings. (The self-employed pay a single tax of 2.9% on earnings.)

Part B is financed through a combination of monthly premiums levied on program beneficiaries and federal general revenues. In 1997, the premium is \$43.80. Beneficiary premiums have generally represented about 25% of Part B costs; federal general revenues (i.e., tax dollars) account for the remaining 75%.

## **Outlays**

In FY1996, total Medicare outlays were \$194.3 billion; net Medicare outlays (i.e., net of premiums beneficiaries pay for enrollment, largely for Part B) were \$174.2 billion. **Table 1** provides historical spending data for Medicare.

The Congressional Budget Office (CBO) estimates, using its January 1997 baseline, that under current law Medicare outlays would total \$230.1 billion in FY1998; estimated net Medicare outlays would be \$208.6 billion. Under current law, total spending would grow to \$468.7 billion by 2007; net spending would increase to \$436.4 billion. (See **Table 2**.)

**Table I. Medicare Outlays**

(\$ in millions)

Fiscal year	Part A	Part B	Total Medicare outlays	Medicare premiums offsets	Net Medicare outlays
1970	\$4,953	\$2,196	\$7,149	(\$936)	\$6,213
1975	10,612	4,170	14,782	(1,907)	12,875
1980	24,288	10,746	35,034	(2,945)	32,089
1985	48,677	22,730	71,397	(5,562)	65,835
1990	66,687	43,022	109,709	(11,607)	98,102
1991	70,742	47,021	117,763	(12,174)	105,589
1992	81,971	50,285	132,256	(13,232)	119,024
1993	91,604	54,254	145,858	(15,305)	130,553
1994	102,770	59,724	162,494	(17,747)	144,747
1995	114,883	65,213	180,096	(20,241)	159,855
1996	125,300	68,900	194,300	(20,000)	174,200

Source: Office of Management and Budget and HHS.

**Table 2. Estimated Medicare Outlays Under Current Law (Prior to Enactment of BBA), FY1997-FY2007**

(in billions)

Fiscal year	Part A outlays	Part B outlays	Total outlays	Premium receipts	Net outlays
1997	137.4	74.6	212.0	-20.2	191.8
1998	148.6	81.5	230.1	-21.4	208.6
1999	161.1	90.3	251.4	-22.4	228.9
2000	176.5	99.8	276.3	-23.4	252.9
2001	184.5	104.7	289.2	-24.5	264.7
2002	201.7	115.7	317.4	-25.6	291.8
2003	217.5	125.7	343.2	-26.7	316.5
2004	234.7	137.6	372.3	-28.0	344.3
2005	259.4	154.6	414.0	-29.3	384.7
2006	275.1	166.9	442.0	-30.7	411.3
2007	289.7	178.9	468.7	-32.3	436.4
Average rate of growth	7.74%	9.14%	8.26%	4.81%	8.57%

Source: Congressional Budget Office (CBO), January 1997 baseline.

## Issues

Medicare is the second largest social welfare program in the federal budget, exceeded only by the Social Security program. It is an open-ended entitlement program that pays for as many medical services as the eligible population needs. Between 1980 and 1996, spending increased at an average annual rate of 11.2% and its share of the federal budget increased from 5.4% to 11.2%. Net Medicare outlays represented about 54% of total federal spending on health programs of various kinds in FY1996. Medicare is expected to continue to grow at a rapid pace. CBO estimated (using its January 1997 baseline) that, under the law in effect prior to the enactment of BBA, net Medicare outlays would increase at an average rate of 8.6% over the FY1997-FY2007 period.

The ability of Medicare's current financing mechanisms to adequately fund program growth has been of concern for many years. Since 1970, the Medicare trustees have been predicting the impending insolvency of the Part A trust fund; however, 1995 was the first year that the insolvency of the trust fund became a major part of the budget debate. The trust fund was projected to become insolvent in 2001. In that year, revenues coming into the trust fund (primarily payroll taxes), together with any balance carried over from prior years, would have been insufficient to cover the payment for Part A benefits in that year.<sup>2</sup> Unlike Part A, Medicare Part B has not faced insolvency because of the way it is financed. However, policymakers have also been concerned with the rapid growth in Part B payments and the impact of this growth on general revenue spending and the federal budget deficit.

Addressing the Part A insolvency issue has been only one of the concerns facing Medicare. Beginning in 2011, Medicare will begin to experience the impact of major demographic changes. First, baby boomers (persons born between 1946 and 1964) begin turning age 65. Second, there is a shift in the number of workers supporting persons receiving benefits under Part A. In 1996, there were 3.9 workers per beneficiary. The ratio is expected to decline to 2.3 by 2030.

Because of its rapid growth, both in terms of aggregate dollars and as a share of the federal budget, the Medicare program has been a major focus of deficit reduction legislation passed by the Congress since 1980. With a few exceptions, reductions in program spending have been achieved largely through reductions in payments to providers, primarily hospitals and physicians. These reductions stemmed, but did not eliminate, the year-to-year increases in Medicare outlays. The 104<sup>th</sup> Congress also considered, but did not enact legislation which would have achieved significant Medicare savings through reductions in the rate of growth in payments to providers and a cap on spending.<sup>3</sup> During the debate, considerable attention was also given to expanding the options available to beneficiaries for obtaining covered services and restructuring the program to make it work more like the private insurance market.<sup>4</sup>

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<sup>2</sup> For a further discussion of Part A financing issues, see U.S. Library of Congress. Congressional Research Service. *Medicare: Financing the Part A Hospital Insurance Program*. CRS Report 95-650, by Jennifer O'Sullivan, May 16, 1997. Washington, 1997.

<sup>3</sup> For a further discussion of the Medicare debate in the 104<sup>th</sup> Congress, see U.S. Library of Congress. Congressional Research Service. *Medicare: 104<sup>th</sup> Congress*. CRS Report 96-866, by Jennifer O'Sullivan and Richard Price, October 30, 1996. Washington, 1996.

<sup>4</sup> For a further discussion of Medicare restructuring issues, see U.S. Library of Congress. Congressional Research Service. *Medicare: The Restructuring Debate in the 104<sup>th</sup> Congress*. CRS Report 97-102, by Beth Fuchs, et al, January 9, 1997. Washington, 1997.

The BBA 97 achieves Medicare savings by slowing the rate of growth in payments to hospitals, physicians, and other providers; and by establishing new payment methodologies for skilled nursing facilities, home health agencies, and other service categories. It further extends the solvency of the Part A trust fund through 2006.

BBA 97 also includes provisions to increase the private plan options available to beneficiaries. While these new options will include fee-for-service arrangements, they will also include managed care plans such as preferred provider organizations and provider sponsored organizations. The agreement also changes the methodology used to pay such plans. The government will continue to set rates for plans. Such rates, however, should better reflect the actual cost of delivering health care in local areas than is the case today. The conference agreement largely reflects a perspective that increased managed care enrollment for Medicare will help slow the rate of growth in Medicare expenditures. This perspective is, in part, encouraged by the experiences of the private sector, where the rapid movement of large group health plans from fee-for-service into managed care has helped to slow the rate of medical care inflation. (In 1987, only 27% of participants in employer plans were enrolled in managed care plans. By 1996, 74% of participants in such plans were enrolled in managed care plans.<sup>5</sup>) While this change is not regarded by everyone as positive (concerns exist, for example, that the growth of managed care has reduced access to services for lower-income populations), the BBA 1997 shows that substantial support exists for trying to restructure Medicare to make it work more like the large group private insurance market.

While the BBA 97 achieves significant savings, it does not address the longer term funding problems that will be exacerbated when the baby boom generation begins to receive program benefits. The question of how to address these issues, including the possibility of significant structural reforms, will be considered by a new National Commission Bipartisan Commission on the Future of Medicare. This Commission, authorized under BBA 97, is required to report its recommendations by March 1, 1999.

## **President's FY1998 Medicare Budget**

The President transmitted the FY1998 Budget to Congress on February 6, 1997. At that time, the Administration estimated that the Medicare provisions would save \$100 billion over the 5-year period, FY1998- FY2002. In March, the Administration made a few modifications to its plan and reestimated the savings at \$106.1 billion; CBO estimated the savings at \$81.6 billion. The proposed savings would be achieved by slowing the rate of growth in payments to hospitals, physicians, and other providers; establishing new payment methodologies for SNFs and home health agencies; and providing flexibility to Medicare to enable it to be a more prudent purchaser of certain services and supplies. Significant savings would also be achieved by making changes in Medicare's payments to HMOs. The budget also provided coverage for additional preventive benefits.<sup>6</sup>

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<sup>5</sup> KPMG Peat Marwick. *Health Benefits in 1996*. Washington, 1996.

<sup>6</sup> For a further discussion of the President's FY1998 Budget see U.S. Library of Congress. Congressional Research Service. *Medicare: President's FY1998 Budget*. CRS Report 95-650, by Jennifer O'Sullivan, Celinda Franco, Beth Fuchs, and Richard Price, April 15, 1997. Washington, 1997.

## **Congressional Action**

### **Bipartisan Budget Agreement; Budget Resolution**

On May 15, 1997, the President and congressional leaders agreed to a Bipartisan Budget Agreement designed to reduce the budget deficit to zero by 2002. The agreement provided for Medicare savings of \$115 billion over the FY1998-FY2002 period. While most of the specifics would be developed by the congressional authorizing committees (namely the House Ways and Means and Commerce Committees and the Senate Finance Committee), it did include several specific elements. These included: (1) extension of the solvency of the Part A trust fund for 10 years through a combination of savings and structural reform (including the reallocation of some home health spending from Part A to Part B); (2) giving beneficiaries more choices among competing health plans, such as PSOs and PPOs; (3) providing beneficiaries with comparative information about their options; (4) maintaining the Part B premium at 25% of program costs and phasing-in over 7 years the inclusion of the new home health spending in the calculation of the premium; (5) reforming the managed care payment methodology to address geographic disparities; (6) establishing prospective payment methodologies for such services as home health, SNF and hospital outpatient services; and (7) providing funding for new health benefits including: (i) expanding mammography coverage; (ii) coverage for colorectal screenings; (iii) coverage for diabetes self-management; and (iv) higher payments to providers for preventive vaccinations to the extent it will lead to greater use by beneficiaries. Further, the agreement called for a \$4 billion investment over 5 years and \$20 billion over 10 years to limit beneficiary copayments for outpatient services, unless there is a more cost-effective way to provide such services to beneficiaries as mutually agreed.

On June 5, 1997, the House and Senate gave final agreement to the conference report on the FY1998 Budget Resolution (H.Con.Res. 84). This measure incorporated the Bipartisan Budget Agreement; it also set out the level of spending reductions that the various congressional committees were required to meet. The Committees were required to develop specific legislation to meet these reconciliation instructions and to transmit the legislation to the House and Senate Budget committees. The Budget committees would then incorporate the recommendations into a budget reconciliation measure.

### **Budget Reconciliation**

#### **House and Senate Action**

The House Ways and Means Committee (which has jurisdiction over the entire Medicare program) ordered reported the Medicare portion of its budget reconciliation recommendations on June 9, 1997. The House Commerce Committee (which shares jurisdiction over Medicare Part B) ordered reported its Medicare recommendations on June 12, 1997. Provisions affecting only Part A were included only in the Ways and Means Committee package. Provisions which affect Part B only or both Parts A and B were included in both the Ways and Means and Commerce Committee packages. The Ways and Means and Commerce reported provisions were generally either very similar or were identical. Both measures were forwarded to the House Budget Committee. The Budget Committee reported the Balanced Budget Act of 1997, H.R. 2015, on June 24, 1997

(H.Rept. 105-149); the reported measure contained both the Ways and Means and Commerce provisions. The House passed the bill on June 25, 1997.

The Senate Finance Committee (which has sole jurisdiction over Medicare in the Senate) ordered reported its Medicare package on June 18, 1997. The package was forwarded to the Senate Budget Committee. The Budget Committee reported the Balanced Budget Act of 1997 (S. 947) on June 20, 1997 without written report. (A report of the Finance Committee recommendations is contained in S.Rept. 105-29.) The Senate passed the bill, as amended, on June 25, 1997. It substituted the text of S.947 into the text of H.R. 2015. A conference to resolve the differences between the House and Senate measures is slated to begin July 10, 1997.

Many of the provisions in the House and Senate bills were similar to provisions incorporated in the Balanced Budget Act of 1995 (which was vetoed by the President) and the President's FY1998 Budget, although the level of savings was lower.

### **Conference Action, Final Passage, and Public Law**

House-Senate conferees began meeting on July 10, 1997. On July 29, 1997, they announced that they had reached agreement on both the spending and tax components of the budget agreement. The conference report was filed on July 29, 1997 (H.Rept. 105-217). It passed the House on July 30, 1997 and the Senate July 31, 1997. It was signed into law by the President as P.L. 105-33 on August 5, 1997.

## **Summary of the Medicare Provisions of BBA 97**

The following sections summarize the major Medicare provisions of the Balanced Budget Act of 1997 (BBA 97) as enacted into law. **Table 7** and **Figure 1** at the end of this report shows that most of the estimated savings from the law come from reductions in payments to providers. **Table 8** shows the impact of these savings on the annual rate of growth in Medicare spending. BBA 97 lowers the average annual rate of growth in net Medicare spending from 8.84% to 5.55% over the FY1997-FY2002 period.

### **Part A**

#### **Hospitals**

##### *Annual Hospital Payment Updates*

*Current Law.* Medicare pays most acute care hospitals under a PPS. A fixed predetermined amount is paid according to the patient's diagnosis. Payments to PPS hospitals are updated annually using an update factor which is determined in part by the projected increase in the hospital market basket index (MBI) which measures the cost of goods and services purchased by hospitals.

*BBA 97.* The BBA 97 includes a 0% update for FY1998; the MBI minus 1.9 percentage points for FY1999; the MBI minus 1.8 percentage points for FY2000; the MBI minus 1.1 percentage points for FY2001 and FY2002; and for FY2003 and each subsequent fiscal year, the MBI percentage

increase for all hospitals in all areas. The BBA 97 also includes a provision which sets a higher update for certain non-teaching, non-DSH, and non-Medicare dependent hospitals to provide these hospitals with temporary relief. In FY1998, these hospitals will receive a payment update equal to the update provided that year for all other hospitals plus 0.5 percentage points; for FY1999, a payment update equal to the update for that year provided for all other hospitals plus 0.3 percentage points.

### ***Hospital Capital Payments***

*Current Law.* Medicare pays its proportionate share of certain hospital capital-related costs. Capital-related costs primarily include interest and depreciation related to construction of facilities and purchase of equipment. A 10-year transition to fully prospective payments for capital costs began in FY1992, during which capital payments are paid prospectively based on average capital costs per case in FY1989, updated for inflation and other cost changes.

From FY1992 through FY1995, HCFA updated base payment rates using a moving average of capital cost increases in previous years. During this period, the Congress required HCFA to adjust the payment rates in each year so that anticipated aggregate capital payments would equal 90% of anticipated aggregate costs. This provision expired on September 30, 1995, resulting in a 20.6% increase in the federal capital payment rate for FY1996.

Under current law, Medicare provides for establishing an appropriate allowance for depreciation and interest on capital indebtedness and a return on equity capital when a hospital or SNF has undergone a change of ownership. The valuation of the asset is the lesser of the allowable acquisition costs of the asset to the owner of record, or the acquisition cost of such asset to the new owner.

*BBA 97.* The BBA 97 requires the Secretary to rebase the capital payment rates for discharges occurring on or after October 1, 1997, by the actual rates in effect in FY1995, so that aggregate capital payments will equal 90% of what payments would have been under reasonable cost payments, with an additional reduction in the capital payment rate of 2.1%. The BBA 97 eliminates the allowance for return on equity capital. In addition, when a facility undergoes a change of ownership, the BBA 97 provides for a depreciation adjustment of the historical cost of the asset recognized by Medicare, less depreciation allowed, to the owner of record as of the date of enactment, or to the first owner of record of the asset in the case of an asset not in existence as of the date of enactment.

### ***Definition of Hospital "Transfer"***

*Current Law.* PPS hospitals that move patients to PPS-exempt hospitals and distinct-part units, or skilled nursing facilities (SNFs) are currently considered to have "discharged" the patient and receive a full diagnosis related group (DRG) payment. In the case of a hospital transferring a patient to another hospital, the DRG payment to the hospital "sending" a patient to a second hospital is reduced and the hospital is paid a per diem rate, while payment in full is made to the second hospital which completes the patient's hospital care and discharges the patient. The transfer policy is applicable only when an acute care hospital transfers a patient to another acute care hospital.

*BBA 97.* The BBA 97 provides that for discharges occurring on or after October 1, 1998, discharges that fall within a specified group of 10 DRGs selected by the Secretary with the greatest number of cases and that have lengths of stays below the average will be treated as a transfer for payment purposes. The provision applies to patients transferred from a PPS hospital to a PPS-exempt hospital or unit, SNF, discharges with subsequent home health care provided within an appropriate period (as defined by the Secretary), and for discharges occurring on or after October 1, 2000, additional post discharge services included by the Secretary.

Payments to PPS hospitals will be fully or partially based on Medicare's current payment policies applicable to patients transferred from one PPS hospital to another PPS hospital (per diem rates). For cases where a substantial portion of the cost of care is incurred in the early days of a hospital stay, the Secretary may not pay a provider more than the sum of 50% of the transfer per diem payment amount and 50% of the total DRG payment amount. For FY2001, the Secretary is required to publish a proposed rule which includes a description of the effect of the transfer policy and a description of additional post-discharge services specified by the Secretary in addition to the 10 diagnosis-related groups originally selected under this policy.

### ***Rural Hospital Provisions***

*Current Law.* The Medicare program includes special payments for certain rural hospitals in order to maintain beneficiary access to health care services and providers.

*BBA 97.* The BBA 97 includes several rural initiatives. The new law replaces and modifies the Essential Access Community Hospital (EACH) program with the Medicare Rural Flexibility Program (MRFP), and provides for the transition and conclusion of the Medical Assistance Facility (MAF) program in Montana. The MRFP is available in all states and authorizes appropriations of \$25 million per year in FY1998-FY2002, for MRFP grants to states to establish networks for improving access to health care services in rural communities. Also included is a new single designation for small rural, limited-service hospitals, referred to as Critical Access Hospitals (CAHs). These hospitals are required to be state certified, be located more than 35 miles from another hospital, provide 24-hour emergency services, and have up to 15 acute care inpatient beds for providing hospital stays of no more than 96 hours. CAHs are reimbursed on a reasonable cost basis, as are the EACH and RPCH hospitals in effect on September 30, 1997, and those facilities participating in the Medical Assistance Facility (MAF) demonstration program.

Under the BBA 97, hospitals designated as rural referral centers (RRCs) since FY1991 are permanently classified as RRCs. In addition, the Medicare Dependent Hospital (MDH) program is extended until October 1, 2001. The new law also requires the Secretary to make Medicare Part B payments for professional consultation via telecommunications system by no later than January 1, 1999, for services provided to Medicare beneficiaries residing in a rural county that is not adjacent to a Metropolitan Statistical Area. A new demonstration project on informatics, telemedicine and education is also authorized. The BBA 97 does not, however, include a provision allowing SCHs the option of choosing an alternative target amount based on operating costs in FY1994 or FY1995.

### ***Graduate Medical Education (GME) Payments***

*Current Law.* Medicare pays teaching hospitals for its share of the costs of providing GME. Direct graduate medical education (direct GME) payments are based on a hospital's per resident

costs (i.e., resident and faculty salaries and fringe benefits, and overhead costs related to teaching activities) and the number of full-time-equivalent residents the hospital employs. The indirect costs are reimbursed through the indirect medical education (IME) adjustment. This adjustment is designed to compensate teaching hospitals for their relatively higher costs attributable to the involvement of residents in patient care and the patients requiring specialized services available only in teaching hospitals. The IME adjustment currently increases Medicare's hospital payments by approximately 7.7% for each 10% increase in a hospital's ratio of interns and residents to beds.

*BBA 97.* The BBA 97 includes a reduction in the IME adjustment from the current 7.7% to 7.0% in FY1998; to 6.5% in FY1999; to 6.0% in FY2000; and to 5.5% in FY2001 and subsequent years.

In addition, the BBA 97 includes: (1) a cap on the total number of residents reimbursed under Medicare at the level for the cost reporting period ending on or before December 31, 1996; (2) payments to qualified non-hospital providers for the direct GME costs of the program including Federally Qualified Health Centers, rural health clinics, MedicarePlus organizations, and other appropriate providers; (3) incentive payments to teaching hospitals to voluntarily reduce the number of medical residents in training; (4) a demonstration project under which direct GME payments are to be made to qualifying consortia that consist of a teaching hospital and one or more specified entities who operate an approved medical residency training program; (5) a study on the variations in the costs of hospital overhead and supervisory physician medical education costs among hospitals; and (6) the requirement that MedPAC make recommendations on long-term payment policies regarding teaching hospitals and GME.

### ***Disproportionate Share Hospital (DSH) Payments***

*Current Law.* Additional payments are made to hospitals that serve a disproportionate share of low-income patients. A hospital's disproportionate patient percentage is defined as the hospital's total number of inpatient days attributable to federal Supplemental Security Income (SSI) Medicare beneficiaries divided by the total number of Medicare patient days, plus the number of Medicaid patient days divided by the total patient days.

*BBA 97.* The BBA 97 includes reductions in the current DSH payment formula amounts of 1% for FY1998; 2% in FY1999; 3% in FY2000; 4% in FY2001; 5% in FY2002; and 0% in FY2003 and each subsequent fiscal year. The BBA 97 also requires the Secretary to submit to the House Ways and Means and Senate Finance Committees, no later than 1 year after enactment, a report that contains a new formula for determining additional DSH payments to hospitals, but the Secretary is not required to look at uncompensated care and charity care in developing the formula.

### ***Payment to Teaching and Disproportionate Share Hospitals (DSHs) From Managed Care Rates***

*Current Law.* Medicare includes in its calculation of payment rates to Medicare risk-contract HMOs additional payments to teaching hospitals operating residency training programs and to hospitals that serve a disproportionate share of low-income persons.

*BBA 97.* The BBA 97 includes a carve out of the direct GME and IME payments from amounts paid to Medicare risk-contract HMOs for FY1998-FY2002. These amounts are to be distributed directly to teaching hospitals. The payments are to be phased in over 5 years in amounts equal to

20% in 1998; 40% in 1999; 60% in 2000; 80% in 2001; and 100% in 2002. The BBA 97 does not include a provision for a carve out of DSH payments from Medicare HMO payment rates. (See “Medicare+Choice.”)

### ***Eliminate IME and DSH Add-Ons for Outliers***

*Current Law.* Medicare makes additional “outlier” payments to hospitals for beneficiaries whose care has been exceptionally costly or required an unusually long hospital stay. When calculating a hospital’s cost when it exceeds the threshold, the outlier formula subtracts the portion of costs attributed to the hospital’s level of teaching and service to low-income patients. When the hospital receives any IME and DSH payments, these payments are determined as a percentage of the combined amount of the DRG and the outlier payment.

*BBA 97.* The BBA 97 eliminates the increased IME and DSH payments that are attributable to “cost outlier” payments, but allows hospitals to count IME and DSH as part of costs that trigger outlier payments, effective in FY1998.

### ***Floor on the Area Wage Index***

*Current Law.* As a part of the process for determining payments to hospitals under Medicare PPS, the Secretary is required to adjust a portion of the standardized amounts for area differences in hospital wage levels by a factor reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average wage level.

*BBA 97.* The BBA 97 provides that, for discharges on or after October 1, 1997, the area wage index applicable for any hospital located in an urban area can not be less than the average of the area wage indices applicable to hospitals located in rural areas in the state in which the hospital is located. The Secretary is required to make any adjustments to the wage index in a budget neutral manner. The BBA 97 also provides that, in the case of a hospital that is owned by a municipality and that was reclassified as an urban hospital for FY1996, in calculating the hospital’s average hourly wage for the purposes of geographic reclassification for FY1998, the Secretary is required to exclude the general service wages and hours of personnel associated with a skilled nursing facility that is owned by the hospital of the same municipality and that is physically separated from the hospital to the extent that the wages and hours of such personnel are not shared with the hospital and separately documented.

### ***Reductions in Payments for Enrollee Bad Debt***

*Current Law.* Certain hospital and other provider bad debts are reimbursed by Medicare on an allowable cost basis. To be qualified for reimbursement, the debt must be related to covered services and derived from deductible and coinsurance amounts left unpaid by Medicare beneficiaries. The provider must be able to establish that reasonable collection efforts were made and that sound business judgement established that there is no likelihood of recovery at any time in the future.

*BBA 97.* The BBA 97 provides for bad debt payments to be reduced by 25% in FY1998, 40% in FY1999, and 45% in FY2000 and each subsequent year.

### ***Permanent Extension of Hemophilia Pass-Through***

*Current Law.* Medicare made additional payments for the costs of administering blood clotting factor to Medicare beneficiaries with hemophilia admitted for hospital stays where the clotting factor was furnished between June 19, 1990 and September 30, 1994.

*BBA 97.* The BBA 97 permanently extends the hemophilia pass-through, effective beginning October 1, 1997.

### ***Increase in Base Payment Rate for Puerto Rico***

*Current Law.* Under PPS, a separate standardized amount is set for determining Medicare payments to hospitals located in Puerto Rico based on a 25% federal/75% local blended rate.

*BBA 97.* The BBA 97 provides for the adjustment of the Puerto Rico payment rate to a blended amount of 50% federal/50% local rate.

## **Payment of PPS Exempt Hospitals**

### ***Payment Update***

*Current Law.* Under Medicare, five types of specialty hospitals (psychiatric, rehabilitation, long-term care, children's and cancer) and two types of distinct-part units in general hospitals (psychiatric and rehabilitation) are exempt from PPS. They are subject to the payment limitations and incentives established in TEFRA of 1982. Each provider is paid on the basis of reasonable cost subject to a rate of increase ceiling on inpatient operating costs. The ceiling is based on a target amount per discharge. The target amount for a cost reporting period is equal to the hospital's allowable inpatient operating costs (excluding capital and medical education costs) per discharge in a base year increased by applicable update factors for subsequent years. This amount is then multiplied by Medicare discharges, to yield the ceiling or upper limit on operating costs.

OBRA 93 provided that the applicable rate of increase percentage, or update, would be equal to the MBI minus 1.0% for FY1994-FY1997.

*BBA 97.* The BBA 97 sets the FY1998 update to 0%, and for FY1999 through FY2002, the update factor is set to vary depending on a hospital's target amount and costs. For hospitals (1) with costs that equal or exceed their target amounts by 10% or more, the update is equal to the market basket; (2) that exceed their target, but by less than 10%, the update factor is equal to zero or, if greater, the market basket minus 0.25 percentage points for each percentage point by which costs are less than 10% over the target; (3) that are either at their target, or below (but not below 2/3 of the target amount for the hospital), the update factor is equal to zero or, if greater, the market basket percentage minus 2.5 percentage points; or (4) that do not exceed 2/3 of their target amount, the update factor is equal to 0%.

### ***Reductions to Capital Payments For Certain PPS-Exempt Hospitals and Units***

*Current Law.* Medicare pays for capital costs for PPS exempt hospitals on a reasonable cost basis.

*BBA 97.* The BBA 97 reduces the capital payment update amount for PPS-exempt hospitals and units by 15% for FY1998-FY2002.

### ***Cap on TEFRA Limits***

*Current Law.* Medicare places limits, referred to as “TEFRA limits,” on the annual increases allowed for the operating costs of certain categories of hospitals.

*BBA 97.* The BBA 97 sets the target amounts for PPS-exempt hospitals or units for cost reporting periods beginning on or after October 1, 1997 and before October 1, 2002. The Secretary is required to estimate the 75<sup>th</sup> percentile of the target amounts for hospitals for cost reporting periods ending during FY1996, and then update the amount up to the first cost reporting period beginning on or after October 1, 1997, by a factor equal to the market basket percentage increase. For cost reporting periods beginning during each of FY1999 through FY2002, the Secretary is required to update the amount by a factor equal to the market basket increase.

### ***Change In Bonus Payments for PPS Exempt Hospitals***

*Current Law.* Medicare provides for bonus payments for hospitals whose operating costs are less than or equal to the target amount, as well as making relief payments to hospitals whose costs exceed their target amount. If the hospital’s costs are less than or equal to the target amount for that period, the hospital receives a bonus payment equal to 50% of the amount by which the target amount exceeds the amount of the operating costs, or 5% of the target amount, whichever is less. If a hospital’s operating costs are greater than the target amount, the amount of the payment is equal to (1) the target amount, plus (2) an additional amount equal to 50% of the amount by which the operating costs exceed the target amount, but not more than 10% of the target amount.

*BBA 97.* The BBA 97 provides bonus payments equal to the lesser of: (1) 15% of the amount by which the target amount exceeds the amount of operating costs, or (2) 2% of the target amount. In addition, for cost reporting periods beginning on or after October 1, 1997, the BBA 97 provides for continuous improvement bonus payments for certain eligible hospitals. Eligible hospitals could receive an increased bonus payment equal to the lesser of: (1) 50% of the amount by which the eligible hospital’s operating costs are less than the expected for the period; or (2) 1% of the target amount for the period. The BBA 97 also provides that the relief payments are limited to 10% of the target amount.

### ***Change in Payment and Target Amount for New PPS Exempt Providers***

*Current Law.* No provision.

*BBA 97.* The BBA 97 establishes different payment and target amount rules for hospitals or distinct-part units within hospitals that first received Medicare payments on or after October 1, 1997. Payments for operating costs for the first 2 cost reporting periods for which the hospital has a settled cost report are equal to the lesser of the amount of operating costs for the period, or 110% of the national median of the target amount for hospitals in the same class of hospital for cost reporting periods ending during FY1996, updated by the hospital market basket increase percentage to the fiscal year in which the hospital first received payments.

For determining national median operating costs for hospitals in the same class, the Secretary is required to provide for an appropriate adjustment to the labor-related portion of the amount determined to take into account differences between average wage-related costs in the area the hospital was located in and the national average of such costs within the same class of hospital. The Secretary is also required to create subclasses of long-term care hospitals based on differences in the case mix and patient severity in calculating and applying the 110% of the national median cost limits.

### ***Rebasing***

*Current Law.* No provision.

*BBA 97.* The BBA 97 provides PPS-exempt hospitals and distinct units of hospitals that received Medicare payments for services furnished before January 1, 1990, the option of rebasing the hospital's target amount for the 12-month cost reporting period beginning during FY1998. The rebased target amount is equal to an average determined by the Secretary as follows: (1) the Secretary is required to determine the allowable operating cost for inpatient hospital services for the hospital unit for each of the five cost reporting periods for which the Secretary has settled cost reports as of the date of enactment; (2) the Secretary is required to increase the amount determined for the five cost reporting periods by the applicable percentage increase used to update costs for each of the cost reporting periods up to FY1998; (3) the Secretary is required to identify among the five cost reporting periods the periods for which the updated cost amount is the highest and the lowest; and (4) the Secretary is required to compute the averages of the updated cost report amounts for the three cost reporting periods that are not the highest or the lowest amounts.

The BBA 97 also allows "qualified long-term care hospitals" that elect to do so, to apply for rebasing of their target amount beginning during FY1998. The provision defines a qualified long-term care hospital as a PPS-exempt hospital that receives Medicare payments during each of the two most recent cost reporting periods during which the hospital's Medicare allowable operating costs exceeds 115% of the hospital's target amount, and that has a disproportionate patient percentage of at least 70% if the hospital were a PPS hospital. The target amount for the hospital's 12-month cost reporting period is equal to the allowable operating costs of inpatient hospital services recognized by Medicare for the 12-month cost reporting periods beginning during FY1996, increased by the applicable percentage increase for the cost reporting period beginning during FY1997.

### ***Treatment of Certain Long-Term Care Hospitals Located Within Other Hospitals***

*Current Law.* No provision.

*BBA 97.* The BBA 97 extends the classification of a hospital that was classified by the Secretary on or before September 30, 1995, as a long-term care hospital, notwithstanding that it is located in the same building as, or on the same campus as, another hospital. The provision applies to discharges occurring on or after October 1, 1995.

### ***Certain Cancer Hospitals***

*Current Law.* Certain special categories of hospitals, including cancer hospitals, are exempt from Medicare inpatient hospital PPS and are paid on the basis of reasonable costs, subject to certain limits.

*BBA 97.* The BBA 97 amends the definition of long-term care hospitals to include long-term care hospitals that first received Medicare payment in 1986 with an average inpatient length of stay of more than 20 days and that had 80% or more of its annual total inpatient discharges with a diagnosis that reflects a finding of neoplastic disease for the 12-month cost reporting period ending in FY1997.

### ***Prospective Payment System (PPS) for Inpatient Rehabilitation Services***

*Current Law.* Rehabilitation hospitals are one of the categories of hospitals not paid by the Medicare PPS for hospitals and are known as PPS-exempt hospitals.

*BBA 97.* The BBA 97 requires the Secretary to establish a case-mix adjusted PPS for rehabilitation hospitals and distinct-part units, effective beginning in FY2001. The Secretary is required to establish: (1) classes of discharges of rehabilitation facilities by patient case-mix groups based on impairment, age, related prior hospitalization, comorbidities, and functional capability of the discharged individual and other appropriate factors; and (2) a method of classifying specific discharges from rehabilitation facilities within these groups.

The Secretary is required to assign each case mix group an appropriate weighting which reflects the relative facility resources used by a discharge group. The Secretary is required to adjust the classifications and weighting factors to correct for forecast errors and to reflect changes in treatment patterns, technology, case mix, number of discharges paid for under Medicare, and other factors which might affect the relative use of resources. The Secretary is authorized to require rehabilitation facilities providing inpatient hospital services to submit data on discharges classified according to case-mix group or other rehabilitation impairment groups, measurement of functional disability, and other patient assessment factors necessary to establish and administer the PPS.

The Secretary is required to determine a prospective payment rate for each rehabilitation facility discharge payable under Medicare. Prospective payment rates are to be phased-in between October 1, 2000, and before October 1, 2002, by blending the prospective rate with the TEFRA percentage of the hospital's target amount that would have been paid under Part A if this provision did not apply, and the prospective payment percentage of the per discharge payment rate established by the Secretary. Payments during the transition period will be based on TEFRA and prospective payment percentage amounts equal to 66 2/3% and 33 1/3%, respectively, for cost reporting periods beginning on or after October 1, 2000, and before October 1, 2001; and 33 1/3% and 66 2/3%, respectively, for cost reporting periods beginning on or after October 1, 2001, and before October 1, 2002. For FY2001 and FY 2002, the Secretary is required to establish prospective payment amounts that are budget neutral, so that total payments for rehabilitation hospitals equal 98% of the amount of payments that would have been made if the prospective payment system had not been enacted. The prospective system will be fully implemented by October 1, 2002.

## ***Study and Report on Payments for Long-Term Care Hospitals***

*Current Law.* No provision.

*BBA 97.* The BBA 97 requires the Secretary to collect data to develop, establish, administer, and evaluate a case-mix adjusted prospective payment system for long-term care hospitals. The Secretary is required to develop a legislative proposal for establishing and administering a payment system that includes an adequate patient classification system that reflected differences in patient resource use. The Secretary is required to submit the proposal to the appropriate committees of Congress by no later than October 1, 1999.

## **Skilled Nursing Facilities (SNFs)**

### ***Payment Reform***

*Current Law.* Currently, Medicare reimburses the great bulk of SNF care on a retrospective cost-based basis. This means that SNFs are paid after services are delivered for the reasonable costs (as defined by the program) they have incurred for the care they provide. For Medicare reimbursement purposes, the costs SNFs incur for providing services to beneficiaries can be divided into three major categories: (1) routine services costs that include nursing, room and board, administration, and other overhead; (2) ancillary services, such as physical and occupational therapy and speech language pathology, laboratory services, drugs, supplies and other equipment; and (3) capital-related costs, including net depreciation expense, taxes, lease and rental payments, improvements that extend the life or increase the productivity of assets, net interest expense, etc.).

Routine costs are subject to national average per diem limits. Separate per diem routine cost limits are established for freestanding and hospital-based SNFs by urban or rural area. Freestanding SNF routine limits are set at 112% of the average per diem labor-related and nonlabor-related costs. Hospital-based SNF limits are set at the limit for freestanding SNFs, plus 50% of the difference between the freestanding limits and 112% of the average per diem routine services costs of hospital-based SNFs. Routine cost limits for SNF care are required to be updated every 2 years. In the interim, the Secretary applies a SNF market basket developed by HCFA to reflect changes in the price of goods and services purchased by SNFs. OBRA93 eliminated updates in SNF routine cost limits for cost reporting periods beginning in FY1994 and FY1995.

Ancillary service and capital costs are both paid on the basis of reasonable costs and neither are subject to limits.

SNFs providing less than 1,500 days of care per year to Medicare patients in the preceding year have the option of being paid a prospective payment rate set at 105% of the regional mean for all SNFs in the region. The rate covers routine and capital-related costs (but not ancillary services) and is calculated separately for urban and rural areas, adjusted to reflect differences in wage levels. Prospective rates can not exceed the routine service costs limits that would be applicable to the facility, adjusted to take into account average capital-related costs with respect to the type and location of the facility.

Congress on a number of occasions has required the Secretary to develop alternative methods for paying for SNF care on a prospective basis. In response, HCFA has conducted research to

develop a PPS that uses a patient classification system, known as resource utilization groups (RUGs), that will account for variations in resource use among Medicare SNF patients.

Cost-based reimbursement has been cited as one of the reasons for significant growth in SNF spending since 1989. Spending has increased from \$3.5 billion in 1989 to \$11.7 billion in 1996, for an average annual rate of growth of 19%. Growth in SNF spending can be explained largely by the increasing number of persons qualifying for the benefit and increases in reimbursements per day of care. Numbers of persons served has nearly doubled since 1989, reaching 1.15 million persons in 1996. Average payments for care have grown from \$117 per day in 1989 to \$292 per day in 1996. Increases in ancillary service reimbursements explain much of this per diem payment growth.

*BBA 97.* BBA 97 phases in a prospective payment system for SNF care that will pay a federal per diem rate for covered SNF services. Covered services will include Part A SNF benefits as well as all services for which payment may be made under Part B during the period when the beneficiary is provided covered SNF care (excluding, however, physician services, certain nurse practitioner and physician assistant services, certified nurse-midwife services, qualified psychologist services, services of a certified registered nurse anesthetist, certain dialysis services and drugs, and in 1998 only, the transportation costs of electrocardiogram equipment).

The federal per diem payment will cover routine service costs, ancillary, and capital-related costs, but will not include costs associated with approved educational activities. The actual per diem rate received by a facility will include adjustments for case-mix based on a resident classification system established by the Secretary to account for relative resource utilization of different patient types. The labor-related portion of the rate will also include budget neutral adjustments to reflect the relative level of wages and wage-related costs for the geographic area in which the facility is located. In the Explanatory Statement of the Conference Report on BBA 97, conferees included intent language that the Secretary develop for the new SNF prospective payment system case-mix adjusters that reflect the medication therapy needs of SNF patients. In developing, these adjusters, the Secretary should consider the results of studies conducted by independent organizations, including those which examine appropriate payment mechanisms for medication therapy under the SNF prospective payment system. (Note that “intent” language generally provides guidance on specific provisions and issues raised by statutory provisions in bills; it does not have the force of law.)

During a transition period lasting through the three cost reporting periods beginning on or after July 1, 1998, a portion of the per diem payment to a SNF will be based on a facility-specific rate, and the remaining portion on the federal rate. For the first cost reporting period, the facility specific percentage will be 75% and federal per diem percentage will be 25%. For the second cost reporting period, the facility-specific percentage will be 50% and the federal 50%. For the last period, the facility-specific percentage will be 25% and the federal 75%.

For a beneficiary residing in a SNF (or a part of facility that includes a SNF) but no longer eligible for Part A SNF care, payments for Part B covered services will have to be made to the facility whether or not the item or service was furnished by the facility, by others under arrangement, or under any other contracting or consulting arrangement. This requirement is often referred to as the “consolidated billing” provision of the new law. Payments for Part B services will be based on existing fee schedules for such services. Claims for Part B items and services must include a code identifying the items or services delivered. In addition, bills submitted by physicians must include the SNF’s provider number.

## Hospice Care

### *Updates in Payments and Other Amendments*

*Current Law.* Medicare covers hospice care, in lieu of most other Medicare benefits, for terminally ill beneficiaries. Persons electing Medicare's hospice benefit are covered for four benefit periods: two 90-day periods, a subsequent 30-day period, and a final period of unlimited duration. Payment for hospice care is based on one of four prospectively determined rates, which correspond to four different levels of care; hospices receive one of these rates for each day a beneficiary is under the care of the hospice. The four rate categories are routine home care, continuous home care, inpatient respite care, and general inpatient care. The prospective payment rates are updated annually by the hospital market basket (MB). Covered hospice services include nursing care; physical and occupational therapy and speech language pathology services; medical social services; home health aide services; homemaker services; medical supplies (including drugs and biologicals) and medical appliances; physician services; short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management); and counseling. Beneficiaries electing hospice waive coverage to most Medicare services when the services they need are related to the terminal illness.

*BBA 97.* BBA 97 reduces the hospice payment update to market basket minus 1 percentage point for each of FY1998 through FY2002. The Secretary is required to collect data from participating hospices on the costs of care they provide for each fiscal year beginning with FY1999. In addition, effective for cost reporting periods beginning on or after October 1, 1997, hospices are required to submit claims on the basis of the location where a service is actually furnished.

Effective April 1, 1998, BBA 97 amends the definition for hospice care to include those services enumerated in current law as well as any other item or service which is specified in a patient's plan of care and which Medicare may pay for. Effective on enactment, BBA 97 also (1) restructures hospice benefit periods to include two 90-day periods, followed by an unlimited number of 60-day periods (the medical director or physician member of the hospice interdisciplinary team will re-certify at the beginning of the 60-day periods that the beneficiary is terminally ill); (2) deletes physician services from a hospice's core services and allows hospices to employ or contract with physicians for their services; (3) allows the Secretary to waive requirements with regard to hospices having to provide certain services so long as they are *not* located in urbanized areas and can demonstrate to the satisfaction of the Secretary that they have been unable, despite diligent efforts, to recruit appropriate personnel; for these hospices, the Secretary can waive specifically the provision of physical or occupational therapy or speech-language pathology services and dietary counseling; (4) extends the limitation of liability protection to determinations that an individual is not terminally ill; and (5) eliminates the specific time frame specified in statute for completion of physicians' certifications for admission to hospice to require only that physicians certify that a beneficiary is terminally ill at the beginning of the initial 90-day period.

## State and Local Government Employees

### *Reduction in Part A Medicare Premium for Certain Public Retirees*

*Current Law.* Almost all persons age 65 or over are automatically entitled to Part A. These individuals (or their spouses) established entitlement during their working careers by paying the

hospital insurance (HI) payroll tax on earnings covered by either the social security or railroad retirement systems. Persons not automatically entitled to Part A may obtain coverage by paying the Part A premium. The 1997 premium is \$311.

Persons not automatically entitled to Part A include some state and local government employees. State and local governments can choose whether or not to participate in Medicare for employees hired before April 1, 1986. They are required to participate (and pay the employer share of the payroll taxes) for all employees hired after that date.

*BBA 97.* The BBA 97 specifies that the premium amount is zero for certain public retirees. An individual covered under this provision is one who established to the satisfaction of the Secretary that the individual was receiving cash benefits under a qualified state or local government retirement system on the basis of the individual's employment over at least 40 calendar quarters (or on the basis of some combination of such covered employment and quarters of coverage under social security totaling at least 40 quarters). For each of the preceding 84 months, the individual must have been enrolled in Part A and not have had his or her premium paid by a governmental entity.

## **Other Part A Provisions**

### *Christian Science Sanatoria*

*Current Law.* Medicare covers the services furnished by Christian Science sanatoria under Part A of the program. In order to be a covered provider, the institution must be listed and certified by the First Church of Christ, Scientist of Boston, MA. A certified sanatorium qualifies as both a hospital and as a SNF. Under Medicare, two separate types of benefits are payable: services received in an inpatient Christian Science sanatorium and extended care services in a sanatorium. Section 1861(e)(9) of the Social Security Act includes a Christian Science sanatorium in the definition of a hospital; 1861(y) defines extended care in a Christian Science SNF.

*BBA 97.* The BBA 97 strikes the reference to Christian Science sanatorium in Medicare's definitions of "hospital," and "extended care in Christian Science skilled nursing facilities," and inserts the term "a religious nonmedical health care institution" in these sections. The provision defines a nonmedical health care institution as an institution that: (1) is exempt from taxes under Section 501(c)(3) of the Internal Revenue Code of 1986; (2) is lawfully operated under all applicable federal, state, and local laws and regulations; (3) provides only nonmedical nursing items and services exclusively to patients who choose to rely solely upon a religious method of healing, and for whom the acceptance of medical health services would be inconsistent with their religious beliefs; (4) provides such nonmedical items and services exclusively through nonmedical nursing personnel who are experienced in caring for the physical needs of such patients; (5) provides such nonmedical items and services to inpatients on a 24-hour basis; (6) on the basis of religious beliefs, does not provide through its personnel or otherwise medical items and services (including any medical screening, examination, diagnosis, prognosis, treatment, or the administration of drugs) for its patients; (7) is not part of, or owned by, or under common ownership with, or affiliated with a health care facility that provided medical services; (8) has in effect a specified utilization review plan; (9) provides the Secretary with information required to implement this section, to monitor quality of care, and to provide for coverage determinations; and (10) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in these institutions.

The Secretary is required to treat an institution as meeting the conditions of participation for Medicare if the accreditation of such an institution by a state, regional, or national agency or association provided reasonable assurances that any or all of the preceding requirements are met. The Secretary is prohibited from requiring any patient of a religious nonmedical health care institution to undergo any medical screening, examination, diagnosis, prognosis, or treatment of any kind or to accept any other medical health care service, if the patient (or legal representative of the patient) objects on religious grounds. The Secretary is prohibited from subjecting a religious nonmedical health care institution (or its patients or personnel) to any medical supervision, regulation, or control, to the extent that such supervision, regulation or control is contrary to the religious beliefs of the institution or its patients or personnel.

Medicare payments are made for inpatient hospital services or post-hospital extended care services furnished to an individual in a religious nonmedical health care institution only if: (1) the individual has made an election that is in effect for such benefits; and (2) the individual has a condition that would qualify for benefits under Medicare for inpatient hospital services or extended care services if the individual was an inpatient of a hospital or skilled nursing facility.

### ***Increase Certification Period for Organ Procurement Organizations***

*Current Law.* The law permits the Secretary to make Medicare and Medicaid payments for organ procurement costs to organ procurement organizations (OPOs) operating under Section 371 of the Public Health Service Act, or having been certified or recertified by the Secretary within the previous 2 years as meeting certain requirements.

*BBA 97.* The BBA 97 provides OPOs with up to 4 years between certifications or recertifications, if the Secretary determines that it is appropriate based on the organizations' past practices.

## **Part B**

### **Physicians and Other Practitioners**

#### ***Establish Single Conversion Factor and Reform Method for Updating Physician Fees***

*Current Law.* Medicare pays for physicians services on the basis of a fee schedule. The fee schedule assigns relative values to services. Relative values reflect three factors: physician work (time, skill, and intensity involved in the service), practice expenses, and malpractice costs. These relative values are adjusted for geographic variations in the costs of practicing medicine. Geographically-adjusted relative values are converted into a dollar payment amount by a dollar figure known as the conversion factor. There are three conversion factors—one for surgical services, one for primary care services, and one for other services. The conversion factors in 1997 are \$40.96 for surgical services, \$35.77 for primary care services, and \$33.85 for other services.

The conversion factors are updated each year by a formula specified in the law. The update equals inflation plus or minus actual spending growth in a prior period compared to a target known as the Medicare volume performance standard (MVPS). (For example, FY1995 data were used in calculating the calendar 1997 update.) However, regardless of actual performance during a base

period, there is a 5 percentage point limit on the amount of the reduction. There is no limit on the amount of the increase.

*BBA 97.* There will be a single conversion factor beginning in 1998. The 1998 amount will be the 1997 primary care conversion factor, updated to 1998 by the average of the three separate updates that would occur in the absence of the legislation. Beginning in FY1998, the MVPS is replaced with a cumulative “sustainable growth rate” based on real gross domestic product (GDP) growth. This new target will begin affecting updates in 1999. An upper limit is placed on allowable fee increases—3 percentage points above inflation. The lower limit on decreases is changed from inflation minus 5 percentage points to inflation minus 7 percentage points.

### ***Implementation of Resource-Based Practice Expenses***

*Current Law.* P.L. 103-432 required that the Secretary develop and provide for the implementation, beginning in 1998, of a resource-based methodology for payment of practice expenses under the physician fee schedule. Such expenses are currently paid on the basis of historical charges. Implementation of the practice expense methodology has been the subject of considerable controversy. Many observers have suggested that sufficient accurate data has not been collected. They also cite the potential large scale payment reductions that may result for some physician specialties, particularly surgical specialties. HCFA issued proposed rule-making on June 18, 1997.

*BBA 97.* In 1998, there will be a reallocation of no more than \$390 million in practice expense relative value units. Practice expense relative value units will be reduced to 110% of work relative value units for specified services. These are services: (1) which have work relative value units; (2) for which the number of practice expense relative value units in 1998 exceeds 110% of the number of work relative value units. Not included are services provided 75% in an office setting or services which would receive an increase under HCFA’s proposed regulations issued June 18, 1997. The amount reduced will be added to the practice expense relative value units of physician office visit procedure codes. The 110% number will be increased, if necessary, to assure that the total amount of the reallocation does not exceed \$390 million.

The new practice expense methodology will be phased-in over the 1999-2002 period. In 1999, 25% of the practice payment will be based on the new methodology. This percentage will increase to 50% in 2000, 75% in 2001, and 100% in 2002.

The General Accounting Office (GAO) is required to review, within 6 months of enactment, the methodology used by HCFA in preparing the proposed regulations.

The Secretary is required to develop new resource-based relative value units for practice expenses. In developing the units, the Secretary is required, to the maximum extent practicable, to utilize generally accepted accounting principles. The Secretary is also required to use actual data on equipment, utilization, and other key assumptions. The Secretary is required to transmit a report to Congress by March 1, 1998, which will include an explanation of the data used and the methodology. Proposed rule-making would have to be published by May 1, 1998.

HCFA is also directed to develop and implement a resource-based methodology for malpractice expenses by January 2000.

### ***Dissemination of Hospital-Specific Per-Admission Relative Values***

*Current Law.* In general, the law does not include a specific limit on the number or mix of physicians services provided in connection with an inpatient hospital stay. (However, the law does require that certain services provided in connection with a surgery be included in a global surgical package and not billed for separately.)

*BBA 97.* The Secretary, during 1999 and 2001, is required to determine for each hospital the hospital-specific per admission relative value for the following year and whether this amount is projected to be excessive (based on the 1998 national median of such values). The Secretary is required to notify the medical executive committee of a subset of hospitals having been identified as having an excessive hospital-specific relative value. This would serve as a notification only; no reduction in payments will be made.

### ***Direct Payment to Physician Assistants, Nurse Practitioners, and Clinical Nurse Specialists***

*Current Law.* Separate payments are made for nurse practitioner (NP) services provided in collaboration with a physician, which are furnished in a nursing facility. Recognized payments equal 85% of the physician fee schedule amount. Nurse practitioners and clinical nurse specialists (CNSs) are paid directly for services provided in collaboration with a physician in a rural area. Payment equals 75% of the physician fee schedule amount for services furnished in a hospital and 85% of the fee schedule amount for other services.

Separate payments are made for physician assistant (PA) services when provided under the supervision of a physician: (1) in a hospital, skilled nursing or nursing facility, (2) as an assistant at surgery, or (3) in a rural area designated as a health professional shortage area. Payments equal 65% of the fee schedule amount for services performed as an assistant at surgery, 75% for other hospital services, and 85% for other services.

*BBA 97.* The restriction on settings is removed. Payment for services can only be made if no facility or other provider charges are paid in connection with the service. Payment will equal 80% of the lesser of either the actual charge or 85% of the fee schedule amount for the same service if provided by a physician. For assistant-at-surgery services, payment will equal 80% of the lesser of either the actual charge or 85% of the amount that would have been recognized for a physician serving as an assistant-at-surgery. The PA may be in an independent contractor relationship with the physician. The provisions are effective January 1, 1998.

### ***Chiropractic Services***

*Current Law.* Medicare covers chiropractic treatment services; however the coverage is limited to treatment by means of manual manipulation of the spine. In addition, a chiropractor's services are covered only if the treatment is to correct a subluxation (i.e., misalignment) demonstrated to exist by X-ray; however, program regulations do not permit Medicare to pay for X-rays either if performed by a chiropractor or ordered by a chiropractor.

*BBA 97.* The X-ray requirement is eliminated, effective January 1, 2000.

## ***Private Contracts***

*Current Law.* Physicians are required to submit claims for services provided to their Medicare patients and are subject to limits on amounts they can bill these patients. The law has been interpreted to preclude situations under which a physician or another health care professional who does not provide items and services under Medicare could enter into a private contract with a Medicare beneficiary for services for which no Medicare claim is to be submitted.

*BBA 97.* BBA permits private contracting, under specified conditions. A contract must provide specified beneficiary protections. It must be written and signed by the beneficiary before services are provided pursuant to the contract. It can not be entered into at a time when the beneficiary is facing an emergency or urgent health care situation. The contract must also clearly indicate to the beneficiary that by signing the contract the beneficiary agrees not to submit a Medicare claim; agrees to be responsible, whether through insurance or otherwise, for payments for services; understands that no Medicare reimbursement will be provided; acknowledges that no Medicare limiting charge limits apply; understands that Medigap plans do not, and other supplemental insurance plans may elect not to, make payments for such items and services; and understands that the beneficiary has the right to have services provided by other physicians for whom Medicare payment would be made.

An affidavit must be in effect at the time services are provided pursuant to the contract. It must be in writing and signed by the physician or practitioner and must be filed with the Secretary. It must provide that the physician or practitioner will not submit any Medicare claim for any item or service provided to a Medicare beneficiary (and will not receive any reimbursement for any such item or service) for a 2-year period beginning on the date the affidavit is signed. If a physician or practitioner signing an affidavit knowingly and willfully submits a Medicare claim (or receives Medicare reimbursement for) an item or service during such 2-year period, the ability to provide services under the private contract provision would not apply for the remainder of the period. Further, the physician or practitioner could not receive Medicare payments during such period.

## **Payments for Durable Medical Equipment**

### ***Updates in Payments and Other Amendments***

*Current Law.*

*(a) Durable Medical Equipment (DME) Updates.* DME is reimbursed on the basis of a fee schedule. Items are classified into five groups for purposes of determining the fee schedules and making payments: (1) inexpensive or other routinely purchased equipment (defined as items costing less than \$150 or which are purchased at least 75% of the time); (2) items requiring frequent and substantial servicing; (3) customized items; (4) oxygen and oxygen equipment; and (5) other items referred to as capped rental items. In general, the fee schedules establish national payment limits for DME. The limits have floors and ceilings. The floor is equal to 85% of the weighted median of local payment amounts and the ceiling is equal to 100% of the weighted median of local payment amounts. Fee schedule amounts are updated annually by the consumer price index for all urban consumers, CPI-U. Medicare requires that the payment amount for covered DME be consistent with what is reasonable and medically necessary to serve the intended purpose. Additional expenses for upgraded or deluxe features or items which are rented or purchased for added convenience or other purposes do not meet the reasonableness test. A

beneficiary wishing upgraded features must purchase the upgraded item and seek reimbursement from Medicare for the basic item. Payment is based on the payment amount for the kind of item normally used to meet the intended purpose (i.e., the standard item). Usually this is the least costly item.

*(b) Update for Orthotics and Prosthetics.* Prosthetics and orthotics are paid according to a fee schedule with principles similar to the DME fee schedule. The fee schedule establishes regional payment limits for covered items. The payment limits have floors and ceilings. The floor is equal to 90% of the weighted average of regional payment amounts and the ceiling is 120%. Fee schedule amounts are updated annually by CPI-U.

*(c) Payment Freeze for Parenteral and Enteral Nutrients (PEN), Supplies, and Equipment.* Parenteral and enteral nutrients, supplies, and equipment are paid on the basis of the lowest reasonable charge levels at which items are widely and consistently available in the community.

*BBA 97.*

*(a) Durable Medical Equipment (DME) Updates.* BBA 97 eliminates updates to the DME fee schedules for the period 1998 through 2002. In addition, for oxygen and oxygen equipment, the national payment limit is reduced by 25% in 1998, and an additional 5% in 1999. These reductions will continue to be reflected in payments for oxygen in subsequent years. The Secretary is authorized to create classes of oxygen equipment with differing payments, so long as there is no net increase in payments for home oxygen equipment. The Secretary is required to establish as soon as practicable service standards for home oxygen providers. The Secretary is also required to arrange with peer review organizations to evaluate access to and quality of home oxygen equipment. GAO is required to report to Congress on access to oxygen equipment within 18 months of enactment.

In addition, the Secretary is authorized under BBA 97 to issue regulations for upgraded DME under which an individual could purchase or rent upgraded DME. Suppliers of the upgraded item will be able to bill the Medicare program for the basic or standard DME item and receive an additional payment from the beneficiary for the difference between the supplier's charge and Medicare's payment for the upgraded or enhanced feature. Purchases or rentals of upgraded items will not be effective until after the effective date of any regulations issued by the Secretary.

*(b) Update for Orthotics and Prosthetics.* Updates for prosthetics and orthotics are limited to 1% for each of the years 1998 through 2002.

*(c) Payment Freeze for Parenteral and Enteral Nutrients (PEN), Supplies, and Equipment.* Payments for PEN are frozen at 1995 levels for the period 1998 through 2002.

## **Hospital Outpatient Departments (OPDs)**

### ***Payment for Hospital Outpatient Departments (OPDs)***

*Current Law.* Medicare's payment to hospital OPDs and hospital-operated ambulatory surgical centers (ASCs) for covered ASC procedures is equal to the lesser of the following two amounts: (1) the lower of the hospital's reasonable costs or customary charges less beneficiary deductibles and coinsurance, or (2) a blended amount comprised of a cost portion and a fee schedule portion,

net of beneficiary cost-sharing. The cost portion of the blend is based on the lower of the hospital's costs or charges, net of beneficiary cost sharing. The fee schedule portion is based, in part, on ambulatory surgery center payment rates or the rates for radiology and diagnostic services in other settings, net of beneficiary coinsurance (for those settings). The hospital cost portion and the fee schedule portion for surgical and radiology services are 42% and 58%, respectively. For diagnostic services the hospital cost portion is 50% and the fee schedule portion is 50%.

A hospital may bill a beneficiary for the coinsurance amount owed for the outpatient service provided. The beneficiary coinsurance is based on 20% of the hospital's submitted charges for the outpatient service, whereas Medicare usually pays based on the blend of the hospital's costs and the amount paid in other settings for the same service. This results in an anomaly whereby the amount a beneficiary pays in coinsurance does not equal 20% of the program's payment and does not result in a dollar-for-dollar decrease in Medicare program payments. On average, beneficiaries pay 37% of the total payment.

Hospital outpatient departments are paid for certain services on the basis of reasonable costs. Hospitals also receive payments for Medicare's share of capital costs associated with outpatient departments. OBRA 93 extended a 5.8% reduction for services paid on a cost-related basis and a 10% reduction in payments for capital costs through FY1998.

*BBA 97.*

**(1) Formula Driven Overpayment (FDO) for Certain Hospital Outpatient Services.** The BBA 97 requires that beneficiary coinsurance amounts be deducted later in the reimbursement calculation for hospital outpatient services, so that Medicare payments for covered services are lower. Medicare's payment for hospital outpatient services are equal to the blended amount less any amount the hospital may charge the beneficiary as coinsurance for services furnished during cost reporting periods beginning on or after October 1, 1997.

**(2) Extension of Reductions in Payments for Costs of Hospital Outpatient Services.** The BBA 97 extends the 5.8% reduction for those services paid on a cost-related basis and the 10% reduction for capital-related costs through FY1999 and during FY2000 before January 1, 2000.

**(3) Prospective Payment System (PPS) for Hospital Outpatient Department Services.** The BBA 97 requires the Secretary to establish a PPS for covered OPD services furnished beginning in 1999. The Secretary is required to develop a classification system for covered OPD services, so that services within each group are comparable clinically and with respect to the use of resources. The Secretary is required to establish relative payment rates for covered OPD services using 1996 hospital claims and cost report data, and to determine projections of the frequency of utilization of each service or group of services in 1999. The Secretary is required to determine a wage adjustment factor to adjust the portions of payment attributable to labor-related costs for relative geographic differences in labor and labor-related costs that are applied in a budget neutral manner. The Secretary is required to establish other adjustments as necessary, including adjustments to account for variations in coinsurance payments for procedures with similar resource costs, and to ensure equitable payments under the system. The Secretary is also required to develop a method for controlling unnecessary increases in the volume of covered OPD services.

Hospital OPD coinsurance payments are limited to 20% of the national median of the charges for the service (or services within the group) furnished in 1996 updated to 1999 using the Secretary's estimate of charge growth during this period. The Secretary is required to develop rules for the establishment of a coinsurance payment amount for a covered OPD service not furnished during 1996, based on its classification within a group of such services. In addition, the BBA 97 provides for the entire fee schedule amount (program payments plus beneficiary coinsurance payments) to be updated by the market basket increase minus one percentage point for 2000 through 2002, and by the market basket percentage increase in subsequent years. Beneficiary coinsurance payments are to be subtracted from the fee schedule amount to determine Medicare program payments. These coinsurance payment provisions for covered OPD services apply instead of the standard 20% coinsurance for other Part B services.

The Secretary is required to establish a procedure under which a hospital, before the beginning of a year (starting with 1999), can elect to reduce the coinsurance payment for some or all covered OPD services to an amount that is not less than 20% of the total (Medicare program plus beneficiary coinsurance payment) amount for the service involved, adjusted for relative differences in labor costs and other factors. A reduced coinsurance payment can not be further reduced or increased during the year involved, and hospitals can disseminate information on the reduction of coinsurance amounts.

The Secretary is authorized to periodically review and revise the groups, relative payment weights, wages and other adjustments to take into account changes in medical practice, medical technology, the addition of new services, new cost data, and other relevant information. Any adjustments made by the Secretary must be made in a budget neutral manner. If the Secretary determines that the volume of services paid for under this subsection increased beyond amounts established through those methodologies, the Secretary is authorized to adjust the update to the conversion factor otherwise applicable in a subsequent year.

## **Other Providers**

### ***Ambulatory Surgical Centers (ASCs)***

*Current Law.* Medicare pays for ASC services on the basis of prospectively determined rates. These rates are updated annually for inflation using the CPI-U. OBRA 1993 eliminated updates for ASCs for FY1994 and FY1995.

*BBA 97.* The BBA 97 reduces the annual update for ASC fees by the CPI-U minus 2 percentage points for each year between FY1998 and specifies that the update can not be less than zero.

### ***Payment for Laboratory Tests***

*Current Law.* Clinical diagnostic laboratory tests are paid on the basis of areawide fee schedules. The law sets a cap on payment amounts equal to 76% of the median of all fee schedules for the test. The fee schedule amounts are updated by the percentage change in the CPI. Variations exist among carriers in rules governing requirements labs must meet in filing claims for payments.

*BBA 97.* The law freezes the fee schedule update for the 1998 - 2002 period. It lowers the cap to 74% of the median beginning in 1998. It also provides for a study, by the Institute of Medicine,

on Medicare payments for lab services. The study is to include a review of the adequacy of the current methodology and recommendations regarding alternative payment systems.

BBA 97 requires the Secretary to divide the country into no more than five regions and designate a single carrier for each region to process lab claims (excluding those for services provided to inpatients of hospitals and skilled nursing facilities) no later than July 1, 1999. The allocation of claims to a particular carrier would be based on whether the carrier serves the geographic area where the specimen is collected or other method selected by the Secretary. The requirement will not apply to those physicians office labs that the Secretary determines would be unduly burdened by the application of billing responsibilities with respect to more than one carrier.

By January 1, 1999, the Secretary is required to adopt uniform coverage, administration, and payment policies for lab tests using a negotiated rule-making process. The policies would be designed to eliminate variation among carriers and to simplify administrative requirements. The provisions permit the use of interim regional policies in cases where a uniform national policy has not been established.

### ***Payment for Ambulance Services***

*Current Law.* Payment for ambulance services provided by freestanding suppliers is based on reasonable charge screens while hospital or other provider-based ambulance services are paid on a reasonable cost basis.

*BBA 97.* BBA 97 specifies that the reasonable cost and charge limits will apply through 1999, with annual increases equal to the CPI minus one percentage point. A fee schedule will be implemented January 1, 2000. The aggregate amount of payments in 2000 can not exceed what would be paid if the interim reductions remained in effect in that year. Annual increases in subsequent years will equal the CPI increase, except that in 2001 and 2002 there will be a 1 percentage point reduction. The Secretary may require the use of a uniform coding system. Assignment is mandated beginning January 1, 2000. Coverage is provided for advanced life support services provided by paramedic intercept service providers in rural areas under contract with one or more volunteer ambulance services.

### ***Payment for Drugs***

*Current Law.* Medicare does not pay for most outpatient prescription drugs. The program will, however, pay for certain drugs including drugs used in connection with home infusion or inhalation equipment, drugs prescribed for dialysis or transplant patients, and certain oral cancer drugs. Payment for drugs is based on the lower of the estimated acquisition cost or the national average wholesale price. Payment may also be made as part of a reasonable cost or prospective payment.

*BBA 97.* BBA 97 provides that in any case where payment is not made on a cost or prospective payment basis, the payment will equal 95% of the average wholesale price. The Secretary is authorized to pay a dispensing fee to pharmacies. Further, the Secretary is required to study the effect of the provision on average wholesale prices.

BBA 97 authorizes coverage for an acute oral anti-emetic (anti-nausea) drug used as part of an anticancer chemotherapeutic regimen. It would have to be administered by (or as prescribed by) a

physician for use immediately before, at, or within 48 hours of the time of the administration of the chemotherapeutic agent and be used as a full replacement for the anti-emetic therapy which would otherwise be administered intravenously.

### ***Rural Health Clinic (RHC) Services***

*Current Law.* Medicare establishes payment limits for RHC services provided by independent RHCs. RHCs, among other requirements, must have appropriate procedures for utilization review of clinic services. The Secretary is required to waive the RHC requirement for certain staffing of health professionals if the clinic has been unable to hire a physician assistant, nurse practitioner, or certified nurse-midwife in the previous 90-day period. The Secretary is prohibited from granting a waiver to a facility if the request for the waiver is made less than 6 months after the date of the expiration of previous waiver of the facility. RHCs are required to be located in a health professional shortage area. For RHCs that are in operation and subsequently fail to meet the requirement of being located in a health professional shortage area, the Secretary would be required to continue to consider the facility to meet the health professions shortage area requirement.

*BBA 97.* The BBA 97 applies a per-visit payment limit to all RHCs, other than such clinics in rural hospitals with less than 50 beds. RHCs are required to have a quality assessment and performance improvement program, in addition to appropriate procedures for utilization review. The waiver on the staffing requirement (to provide a waiver if the facility could not meet the requirement of having a nurse practitioner, physician assistant, or a certified nurse-midwife available 50% of the time the clinic operates) is only available to clinics once they are certified. Shortage designations for RHCs are required to be reviewed every 3 years. In addition, the shortage area requirement is amended to require that RHCs must be located in an area in which there are insufficient numbers of needed health care practitioners as determined by the Secretary. Operating RHCs that subsequently fail to meet the requirement of being located in a health professional shortage area can continue to be considered to meet the health professional shortage requirement, but only when, under criteria established by the Secretary in regulations, the RHCs are determined to be essential to the delivery of primary care services that are otherwise unavailable in the geographic area served by the clinic. The Secretary is required to issue final regulations implementing the grandfathered clinics that take effect no later than January 1, 1999.

The BBA 97 also provides for the direct payment to physician assistants (PAs) for any PA services provided at an RHC that is principally owned, as determined by the Secretary, by a PA as of the date of enactment and continuously from that date through the date on which services are provided. The PA payment provision is required to sunset (not apply) after January 1, 2003.

### ***Outpatient Therapy Providers***

*Current Law.* Payments for physical or occupational therapy services provided by therapists in independent practice are made under the physician fee schedule, subject to an annual per beneficiary cap or \$900 for each type of therapist. Medicare pays for therapy services provided in other settings, such as skilled nursing facilities, comprehensive outpatient rehabilitation facilities (CORFs), or hospital outpatient departments, on the basis of reasonable costs, subject to certain limits.

*BBA 97.* The BBA 97 provides for revisions in payment for outpatient therapy services in certain settings. For 1998, these services will be paid the lesser of the actual charges for the services or the adjusted reasonable costs for the services minus beneficiary coinsurance payments. Adjusted reasonable costs are defined as operating costs and capital costs reduced by 10%. Beginning in 1999, payment for these services will be equal to 80% of the lesser of the actual charge for the services, or 80% of the applicable physician fee schedule amount.

These payment revisions apply specifically to outpatient physical therapy services (including outpatient speech-language pathology services) and outpatient occupational therapy services furnished (1) by a rehabilitation agency, public health agency, clinic, CORF, or skilled nursing facility; (2) by a home health agency to an individual who is not homebound; or (3) by another entity under an arrangement with the entities in specified above. They also apply to outpatient physical therapy services (including outpatient speech-language pathology services) and outpatient occupational therapy services furnished by (1) a hospital to an outpatient or to a hospital inpatient who is entitled to benefits under Medicare Part A but has exhausted benefits for inpatient hospital services during a spell of illness, or (2) another entity under an arrangement with a hospital described above beginning in 1999.

The BBA 97 also replaces, beginning in 1999, the current \$900 per beneficiary cap with a \$1,500 per beneficiary cap applied to all outpatient services provided by physical therapists (except those services provided by hospitals). A separate \$1,500 cap applies to all outpatient occupational therapy services (except those provided by hospitals). Beginning in 2002, the amount will increase by the MEI, rounded to the nearest multiple of \$10.

The BBA 97 requires the Secretary to report to the Congress, by no later than January 1, 2001, on recommendations on a revised coverage policy of outpatient physical therapy services and outpatient occupational therapy services based on a classification of individuals by diagnostic category and prior use of services, in both inpatient and outpatient settings, in place of uniform dollar limitations. The recommendations are required to include how a system of durational limits by diagnostic category might be implemented in a budget-neutral manner.

### ***Replacement of Reasonable Charge Methodologies by Fee Schedules***

*Current Law.* Medicare pays for most Part B services (including physicians services, lab services, and durable medical equipment on the basis of fee schedules. A few items are still paid on the basis of reasonable charges.

*BBA 97.* BBA 97 authorizes the Secretary to implement statewide or areawide fee schedules for payment of the following specified items and services: medical supplies; home dialysis equipment and supplies; therapeutic shoes; parenteral and enteral nutrients, equipment, and supplies; electromyogram devices; salivation devices; blood products; and transfusion medicine. The fee schedule will be updated each year by the CPI, with no increase for parenteral and enteral nutrients, equipment and supplies to occur before 2003.

### ***Inherent Reasonableness Authority***

*Current Law.* The Secretary is permitted to increase or decrease Medicare payments in cases where the payment amount is “grossly excessive or grossly deficient and not inherently

reasonable.” The Secretary’s authority to make these payment adjustments is generally referred to as “inherent reasonableness authority.”

*BBA 97.* BBA 97 requires the Secretary to describe by regulation the factors to be used in determining cases in which application of Part B payment rules (other than for physicians services) results in amounts not inherently reasonable. The Secretary would provide in these cases for factors to be used in establishing a realistic and equitable amount. The Secretary could not increase or decrease the payment amounts by more than 15 percent from the preceding year, except under specified conditions.

### ***Requirement to Furnish Diagnostic Information***

*Current Law.* Diagnostic test and durable medical equipment suppliers may be required to provide certain diagnostic information when they submit a claim. However, that information may be available only to the ordering physician or other practitioner.

*BBA 97.* The law requires the physician or other practitioner to provide such information to the diagnostic testing or durable medical equipment supplier.

## **Beneficiary Payments**

### ***Part B Premiums***

*Current Law.* The 1997 Part B premium is \$43.80. When Medicare was established in 1965, the Part B monthly premium was intended to equal 50% of program costs. The remainder was to be financed by federal general revenues, i.e., tax dollars. Legislation enacted in 1972 limited the annual percentage increase in the premium to the same percentage by which social security benefits were adjusted for the cost-of-living (i.e., cost-of-living or COLA adjustments). As a result, revenues dropped to below 25% of program costs in the early 1980s. Since the early 1980s, Congress has regularly voted to set the premium equal to 25% of costs. Under current law, the 25% provision is extended through 1998; the COLA limitation would again apply in 1999.

*BBA 97.* The agreement permanently sets the Part B premium at 25% of program costs. (See “Transfer of Some of Home Health Benefits Part B,” below, for a discussion of the impact on the Part B premium of the transfer of home health costs from Part A to Part B.)

**Table 3** shows the estimated premium under current law as in effect prior to BBA (assuming no Medicare Part B changes) and under BBA 97. It should be noted that the estimated premium changes reflect not only the fact that the premium is permanently set at 25%, but also all other changes affecting Part B.

**Table 3. Estimated Medicare Part B Monthly Premium**  
(Calendar years 1998-2002)

	1998	1999	2000	2001	2002
Current Law	\$45.80	47.10	48.50	50.00	51.50
BBA 97	\$45.70	\$50.60	\$55.30	\$60.70	\$67.00

**Source:** Congressional Budget Office.

### *Assistance for Low-Income*

*Current Law.* Medicare beneficiaries are liable for specific cost-sharing charges, namely premiums, deductibles, and coinsurance. Certain low-income beneficiaries, known as qualified Medicare beneficiaries (QMBs), are entitled to have their Medicare cost-sharing charges paid by the federal-state Medicaid program. A QMB is an aged or disabled person with income at or below the federal poverty line (\$7,890 for a single and \$10,610 for a couple in 1997) and resources below \$4,000 for an individual and \$6,000 for a couple. Medicaid protection is limited to payment of Medicare cost-sharing charges unless the individual is otherwise entitled to Medicaid.

States are also required to pay Medicare Part B premiums for Specified Low-Income Medicare beneficiaries (SLIMBs). These are persons who meet the QMB criteria, except that their income is slightly over the QMB limit. The SLIMB limit is 120% of the federal poverty line. Medicaid protection is limited to payment of the Medicare Part B premium unless the individual is otherwise entitled to Medicaid.

The federal government and the states share in the payment for QMB and SLIMB benefits according to the matching formula applicable for Medicaid services (known as the Federal Medical Assistance Percentage (FMAP)).

*BBA 97.* The Medicaid portion of the law requires states to pay Part B premiums for beneficiaries with incomes up to 135% of poverty. For Medicare beneficiaries with incomes between 135% and 175% of poverty, state Medicaid programs are required to cover that portion of the Medicare Part B premium attributable to the transfer of home health visits. These new state requirements apply to premiums payable between January 1998 and December 2002.

The federal government will pay 100% of the costs associated with expanding Medicare Part B premium assistance from 120% to 135%, as well as the extra premium cost attributable to the home health transfer for persons between 135% and 175%. To cover these costs, the Secretary will be required to provide for allocations to states based on the sum of (1) a state's number of Medicare beneficiaries with incomes between 135% and 175% of poverty and (2) twice the number of Medicare beneficiaries with incomes between 120% and 135% of poverty, relative to the sum for all eligible states. Total amounts available for allocations are \$200 million for FY1998, \$250 million for FY1999, \$300 million for FY2000, \$350 million for FY2001, and \$400 million for FY2002. The FMAP for each participating state will be 100% up to the state's allocation. If a state exceeds its allocation, the FMAP will be zero. Payments are to be made from Medicare Part B for the costs of this program.

## **Prevention Initiatives**

### ***Mammography Services***

*Current Law.* Medicare provides coverage for screening mammograms. Frequency of coverage is dependent on the age and risk factors of the woman. For women ages 34-39, one test is authorized. For women ages 40-49, a test is covered every 24 months, except, an annual test is authorized for women at high risk. Annual tests are covered for women ages 50-64. For women aged 65 and over, the program covers one test every 24 months. Medicare's Part B deductible and coinsurance apply for these services.

*BBA 97.* BBA authorizes coverage for annual mammograms for all women ages 40 and over and waives the deductible for screening mammograms. These provisions are effective January 1, 1998.

### ***Screening Pap Smear and Pelvic Exams***

*Current Law.* Medicare covers a screening Pap smear once every 3 years. The Secretary is permitted to specify a shorter time period in the case of women at high risk of developing cervical cancer.

*BBA 97.* BBA authorizes coverage, every 3 years, for a screening pelvic exam which includes a clinical breast examination. Coverage is authorized on a yearly basis for both Pap smears and screening pelvic exams for women at high risk of developing cervical or vaginal cancer. Coverage is also authorized on a yearly basis for a woman of childbearing age who has had a positive test in any of the preceding 3 years. The deductible would not apply for these services. The provisions are effective January 1, 1998.

### ***Prostate Cancer Screening Tests***

*Current Law.* Medicare does not cover prostate cancer screening tests.

*BBA 97.* BBA 97 authorizes an annual prostate cancer screening test for men over age 50. The test could consist of any (or all) of the following procedures: (1) a digital rectal exam; (2) a prostate-specific antigen blood test; and (3) after 2002, other procedures as the Secretary finds appropriate for the purpose of early detection of prostate cancer. The provisions are effective January 1, 2000.

### ***Colorectal Screening***

*Current law.* Medicare does not cover preventive colorectal screening procedures. Such services are only covered as diagnostic services.

*BBA 97.* BBA 97 authorizes coverage of, and establishes frequency limits for, colorectal cancer screening tests. A covered test is any of the following procedures furnished for the purpose of early detection of colorectal cancer: (1) screening fecal-occult blood test (for persons over 50, no more than annually); (2) screening flexible sigmoidoscopy (for persons over 50, no more than one every 4 years); (3) screening colonoscopy for high-risk individuals (limited to one every 2 years); and (4) other procedures as the Secretary finds appropriate for the purpose of early detection of colorectal cancer. The Secretary is required to publish, within 90 days of enactment,

a determination on the coverage of screening barium enema. Payment limits are established for the tests. The provision is effective January 1, 1998.

### ***Diabetes Screening Tests***

*Current Law.* In general, Medicare covers only those items and services which are medically reasonable and necessary for the diagnosis or treatment of illness or injury. In addition, Medicare covers home blood glucose monitors and associated testing strips for certain diabetes patients. Home blood glucose monitors enable diabetics to measure their blood glucose levels and then alter their diets or insulin dosages to ensure that they are maintaining an adequate blood glucose level. Home glucose monitors and testing strips are covered under Medicare's durable medical equipment benefit. Coverage of home blood glucose monitors is currently limited to certain diabetics, formerly referred to as Type I diabetics, if: (1) the patient is an insulin-treated diabetic; (2) the patient is capable of being trained to use the monitor in an appropriate manner, or, in some cases, another responsible person is capable of being trained to use the equipment and monitor the patient to assure that the intended effect is achieved; and (3) the device is designed for home rather than clinical use.

*BBA 97.* Effective July 1, 1998, Medicare's covered benefits will include diabetes outpatient self-management training services. These services are defined as including educational and training services furnished (at such times as the Secretary determines appropriate) to an individual with diabetes by a certified provider in an outpatient setting. They will be covered only if the physician who is managing the individual's diabetic condition certifies that the services are needed under a comprehensive plan of care to ensure therapy compliance or to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) to participate in the management of the individual's condition. Certified providers for these purposes are defined as physicians or other individuals or entities that, in addition to providing diabetes outpatient self-management training services, provide other items or services reimbursed by Medicare. Providers must meet quality standards established by the Secretary. They would be deemed to meet the Secretary's standards if they meet standards originally established by the National Diabetes Advisory Board and subsequently revised by organizations who participated in the establishment of standards of the Board, or if they are recognized by an organization representing persons with diabetes as meeting standards for furnishing such services. In establishing payment amounts for diabetes outpatient self-management training provided by physicians and determining the relative value for these services, the Secretary is required to consult with appropriate organizations, including organizations representing persons or Medicare beneficiaries with diabetes.

In addition, beginning July 1, 1998, Medicare will cover blood glucose monitors and testing strips for Type I or Type II diabetics (without regard to a person's use of insulin, as determined under standards established by the Secretary in consultation with appropriate organizations). The national payment limit for testing strips is reduced by 10% beginning January 1, 1998.

The Secretary, in consultation with appropriate organizations, is required to establish outcome measures, including glycosolated hemoglobin (past 90-day average blood sugar levels), for purposes of evaluating the improvement of the health status of Medicare beneficiaries with diabetes. The Secretary is also required to submit recommendations to Congress from time to time on modifications to coverage of services for these beneficiaries.

### ***Bone Mass Measurements***

*Current Law.* Medicare does not include specific coverage of bone mass measurement.

*BBA 97.* Effective July 1, 1998, coverage is authorized for bone mass measurement for the following high risk persons: an estrogen-deficient woman at clinical risk for osteoporosis; an individual with vertebral abnormalities; an individual receiving long-term glucocorticoid steroid therapy; an individual with primary hyperparathyroidism; or an individual being monitored to assess osteoporosis drug therapy. The Secretary would be required to establish frequency limits.

### ***Preventive Injections***

*Current Law.* Medicare covers influenza and pneumococcal pneumonia vaccines. HCFA, in conjunction with the Centers for Disease Control and the National Coalition for Adult Immunization, conducts an Influenza and Pneumococcal Vaccination Campaign.

*BBA.* BBA 97 extends the campaign through the end of FY2002.

### ***Study on Preventive Benefits***

*Current Law.* No provision

*BBA 97.* The law provides for a study to analyze the potential expansion or modification of preventive and other services covered under Medicare. The study is to consider both the short term and long term benefits and costs to Medicare. It must include specific findings with respect to the following: (1) nutrition therapy, including parenteral and enteral nutrition, and including the provision of such services by a registered dietician; (2) skin cancer screening; (3) medically necessary dental care; (4) routine patient care costs for beneficiaries enrolled in approved clinical trial programs; and (5) elimination of the time limitation for coverage of immunosuppressive drugs for transplant patients; and skin cancer screening.

## **Parts A and B**

### **Supplementary Coverage**

#### ***Medigap Enrollment***

*Current Law.* Medigap is the term used to describe individually-purchased Medicare supplement policies. In 1990, Congress provided for a standardization of Medigap policies; the intention was to enable consumers to better understand policy choices. Implementing regulations generally limit the number of different types of Medigap plans that can be sold in a state to no more than 10 standard benefit plans; these are known as Plans A through J. The Plan A standardized package covers a basic benefits package. Each of the other nine plans includes the basic benefits plus a different combination of additional benefits.

All insurers offering Medigap policies are required to offer a 6-month open enrollment period for persons turning age 65. This is known as guaranteed open enrollment. There is no guaranteed open enrollment provision for the under-65 disabled population.

At the time insurers sell a Medigap policy, whether or not during an open enrollment period, they are permitted to limit or exclude coverage for services related to a preexisting health condition; such exclusions cannot be imposed for more than 6 months. An individual who has met the preexisting condition limitation in one Medigap policy does not have to meet the requirement under a new policy for previously covered benefits. However, an insurer could impose exclusions for newly covered benefits.

Federal requirements for open enrollment and limits on preexisting condition exclusions are designed to insure beneficiaries have access to Medigap protection. However, persons who disenroll (or wish to disenroll) from managed care plans and move back into fee-for-service Medicare may not have the same access to Medigap coverage as those who join during the open enrollment period.

*BBA 97.* The law guarantees issuance of specified Medigap policies without a pre-existing condition exclusion for certain continuously enrolled individuals. The insurer is prohibited from discriminating in the pricing of such policy on the basis of the individual's health status, claims experience, receipt of health care, or medical condition.

The guaranteed issuance is extended to the following persons provided they enroll within 63 days of termination of other enrollment:

- (i) An individual enrolled under an employee welfare benefit plan that provides benefits supplementing Medicare and the plan terminates or ceases to provide such benefits.
- (ii) A person enrolled with a Medicare+Choice organization who discontinues enrollment under circumstances permitting disenrollment other than during an annual election period. (These include: (1) the termination of the entity's certification, (2) the individual moves outside of the entity's service area; or (3) the individual elects termination due to cause.)
- (iii) An individual enrolled with an HMO and enrollment ceases for the reasons noted above.
- (iv) An individual enrolled under a Medigap policy and enrollment ceases because : (1) of the bankruptcy or insolvency of the issuer, or because of other involuntary termination of coverage and there is no provision under applicable state law for the continuation of such coverage, or (2) the issuer substantially violates a material provision; or (3) the issuer materially misrepresented the policy's provisions.
- (v) An individual who: (1) was enrolled under a Medigap policy; (2) subsequently terminates such enrollment and enrolls with a Medicare+Choice organization, a risk or cost contract HMO, a similar organization operating under a demonstration project authority, or a Medicare SELECT policy; and (3) terminates such enrollment during any period within the first 12 months during which the individual is permitted to terminate enrollment, but only if the individual was never previously enrolled with such an entity.
- (vi) An individual who upon first becoming eligible for Medicare at age 65, enrolls in a Medicare+Choice plan, and disenrolls from such plan within 12 months.

The guaranteed issue is generally for Policy “A”, “B”, “C” or “F.” (These four policy types account for an estimated three-fourths of new Medigap sales.). However: (1) for persons described in (v) it refers to the same policy in which the person was previously enrolled; and (2) for persons described in (vi) it is for any Medigap policy. At the time of the event which resulted in the cessation of enrollment or loss of coverage, the organization, insurer, or plan administrator (whichever was appropriate) would have to notify the individual of his or her rights and the obligations of issuers of Medigap policies.

BBA 97 prohibits the imposition of a preexisting exclusion period for persons who on the date of application, have at least six months of creditable coverage. Specifically, such an exclusion can not be imposed on an individual who, on the date of application, has a continuous period of at least 6 months of health insurance coverage defined as “creditable coverage” under the Health Insurance Portability and Accountability Act (HIPAA). If the individual has less than 6 months coverage, the policy would have to reduce the period of any pre-existing exclusion by the aggregate of periods of “creditable coverage” applicable to the individual as of the enrollment date. The rules used to determine the reduction would be based on rules used under HIPAA.

BBA 97 provides for high deductible Medigap plans. Specifically, it adds 2 plan types to the current list of 10 standard Medigap plans. These will offer the benefit package of either Plan F or Plan J, except for the high deductible feature. The high deductible is \$1,500 in 1998 and 1999, increased by the CPI in subsequent years. The beneficiary would be responsible for expenses up to this amount.

### ***Payments for Persons Receiving Care at Military Facilities***

*Current Law.* Medicare generally is barred from making payments for services furnished, paid for, or authorized by a governmental entity. Thus Medicare does not pay for services provided to military retirees at Department of Defense (DoD) facilities.

*BBA 97.* BBA 97 authorizes a 3-year demonstration project at six sites under which beneficiaries would be able to enroll in the DoD TRICARE managed care program or continue to use military treatment facilities on a space available basis. Beneficiaries could also receive services through a Medicare+Choice plan. Payments will equal 95% of what would be paid to a Medicare+Choice organization for that individual. The agreement provides for a detailed study by the GAO.

BBA 97 does not provide for a Veterans Affairs (VA) demonstration; however, it does require the Secretary of HHS and VA to jointly submit to Congress a detailed implementation plan for a subvention demonstration project for veterans. The plan must be submitted within 12 months of the start of the project for military retirees.

## **Home Health Services**

### ***Payment Reform***

*Current Law.* Medicare reimburses home health agencies on a retrospective cost-based basis. This means that agencies are paid after services are delivered for the reasonable costs (as defined by the program) they have incurred for the care they provide to program beneficiaries, up to certain limits.

Cost limits are determined separately for each type of covered home health service (skilled nursing care, physical therapy, speech pathology, occupational therapy, medical social services, and home health aide), and according to whether an agency is located in an urban or rural area. Cost limits, however, are applied to aggregate agency payments; that is, an aggregate cost limit is set for each agency that equals the agency's limit for each type of service multiplied by the number of visits of each type provided by the agency. Limits for the individual services are set at 112% of the mean labor-related and nonlabor per visit costs for freestanding agencies (i.e., agencies not affiliated with hospitals). To reflect differences in wage levels from area to area, the labor-related portion of a service limit is adjusted by the current hospital wage index. Cost limits are updated annually by applying a MBI to base year data derived from home health agency cost reports.

Cost-based reimbursement for home health care has been criticized as providing few incentives for maximizing efficiency, minimizing costs, or controlling volume of services. It is cited as one of the reasons for the significant growth in home health spending since 1989. Spending has increased from \$2.5 billion in 1989 to \$18.1 billion in 1996, for an average annual rate of growth of 33%. Most of the growth in spending has been the result of an increasing volume of services being covered under the program, both in terms of increases in the numbers of users as well as the number of covered visits per user.

In provisions contained in the Orphan Drug Act of 1983, OBRA 87 and OBRA 90, Congress required the Secretary to develop alternative methods for paying for home health care on a prospective basis. In 1994, the Office of Research and Demonstration in HCFA completed a demonstration project that tested prospective payment on a per visit basis. Preliminary analysis indicates that the per visit prospective payment methodology had no effect on cost per visit or volume of visits. HCFA has begun a second project, referred to as Phase II, to test prospective payment on a per episode basis, and has also undertaken research to develop a home health case-mix adjustor that would translate patients' varying service needs into specific reimbursement rates.

*BBA 97.* The Secretary is required to establish a prospective payment system (PPS) for home health and implement the system beginning October 1, 1999. All services covered and paid on a reasonable cost basis at the time of enactment of BBA 97, including medical supplies, must be paid on a prospective basis. For the new prospective system, the Secretary will consider an appropriate unit of service and the number, type, and duration of visits provided within that unit, potential changes in the mix of services provided within that unit and their cost, and a general system design that provides for continued access to quality services. All home health care agencies will be paid according to the PPS. In implementing the system, the Secretary can provide for a transition of not longer than 4 years during which a portion of the payment will be based on agency-specific costs, but only if aggregate payments are not greater than they would have been if a transition had not occurred.

Under the new system, the Secretary will compute a standard prospective payment amount (or amounts) that will initially be based on the most current audited cost report data available to the Secretary. For FY2000, payment amounts under the prospective system must be computed in such a way that total payments will equal amounts that would have been paid had the system not been in effect, but will also reflect a 15% reduction in cost limits and per beneficiary limits in effect September 30, 1999. To assure savings from this reduction, the Secretary will be required to reduce cost limits and per beneficiary limits in effect September 30, 1999, by 15%, even if the Secretary is not prepared to implement the new system on October 1.

The payment amount for a unit of home health service will be adjusted by a case-mix adjustor factor established by the Secretary to explain a significant amount of the variation in the cost of different units of service. The labor-related portion of the payment amount will be adjusted by an area wage adjustment factor that reflects the relative level of wages and wage-related costs in a particular geographic area as compared to the national average.

Claims for home health services furnished on or after October 1, 1998, will have to contain an appropriate identifier for the physician prescribing home health services or certifying the need for care. Claims will also be required to include information on the length of time of a service unit, as measured in 15 minute increments. The categories of services for which time information must be included on a claim are skilled nursing care; therapies—physical and occupational therapy and speech language pathology; medical social services; and home health aide services.

In order for home health services to be considered covered care, home health care agencies will be required to submit claims for all services, and all payments will have to be made to a home health agency without regard to whether or not the item or service was furnished by the agency, by others under arrangement, or under any other contacting or consulting arrangement.

### ***Interim Payments for Home Health Services***

*Current Law.* Limits on reimbursements for home health exist only in terms of per visit cost limits that are applied to aggregate agency payments; that is, an aggregate cost limit is set for each agency that equals the agency's limit for each type of service multiplied by the number of visits of each type provided by the agency. The per visit limits are set at 112% of the mean labor-related and nonlabor per visit costs for freestanding agencies (i.e., agencies not affiliated with hospitals). The limits are effective for cost reporting periods beginning on or after July 1 of a given year and ending June 30 of the following year.

These limits do not constrain the volume of visits reimbursed; home health agencies are paid for every medically necessary visit they provide, up to their aggregate cost limit. As noted above, most of the growth in home health spending has been the result of an increasing volume of services covered by the program, both in terms of increasing numbers of users, and especially an increasing number of covered visits per person served. The number of persons served with home health per 1,000 enrollees almost doubled between 1989 and 1996, increasing from 50 in 1989 to 99 in 1996. Average number of visits per person served increased from 27 in 1989 to 76 in 1996, an increase of 181 percent. Increasing costs for home health visits have accounted for comparatively little spending growth. Payments per visit increased at a relatively low rate, rising from \$54 per visit in 1989 to \$62 in 1996, a 15 percent increase for the period.

*BBA 97.* Prior to implementation of the new home health PPS, per visit cost limits will be reduced to 105% of the national *median* of labor-related and nonlabor costs for freestanding home health agencies, effective for cost-reporting periods beginning October 1, 1997 (in effect, delaying the cycle for updating the limits).

In addition, home health agencies, for cost reporting periods beginning on or after October 1, 1997, and through September 30, 1999 (when the new home health PPS should go into effect), will be paid the lesser of: (1) their actual costs (i.e., allowable reasonable costs); (2) the per visit limits, reduced to 105% of the national median, applied in the aggregate; or (3) a new blended agency-specific per beneficiary annual limit applied to the agency's unduplicated census count of patients. The blended per beneficiary limit will be based 75% on an agency's own costs per

beneficiary and 25% on the average cost per beneficiary for agencies in the same census region (adjusted for differences in labor costs). These costs will be calculated from cost reports for cost reporting periods ending in FY1994, recognizing 98% of reasonable costs for that period and updating them by the home health market basket. The costs associated with non-routine medical supplies would be included in this calculation. For new providers and those providers without a 12-month cost reporting period ending in FY1994, the per beneficiary limit will equal the median of these limits (or the Secretary's best estimates) applied to home health agencies. Home health agencies that have altered their corporate structure or name will not be considered new providers for these purposes. For beneficiaries using more than one home health agency, the per beneficiary limitation will be prorated among the agencies.

With the per beneficiary limit, home health agencies will for the first time face constraints on the volume of services they provide Medicare beneficiaries. The per beneficiary limit of a given dollar amount (e.g., \$5,000) represents in a general sense the product of the average cost of all visits and the average number of *visits* provided to Medicare beneficiaries. The actual per beneficiary limit that applies to a given agency, of course, will be a blended amount of its own experience (75%) and the region's experience (25%) for cost reporting periods ending in FY1994, with costs updated by the home health market basket. The 75%/25% blend is intended to decrease the cost experience disparity among agencies by slightly increasing the cap for agencies (in each region) with low historical costs and by slightly decreasing the cap for agencies (in each region) with high historical costs.

Note that this per beneficiary limit (e.g., \$5,000) is *not* applied to each individual beneficiary served by the home health agency, but rather to its unduplicated count of Medicare patients. This means that the actual limit faced by the agency is determined by multiplying an agency's per beneficiary limit by the number of people served by that agency. As a result, agencies can serve beneficiaries who cost more than the per beneficiary cap, so long as they also serve persons who cost less. To continue the example of an agency with a per beneficiary cap of \$5,000: if this agency served 3 Medicare beneficiaries in a year, and two beneficiaries cost \$6,000 each and the third \$3,000, the agency would not exceed its limit, since the sum of its cost for these three patients (\$15,000) is the same as its limit (3 x \$5,000).

The Secretary will be required to establish the per visit limits in effect for FY1998 by January 1, 1998, and the per beneficiary limits by April 1, 1998. For subsequent fiscal years (beginning October 1), the Secretary will be required to establish limits by the prior August 1.

Furthermore, the Secretary is required to expand research on a PPS for home health that ties prospective payments to a unit of service, including an intensive effort to develop a reliable case mix adjuster that explains a significant amount of variance in cost. The Secretary is authorized to require all home health agencies to submit additional information that is necessary for the development of a reliable case-mix system, effective for cost reporting periods beginning on or after October 1, 1997.

### ***Extend Savings from Home Health Cost Limits Freeze***

*Current Law.* Home health limits are updated annually. The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) required that there be no updates in home health cost limits (including no adjustments for changes in the wage index or other updates of data) for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996.

*BBA 97.* The Secretary, in establishing home health limits for cost reporting periods beginning after September 30, 1997, will be required to capture the savings stream resulting from the OBRA 93 freeze of home health limits by not allowing for the market basket updates to the limits that occurred during the cost reporting periods July 1, 1994 through June 30, 1996. In granting exemptions or exceptions to the cost limits, the Secretary can not consider the provision for recapturing savings from the OBRA 93 freeze.

### ***Clarification of Part-Time or Intermittent Nursing Care***

*Current Law.* Both Parts A and B of Medicare cover home health visits for persons who need skilled nursing care on an intermittent basis or physical therapy or speech therapy. Once beneficiaries qualify for the benefit, the program covers part-time or intermittent nursing care provided by or under the supervision of a registered nurse and part-time or intermittent home health aide services, among other services. Coverage guidelines issued by HCFA have defined part-time and intermittent.

*BBA 97.* Effective for services furnished on or after October 1, 1997, Medicare statute will include definitions for part-time and intermittent skilled nursing and home health aide services. For purposes of receiving skilled nursing and home health aide services, “part-time or intermittent” is defined as skilled nursing and home health aide services furnished any number of days per week as long as they were furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). For purposes of qualifying for Medicare’s home health benefit because of a need for intermittent skilled nursing care, “intermittent” is defined as skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care was finite and predictable).

### ***Study on Definition of Homebound***

*Current Law.* In order to be eligible for home health care, a Medicare beneficiary must be confined to his or her home. The law specifies that this “homebound” requirement is met when the beneficiary has a condition that restricts the ability of the individual to leave home, except with the assistance of another individual or with the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. The law further specifies that while an individual does not have to be bedridden to be considered confined to home, the condition of the individual should be such that there exists a normal inability to leave home, that leaving home requires a considerable and taxing effort by the individual, and that absences from home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment.

*BBA 97.* The Secretary of Health and Human Services is required to conduct a study on the criteria that should be applied for determining whether an individual should be considered homebound for purposes of qualifying for Medicare’s home health benefit. The criteria should include the extent and circumstances under which a person may be absent from the home but nonetheless qualify. The Secretary is required to report to Congress by October 1, 1998, and make specific recommendations on such criteria.

### ***Payment Based on Location Where Home Health Service is Furnished***

*Current Law.* Some home health agencies are established with the home office in an urban area and branch offices in rural areas. Payment is based on where the service is billed, in this case the urban area with its higher wage rate, even if the service had been delivered in a rural area.

*BBA 97.* Effective for cost reporting periods beginning on or after October 1, 1997, home health agencies will be required to submit claims on the basis of the location where a service is actually furnished.

### ***Normative Standards for Home Health Claims Denials***

*Current Law.* As long as they remain eligible, home health users are entitled to unlimited number of visits.

*BBA 97.* Effective for services furnished on or after October 1, 1997, the Secretary is required to establish normative guidelines for the frequency and duration of home health services. Payments will be denied for visits that exceed the normative standards. The Secretary is also authorized to establish a process for notifying a physician when the number of home health visits furnished according to a prescription or certification of the physician significantly exceeds the threshold normative guidelines. The Secretary may adjust thresholds to reflect demonstrated differences in the need for home health services among different beneficiaries.

### ***No Home Health Benefits Based Solely on Drawing Blood***

*Current Law.* In order to qualify for Medicare's home health benefit, a person must be homebound and be in need of intermittent skilled nursing care or physical or speech therapy. Once a person qualifies for home health, they become entitled to all covered home health services. In 1989, the Health Care Financing Administration published revised manual instructions that clarified the criteria which must be met for Medicare coverage of home health services. These instructions specified that skilled nursing services that qualified a person for home health included, among other things, venipuncture (the drawing of a blood specimen).

*BBA 97.* BBA 97 clarifies that a person can not qualify for Medicare's home health benefit on the basis of needing skilled nursing care for venipuncture for the purpose of obtaining a blood sample. Note that for persons needing only a blood draw, Medicare will pay a clinical lab to travel to a homebound beneficiary's home to obtain the specimen (section 1833(h)(3)). This service is covered as a clinical lab test. As a clinical lab test, the blood draw does not entitle the beneficiary to any other service. Also note that persons who had been receiving home health services on the basis of needing a blood draw may continue to qualify if they demonstrate a need for other skilled nursing or therapy services.

### ***Transfer of Some of the Home Health Benefit to Part B***

*Current Law.* Both Parts A and B of Medicare cover home health. Neither Part of the program applies deductibles or coinsurance to covered visits, and beneficiaries are entitled to an unlimited number of visits as long as they meet eligibility criteria. Section 1833(d) of Medicare law prohibits payments to be made under Part B for covered services to the extent that individuals are

also covered under Part A for the same services. As a result, the comparatively few persons who have no Part A coverage are the only beneficiaries for whom payments are made under Part B.

*BBA 97.* BBA 97 gradually transfers from Part A to Part B home health visits that are not part of the first 100 visits following a beneficiary's stay in a hospital or SNF (i.e. post-institutional visits) and during a home health spell of illness.

The transfer will be phased-in over a period of *6 years*, between 1998 and 2003, with the Secretary transferring one-sixth of the aggregate expenditures associated with transferred visits in 1998; two-sixths in 1999; three-sixths in 2000; four-sixths in 2001; five-sixths in 2002; and six-sixths in 2003. Beginning January 1, 2003, Part A will cover only post-institutional home health services for up to 100 visits during a home health spell of illness, except for those persons with Part A coverage only, who will be covered for services without regard to the post-institutional limitation.

The increase in the Part B premium attributable to transferred expenditures will be phased in over a period of *7 years*, between 1998 and 2004. For 1998, the Part B premium will be increased by one-seventh of the extra costs due to the transfer; for 1999, the Part B premium will be increased by two-sevenths of the extra costs; for 2000, three-sevenths; for 2001, four-sevenths; for 2002, five-sevenths; for 2003, six-sevenths; and for 2004, the total of the extra costs due to the transfer. CBO has estimated that the extra monthly Part B premium costs attributable to the transfer are \$2.70 for 1999; \$4.10 for 2000; \$5.90 for 2001; \$8.10 for 2002; \$10.40 for 2003; and \$12.70 for 2004.

Post-institutional home health services are defined for these purposes as services furnished to a Medicare beneficiary: (1) after an inpatient hospital or rural primary care hospital stay of at least 3 consecutive days, initiated within 14 days after discharge; or (2) after a stay in a SNF, initiated within 14 days after discharge. Home health spell of illness is defined as the period beginning when a patient first receives post-institutional home health services and ending when the beneficiary had not received inpatient hospital, SNF, or home health services for 60 days.

Claims administration for transferred visits will continue to be done by Part A fiscal intermediaries. In addition, BBA 97 lowers the hearing threshold from \$500 to \$100 for home health services covered under Part B.

In related Medicaid provisions, states will receive allotments to cover under their Medicaid programs that portion of the Medicare Part B premium attributable to the transfer of visits to Part B for Medicare beneficiaries with incomes between 135% and 175% of poverty. The federal government will pay 100% of these costs, just so long as a state does not exceed its allotment. (See "Assistance for Low-Income," above.)

BBA 97 also includes a provision requiring the Secretary, not later than October 1, 1997, to report to the Commerce, Ways and Means, and Finance Committees on an estimate of Medicare home health outlays under parts A and B during each of FY1998 through FY2002. Not later than the end of each of the years 1999 through 2002, the Secretary is also required to submit a report that compares actual outlays with estimated outlays. If the Secretary finds for a fiscal year that actual outlays were greater than estimated outlays, the report is also required to include recommendations regarding beneficiary copayments or such other methods as will reduce the growth in outlays for Medicare home health services.

## **Integrated Acute and Long-Term Care Programs**

### *Extension of Certain Demonstration Programs*

*Current Law.* At various times over the years, Congress has required the Secretary to grant waivers of certain Medicare and Medicaid requirements for certain demonstration programs. One of these projects, known as the Programs of All Inclusive Care for the Elderly, or PACE projects provide health and long-term care services on a capitated basis to frail elderly persons at risk of institutionalization. Another demonstration, Social Health Maintenance Organizations (SHMOs), provides integrated health and limited long-term care services on a prepaid capitation basis to Medicare beneficiaries; its waivers expire at the end of 1997. Two other projects, the Municipal Health Services Demonstration Project and the Community Nursing Organization Demonstration, also have expiring waivers.

*BBA 97.* BBA 97 includes provisions to establish PACE as a permanent benefit category under Medicare and an optional benefit under Medicaid. States are permitted to limit under their Medicaid programs the number of persons enrolled in PACE programs. Waivers for SHMOs are extended through December 31, 2000, and the number of persons who can be served per site is expanded from 12,000 to 36,000. The Municipal Health Services Demonstration is extended through December 31, 2000, and the Community Nursing Organization Demonstration for 2 years.

## **Program Administration; Management Initiatives**

### *Medicare Secondary Payer*

*Current Law.* Generally, Medicare is the primary payer, that is, it pays health claims first, with an individual's private or other public plan filling in some or all of the coverage gaps. In certain cases, the individual's other coverage pays first, while Medicare is the secondary payer. This is known as the Medicare secondary payer (MSP) program. The MSP provisions apply to group health plans for the working aged, large group health plans for the disabled, and employer health plans (regardless of size) for the end-stage renal disease (ESRD) population. The MSP provisions for the disabled expire October 1, 1998. The MSP provisions for the ESRD population apply for 12 months, except the period is extended to 18 months for the February 1, 1991-October 1, 1998 period.

The law authorizes a data match program which is intended to identify potential secondary payer situations. Medicare beneficiaries are matched against data contained in the Social Security Administration and Internal Revenue Service files to identify cases where a working beneficiary (or working spouse) may have employer-based health insurance coverage. Recent court action has made recoveries more difficult in certain cases.

*BBA 97.* The provisions relating to the disabled and the data match program are made permanent. The application of the MSP provisions for the ESRD population is extended to 30-months. This will apply to items and services furnished on or after enactment with respect to periods beginning on or after the date that is 18 months prior to enactment.

The provision also clarifies Medicare's recovery authority. It permits recovery of MSP incorrect payments within 3 years of the date of service. It also permits recovery of MSP incorrect

payments from third-party administrators of primary plans. This recovery provision would not apply in cases where the third-party administrator would not be able to recover from the employer or plan due to insolvency or bankruptcy or where the third-party administrator is not employed by or under contract with the employer or group health plan at the time the recovery action is initiated.

### ***Competitive Bidding***

*Current Law.* Medicare does not use competitive bidding for the selection of providers authorized to provide covered services to beneficiaries.

*BBA 97.* The law requires the Secretary to implement five competitive bidding demonstration projects. Under each project, up to 3 competitive acquisition areas in each project are to be established for furnishing Part B services (except for physicians services). Different areas could be established for different classes of items and services. At least one demonstration project will include oxygen and oxygen equipment. The Secretary will conduct a competition among individuals and entities supplying items and services for each acquisition area. The Secretary can not award a contract unless the Secretary finds that the entity meets quality standards. The Secretary is authorized to limit the number of contractors in an area to the number needed to meet projected demand. Payment can not be made in a competitive acquisition area to a noncontracting entity unless the Secretary finds that the expenses are incurred in a case of urgent need or other circumstances specified by the Secretary. The Secretary is required to evaluate the projects. The Secretary could expand a project to additional competitive acquisition areas if the Secretary determines, based on the evaluations, that there is clear evidence that a project results in reduced federal expenditures and does not have an adverse impact on access, diversity of product selection, and quality.

## **Commissions**

### ***Medicare Payment Advisory Commission***

*Current Law.* The Prospective Payment Assessment Commission (ProPac) is charged with reporting each year its recommendation of an update factor for PPS hospital payment rates and for other changes in reimbursement policy. It is also required each year to submit a report to Congress which provides background information on trends in health care delivery and financing. The Physician Payment Review Commission (PPRC) makes recommendations to Congress concerning physician payments; it is also charged with additional responsibilities relating to the Medicare and Medicaid programs as well as the health care system more generally.

*BBA 97.* The law replaces ProPac and PPRC with a 15-member Medicare Payment Advisory Commission (MedPAC). The Commission is charged with specific review responsibilities for both Medicare+Choice and the fee-for-service system (FFS) and is required to make recommendations to Congress concerning payment policies under Medicare.

### ***Establishment of Commissions to Address Long-Term Issues***

*Current Law.* No provision.

*BBA 97.* The law establishes a 17-member National Bipartisan Commission on the Future of Medicare. Four members are to be appointed by the President; six members are to be appointed by the Speaker of the House in consultation with the Minority Leader (of whom no more than 4 are of the same party); six members are to be appointed by the Majority Leader of the Senate in consultation with the Minority Leader (of whom no more than 4 are of the same party); and one member who will serve as Chairman will be jointly appointed by the President, Speaker, and Majority Leader.

The Commission is required to review the long-term financial condition of Medicare; identify problems that threaten the financial integrity of the trust funds (including the financial impact of the increase in the number of beneficiaries that will occur with the baby boom and the extent to which current update indexes do not accurately reflect inflation), and analyze potential solutions. It is required to make recommendations concerning the following issues: (1) restoring financial solvency and integrity; (2) establishing an appropriate financial structure for the program as a whole; (3) establishing the appropriate balance of benefits and beneficiary contributions; (4) financing graduate medical education (GME); (5) whether the eligibility age should be modified to conform to that applicable to social security; (6) the feasibility of allowing those between age 62 and the Medicare eligibility age to buy into the program; (7) impact of chronic disease and disability trends on the future costs and quality of services under the current system; and (8) time periods during which recommendations in (1) - (3) should be implemented. It is further required to make recommendations concerning a comprehensive approach to preserve the program.

The Commission is to be appointed by December 1, 1997. It is to submit a report by March 1, 1999. The report is to include only those detailed recommendations, findings, and conclusions of the Commission that receive approval of at least 11 members of the Commission.

## **Fraud and Abuse**

*Current Law.* Federal penalties for fraudulent activities in health care include civil and criminal penalties, as well as permissive and mandatory exclusions from federal health care programs. Program-related anti-fraud provisions are generally found in Title XI of the Social Security Act, and these provisions are reinforced by general federal health care criminal provisions in Title 18 of the United States Code.

Recent additions to anti-fraud efforts enacted by Title II of the Health Insurance Portability and Accountability Act include: a new fraud and abuse control program to coordinate federal, state and local law enforcement efforts against fraud in federal and private health care programs; a new Medicare integrity program providing for contracting with private entities for audits and other provider review activities; a beneficiary incentive program to encourage individuals to report fraudulent activities against federal health care programs; a national health care fraud and abuse data collection program containing reports of final adverse actions against health care providers, suppliers, and practitioners; and, written advisory opinions to be issued by the Secretary of HHS regarding whether proposed business transactions violate anti-kickback restrictions.

*BBA 97.* The BBA 97 strengthens fraud and abuse civil and criminal penalties and increases efforts to combat fraud and abuse in several ways. A “three strikes and you’re out” provision is added excluding a provider from federal health care programs for 10 years for a second fraud-related offense, and permanently excluding a provider from federal health care programs for a third offense. The Secretary is given authority to bar felons from participation in federal health care programs and to exclude entities controlled by a family member of a sanctioned individual;

to impose new civil money penalties for persons who contract with an excluded provider; to require surety bonds of at least \$50,000 for certain Medicare providers such as home health care providers, durable medical equipment providers and rehabilitation agencies as a condition of participation in Medicare after January 1, 1998; to require surety bonds of at least \$50,000 for home health agencies and durable medical equipment suppliers under the Medicaid program as of January 1, 1998; and to impose a civil money penalty on health plans that fail to report adverse actions under the health care data collection program. In addition, a beneficiary may request an itemized bill for Medicare services. A toll-free telephone number will be included in beneficiary explanation of benefits forms to report fraud and abuse. Written advisory opinions may be requested concerning whether certain physician self-referrals are prohibited under federal law. Further, hospital discharge planning evaluations must include information on the availability of Medicare home health services, as well as information on the hospital's financial interest in any such agencies. The new provisions also require GAO to submit its first report on the new Medicare fraud and abuse control program 2 years earlier than scheduled, and the definition of "reasonable costs" of medical services under Medicare has been clarified.

## **Medicare+Choice**

Under current law, persons enrolling in Medicare have two basic coverage options. They may elect to obtain services through the traditional fee-for-service system under which program payments are made for each service rendered. Under Section 1876 of the Social Security Act, they may also elect to enroll with a managed care organization which has entered into a payment agreement with Medicare. Three types of managed care organizations are authorized to contract with Medicare: an entity that has a risk contract with Medicare, an entity that has a cost contract with Medicare, or a health care prepayment plan (HCPP) that has a cost contract to provide Medicare Part B services. Risk-contracts are frequently referred to as TEFRA *risk* contracts and *cost* contracts are frequently referred to as TEFRA cost contracts. TEFRA refers to the 1982 legislation, the Tax Equity and Fiscal Responsibility Act of 1982, which established the rules governing these types of contracts.

A beneficiary in an area served by an HMO or competitive medical plan (CMP) with a Medicare risk contract may voluntarily choose to enroll in the organization. (A CMP is a health plan that is not a federally qualified HMO but that meets specific Medicare requirements.) Medicare makes a single monthly capitation payment for each of its enrollees, called the adjusted average per capita cost or AAPCC (discussed below). In return, the entity agrees to provide or arrange for the full range of Medicare services through an organized system of affiliated physicians, hospitals, and other providers. In general, the beneficiary must obtain all covered services through the HMO or CMP, except in emergencies. The beneficiary may be charged the usual cost-sharing charges or pay the equivalent in the form of a monthly premium to the organization. In 1995, risk plans were authorized to offer point-of-service options (POS) in which enrollees can go out of plan for services, with cost sharing responsibilities varying with the choice of provider (the highest cost sharing associated with the use of non-network providers).

Beneficiaries are expected to share in any of the HMO's/CMP's projected cost savings between Medicare's capitation payment and what it would cost the organization to provide Medicare benefits to its commercial enrollees through the provision of additional benefits. (It could also return the "savings" to Medicare.)

Beneficiaries may also enroll in organizations with TEFRA cost contracts. These entities must meet essentially the same conditions of participation as risk contractors; however they may have

as few as 1,500 enrollees (rather than 5,000) to qualify. Under a cost contract, Medicare pays the actual cost the entity incurs in furnishing covered services (less the estimated value of beneficiary cost-sharing). A third type of managed care arrangement is the HCPP. A HCPP arrangement is similar to a TEFRA cost-contract except that it provides only Part B services. Further, there are no specific statutory conditions to qualify for a HCPP contract.

Any Medicare beneficiary residing in the area served by an HMO/CMP may enroll, with two exceptions. The first exception applies to beneficiaries not enrolled in Part B. The second exception applies to persons qualifying for Medicare on the basis of end-stage renal disease (ESRD); however, persons already enrolled who later develop ESRD may remain enrolled in the entity.

The HMO/CMP must have an annual open enrollment period of at least 30 days duration. During this period, it must accept beneficiaries in the order in which they apply up to the limits of its capacity, unless to do so would lead to violation of the rule requiring HMOs to have no more than 50% of their enrollees as Medicare-Medicaid beneficiaries or to an enrolled population unrepresentative of the population in the area served by the HMO.

An enrollee may request termination of his or her enrollment at any time. An individual may file disenrollment requests directly with the HMO or at the local Social Security Office. Disenrollment takes effect on the first day of the month following the month during which the request is filed. The HMO may not disenroll or refuse to re-enroll a beneficiary on the basis of health status or need for health services.

The Secretary is authorized to prescribe procedures and conditions under which eligible organizations contracting with Medicare may inform beneficiaries about the organization. Brochures, applications forms, or other promotional or informational material may be distributed only after review and approval by the Secretary of HHS. HMOs may not disenroll or refuse to re-enroll a beneficiary because of health status or need for health care services. HMOs must provide enrollees, at the time of enrollment and annually thereafter, an explanation of rights to benefits, restrictions on services provided through nonaffiliated providers, out-of-area coverage, coverage of emergency and urgently needed services, and appeal rights. A terminating HMO must arrange for supplementary coverage for Medicare enrollees for the duration of any preexisting condition exclusion under their successor coverage for the lesser of 6 months or the duration of the exclusion period.

Provider Sponsored Organizations (PSOs) and Preferred Provider Organizations (PPOs) that are not organized under the laws of a state and are neither a federally qualified HMO or CMP are not eligible to contract with Medicare under the risk contract program. A PSO is generally a cooperative venture of a group of providers who control its delivery and financial arrangements. PPOs are generally groups of physicians and hospitals who contract with an insurer or employer to serve a group of enrollees on a fee-for-service basis at negotiated rates that are lower than those charged to nonenrollees. PPOs do not traditionally have primary care gatekeepers.

Enrollees in risk contract HMOs have the same balance billing protections as beneficiaries under Medicare FFS, so long as they do not obtain unauthorized services from a provider that is not part of the HMO's network. Under current Medicare FFS, participating physicians agree to accept Medicare's payment amount as payment in full. They can only bill patients for the coinsurance and any unmet deductible. Physicians who are not "participating physicians" in the Medicare program, and not accepting Medicare's payment as payment in full, can bill beneficiaries only

15% above Medicare's recognized payment amount.<sup>7</sup> The amount in excess of Medicare's recognized payment amount is known as "balance billing." Balance billing limits do not apply to certain services (e.g., durable medical equipment).

As noted above, a risk contract HMO agrees to provide or arrange for the full scope of covered Medicare services in return for a single monthly capitation payment issued by Medicare for each enrolled beneficiary, the AAPCC. The AAPCC is Medicare's estimate of 95% of the average per capita amount it would spend for a given beneficiary (classified by certain demographic characteristics and county of residence) who was not enrolled in an HMO and who obtained services on the usual fee-for-service basis.

The AAPCCs are calculated from Medicare's fee-for-service expenditures in a county. As a result, the AAPCCs include amounts that Medicare pays to hospitals in an area for indirect medical education (IME) and direct medical education (DME) costs and for providing care to a disproportionate share of low-income beneficiaries (i.e., the disproportionate share adjustment or DSH). These amounts may not correspond with actual risk plan costs, however, because not all such plans have medical education programs or use teaching or DSH hospitals.

## **Medicare+Choice Plan Options and Enrollment**

The BBA 97 amends Medicare to establish a new Part C, Medicare+Choice. Every individual entitled to Medicare Part A and enrolled in Part B will be able to elect the existing package of Medicare benefits through two options: the existing Medicare fee-for-service program (Medicare FFS) or through a Medicare+Choice plan. A Medicare+Choice plan can be: (i) a coordinated care plan (including an HMO (with or without a point-of-service plan), a PPO, or a PSO), (ii) a private fee-for-service plan (private FFS),<sup>8</sup> or (iii) a combination of a medical savings account (MSA) plan and contributions to a Medicare+Choice MSA. Up to 390,000 individuals can enroll in MSA plans. (The specific rules for MSA plans are described below.) Individuals with end stage renal disease (ESRD) cannot enroll in a Medicare+Choice plan but can remain in one if they are diagnosed after joining.

After a transition period in which individuals are able to make and change elections on an ongoing basis, elections will be made and changed only during an annual coordinated election period. (There will also be a 3-month period after making an election in which an individual can change their election.) Additional election periods (called "special election periods") will apply for newly eligible Medicare beneficiaries and beneficiaries who experience certain events (for example, the individual is no longer eligible to participate in a plan because he or she moves.) **Table 4** summarizes the enrollment schedule.

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<sup>7</sup> Medicare's recognized payment for these physicians is actually 95% of the fee schedule amount for the service.

<sup>8</sup> The private fee-for-service plan is defined as a plan that reimburses hospitals, physicians, and other providers at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk; does not vary rates for a provider based on the utilization relating to the provider; and does not restrict the selection of providers among those who are lawfully authorized to provide the covered services and agree to accept the terms and conditions of payment established by the plan.

**Table 4. Transition to Annual Coordinated Election of Medicare+Choice Plans**

Date	Event
June 1, 1998	Secretary of HHS must issue regulations implementing standards (other than those for solvency) for Medicare+Choice plans. Medicare+Choice contracts cannot be signed until such standards are in place.  Upon signing a contract with HHS, Medicare+Choice plans begin accepting Medicare beneficiaries on a continuous open enrollment and continuous disenrollment basis.
November 1998	Medicare+Choice Information Fair—nationwide coordinated educational and publicity campaign. Individuals can begin enrolling in Medicare+Choice MSAs (with coverage becoming effective beginning January 1, 1999).
January 1, 1999	Current risk contract enrollees are hereafter considered to be enrolled in Medicare+Choice plans. MSA plans begin providing coverage.
November 1999	First coordinated annual election period for Medicare+Choice plans (for coverage becoming effective January 1, 2000) and first mailing of informational materials to all Medicare beneficiaries.
December 31, 2001	Last day of continuous open enrollment/disenrollment during which an individual can change elections an unlimited number of times.
January 1, 2002	First year in which elections become locked in. First 6 months of 2002 is a transition period when an individual can change election <i>only once</i> (other than an election during the coordinated annual election period or in the case of an event qualifying for a special election). Limited exceptions are provided.
December 31, 2002	New elections end for Medicare+Choice MSA plans (unless 390,000 cap is reached prior to this date).
January 1, 2003	New elections become effective the first day of January following each election period. Each year there is a 3-month period when an individual can change election one time. Otherwise, elections cannot be changed until the next annual coordinated election period (unless individual qualifies for special enrollment period). Limited exceptions are provided.

*Marketing Rules.* Medicare+Choice organizations and the plans they offer to Medicare beneficiaries will have to meet certain marketing rules. They will have to submit marketing material to the Secretary at least 45 days before distribution. The material can then be distributed if it is not disapproved by the Secretary. The Secretary is required to disapprove such material if it is materially inaccurate or misleading. Each organization will have to conform to fair marketing standards, and will not be able to permit an organization to provide for cash or other monetary rebates as an inducement for enrollment or otherwise. The Secretary is permitted to prohibit an organization (or its agent) from completing any portion of any election form on behalf of any individual.

*Information to Beneficiaries.* The Secretary is required to provide for activities to disseminate broadly information on Medicare FFS and Medicare+Choice plans to current and prospective Medicare beneficiaries. The information has to be comparative to help beneficiaries make informed choices among available options. The Secretary is required to conduct an educational and publicity campaign during November 1998 to inform Medicare+Choice individuals about the identity of Medicare+Choice plans and risk contract plans offered in different areas and the election process. As shown in **Table 4**, the Secretary also is required to hold a Medicare+Choice health information fair every November, beginning with 1999.

*Nondiscrimination.* Medicare+Choice organizations are required to accept eligible individuals without restriction during election periods. (Election periods may also be referred to as open enrollment periods.) In general, organizations and plans cannot deny enrollment on the basis of

health-status related factors. These include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) and disability. These provisions do not apply if they will result in enrollment substantially misrepresentative of the Medicare population in the service area. Organizations also cannot terminate an enrollee's election except for failure to pay premiums on a timely basis, disruptive behavior, or because the plan ends for all Medicare+Choice enrollees.

### **Medicare+Choice Benefits and Beneficiary Cost-Sharing**

Each Medicare+Choice plan will have to provide the same benefits as required under Medicare FFS. It will also have to provide additional benefits and reduced cost-sharing if Medicare's payment to the plan is less than the plan's cost of providing the basic Medicare benefits to commercial enrollees. A plan will also be able to offer extra benefits, known as supplemental benefits. (See MSA description below for different requirements on MSA plans.)

All Medicare+Choice enrollees will pay the Part B premium. Additional beneficiary out-of-pocket liabilities will differ depending on the type of Medicare+Choice plan the individual elects. Enrollees in Medicare+Choice coordinated care plans are likely to experience the least amount of out-of-pocket costs (compared to other Medicare+Choice options). For them, the amount of cost-sharing per enrollee (including premium) for covered services can be no more than the actuarial value of the deductibles, coinsurance, and copayments under Medicare FFS. A physician, provider, or other entity cannot impose balance billing charges on coordinated care enrollees. Coordinated care plans will have to pay noncontracting providers at least the same amount they would have received if the enrollee was in Medicare FFS, including allowed balancing billing amounts. The rules for MSA plans and private FFS plans are different, as shown in **Table 5**.

The rules in **Table 5** apply to the basic benefit package and required additional benefits. The basic benefit package includes benefits required under Medicare FFS. Medicare+Choice plans might also have to cover additional benefits as part of the basic package if their capitation payment exceeds the estimate of the amount it would cost them to cover Medicare's benefits for a commercial population. The term "contract provider" refers to providers who have entered into an explicit agreement with a plan establishing payment amounts for services rendered to the plan's enrollees. A provider can be deemed to have a contract with a Medicare+Choice private fee-for-service plan if, before furnishing services to the enrollee of such a plan, the provider: (i) received a notice of the individual's enrollment in a private fee-for-service plan and had been informed of the terms and conditions of the plan's payment or (ii) if the provider was given reasonable opportunity to obtain such information.

### **Medicare+Choice Beneficiary Protections**

Each Medicare+Choice plan will have to provide specific information to enrollees at the time of enrollment and annually thereafter about plan features, including information on quality of care, utilization review, and the specific procedures for grievances and appeals.

Each plan will also have to ensure access to emergency services for emergency medical conditions. The law uses the prudent layperson definition: an emergency medical condition is one manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could

reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the individual in serious jeopardy (and in case of a pregnant women, her health or that of her unborn child); (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

Medicare+Choice organizations and plans will have to comply with specific quality assurance requirements. All plans will have to have a quality assurance program that: stresses health outcomes and provides for data permitting measurement of outcomes and other indices of quality; monitors and evaluates high volume and high risk services and the care of acute and chronic conditions; evaluates the continuity and coordination of care that enrollees receive; is evaluated on an ongoing basis as to its effectiveness; includes measures of consumer satisfaction, and provides the Secretary with certain information to monitor and evaluate the plan's quality. Only coordinated care plans (and not private fee-for-service and non-network MSA plans) will have to comply with other quality assurance requirements, such as providing for internal peer review, establishing written protocols for utilization review, and establishing mechanisms to detect under and over utilization.

In addition, Medicare+Choice organizations will have to obtain external review of the quality of their inpatient and outpatient services and of their response to written complaints about poor quality of care from an independent quality review and improvement organization (such as a Peer Review Organization). However, the Secretary is required to ensure that the external review activities do not duplicate the review activities conducted as part of the accreditation process. Also, the Secretary may waive the external review requirement if she determines that the organization has consistently maintained an excellent record of quality assurance and compliance with other Medicare+Choice requirements.

**Table 5. Beneficiary Cost-Sharing and Provider Reimbursement Under Medicare+Choice Plans for Basic Benefit Package**

Item	Coordinated Care Plan	Private Fee-For- Service Plan	MSA Plan
Beneficiary out-of-pocket costs (premium plus any deductibles, coinsurance, and copayments)	Premium and actuarial value of other cost-sharing (e.g., coinsurance) on average cannot exceed the actuarial value of the cost-sharing applicable on average under Medicare FFS.	The actuarial value of the cost-sharing (not including the premium) on average cannot exceed the actuarial value of cost-sharing on average under Medicare FFS.	A deductible of no more than \$6,000 (indexed for inflation in future). Amounts above Medicare FFS payments (including coinsurance) do not have to be counted towards satisfying the deductible.  Once deductible is met, MSA plan would have pay for all Medicare-covered expenses including cost-sharing. Plans are allowed to charge beneficiary for services not covered by Medicare (e.g., very long hospital stays or experimental treatments).

Item	Coordinated Care Plan	Private Fee-For- Service Plan	MSA Plan
Beneficiary Liability for Balance Billing	Beneficiaries are not liable for any balance billing amounts.	Contract providers can bill 15% above the private fee schedule (or other provider reimbursement amount).  Non-contract providers cannot balance bill beneficiaries.	Balance billing is allowed and would not be subject to any limits, regardless of whether the deductible has been met.
Medicare+Choice Plan Payment Obligation to Physicians, Hospitals, and other Providers	Contract providers are paid fees or rates that are privately negotiated by the plan with them.  Non-contract providers must accept as payment in full Medicare's fee schedule (or other Medicare reimbursement rate) including the allowed balance billing amounts (if any) allowed under Medicare.	Contract providers are paid private fees (or rates) minus beneficiary cost-sharing amounts. Fee schedule or rates must be as generous as Medicare unless plan has a sufficient number and range of provider contracts.  Non-contract providers—same as for non-contract providers in coordinated care plans.	Above the deductible, plan reimburses provider for traditional Medicare FFS amounts including coinsurance.
Medicare+Choice Payments Received by Physicians, Hospitals, and other Providers	Contract providers receive payments based on a privately negotiated fee schedule.  Non-contract providers receive payments based on traditional Medicare payment systems, including allowable balance billing (paid by the plan).	Contract providers receive payment based on a private fee schedule and can collect up to 15% additional from the beneficiary.  Non-contract providers—same as for non-contract providers in coordinated care plans	Providers receive payments based on their charges.  After the beneficiary's deductible is met, the plan's payment is based on traditional Medicare payment systems, but unlimited balance billing is allowed.

**Source:** Table prepared by Congressional Research Service and Physician Payment Review Commission.

*Grievances and Appeals.* A Medicare+Choice organization will have to have meaningful procedures for hearing and resolving grievances between the organization and enrollees. It will also have to maintain a process for making determinations regarding whether an individual enrolled within the plan is entitled to receive a health service and the amount (if any) that the individual is required to pay with respect to the service. These determinations will have to be made on a timely basis, depending on the urgency of the situation. The explanation of the determination will have to be in understandable language and state the reasons for the denial. A description of the reconsideration and appeals processes will have to be provided.

Upon request by the enrollee, the organization generally will have to provide for reconsideration of a determination. The reconsideration will have to be done within a time period specified by the Secretary, but (except for those falling under expedited determinations and reconsiderations) no longer than 60 days after the date of the receipt of the request. A reconsideration relating to a determination to deny coverage based on lack of medical necessity will have to be made by a physician with appropriate expertise who is other than a physician involved in the initial determination.

An enrollee in a Medicare+Choice plan or a physician will be able to request an *expedited determination or an expedited reconsideration*. In the case of a request for an expedited determination or reconsideration made by a physician, a Medicare+Choice organization will be required to expedite the determination or reconsideration if the request indicates that the application of the normal time frame for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. The time limits for the organization to respond to the request will be established by the Secretary generally but will have to be within 72 hours of the time of receipt of the request for determination or reconsideration.

### **Medicare+Choice Provider Protections and Requirements**

Each Medicare+Choice organization will be required to establish reasonable procedures relating to the participation of physicians under a Medicare+Choice plan offered by the organization. The procedures include: (i) providing notice of the rules regarding participation; (ii) providing written notice of adverse participation decisions; and (iii) providing a process for appealing adverse decisions. The organization will have to consult with contracting physicians regarding the organization's medical policy, quality, and medical management procedures. The use of gag clauses (restricting communications between providers and their patients) will be prohibited. The use of physician financial incentive plans will be limited. (A financial incentive plan is any compensation arrangement between the organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided to enrollees.)

### **Medicare+Choice Payments to Plans**

The Secretary will make monthly payments in advance to each organization for each covered individual in a payment area (typically a county) equal to 1/12 of the *annual Medicare+Choice capitation rate* with respect to that individual for that area. The payment will be adjusted for age, disability status, gender, institutional status, and other such risk factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. By March 1, 1999, the Secretary will have to submit to Congress a report on a method of risk adjustment of payment rates that accounts for variations in per capita costs based on health status. By January 1, 2000, the Secretary will have to implement such a risk adjustment methodology. The Secretary will be required to determine annually, and announce before the calendar year concerned, the annual Medicare+Choice capitation rate for each payment area, and the risk and other factors to be used in adjusting such rates.

The major factors for determining Medicare's *annual Medicare+Choice capitation rates* are summarized in **Table 6**. The annual Medicare+Choice capitation rate, for a payment area (for a contract for a calendar year) will equal the greatest of the following:

(A) A *blended capitation rate*, defined as the sum of:

- (1) a percentage of the *annual area-specific Medicare+Choice capitation rate* for the year for the payment area, and
- (2) the national percentage of the *input-price adjusted annual national Medicare+Choice capitation rate* for the year.

The area-specific rate is based on the 1997 AAPCC for the payment area. Rates are updated each year by the national per capita Medicare+Choice growth percentage (described below). The national rate is the weighted average of the area-specific rates.

The percentage applied to the area-specific rate will be reduced in increments over 6 years from 90% to 50% in 2003. The national component of the blend (adjusted to reflect differences in certain input prices, such as hospital labor costs) will be increased over the same 6 years from 10% to 50% so that in 2003 the blended rate will be based on 50% area-specific costs and 50% national, input-price adjusted costs.

A *budget neutrality adjustment* will be applied to the blended rates to ensure that the aggregate of payments for all payment areas equals that which would have been made if the payment was based on 100% of the area-specific Medicare+Choice capitation rates for each payment area.

(B) A *minimum (i.e. "floor")* monthly payment amount set at \$367 for 1998 (but not to exceed, in the case of an area outside the 50 states and the District of Columbia, 150% of the 1997 AAPCC). For a subsequent year, this payment amount will be increased by the national per capita Medicare+Choice growth percentage (described below).

(C) A *minimum percentage increase (i.e., "hold harmless" amount)*. In 1998, the payment area will receive a rate that is 102% of its 1997 AAPCC. For a subsequent year, it will be 102% of its annual Medicare+Choice capitation rate for the previous year.

Payments (direct and indirect) for graduate medical education will be "carved out" of the payments to the Medicare+Choice plans over 5 years. Specifically, in determining the area-specific Medicare+Choice capitation rate, amounts attributable to payments for the indirect costs of medical education, and payments for direct graduate medical education costs will be deducted from the 1997 payment amount as follows: 20% of such payments in 1998; 40% of such payments in 1999; 60% of such payments in 2000; 80% of such payments in 2001; and 100% of such payments in 2002. Payments for disproportionate share hospitals (DSH) will not be carved out.

The national per capita Medicare+Choice growth percentage is defined as the per capita increase in Medicare expenditures minus a specific percentage. For example, in 1999, the Medicare+Choice growth percentage equals the per capita growth in Medicare minus 0.5 percentage points. Over the period 1998-2002, the payments to the floor counties will increase by an average of about 5% annually.

A Medicare+Choice payment area is defined as a county or equivalent area specified by the Secretary. (In the case of individuals determined to have ESRD, the Medicare+Choice payment area is each state, or other payment areas as the Secretary specifies.) Upon request of a state for a contract year (beginning after 1998), the Secretary will redefine Medicare+Choice payment areas in all or a portion of the state to: (1) a single statewide payment area; (2) a metropolitan system; or (3) a single payment area consolidating noncontiguous counties (or equivalent areas) within a state.

Special rules will apply for payments to MSA plans. If the monthly premium for an MSA plan (i.e., a high deductible plan) for a Medicare+Choice payment area is less than 1/12 of the annual Medicare+Choice capitation rate for the area and year involved, the Secretary is required to

deposit the difference in a Medicare+Choice MSA established by the individual. For cases when an MSA election was terminated before the end of the year, the Secretary will have to establish a procedure to recover deposits attributable to the remaining months.

Payments to Medicare+Choice organizations and payments to Medicare+Choice MSAs will be made from the Medicare trust funds in such proportion as the Secretary determines reflects the relative weights that benefits under Parts A and B represent of Medicare’s actuarial value of the total benefits. These provisions apply for contracts on or after January 1, 1998.

**Medicare+Choice Premiums**

No later than May 1 of each year, each Medicare+Choice organization will be required to submit to the Secretary for each of its Medicare+Choice plans specific information about premiums, cost-sharing, and additional benefits (if any) and the enrollment capacity (if any) in relation to the plan and the area. The Secretary will be required to review this information and approve or disapprove the premiums, cost-sharing amounts, and benefits. The Secretary will not have the authority to review the MSA premiums or the premiums for the private fee-for-service plans.

Each Medicare+Choice organization will have to permit monthly payment of premiums. An organization will be able to terminate election of individuals for a Medicare+Choice plan for failure to make premium payments but only under specified conditions. A MedicarePlus organization will not be able to provide cash or other monetary rebates as an inducement for enrollment.

**Table 6. Major Factors for Determining Medicare Payments to Medicare+Choice Plans**

Factor	BBA97
Blended counties (blend of local and national rates)	6 years to 50% area-specific/50% national by 2003. National rates are adjusted for differences in input prices.
Minimum payment (“floor”) counties	\$367 in 1998 (minimum of \$367 or 150% of 1997 payment outside US). 1999-2002=previous year’s payment times annual percentage increase.
Minimum percent increase (“hold harmless”) counties	1998 = 102% of 1997 AAPCC; 1999 and thereafter = 102% of prior year’s rate.
Treatment of GME/DSH	Carved out over 5 years. DSH is not carved out.
Budget neutrality	Total Medicare+Choice payments may not exceed what would have been spent if area specific percentage for local rates were 100%.
Annual percentage increase	1998 = increase in Medicare per capita expenditures minus .8 percentage points; 1999-2002 = increase in Medicare per capita expenditures minus .5 percentage points; after 2002 = increase in Medicare per capita expenditures.
Risk adjustment	Payments adjusted by Secretary to reflect demographic and other factors. Study to be done and, starting 2000, payments risk adjusted based on Secretary’s recommendations.

## **Medicare+Choice Organizational and Financial Requirements and PSOs**

In general, a Medicare+Choice organization will have to be organized and licensed under state law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each state in which it offers a Medicare+Choice plan. Special rules will apply to PSOs. A PSO will be able to seek a waiver of state law by filing an application with the Secretary by no later than November 1, 2002. The waiver will be effective for 3 years and will not be renewable. With respect to waiver applications filed on or after the date of publication of the federal solvency standards (see below), the Secretary will have to approve the waiver application if the state denied the PSO's licensing application based on its failure to meet solvency requirements that are the same as the federal ones or that the state imposed as a condition of approval procedures or standards regarding solvency that were different from those applied under federal law.

A waiver granted to a PSO will depend upon the organization's compliance with all state consumer protection and quality standards insofar as such standards: (i) apply in the state to the organization if it were licensed under state law; (ii) are generally applicable to other Medicare+Choice organizations and plans in the state, and (iii) are consistent with the federal standards established under the Act. Certain state standards (described below) will be preempted (overridden) as they apply to PSOs and Medicare+Choice plans more generally.

The Secretary is required to establish, on an expedited basis and using a negotiated rule-making process, final standards related to financial solvency and capital adequacy of organizations seeking to qualify as PSOs. The target date for publication of the resulting rules is April 1, 1998. The negotiated rule-making committee will be appointed by the Secretary. In establishing the standards for PSO solvency, the Secretary is required to take into consideration any standards developed by the National Association of Insurance Commissioners specifically for risk-based health care delivery organizations.

The Secretary also is required to establish by regulation non-solvency standards for Medicare+Choice organizations and plans. By June 1, 1998, the Secretary will have to issue interim standards based on currently applicable standards for Medicare HMOs/CMPs. These federal non-solvency standards will preempt any state law or regulation (including those about to be described) with respect to Medicare+Choice plans to the extent such law or regulation was inconsistent with the federal standards. State standards relating to the following will be preempted: (i) benefit requirements, (ii) requirements relating to inclusion or treatment by providers, and (iii) coverage determinations (including related appeals and grievance processes).

## **Medicare+Choice Contracts**

Contracts with Medicare+Choice organizations will be made for at least 1 year and will be automatically renewable in the absence of notice by either party of intention to terminate. Organizations will have to have at least 5,000 individuals (or 1,500 in the case of a PSO) who are receiving health benefits through the organization or at least 1,500 individuals (or 500 in the case of a PSO) who are receiving health benefits if the organization primarily serves individuals residing outside of urbanized areas.

The Secretary will be able to terminate a contract at any time if the Secretary determines that the organization: (i) fails substantially to carry out the contract; (ii) is carrying it out in a manner substantially inconsistent with the efficient and effective administration of MedicarePlus; or (iii) no longer substantially meets Medicare+Choice conditions.

The Secretary is authorized to carry out specific remedies in the event that a Medicare+Choice organization: (i) fails substantially to provide medically necessary items and services required to be provided, if the failure adversely affects (or has the substantial likelihood of adversely affecting) the individual; (ii) imposes premiums on individuals that are in excess of those allowed; (iii) acts to expel or refuses to re-enroll an individual in violation of federal requirements; (iv) engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by law) of eligible individuals whose medical condition or history indicates a need for substantial future medical services; (v) misrepresents or falsifies information to the Secretary or others; (vi) fails to comply with rules regarding physician participation; or (vii) employs or contracts with any individual or entity that has been excluded from participation in Medicare. The remedies include civil money penalties, and suspension of enrollment until the Secretary is satisfied the deficiency has been corrected and is not likely to recur. A noncomplying contractor can also be terminated from participation in Medicare+Choice.

The BBA 97 provides for the phasing out of risk, cost, and HCPP types of contracts.

### **Medical Savings Account (MSA) Demonstration**

*Current Law.* No provision. (The Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) authorized an MSA demonstration for employed individuals who are not yet eligible for Medicare.)

*BBA97.* The BBA97 includes a Medicare+Choice option that is a combination of an “MSA plan” providing health insurance (annual deductible limited to \$6,000, indexed for inflation) and a “Medicare+Choice MSA.” MSA plans will be limited to a demonstration: the initial year will be 1999 but new enrollments will not be allowed after 2002 or after the number of enrollees reaches 390,000. MSA plans will not be available to certain low-income or disabled individuals, among others. When enrolled in an MSA plan, individuals will not be able to have other health insurance (including Medigap policies), with some exceptions, and they will have to reside in the United States for at least half the year. Individuals will be able to disenroll from an MSA plan only during an annual election period or under special circumstances.

An MSA plan will provide reimbursement for items and services covered under Parts A and B of Medicare, though only after the enrollee incurs *countable* expenses equal to the annual deductible (limited to \$6,000, indexed for inflation). Countable expenses include at least those payable by Medicare under Parts A and B as well as the deductibles, coinsurance, and copayments the enrollee would have paid under those parts. At a plan’s option, other expenses (such as prescription drugs) may also be counted. After the deductible is met, the plan will have to reimburse at least 100% of Parts A and B expenses (the provider charges) or 100% of what Medicare would have paid for these expenses without regard to deductibles or coinsurance, whichever is less. MSA plans will not be subject to balance billing limitations, nor will they have to pay balance billing charges, though some might do so. **(See Table 5.)**

Contributions to a Medicare+Choice MSA will be made annually from the enrollee’s capitation rate after the MSA plan insurance premium has been paid. Contributions to accounts will be exempt from taxes, as will account earnings. Withdrawals will likewise not be taxed nor be subject to penalties if they are used to pay unreimbursed enrollee medical expenses that are deductible under the Internal Revenue Code. However, qualified withdrawals cannot be made

to pay insurance premiums other than for long-term care insurance, continuation coverage (such as COBRA), or coverage while an individual is receiving unemployment compensation.

Non-qualified withdrawals will be included in the individual's gross income for tax purposes. They would also be subject to an additional 50% penalty to the extent they exceed the amount by which the account balance on December 31<sup>st</sup> of the prior year is greater than 60% of the MSA plan deductible for the year of withdrawal. For example, if the account balance on December 31<sup>st</sup> was \$3,500 and the plan deductible the next year was \$5,000, the amount that could be withdrawn for non-qualified purposes without the penalty is \$500 (i.e. \$3,500 minus 60% of \$5,000). The 50% penalty will not apply in cases of death or disability. Account balances at death will be subject to various tax treatments depending on their disposition.

If MSA plan enrollees switch to another Medicare+Choice option or traditional Medicare, they will be able to maintain their account and use it to pay qualified medical expenses. No additional contributions will be allowable unless enrollees elect an MSA plan again.

### **Medicare Competitive Pricing Demonstration**

*Current Law.* Under Section 402 of the Social Security Amendments of 1967 (P.L. 90-248, 42 U.S.C. 1395b-1), the Secretary is authorized to develop and engage in experiments and demonstration projects for specified purposes. One purpose is to determine whether, and if so, which changes in methods of payment or reimbursement for Medicare services, including a change to methods based on negotiated rates, would have the effect of increasing the efficiency and economy of such health services. Under this authority, HCFA is seeking to demonstrate the application of competitive bidding as a method for establishing payments for risk contract HMOs in the Denver area. HCFA's actions have been challenged in the courts, and HCFA will not be allowed to pursue the demonstration in FY1997.

*BBA97.* The BBA requires the Secretary of HHS to establish a demonstration project under which payments to Medicare+Choice organizations in Medicare payment areas in which the project is being conducted are determined in accordance with one of the competitive pricing methodologies established in this provision.

The Secretary is required to designate, in accordance with recommendations of the Competitive Pricing Advisory Committee (CPAC), up to 7 Medicare payment areas in which the project would be conducted. The provision spells out the composition and responsibilities of the CPAC. The CPAC is required to recommend to the Secretary the designation of 4 specific areas to be included. Such recommendations will be made to ensure that payments under the project in 2 areas begin January 1, 1999 and in 2 areas on January 1, 2000. Of the 4 areas recommended, 3 have to be in urban areas and 1 in a rural area. By December 31, 2001, the Committee could recommend to the Secretary the designation of up to 3 additional payment areas to be included in the project. The CPAC will terminate on December 31, 2004.

For each Medicare payment area to be included in the project, the Secretary will (in accordance with recommendations of the CPAC), establish the benefit design among plans, structure the method for selecting plans, establish methods for setting the price to be paid to plans, and provide for the collection and dissemination of plan information. In doing this, the Secretary will have to consult the area advisory committee and will have to monitor the project and report to Congress on its impact.

The BBA97 prohibits the implementation or continuance of ongoing pricing demonstrations.

### **Medicare Choice Enrollment Demonstration**

*Current Law.* HMOs and CMPs with Medicare contracts may directly market to and enroll Medicare beneficiaries.

*BBA97.* The provision authorizes the Secretary to conduct a 3-year demonstration using a third-party contractor to conduct the Medicare Choice plan enrollment and disenrollment functions in an area. The demonstration has to be conducted separately from the Medicare competitive pricing demonstrations. Before implementing the project, the Secretary will have to consult with affected parties on the design of the project, the selection criteria, and the establishment of performance standards. The Secretary will be required to establish performance standards for accuracy and timeliness of enrollment and disenrollment. In the event that the third-party contractor fails to substantially comply with the performance standards, the enrollment and disenrollment functions will be performed by Medicare+Choice organizations until a new contractor is appointed by the Secretary.

## **Cost Estimate of BBA 97**

**Table 7** shows CBO's estimate of the savings over the FY1998-FY2002 period for BBA 97. **Figure 1** shows the distribution of the savings among provider types. The highest level of savings is from hospitals and managed care organizations. Added program benefits cost the program money; however these costs are more than offset by increased beneficiary payments.

**Table 7. CBO Estimate of Medicare Savings in the Balanced Budget Act of 1997, FY1998-FY2002**

(in billion of dollars)

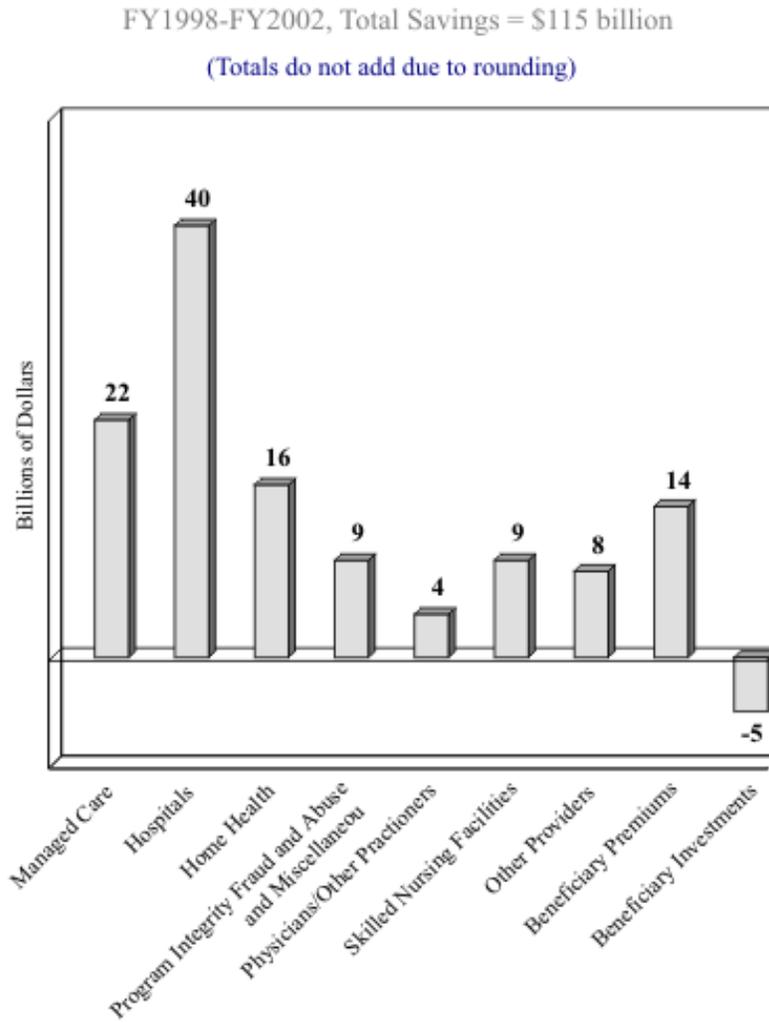
<b>Provision</b>	<b>Savings, FY1998-FY2002</b>	<b>Savings, FY1998- FY2007</b>
<b>Hospitals</b> (inpatient services)	<b>-32.9</b>	<b>-82.8</b>
PPS Update	-17.1	-46.3
PPS Capital	-5.5	-11.9
Definition of Hospital Transfer	-1.3	-4.2
Rural Health Provisions	0.4	0.9
Graduate Medical Education - Indirect Medical Education	-5.6	-17.9
Direct Graduate Medical Education (includes some Part B costs)	-0.9	-3.7
Disproportionate Share (DSH) Payments	-0.6	-0.6
Payment to Teaching and Disproportionate Share Hospitals from Managed Care Rates	4.0	17.3
Eliminate Add-On for Outliers	-2.2	-4.8
Reductions in Payments for Enrollees Bad Debt	-0.5	-1.3
Permanent Extension of Hemophilia Pass Through	0.0	0.1
Increase in Base Payment for Puerto Rico	0.0	0.1
PPS-Exempt Hospitals - Updates, Cap, and Incentives	-3.5	-9.4
PPS- Exempt - Capital, New Providers and Other Policies	-0.5	-0.6
Treatment of Long-Term Care Hospitals Within Other Hospitals	0.1	0.2
PPS for Rehabilitation Hospitals	0.3	-0.7
<b>Skilled Nursing Facilities</b> - (includes Part B impact)	<b>-9.5</b>	<b>-32.4</b>
<b>Hospice Care</b>	<b>-0.2</b>	<b>-0.6</b>
<b>Other Part A</b>	<b>1.1</b>	<b>4.0</b>
Christian Science Sanatoria	0.0	0.0
Organ Procurement Organizations	0.0	0.0
Part A Premium Interaction	1.1	4.0

<b>Provision</b>	<b>Savings, FY1998-FY2002</b>	<b>Savings, FY1998- FY2007</b>
<b>Physicians and Other Practitioners</b>	<b>-4.5</b>	<b>-7.9</b>
Physician Payments - Single Conversion Factor and Updates	-5.3	-11.7
Resource-Based Practice Expenses	0.0	0.0
Direct Payments to Physician Assistants, Nurse Practitioners, and Clinical Nurse Specialists	0.5	1.9
Chiropractors	0.3	1.9
<b>Other Part B Providers and Services</b>	<b>-14.5</b>	<b>-27.2</b>
Durable Medical Equipment	-0.8	-3.1
Durable Medical Equipment - Oxygen	-2.1	-6.6
Hospital Outpatient Departments	-7.2	-4.3
Ambulatory Surgical Centers	-0.3	-1.0
Clinical Laboratories	-1.9	-6.1
Ambulance Services	0.0	-.1
Ambulance Services - Paramedic Intercept Services	0.1	.3
Payments for Drugs	-0.4	-.6
Coverage of Oral Anti-Emetics	0.0	0.1
Rural Health Clinic Services	-0.2	-0.6
Outpatient Therapy Providers	-1.7	-5.2
<b>Services Covered Under Parts A and B</b>	<b>-15.5</b>	<b>-48.3</b>
Home Health Services	-16.2	-49.6
Integrated Acute and Long-Term Care Programs	0.5	0.5
Telemedicine	0.2	0.7
<b>Prevention Initiatives</b>	<b>3.9</b>	<b>8.6</b>
Mammography Screening	0.2	0.4
Screening Pap Smears and Pelvic Exams	0.1	0.3
Prostate Cancer Screening	0.6	1.6
Colorectal Screening (includes some Part A costs)	0.6	0.9
Diabetes Self-Management (includes some Part A costs)	2.1	4.8
Bone Mass Measurement	0.3	0.6
Preventive Injections	0.0	0.0
Study on Preventive Benefits	0.0	0.0

<b>Provision</b>	<b>Savings, FY1998-FY2002</b>	<b>Savings, FY1998- FY2007</b>
<b>Beneficiary Payments</b>	<b>-14.2</b>	<b>-90.3</b>
Reduction in Part A Premium for Certain Public Retirees	0.6	2.2
Part B Premiums - Permanently set at 25% of Costs	-14.9	-92.7
Part B Premium - Disabled Workers	0.1	0.2
<b>Other Provisions</b>	<b>0.3</b>	<b>0.7</b>
Medigap	0.2	0.6
Payments for Persons Receiving Care at Military or Veterans Facilities	0.1	0.1
<b>Medicare Secondary Payer</b>	<b>-7.9</b>	<b>-20.1</b>
<b>Fraud and Abuse</b>	<b>-0.1</b>	<b>-0.3</b>
Advisory Opinions Regarding Self-Referral	0.2	0.2
Fraud and Abuse Provisions (includes some program integrity provisions)	-0.3	-0.5
<b>Medicare Plus/ Medicare Choice</b>	<b>-22.5</b>	<b>-97.0</b>
<b>Total, Net Medicare Outlays</b>	<b>-116.4</b> (\$111.9 after impact of other changes in the law)	<b>-393.8</b> (\$384.9 after impact of other changes in the law)

**Note:** Table prepared by CRS; total may not add due to rounding.

**Figure I. Estimate of Medicare Savings in Conference Agreement on BBA 1997**



Source: Congressional Budget Office.

**Table 8** shows estimated changes in federal spending over the FY1997-FY2002 period attributable to passage of BBA 97. In the absence of this legislation, *total* Medicare spending was expected to grow from \$208.8 billion in FY1997 to \$313.7 billion in FY2002 and \$464.1 billion in FY2007. BBA 97 lowers the projected total spending levels to \$278.9 billion in FY2002 and \$427.5 billion in 2007. The estimated average annual rate of increase in total spending over the FY1997-FY2002 period is lowered from 8.48% to 5.96%; similarly the rate over the 10 year period, FY1997-FY2007, is lowered from 8.31% to 7.43%

*Net* federal spending (after deduction of beneficiary premiums) is also expected to grow at a slower rate. Prior to enactment of BBA 97, net Medicare spending was expected to grow to \$431.8 billion in 2007; with BBA 97, the figure is expected to reach \$374 billion in that year. The estimated average annual rate of increase in net spending over the FY1997-FY2002 period is

lowered from 8.84% to 5.55%; the rate over the 10 year period, FY1997-FY2007, is lowered from 8.64% to 7.09%.

Changes in overall spending are also reflected in changes in per capita spending. *Gross* per capita Medicare payments in FY1997 are estimated at \$5480. These numbers had been projected to grow to \$7746 in 2002 and \$10,620 in 2007. Under BBA they are expected to increase to \$6886 in FY2002 and \$9783 in 2007. This represents a decline in the average annual rate of growth from 7.16% to 4.67% over the FY1997-FY2002 period, and from 6.84% to 5.97% over the FY1997-FY2007 period.

Reductions are also recorded in *net* per capita spending. Net per capita Medicare payments in FY1997 are estimated at \$4950. These numbers had been projected to grow to \$7114 in 2002 and \$9881 in 2007. Under BBA they are expected to increase to \$6101 in FY2002 and \$8558 in 2007. This represents a decline in the average annual rate of growth from 7.52% to 4.27% over the FY1997-FY2002 period, and from 7.16% to 5.63% over the FY1997-FY2007 period.

**Table 8. Impact of BBA 97 on Medicare, FY1997-FY2002**

By Fiscal Year, in Billions of Dollars											
	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>Projected Spending Under Prior Law</b>											
Total outlays <sup>a</sup>	208.8	227.0	248.2	273.0	285.6	313.7	339.4	368.2	409.8	437.6	464.1
Premiums	-20.2	-21.4	-22.4	-23.4	-24.5	-25.6	-26.7	-28.0	-29.3	-30.7	-32.3
Net Medicare outlays <sup>a</sup>	188.6	205.5	225.7	249.5	261.1	288.1	312.6	340.3	380.5	407.0	431.8
<b>Changes, Medicare Provisions of BBA 97</b>											
Total outlays <sup>a</sup>	0	-6.9	-15.5	-27.6	-17.1	-35.9	-33.1	-35.9	-40.8	-55.1	-37.7
Premiums	0	0.2	-0.9	-2.4	-4.1	-6.2	-8.8	-11.8	-15.0	-18.1	-21.2
Net Medicare outlays <sup>a</sup>	0	-6.7	-16.4	-30.0	-21.2	-42.1	-41.9	-47.7	-55.8	-73.2	-58.9
<b>Changes, Medicaid and Pace Provisions of BBA 97</b>											
Total outlays <sup>a</sup>	0	0.7	0.8	0.9	1.0	1.1	0.8	0.8	0.9	1.0	1.1
Premiums	0	0	0	0	0	0	0	0	0	0	0
Net Medicare outlays <sup>a</sup>	0	0.7	0.8	0.9	1.0	1.1	0.8	0.8	0.9	1.0	1.1
<b>Projected Spending Under BBA 97</b>											
Total outlays <sup>a</sup>	208.8	220.7	233.4	246.3	269.5	278.9	307.1	333.1	369.9	383.5	427.5
Premiums	-20.2	-21.2	-23.4	-25.8	-28.6	-31.8	-35.5	-39.8	-44.3	48.8	-53.5
Net Medicare outlays <sup>a</sup>	188.6	199.5	210.0	220.4	241.0	247.1	271.6	293.4	325.6	334.8	374.0

**Source:** Congressional Budget Office.

**Note:** Totals may not add because of rounding.

a. Excludes discretionary administrative costs.

## Provisions Not Included in BBA

The House and Senate reconciliation measures included a number of provisions which were **not included** in the final legislation. The following highlights some of the major provisions which were dropped by the House-Senate conferees.

### *Income-Related Part B Premium*

Under current law, all persons enrolled in Part B pay a premium equal to 25% of program costs. Federal general revenues account for the remaining 75%. The Senate bill would have provided for an income-related Part B premium for individuals with incomes over \$50,000 and couples with incomes over \$75,000. Individuals with incomes at \$100,000 and couples with incomes at \$125,000 would have paid 100% of program costs. The federal subsidy would have been phased-out on a straight-line sliding scale. For individuals, the phase-out would have occurred over the \$50,000 to \$100,000 income range and for couples over the \$75,000 to \$125,000 income range. For example, the 1997 Part B premium is \$43.80 per month (\$525.60 per year) which represents 25% of costs; the federal subsidy is \$131.40 per month (which represents 75% of costs). Over the year, the federal subsidy is \$1,576.80. If the Senate provision were in effect, individuals with incomes over \$100,000, would be subject to a Part B premium of \$2,102.40 (100% of costs). Those with incomes between \$50,000 and \$100,000 would have a premium amount between \$525.60 and \$2102.40. The Congressional Research Service (CRS) estimated that if the Senate provision had been in effect in 1995, 5% of the noninstitutionalized aged population would experience increased premiums.

### *Part B Enrollment and Penalties for Delayed Enrollment*

People generally enroll in Part B when they turn 65. Persons who delay enrollment after their initial enrollment period are subject to a premium penalty. This penalty is a surcharge equal to 10% of the premium amount for each 12 months of delayed enrollment. The House bill would have waived the penalty for certain military retirees.

### *Eligibility Age*

The Social Security Amendments of 1983 raised the full retirement age (the age at which one receives unreduced benefits) for social security cash benefits from age 65 to 67 over the 2003-2027 period. The Senate bill would have raised the Medicare eligibility age from age 65 to 67 according to the same schedule established in law for social security cash benefits.

### *Copayment for Home Health*

Medicare's home health benefit is subject neither to deductibles nor coinsurance. The Senate bill would have established a \$5 per visit copayment for Part B covered home health services, capped annually at an amount equal to the Part A hospital deductible.

### *Centers of Excellence*

HCFA is conducting a bundled payment demonstration project under which 10 facilities, considered “centers of excellence,” are paid a flat fee to provide cataract surgery or coronary artery bypass (CABG) surgery. The facilities were selected on the basis of their experience, outcomes, and efficiency in providing these services.

The House bill would have created a new program, the Centers of Excellence, under which the Secretary would have been required to use a competitive process to contract with specific hospitals or other entities for furnishing services related to surgical procedures, and for furnishing services (unrelated to surgical procedures) to hospital inpatients that the Secretary determines to be appropriate.

### *Medical Malpractice*

There are no uniform federal standards governing health care liability actions. To date, reforms of the medical malpractice system have occurred primarily at the state level and have generally involved changes in the rules governing tort cases. (A tort case is a civil action to recover damages, other than for a breach of contract.) The House bill included provisions which would have provided for federal standards in health care liability actions. They would have established a \$250,000 cap on noneconomic damages; limited a defendant’s liability for the amount of noneconomic damages attributable to that defendant’s proportionate share of fault; limited punitive damages to \$250,000 or three times the amount of economic damages whichever was greater; specified that punitive damages they could only be applied in egregious cases; and provided for a uniform statute of limitations.