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BALANCED BUDGET ACT

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

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Balanced Budget Act: Any Proposed Fee-for-Service Payment Modifications Need Thorough Evaluation

Mr. Chairman and Members of the Committee:

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

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

Calls by providers to moderate the effect of BBA changes come at a time when federal budget surpluses and smaller-than-expected increases in Medicare outlays may make it easier to accommodate higher Medicare payments. Indeed, many provider groups contend that BBA changes produced more savings than originally intended. The Congressional Budget Office has revisited and lowered its estimates of Medicare spending since BBA enactment. As a result of the lower projected spending, the estimated savings from the BBA provisions will represent a proportionately larger share of Medicare expenditures. Lower projected Medicare spending, however, does not necessarily mean that the effect of

the BBA changes was greater than intended. Rather, it merely raises again issues of how much the federal government should pay for health care for the elderly and what payment levels are appropriate for the various provider groups.

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

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

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

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

As a result of the swift implementation of the home health IPS and the lack of a transition period, the BBA's impact on home health agencies has been more noticeable. The number of participating agencies declined by 14 percent between October 1997 and January 1999, and utilization has dropped to 1994 levels, the base year for the IPS. However, since the number of HHAs and utilization had both grown considerably throughout most of the decade, beneficiaries are still served by over 9,000 HHAs—approximately the same number that were available just prior to the recent declines. Our interviews with HHAs, advocacy groups, and others in rural areas that lost a significant number of agencies indicated that the recent decline in HHAs has not impaired beneficiary access. While the drop in utilization does not appear to be related to HHA closures, it is consistent with IPS incentives to control the volume of services provided to beneficiaries. In short, after years of substantial increases in home health visits, the IPS has curbed the growth in home health spending. Some of the decline in utilization appears to involve greater sensitivity to who qualifies for the home health care benefit, with some who do not qualify, but who may have been previously served, not receiving services now. There are indications, however, that beneficiaries who are likely to be costlier to serve than the average may have more difficulty than before in obtaining home health services because the revenue caps imposed by the IPS are not adjusted to reflect variations in patient needs. This problem should be ameliorated with the implementation of the PPS. In designing the PPS, it will be essential that HCFA adequately adjust payments to account for the wide differences in patient needs.

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

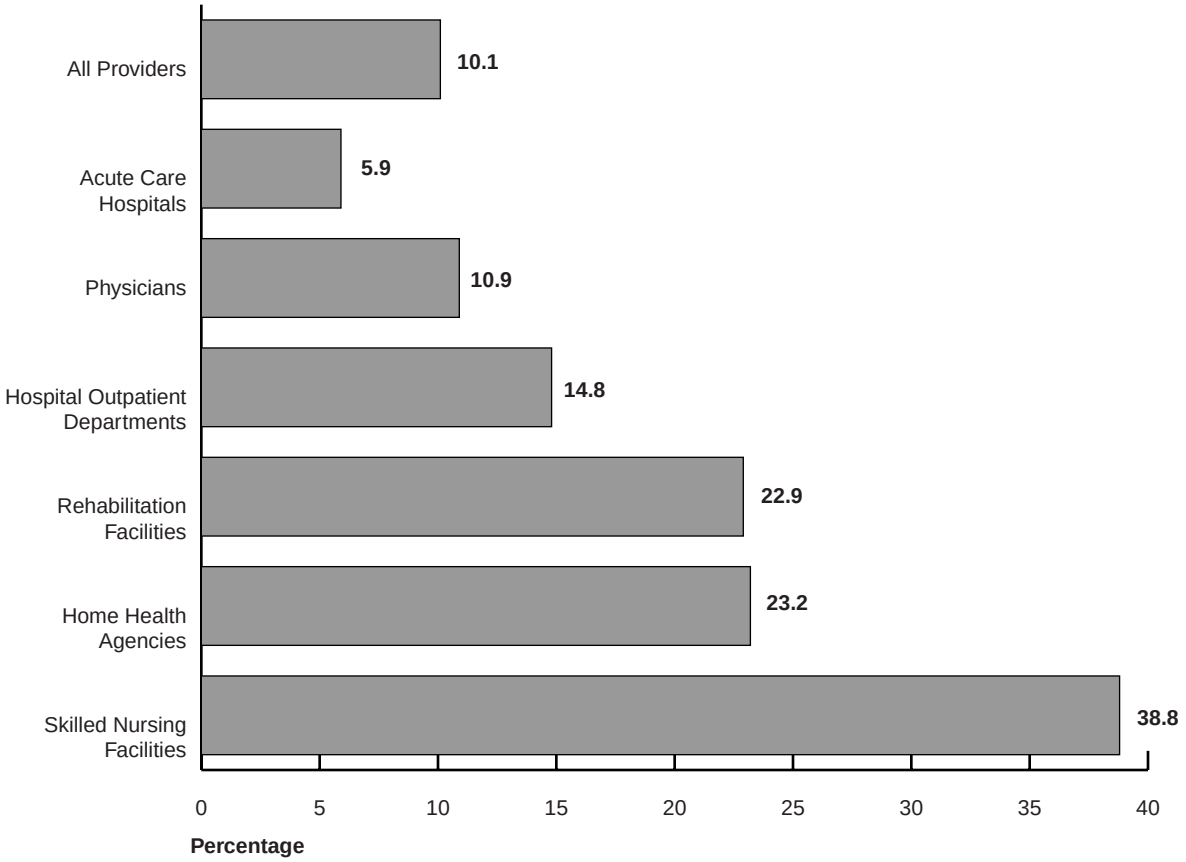
- the particulars of payment mechanisms largely determine the extent to which a reform option can control excess government spending while protecting beneficiary access to care and
- revisions to newly implemented policies should be based on a thorough assessment of their effects so that, at one extreme,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

Background

Medicare is the nation's largest health insurance program, covering about 39 million elderly and disabled beneficiaries at a cost of more than $193 billion a year. The sheer size of this program during a period of

particular concern over government spending made it the target of spending reforms. That Medicare was growing faster than the overall economy and the Medicare Hospital Insurance Trust Fund was facing imminent depletion only heightened attention on this program. Medicare expenditures had been rising at an average annual rate of 10.1 percent between 1985 and 1995 (see fig. 1). While the outlook for the federal budget has changed, with projected surpluses replacing deficits, the importance of ensuring that Medicare is an efficient purchaser of health services remains.

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



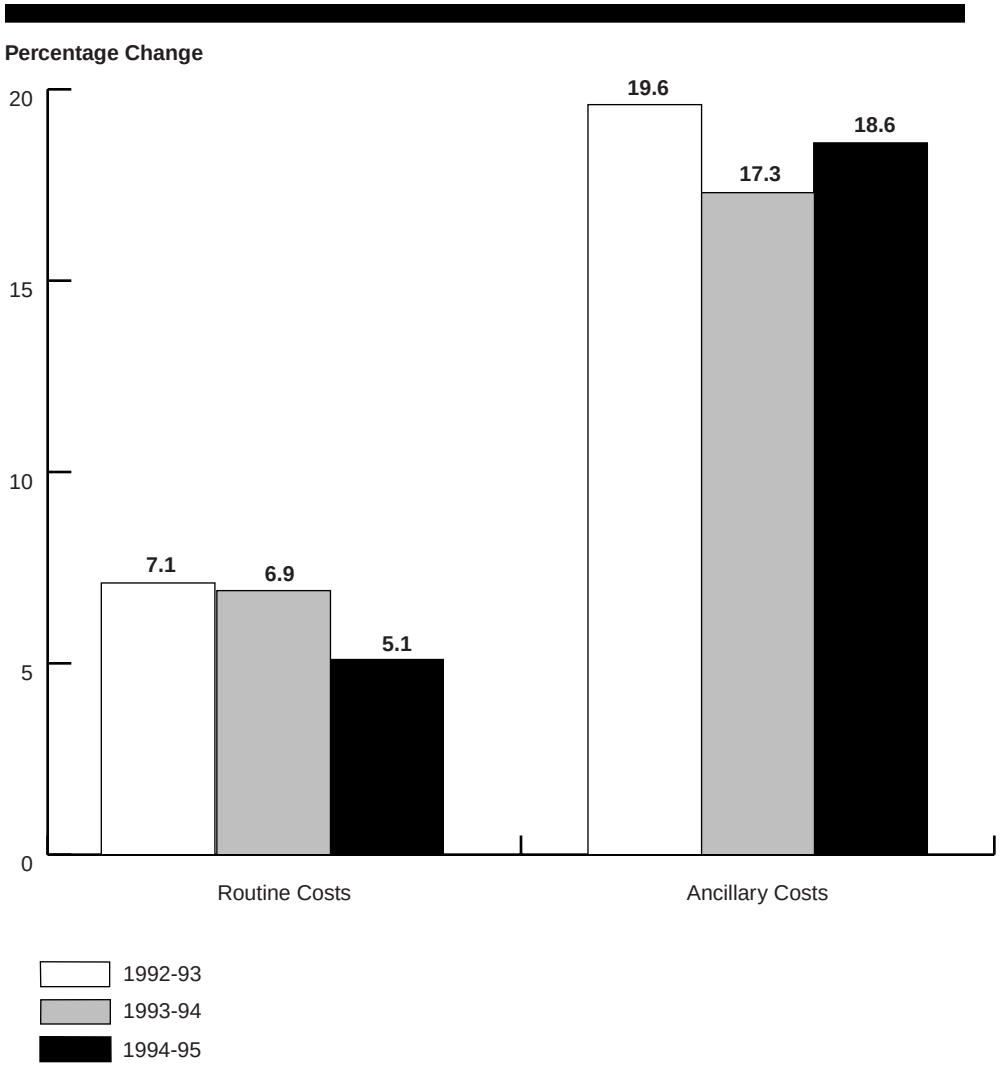
Sources: HCFA Office of the Actuary and Medicare Payment Advisory Commission.

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

Industry and Other Concerns About SNF PPS Require Thorough Analysis

Prior to the PPS, SNFs were paid the reasonable costs they incurred in providing Medicare-allowed services. Although there were limits on the payments for the routine portion of care—that is, general nursing, room and board, and administrative overhead—payments for other costs—primarily ancillary services such as rehabilitative therapy—were virtually unlimited. Because higher ancillary service costs triggered higher payments, facilities had no incentive to provide these services efficiently or only when necessary. Thus, growth in ancillary costs far outpaced the growth in routine service costs between 1992 and 1995 and drove up overall Medicare payments to SNFs (see fig. 2). Moreover, new providers were exempt from even the routine caps for their first 4 years of operation, which encouraged expansion of the industry.

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



Source: Prospective Payment Assessment Commission.

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

per diem amount, the PPS attempts to provide incentives for SNFs to deliver care more efficiently and judiciously.

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

Recent industry reports, however, have questioned the ability of some organizations operating SNF chains to adapt to the new PPS. Indeed, claims of pending bankruptcies have been linked to the Medicare payment changes. It is likely, however, that a combination of factors has contributed to the poor financial performance of these businesses. For example, many of the organizations have other lines of post-acute-care services—including the provision of outpatient rehabilitation therapy and ancillary services to affiliated SNFs as well as independent SNFs. The PPS may have affected the demand for these services, but other BBA provisions likely have had an effect as well.[3] In addition, some of these organizations invested heavily in the nursing home and ancillary service businesses not long before the enactment of the PPS, both expanding their acquisitions and upgrading facilities to provide higher-intensity services. Yet HCFA had been developing a PPS for some time that would curtail unnecessary growth in ancillary payments. We are studying these issues and will provide more details later this year on the effect of the PPS on solvency and beneficiary care.

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

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

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

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

Source: GAO analysis of data from HCFA's May 12, 1998, Interim Final Rules.

Our second concern is whether the system adequately identifies the most expensive patients and adjusts payment rates accordingly. This concern emanates from limitations in the data HCFA had available to establish the case-mix groups and the rates. The classification system was based on a small sample of patients and, because of the age of the data, may not reflect current treatment patterns. As a result, the classification system may aggregate expensive patients with widely differing needs into too few

groups to distinguish adequately among patients' resource needs. In addition, the classification system does not take into account varying nontherapy ancillary service needs and is likely to overpay SNFs for treating patients with low service needs and underpay those SNFs treating patients with high service requirements. These design weaknesses could result in access problems or inadequate care for some high-cost beneficiaries. Hospitals have reported an increase in placement problems due to the reluctance of some facilities to admit certain beneficiaries with high expected treatment costs, which will increase hospital lengths of stay for these patients. HCFA is aware of the limitations of the case-mix adjusters and is working to refine these measures to more accurately reflect patient differences.

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

HHA Closures and Declining Utilization Signal IPS Impact, but There Is Little Evidence of Impaired Access

Medicare spending for home health care rose at an annual rate of 25.2 percent between 1990 and 1997. Several factors accounted for this spending growth, most notably the relaxation of coverage guidelines. In response to a 1988 court case, the benefit was essentially transformed from one that focused on patients needing short-term care after hospitalization to one that serves chronic, long-term-care patients as well.[4] Thus, Medicare may now be covering services that would previously have been paid for by Medicaid or by beneficiaries themselves. The loosening of coverage criteria contributed to an increase in the number of beneficiaries receiving services. Between 1990 and 1997, the number of Medicare home health users per 1,000 beneficiaries increased from 57 to 109.[5] Associated with the increase in beneficiaries being served over this period was the near doubling of Medicare-certified HHAs to 10,524 by 1997.

Also contributing to the historical rise in spending were a payment system that provided few incentives to control how many visits beneficiaries received and lax Medicare oversight of claims. Between 1990 and 1997, the average number of visits per user climbed from 36 to 73. HHAs could boost

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

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

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

To control spending while ensuring the appropriate provision of services, the BBA mandated expeditious implementation of the IPS while the PPS was under development. Prior to BBA, HHAs were paid on the basis of their costs, up to preestablished limits. The limits were set for each type of visit but were applied in the aggregate for each agency; that is, costs above the limit for one type of visit could still be paid if costs were sufficiently below the limit for other types of visits. The IPS lowered the visit payment limits and subjected HHAs to an aggregate Medicare revenue cap based on a historical per beneficiary amount that factors in both agency-specific and regional average per beneficiary payments. The purpose of the cap is to control the number of services provided to users. The blending of agency-specific and regional amounts accounts for the significant differences in service use across agencies and geographic areas. For new HHAs, without historical cost data, the caps are based solely on the national median. Because per beneficiary limits are tied to fiscal year 1994 payments, the new payment limits will be more stringent for agencies and

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

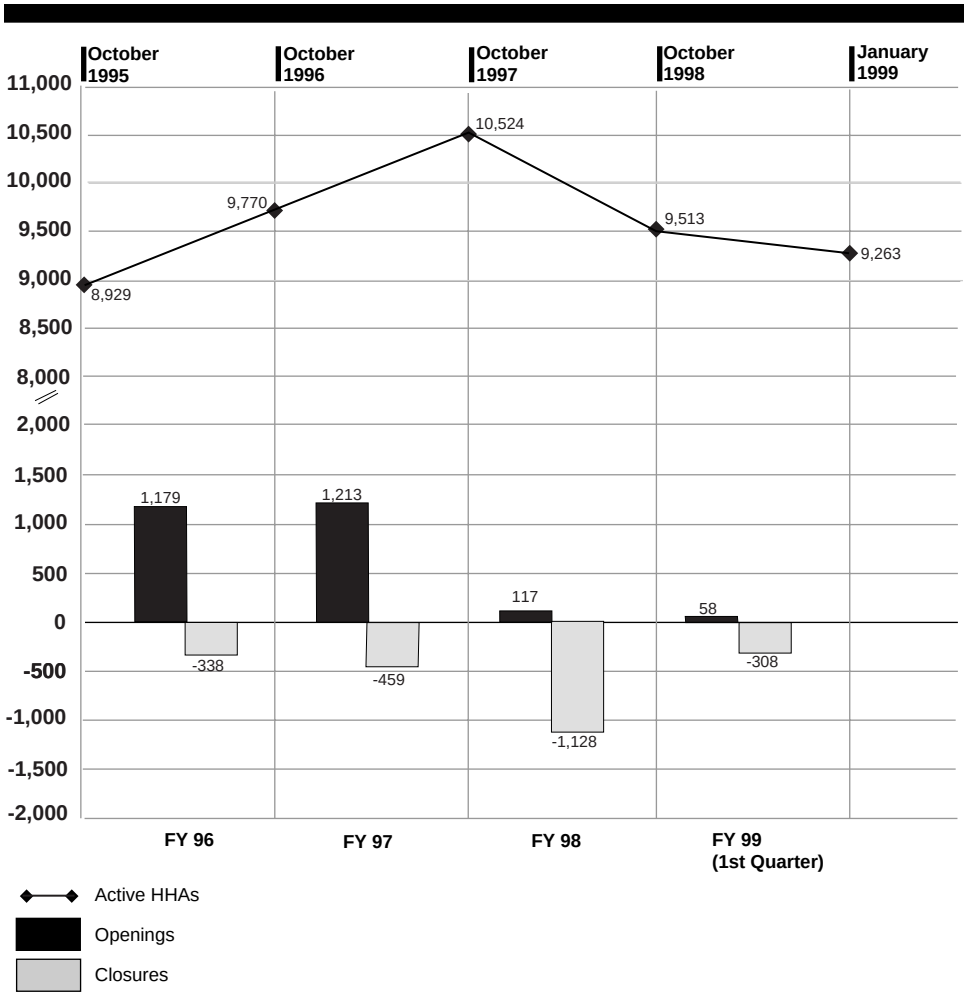
[7]Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996).

[8]Medicare: Improper Activities by Mid-Delta Home Health (GAO/T-OSI-98-6, Mar. 19, 1998) and Department of Health and Human Services, OIG, Variation Among Home Health Agencies in Medicare Payment for Home Health Services (Washington, D.C.: HHS, July 1995). Our 1997 analysis of a small sample of high-dollar claims found that over 40 percent of these claims should not have been paid by the program. See Medicare: Need to Hold Home Health Agencies More Accountable for Inappropriate Billings (GAO/HEHS-97-108, June 13, 1997).

areas that experienced significant growth in the number of visits per user between 1994 and 1997. Notably, the growth in Louisiana, Oklahoma, and Texas, where 1994 utilization levels were approximately twice the national average, greatly exceeded the average increase nationally. By comparison, utilization levels declined in one-fifth of the states with utilization levels below the national average in 1994, making it easier for HHAs in those states to cope with the cap.

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

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



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

and for newer agencies. In fact, HHAs that closed had provided over 40 percent more services per user than agencies that remained open. Closing HHAs were also about half the size of those that remained open, and they had been losing patients before the implementation of IPS.

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

	HHA closures as a percentage of active agencies, Oct. 1, 1997	Number of Medicare-certified HHAs, Jan. 1, 1999	People served per 1,000 Medicare fee-for-service enrollees			Visits per user		
			1994	1997	Percentage change	1994	1997	Percentage change
Nationwide	–14.0	9,263	94.2	109.2	15.9	66.0	72.9	10.5
Louisiana	–21.6	407	138.6	157.3	13.5	125.8	161.0	28.0
Oklahoma	–23.2	299	108.9	131.9	21.1	105.7	147.0	39.1
Texas	–20.1	1,580	106.9	133.7	25.1	97.4	141.0	44.8

Despite the widespread attention focused on closures, the critical issue is whether beneficiaries who are eligible to receive services are still able to do so. Utilization rates during the first 3 months of 1998 are consistent with IPS incentives to control costs. Home health utilization in the first quarter of 1998 was lower than during a comparable period in 1996 but was about the same as during a comparable period in 1994—the base year for the IPS. Moreover, the sizeable variation in utilization between counties with high and low use has narrowed. In counties without an HHA, both the proportion of beneficiaries served and the visits per user declined slightly during the first 3 months of 1998, compared with a similar period in 1994, but these counties' levels of utilization remained above the national average. Our February 1999 interviews with officials at HHAs, hospital discharge planners, advocacy groups, and others in 34 primarily rural counties with significant closures indicated that beneficiaries continue to have access to services. Some of the decline in utilization appears to be for beneficiaries who no longer qualify for the home health care benefit. However, these interviews also suggested that as HHAs change their operations in response to the IPS, beneficiaries who are expected to be costlier than average to treat may have increased difficulty obtaining home health care. The pending implementation of the PPS, which will adjust payments to account for costlier patients, has the potential to ameliorate future access problems.[9]

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

Conclusion

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

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

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

GAO Contact and Acknowledgments

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

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