

**CONGRESS PASSES BBA REFINEMENT LEGISLATION,
MEDICARE PROVIDERS TO RECEIVE ADDITIONAL
\$16 BILLION OVER FIVE YEARS**

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The President is expected to sign into law a sweeping Medicare and Medicaid legislative package targeted at softening the financial blows many health care providers experienced as a consequence of the Balanced Budget Act of 1997. Specifically, the legislation provides hospitals with \$7.2 billion (including \$800 million to rural hospitals and \$600 million to teaching hospitals) in relief over five years, skilled nursing facilities with \$2.1 billion, home health agencies with \$1.3 billion, and Medicare managed care plans with \$5 billion. The new law also implements physician payment reforms and modifies payments under the Medicaid and State Children's Health Insurance Programs.

The major provisions of the bill are reviewed below by type of provider. Because of the comprehensive nature of this legislation, this summary does not address every provision in the bill.

HOSPITALS

Graduate Medical Education

Direct Graduate Medical Education. In an effort to reduce the wide disparity among providers in payments for direct graduate medical evaluation ("GME"), the bill establishes a new GME payment methodology based on a national average per resident amount, as adjusted for area wage differences. Beginning in FY 2001, hospitals with per resident amounts below 70% of the national average will have their per resident amounts increased to the 70% threshold, while hospitals with per resident amounts that exceed 140% of the national average will have their inflation adjustments for GME payments limited in subsequent years. Hospitals with per resident amounts between 70% and 140% will continue to be paid based upon their hospital-specific per-resident amounts, as adjusted for inflation. This revised GME methodology reportedly will increase GME payments for approximately 270 hospitals and freeze payments for approximately 100 hospitals, while another 700 hospitals will not be affected.

Indirect Medical Education. The new law modifies the freeze in the indirect medical education ("IME") adjustment enacted under the BBA. The IME adjustment will now be frozen at 6.5% through FY 2000, and reduced to 6.25% in FY 2001 and to 5.5% in FY 2002 and subsequent years (compared to 6.5% in FY 1999, 6.0% in FY 2000, and 5.5% in FY 2001 and thereafter under the BBA).

Nursing and Allied Health Professional Education Payments for Medicare+Choice Enrollees. The bill calls for additional payments to hospitals that operate nursing and allied health professional training programs to reflect the utilization of Medicare+Choice enrollees.

Outpatient Services

Transitional Payments. In a provision heavily lobbied by the hospital industry, the bill provides for additional payments to hospitals during the first three years of the outpatient Prospective Payment System ("OPPS") if OPPS payments are less than payments which would have been made prior to the new system.

The payments are a specified percentage of the differences between the old and new payment levels. Designed to smooth the transition to OPPS, these payment floors are expected to restore \$1.4 billion to hospitals over five years.

OPPS Exemptions. The bill provides a temporary exemption from OPPS for rural hospitals and a permanent exemption for cancer hospitals.

Outlier Adjustment. The bill authorizes the Secretary to provide additional payments for high cost, or outlier, patients where the hospital's costs exceed certain thresholds. The payments cannot exceed 2.5% of total OPPS payments up to 2004, and three percent thereafter.

Transitional Pass-Through Payments for Medical Devices, Drugs and Biologicals. The new law will allow for three years of additional payments under OPPS for certain medical devices, drugs and biologicals, including orphan drugs, cancer therapy drugs and biologicals and new medical devices, drugs and biologicals.

Limitations on Copayments. Under the refinement legislation, a beneficiary's copayment for an outpatient procedure can be no higher than the beneficiary's deductible for an inpatient hospital stay under Part A (\$776 in 2000).

Disproportionate Share Hospitals

The bill limits the BBA's reductions in payments to hospitals serving a disproportionate share of low income Medicare and Medicaid patients. While the BBA had reduced disproportionate share hospital ("DSH") payments by three percent in FY 2000, four percent in FY 2001, and five percent in FY 2002, the new law freezes the reduction at three percent for FY 2001 and four percent in FY 2002. In addition, it requires submission of DSH-related data in hospital cost reports for cost reporting periods beginning on or after October 1, 2001.

Rural Hospitals

Reclassification of Urban Hospitals. The legislation permits urban hospitals to apply for designation as rural hospitals, if they are located in a rural census tract of a Metropolitan Statistical Area, are designated by state law or regulation as rural or meet other criteria established by the Secretary. It also permits otherwise qualifying urban hospitals to be classified as sole community hospitals, regional referral centers, or national referral centers.

Critical Access Hospitals. The law expands the criteria for designation as a critical access hospital. These hospitals currently must have hospital stays of no more than 96 hours. Under the refinement law, the 96 hour length of stay limitation for these hospitals will now be applied on the basis of an annual average. The bill also permits for-profit hospitals and hospitals which have closed in the past 10 years to apply for this designation.

Medicare-Dependent Hospitals. The bill extends this program through FY 2006.

Sole Community Hospitals. The law allows rebasing certain sole community hospitals by permitting those currently paid the federal rate to transition to payments based on 1996 costs. In addition, these hospitals will receive payment adjustments for FY 2001 and FY 2002 consisting of the market basket percentage increase minus 1.1%.

Swing Bed Program. This provision obviates the existing requirement that hospitals obtain a state certificate of need to be eligible for the swing bed program, which allows rural hospitals to use inpatient facilities to provide long term care services.

Graduate Medical Education. The law permits rural hospitals to increase their resident limits by 30% for GME and IME. In addition, non-rural facilities that operate rural training programs may increase their resident limits.

Grant Program for Transition to Prospective Payment. Rural hospitals with fewer than 50 beds may apply for \$50,000 grants for implementing data systems to facilitate their transition to OPPTS.

PPS-Exempt Hospitals

Bonus Payments for Long Term Care and Psychiatric Hospitals Pending Development of a Prospective Payment System. The bill increases the TEFRA bonus payments to eligible long-term care and psychiatric hospitals until a prospective payment system is established for these institutions.

Prospective Payment System for Long-Term Care Hospitals. The law requires the Secretary to report to Congress by October 1, 2001 on a discharge-based PPS system for long-term care hospitals, to be implemented in a budget-neutral manner for cost reporting periods beginning on or after October 1, 2002.

Prospective Payment System for Psychiatric Hospitals. Similarly, the Secretary must report to Congress by October 1, 2001 on a per diem-based PPS system for psychiatric hospitals, to be implemented in a budget-neutral manner for cost reporting periods beginning on or after October 1, 2002.

Refinement of Prospective Payment for Rehabilitation Hospitals. The new law requires that the PPS for rehabilitation hospitals be based on discharges or cases rather than on a per-diem basis.

Hospice Care

The bill increases payments for hospice services by 0.5% for FY 2001 and 0.75% for FY 2002. In addition, the legislation requires GAO to conduct a study on hospice payments within one year of the date of enactment.

SKILLED NURSING FACILITIES

Payments for High Cost Cases

The new law provides additional payments under PPS for treatment of high cost patients in skilled nursing facilities (“SNFs”). Per diem payments for 12 complex diagnoses and three rehabilitation diagnoses are increased by 20% for services provided after April 1, 2000 and before October 1, 2000, or until the Secretary implements a modified case mix classification system, whichever is later. In addition, for FY 2001 and FY 2002, the per diem payment is increased by four percent each year for all diagnoses.

Transition to the Federal Rate

The new bill provides that SNFs may elect to waive the current three-year transition to PPS and be paid fully on the basis of the federal per diem rate for cost reporting periods beginning January 1, 2000. SNFs may make this election on or after December 15, 1999, for up to 30 days after the start of a cost reporting period.

Exclusion for Ambulance Services, Prostheses and Chemotherapy Drugs

Effective April 1, 2000, this provision provides for separate payments under PPS for ambulance services furnished in conjunction with renal dialysis provided outside the SNF, certain chemotherapy items and services, radioisotope services and customized prosthetic devices.

HOME HEALTH SERVICES

Delay in 15% Reduction

The law delays the scheduled 15% reduction in total Medicare home health payments if home health PPS is not implemented by October 1, 2000. The 15% reduction will instead be effective 12 months after the beginning of PPS.

Adjustment to Include Administrative Costs

This law provides for the payment of an additional \$10 per beneficiary for collection of home health data under the Outcome and Assessment Information Set (“OASIS”) system. The bill also calls for a GAO report on the costs of OASIS and its impact on patient privacy.

Increase in Per Beneficiary Limits

Under the new law, the agency per beneficiary limits are increased by one percent for cost reports beginning October 1, 1999 or later. For agencies with per beneficiary limits below the national median, the increase is two percent.

Surety Bond Requirements

Under the new law, the surety bond amount is set at the lesser of \$50,000 or 10% of the agency’s prior year Medicare payments. The bond must be effective for four years, or longer if the agency ownership changes, as determined by the Secretary.

PHYSICIAN SERVICES

Calculation of Annual Updates

In order to reduce volatility in physician payments, Congress made a number of changes to the calculation of the conversion factor that is used to translate the physician relative value units into payment amounts. The bill further requires that the Sustainable Growth Rate (“SGR”), which updates the conversion factor based on inflation, enrollment changes and economic growth, be calculated on a calendar basis.

Use of Groups’ Data in Calculating Practice Expense Relative Values

Under the legislation, the Secretary must establish a process under which data collected by private organizations and entities will be accepted and used in calculating rates. Although not specified in the bill, these presumably will include physician groups.

RENAL DIALYSIS SERVICES

Update of the Composite Rate

Congress updated the composite rate—the fixed payment to renal dialysis facilities for the provision of dialysis services—by 1.2% for services performed in 2000 and an additional 1.2% for services furnished in 2001.

AMBULATORY SURGICAL CENTERS

The new law mandates a phase-in of the PPS for ASCs if HCFA fails to utilize new cost survey data in determining the rates. In the first year of PPS, the prospective rate cannot exceed one-third of an ASC’s total payments; in the second year, the new rate cannot exceed two-thirds of total payments.

OTHER MEDICARE PROVISIONS

Moratorium on Cap for Outpatient Therapy Services

The bill provides that the outpatient physical and occupational therapy caps set by the BBA will not apply to services furnished in 2000 and 2001.

Expanded Benefits for Immunosuppressive Drugs

Under the new law, the Secretary must provide for an extension of the current 36 month limit on coverage for immunosuppressive drugs. The extension applies to beneficiaries whose benefits under the current limit expire between January 1, 2000 and December 31, 2004. Beneficiaries whose benefits expire in 2000 and 2001 will receive an additional eight months of coverage. Beginning in May 2001, the Secretary will set an annual limitation on the additional periods of coverage for beneficiaries. The limitation will be based on total expenditures for these expanded benefits, which cannot exceed \$150 million over the five-year period.

Durable Medical Equipment

Payments under the DME fee schedule are increased by 0.3% for 2001 and 0.6% for 2002. These additional payments cannot be taken into account in calculating the payment amounts for future years.

Implementation of Inherent Reasonableness Authority

The bill imposes certain restrictions on the Secretary's ability to exercise "inherent reasonableness" authority. Under this authority, the Secretary may modify payment rates for Part B services other than physician services if the rates are "grossly excessive or grossly deficient." The bill prohibits exercise of this authority until the GAO issues a report on the agency's use of this authority and the Secretary promulgates a final rule.

MEDICARE+CHOICE

Phase-In of Risk Adjustment

Congress slowed the implementation of the risk adjustment to Medicare+Choice rates by providing that payments in FY 2001 will be based 90% on the current method and 10% on a risk-adjusted basis and that payments in FY 2002 will be based 80% on the existing methodology and 20% risk-adjusted.

Changes in Enrollment Rules

The bill permits institutionalized beneficiaries to enroll in a Medicare+Choice plan or change from one plan to another at any time, rather than only during open enrollment. In addition, it permits a plan leaving a payment area to offer beneficiaries the option of continuing enrollment in the plan, so long as the beneficiaries agree to obtain all basic services through plan providers in other areas.

Other Provisions

The legislation contains a number of other Medicare+Choice reforms. Specifically, it

- Extends the cost contract program through 2004
- Provides for bonus payments for plans which enter new unserved areas
- Loosens the restrictions on a plan entering into a new Medicare contract following contract termination by the plan
- Permits flexibility in tailoring benefits and premiums within a service area

- Delays the annual deadline for submission of adjusted community rates
- Reduces the inflation adjustment for FY 2002 to .2%
- Allows plans accredited by approved private organizations to be deemed to have met Medicare+Choice requirements relating to quality assurance, anti-discrimination, access to services, confidentiality and accuracy of enrollee records, advance directives and provider participation rules
- Expands the time periods for HCFA's health information fairs by two months
- Exempts preferred provider organizations from quality assurance requirements in an effort to encourage expansion of Medicare+Choice in rural areas
- Exempts Medicare+Choice plans or enrollees from certain aspects of discharge planning relating to referrals to post-acute facilities and information on home health services
- Requires dedication of user fees to education and enrollment activities
- Clarifies that a user fee is based on a plan's share of the total Medicare population
- Allows plans sponsored by religious fraternal organizations to restrict enrollment to members
- Amends the physician anti-self-referral law (Stark law) to include coordinated care plans in the exception for prepaid health plans
- Makes numerous changes to demonstration projects authorized by the BBA, including a delay in implementation of the competitive bidding demonstration project
- Extends guaranteed Medigap coverage to PACE enrollees

MEDICAID

Disproportionate Share Hospital Payments

Increase for Certain States. The bill increases the ceiling on the federal share of DSH payments for the District of Columbia, Minnesota, New Mexico, and Wyoming. For California, the bill indefinitely extends a unique exception to federal requirements on state payments to public hospitals. This exception is viewed as necessary for the viability of the program in California because of the state's specific funding mechanism.

Clarification on Matching Rates. The bill clarifies that the enhanced federal matching rate used under the Children's Health Insurance Program ("CHIP") is not used to calculate DSH payments.

Extension of Outreach Funding

The bill extends the availability of a \$500 million federal outreach fund for the administrative costs associated with determinations of Medicaid eligibility.

Slowing of Phase-Out of Cost-Based Payment for Federally-Qualified Health Center Services and Rural Health Clinic Services

This provision freezes the phase-down of the cost-based reimbursement system for these facilities. The scheduled phase-down is frozen for FYs 2001 and 2002, and resumes in FY 2003. Cost reimbursement will end in FY 2005. The GAO must report to Congress on the effect of the phase-down on these providers and the populations they serve within 12 months of enactment of the bill.

Medicaid Managed Care Provisions

The new law removes an existing disparity in the law which provides enhanced federal Medicaid matching funding for utilization review and quality control services performed by peer review organizations which contract with the Medicare program. Under the bill, states contracting with PROs certified as meeting the Medicare requirements will receive the same federal matching funds. The bill also eliminates duplicative requirements for external quality review of Medicaid managed care organizations.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Allotments to the States

The bill provides that payments to states will be based more heavily on their proportion of low income children (rather than low income uninsureds, as under current law), and also sets forth new floors and ceilings for allotments. The bill also increases allotments for commonwealths and territories.

Data Collection and Evaluation

The bill appropriates funds for monitoring and evaluating implementation and outcomes and various studies related to the CHIP program.