ISSUE BRIEF

The Massachusetts Health Policy Forum

MEDICARE IN MASSACHUSETTS: THE IMPACT OF THE 1997 BALANCED BUDGET AGREEMENT

Wednesday, July 15, 1998
8:30 to 9:00AM - Breakfast
9:00 to 11:00 AM - Presentation and Discussion
The Parker House
60 School Street, Boston

A Discussion Featuring:
Dr. Joseph Newhouse
Harvard Medical School and
Medicare Payment Advisory Commission (MEDPAC)
Judith Stein
The Center for Medicare Advocacy
Dr. Stuart Altman
Brandeis Heller School and
The National Bipartisan Commission on the Future of Medicare

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"Massachusetts Medicare: The Impact of the 1997 Balanced Budget Agreement"

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EXECUTIVE SUMMARY

PURPOSE OF THE AMENDMENTS

Congress amended the Medicare program through The Balanced Budget Act of 1997, P.L. 105-33, to achieve two major goals. First, the amendments served to balance the federal budget. "(W)ithout the $116.4 billion in net spending reductions, a balanced budget would not have been achieved." (fn. Urban Institute) Second, these changes were made to stem the rapid growth of Medicare expenditures, particularly in the Part A trust fund, which otherwise would have been exhausted by the year 2001.

MEDICARE

Enacted in 1965, the Medicare program operated exclusively on a fee-for-service basis for many years. In recent years, Medicare has followed private insurance trends and increased its use of managed care plans.

Medicare coverage is administered by the Health Care Financing Administration (HCFA) and divided into two parts - Part A (Hospital Insurance) and Part B (Supplementary Medical Insurance). Part A covers inpatient hospital services, nursing facility services and hospice care. Prior to the BBA it also covered all home health services, some of which are now covered under Part B. There is a deductible for hospital coverage. For 1998, the hospital deductible is $760.

Part B covers physician services, laboratory services, outpatient hospital services, durable medical equipment and similar outpatient medical services. An important outpatient service that Part B does not cover is prescription drugs. Beneficiaries pay a premium, currently $43.80/month, for Part B coverage and an annual deductible of $100. Overall, Medicare cost sharing relatively high, often exceeding the cost-sharing requirements in employer-based plans.

Medicare eligible individuals include retirees and younger disabled individuals who have worked and paid payroll taxes or who become eligible based upon the record of a family member who has done so. In 1997, Massachusetts had 941,000 Medicare beneficiaries, ranking 11th in the U.S. for the number of enrollees.

Medicare also pays for Graduate Medical Education (GME) for physicians. It covers both indirect medical education (IME) costs for resident training and involvement in treating patients with complex medical conditions and direct medical education costs such as resident and faculty salaries.

THE BALANCED BUDGET ACT

Enacted on August 5, 1997, the Balanced Budget Act (P.L. 105-33) served the dual purpose of balancing the federal budget and delaying the exhaustion of the Medicare Part A Trust Fund. It reduced the expected rate of growth in Medicare funding by a total of $116.4 billion over the next 5 years.

The Balanced Budget Act (BBA) contained several overarching themes. First, it changed the nature of Medicare by expanding the range of plans available to beneficiaries. It thereby takes the first step toward transforming the Medicare program from a "defined benefits program" where everyone gets roughly the same benefits to a "defined contribution" program where everyone pays according to the same formula, but may ultimately enjoy very different benefits.[1] In so doing, it also expanded federal authority over this growing market. The BBA made adjustments to the rates paid to managed care plans to better reflect actual enrollee costs and to achieve greater equity between various regions of the U.S. By reducing provider payments, the BBA indirectly reinforced the role of the Medicare home health benefit as a short-term, acute care benefit versus a long-term source of support for frail elders and people with disabilities living in the community.

The BBA also reflected changes in the delivery of health care by encouraging a reduction in the number of medical residents in teaching hospitals while authorizing payments for the costs of their training in outpatient settings for the first time.[2] It further reduced prospective payments to acute-care hospitals and extended the prospective payment system to a much broader array of providers including home health agencies, rehabilitation hospitals, skilled nursing facilities (SNFs) and other entities. The BBA also revised payment method-

ologies to physicians and other providers. These changes are described in more detail below.

Impact on Beneficiaries

Although most provisions of the BBA will ultimately have an impact on beneficiaries, three provisions will affect them most directly:

Beneficiary cost sharing - the BBA increases Part B premiums and changes the rules for payment of those premiums and other out-of-pocket costs through the Medicaid Qualified Medicare Beneficiary (QMB) and Specified Low Income Beneficiaries (SLMB) programs. With the exception of a small number of individuals who will become eligible for the SLMB program, the overall effect of these changes will be to increase the high out-of-pocket costs already being paid by most beneficiaries.

Preventive benefits - the BBA adds new preventive benefits to the Medicare program including enhanced access to several preventive benefits including mammography, pap smears and pelvic examinations, prostate cancer, colorectal screening, screening for bone mass density and diabetes self management. It also extends HCFA's Influenza and Pneumococcal Vaccination Campaign in conjunction with other agencies through 2002. The estimated cost of the preventive services is $4 billion dollars between 1998 and 2002. The BBA further requires gradual reductions in the copayment for hospital outpatient services. These changes will increase access to these preventive services.

New Medicare+Choice Plan Options - the BBA amends the Medicare statute to provide beneficiaries with alternatives to the traditional fee-for-service package and current managed care plans. These new plan options include "Coordinated Care Plans" such as HMO plans with or without point of service (POS) options, preferred provider organizations (PPOs) and Provider sponsored organizations (PSOs). The BBA will also authorize carriers to offer private fee-for-service plans, fraternal benefit society plans and a limited number of Medical Savings accounts (MSAs).

Carriers may offer these plans for the first time in November, 1998. Thereafter, the month of November will be the "Annual Coordinated Election Period" during which beneficiaries will be able to sign up for new plans or renew their existing plans. For 1998 through 2001, there will be continuous open enrollment in all plans, i.e. beneficiaries will be able to switch plans at any time. Continuous open enrollment will end in 2002 when beneficiaries will only be able to switch plans during the November election period and the first six months of the year, January - June, 2002. Beginning in 2003, this six month period will be narrowed to three months, January–March, when beneficiaries will have the option to switch. Slightly different rules apply to new beneficiaries and exceptions will be made under certain circumstances as defined by HCFA.

These changes may increase enrollment in non-traditional Medicare plans. With this change also comes an increased risk of adverse selection as the market divides itself into smaller segments.

Impact on HMOs

In addition to adjusting to an expanded market, health maintenance organizations will see changes to the formulas for calculating their Medicare plan rates. The Average Adjusted Per Capita County (AAPCC) rate will be calculated to account more accurately for the costs of managed care enrollees. It will also be adjusted to provide greater equity in rates between different parts of the country. There will be changes to the updates for these rates also. The Adjusted Community Rate (ACR) submitted by individual plans will also be adjusted for risk.

These changes will result in reduced revenues to the Massachusetts managed care plans. Over time, these reductions may cause plans to increase their rates or reduce benefits.

Impact on Home Health Care

Nationally, home health expenditures "have more than doubled as a share of the total Medicare budget" with "annual average increases of more than 28 percent per beneficiary . . . between 1990 and 1996".[3] Contributing to this rapid increase were regulatory changes in eligibility and scope of coverage as well as trends in the overall health system which encouraged community-based, rather than institutional, care. In Massachusetts, a high percentage of elders and the Commonwealth's attempts to maximize Medicare dollars may have also contributed to this trend.

Federal concerns about both fraud and abuse in the system and the rapid growth in the number of home health agencies were also factors. HCFA's "Operation Restore Trust" program increased audits and other anti-fraud measures in many states, including

Massachusetts. Thus far, no fraud and little abuse have been uncovered in the Commonwealth.

The BBA seeks to reduce this rapid growth by reinforcing Medicare's original purpose to serve primarily beneficiaries with short-term, post-acute needs rather than those with chronic needs. It did so primarily by reducing payments to providers. Starting in October, 1997, home health agencies began a transition from cost-based reimbursement to an interim payment system (IPS) with the ultimate goal of implementing a prospective payment system (PPS), similar to that operating in hospitals, on October 1, 1999. Under the interim payment system, many agencies receive a capped payment per beneficiary using FY 1994 data. The BBA also changes definitions regarding eligibility and the scope of services. Other changes include surety bond requirements, additional fraud and abuse requirements, a transfer of some home health costs from Part A to Part B and other amendments.

Beneficiaries, home health agencies and the Commonwealth have already felt the impact of these changes. Many beneficiaries have reported service reduction or terminations. In addition to reducing services to certain beneficiaries, agencies have laid off staff and streamlined in other ways. HCFA's fraud and abuse initiative has made agencies even more conservative regarding eligibility and coverage decisions.

Beneficiaries have turned to services from state-funded programs such as the Massachusetts home care agencies and Medicaid. State officials and others have expressed concerns regarding rising caseloads and increases in state expenditures as a result of these changes. They have also noted the possibility of an increase in nursing home occupancy.[4]

Impact on Acute Care Hospitals

Acute care hospitals have been receiving prospective payments for Medicare beneficiaries since the mid-1980's. These payments are updated annually and include reimbursement for direct and indirect medical education (IME) payments.

Hospital payments nationally account for about 44 percent of Medicare expenditures and represent almost 30 percent of the BBA budget savings over five years (1998 through 2002). Half of these savings are from reductions in the update factors for prospective payment system (PPS) hospitals. [5]

Some observers expect these changes to reduce profit margins for Massachusetts hospitals. These reductions may exacerbate existing inequities between teaching hospitals and community hospitals that do not provide medical education and may also exacerbate trends toward industry consolidation.[6] Discharge policies and timing may be affected dramatically by these changes and those to the SNF reimbursement policies.

Impact on Non-Acute Care Hospitals

The PPS hospital reimbursement system does not apply to "five types of specialty hospitals (rehabilitation, psychiatric, long-term care, children's and cancer)."[7] In recent years, these hospitals have had to confront many of the same competitive pressures as acute care hospitals. To respond, they have utilized cost reduction strategies such shorter lengths of stay and have also participated in the consolidation trend.

Non-PPS hospitals receive "TEFRA" payments.[8] The BBA levels the playing field for old and new facilities that received payments under this scheme.[9] Prior to the BBA changes, new facilities held a reimbursement advantage, fueling the development of new facilities and contributing to poorer financial performance among older ones.[10] The BBA provisions make it likely that long-term care hospitals and rehabilitation facilities will make the transition to a prospective system.

These changes may also cause reductions in Medicaid revenues to these facilities as well.[11] These reductions may in turn require hospitals to redouble their current cost-cutting efforts, thus increasing concerns about shortened lengths of stay and less patient choice because of further industry consolidation.

Impact on Skilled Nursing Facilities

Medicare skilled nursing facility (SNF) costs and utilization have risen sharply in recent years. One significant reason for this growth has been the introduction of transitional care units (TCUs) by hospitals into this market.

The BBA targets SNFs as yet another sector to face implementation of a prospective payment system. In addition, more services, ancillary services such as physical therapy, will be bundled together under a new consolidated billing system. The combination of reduced revenues and increased administrative burdens will have a substantial impact on SNFs. Small, family-owned facilities will have more difficulty adjusting to

these changes, accelerating the existing wave of industry consolidation. These changes may also cause cutbacks and closures of hospital TCUs.

The new payment system incentives may create more access for beneficiaries with complex rehabilitation needs and less for others, such as those with cognitive limitations.[12] Some beneficiaries may benefit from improvements in quality control made possible by information capabilities accompanying the new PPS system.[13]

Impact on Physicians

Physicians who treat Medicare beneficiaries are paid according to a fee schedule. The fee schedule addresses three types of physician resources: physician work, practice expense, and malpractice insurance costs.[14]

The BBA changes how these cost components are calculated. Primary care providers and some specialists will receive increased payments while fees paid to other specialists for services such as coronary artery bypass grafts will decrease. Although these changes are estimated to reduce overall Medicare physician payments by $5.3 billion over the next several years, many individual physicians will be paid more for certain services.

Physicians face uncertain benefits from BBA provisions regarding provider service organizations (PSOs). Although the regulatory framework for PSOs is still uncertain, this BBA change may present an opportunity for physicians to achieve enhanced autonomy.

Table 1 on the next page outlines the major changes to Medicare because of the BBA, as well as predicted provider and consumer impacts.

TABLE 1: MAJOR BBA AMENDMENTS AND THEIR IMPACT

Category	Major BBA Changes	Potential Provider Impact	Potential Consumer Impact
Beneficiaries	1) Increase in Part B Premium	Absorb more unpaid patient costs	Higher Out-of-Pocket Expenses
	2) New Medicare+Choice Plan Options	More plan competition	May Increase Enrollment in Non-Traditional Medicare Plans Potential for Adverse Selection
	3) New Preventive Benefits	Additional Reimbursed Services	Better Access to Preventive Services
HMOs	1) Changes to Payment Formulas (ACR, AAPCC), updates Risk Adjustment 2) Reallocation of GME Payment	Reduced Revenues	Increased Premiums and/or Fewer Benefits Over Time
Home Health	1) New Payment Systems (Interim PS and Prospective PS) and Eligibility/Service Scope Definitions	Reduced Revenues Layoffs/Other Staffing Changes Closure of Some Agencies	Less Availability/Duration of Service May Increase Reliance Upon Family More Nursing Home Use/Medicaid Costs
	2) Fraud and Abuse Provisions	More Conservative Eligibility and Scope of Service Decisions	More Use of Home Care Agencies
	3) Surety Bond Requirement	Barrier to Market Entry/Increased Cost	Fewer Agencies/Reduced Choice
Hospitals **(Acute, PPS)**	1) Changes to Prospective Payments a) Reduced PPS Updates b) Reduced IME and DSH payments c) Transfer Payment Changes	May Affect Discharge Policies Increased Industry Consolidation Less Financial Stability, Particularly For Community Hospitals Reduced Revenue From Transitional Care Units And Possible Closure	May Affect Discharge Timing/Setting
	2) Increased GME payments for Medicare+Choice Enrollees.	Will Offset Revenue Reductions from Other PPS Changes for Some	
	3) Changes in Direct GME to Reduce Number of Residents. 4) Reimbursement for Residents in Outpatient Settings.	Increased Labor Costs for Inpatient Units In Hospitals Lower Labor Costs in Other Settings	May Cause Change in Treatment Setting
Non Acute Hospitals: — Rehab, Psych, LTC, Cancer & Childrens)	1) Changes to Payment Formulas 2) Future Prospective Payment System for Rehab. and Long Term Care Hospitals	Old and New Facilities on More Even Footing Increased Industry Consolidation	May Affect Discharge Timing and Setting Less Provider Choice
Nursing Facilities	1) New Prospective Payment System and Consolidated Billing	Reduced Revenues/ Stabilization or Decrease in Medicare Admissions Reduced Ancillary Services Greater Administrative Burdens More Consolidation	More Access for Beneficiaries with Certain Conditions and Less Access for Others
Physicians	1) Changes to Payment Formulas	More Revenue for Primary Care Providers and Some Specialists and Less Revenue for Other Specialists Easier to Form PSOs	Potential Impact on Medical Practice May Increase Provider Choice

I. INTRODUCTION

"Changes in the Medicare program were an essential part of the budget agreement that led to the Balanced Budget Act of 1997 (BBA)."[15] Signed into law on August 5, 1997, these Medicare revisions served a dual purpose. First, they served as key components of a strategy to balance the federal budget. "Medicare's growing share of federal spending, about 11 percent of total outlays in 1995, made it a primary focus for reaching a balanced budget."[16] According to a report published by the Urban Institute,"(w)ithout the $116.4 billion in net spending reductions over the next five years (contained in the 1997 BBA), a balanced budget would not have been achieved."[17]

Second, these changes were designed to stem the rapid growth of Medicare expenditures, particularly Part A costs, which threatened the Medicare program's ability to meet the future needs of retired and disabled beneficiaries. Because of increases in the ratio of beneficiaries to workers, prior to the BBA, HCFA had predicted that Part A funds would be exhausted before the year 2001.[18] One of the most important functions of these revisions was to delay the exhaustion of the Part A trust fund from the year 2001 to 2008.[19] Although these changes will not reduce overall Medicare spending below its current levels, they will reduce its estimated annual rate of growth from between 8 and 9 percent to roughly 6 percent during the period from 1998 to 2002.[20] Between 1998 and 2002, the bulk of Medicare savings will be realized from reduced payments to hospitals. By the year 2007, however, these savings will be outweighed by savings from reductions in payments to private plans and increases in beneficiary Part B premiums.[21]

The importance of the Medicare program in improving the health and well being of elderly people in the U.S. cannot be overstated. "Before it was enacted, half of older Americans were uninsured, leaving them and their families at risk of financial catastrophe in the face of major illness."[22] Furthermore, "(l)ife expectancy at age 65 has increased by three years since Medicare was enacted, and the United States is a world leader in life expectancy of older adults."[23] Through extensive Graduate Medical Education payments to academic medical centers (teaching hospitals), the Medicare program has also contributed substantially to the technological innovations that have benefited many citizens of all ages. These same funds have also supported the training of a generation of physicians.[24]

This brief explains the major provisions of the BBA and describes its potential impact on Medicare beneficiaries and providers in Massachusetts. This brief first describes the structure and operation of the Medicare program and the benefits it provides. It then provides an outline of the related provisions of the BBA and their potential impact on Medicare providers and beneficiaries in Massachusetts.

STRUCTURE AND OPERATION OF MEDICARE

Created in 1965, the Medicare program was designed to resemble Blue Cross and Blue Shield plans then dominant in the fee for service reimbursement environment.[25] In 1983, Medicare implemented the Prospective Payment System to pay hospitals for acute inpatient services according to the patient's principal diagnosis or "diagnosis related group" (DRG). In 1990, the program implemented a new prospective payment system for physicians called the "Resource Based Relative Value Scale" (RBRVS). Medicare began to experiment with managed care in the early 1980s with the Medicare capitation and Social Health Maintenance Organization (SHMO) demonstration projects. Fallon Health Plan in Central Massachusetts participated in the early capitation demonstration project.[26] Nationally, 12.5% of Medicare beneficiaries were enrolled in capitated managed care plans in 1996 (17% in Massachusetts).[27]

1. BENEFITS

Medicare coverage is divided in two-Part A (Hospital Insurance) and Part B (Supplementary Medical Insurance).[28] Part A is financed primarily through payroll taxes covering 60 days of inpatient hospital services, and a maximum of 100 days of post-hospital nursing facility services and hospice care. Prior to the BBA, Part A also covered all home health care.[29] Part A covers inpatient and outpatient expenses, including a three year supply of drugs for individuals with End Stage Renal Disease (ESRD).

Part B covers physician, laboratory, outpatient hospital, durable medical equipment and other outpatient medical services. As a result of the BBA, it now pays for some home health services. Beneficiary premiums cover 25% of Part B costs with the remaining 75% paid through general federal revenues. Traditional fee for service beneficiaries also pay 20% coinsurance based

on Medicare's fee schedule.[30] An important outpatient service not covered is outpatient prescription drugs.[31]

While Medicare service delivery and payment mechanisms had undergone significant changes over the years, prior to the BBA, the Medicare benefit package had been "essentially unchanged over the last thirty years."[32] For those in fee for service plans, this remains true except for the addition of some new preventive services. For individuals joining the new Medicare+Choice plans, benefits could change.

The real value of the Medicare package as a whole has gone down because of increases in premiums and cost sharing requirements. "In 1966 the hospital deductible was $40 ($190 in 1996 dollars); in 1996 it was $736."[33] Today, the premium is $760. "The premiums and cost sharing requirements exceed those paid by many working people covered by employer plans."[34] In 1994, the average cost-sharing liability per Medicare beneficiary in Massachusetts was $809 per year.[35]

2. ELIGIBILITY

Senior citizens who receive Social Security retirement benefits are automatically entitled to Part A benefits when they turn 65, without payment of any premium. People with disabilities who qualify for Social Security Disability Insurance payments may wait for as long as 29 months to receive Medicare benefits.[36]

To receive Part B coverage, beneficiaries must pay a monthly premium. For 1998, that premium is $43.80 per month. Beneficiaries must also pay an annual deductible of $100.00. The annual deductible does not apply to certain services such as two of the new preventive services included in the BBA, annual pap smears and mammograms.[37]

3. GRADUATE MEDICAL EDUCATION

Following Medicare's enactment, there was widespread concern regarding "an impending shortage of physicians."[38] In response Congress enacted the Graduate Medical Education program (GME). Under this program, Medicare funds the education of physicians through payments to teaching hospitals.[39]

The Graduate Medical Education program has two components, direct medical education payments and an for adjustment indirect medical education expenses (IME). Direct medical education payments cover the costs of medical education such as faculty and resident salaries, costing $2.2 billion in FY 1997.[40] The IME program reimburses teaching hospitals by making a rate adjustment for additional costs associated with resident training and for providing highly specialized care to individuals with more costly conditions. Medicare reimbursements to hospitals under the IME program totaled $4.6 billion in FY 1997.[41]

"In 1994, the average cost-sharing liability per Medicare beneficiary in Massachusetts was $809 per year."

4. ADMINISTRATION

Medicare is administered by the Health Care Financing Administration (HCFA), a division of 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 generally commercial insurers or Blue Cross or Blue Shield Plans."[42] In Massachusetts and other Northeast states, Associated Health Plan of Maine is the intermediary.

The BBA, passed in August, 1997, became effective less than two months later in October, 1997 at the start of federal fiscal year 1998. HCFA faced a short time frame to develop and issue regulations to implement these sweeping changes. As a result, many managed care contractors, providers and other interested parties have had to comply with the BBA with limited guidance.

5. MEDICARE BENEFICIARIES IN MASSACHUSETTS

In 1996, approximately 14% of the Commonwealth's 6.1 million residents were 65 or older. Nearly half of these individuals, 6.8% of the state's population, were 75 or older ranking Massachusetts 8th in the U.S. for the number of individuals 75 or over. Figures show that 1.7% percent of the Massachusetts population was over age 85 in 1996 compared with a US rate of 1.4%. About 7.2% of Massachusetts residents were between the ages of 65 and 74.[43] *(See table 2 on next page.)* Massachusetts ranked 11th among the 50 states and the

District of Columbia for the number of Medicare beneficiaries with 941,000 elderly and disabled individuals enrolled in Medicare.[44]

Enrollment in Medicare managed care plans grew 172% between the June, 1992 and the end of 1997.[45] At the end of 1997, an estimated 20% of Massachusetts Medicare beneficiaries were enrolled in managed care plans. Previous estimates had placed Medicare managed care enrollment at 17%, 10th in the nation for percent of elders enrolled in capitated plans. Despite this growth in managed care enrollment a substantial number of elders, 20% at the end of 1996, had no Medigap coverage at all.[46]

II. THE BALANCED BUDGET ACT AND ITS IMPACT

The BBA (PL 105-33) contained several overarching themes. First it altered the face of Medicare by expanding the range of plans available to beneficiaries and expanding its reliance on managed care. In doing so, it also expanded federal authority over this market. Second, it reinforced the role of Medicare home health benefits as a short-term acute care benefit versus a long term source of support for frail elders and persons with disabilities by reducing provider payments. It reflected changes in health care delivery by encouraging a reduction in the number of medical residents in teaching hospitals while authorizing payments for the costs of physician training in outpatient settings for the first time. It further reduced payments to acute care hospitals and extended the prospective payment system to a much broader array of providers including home health agencies, rehabilitation hospitals, and other entities. It revised payment methodologies to physicians and other providers. How it allocated these reductions among the various parties is illustrated in *Figure 1* on the next page.

A. IMPACT ON BENEFICIARIES

1. PART B PREMIUM INCREASES

The Urban Institute reports that because of the BBA changes, Part B premiums will increase to about $105 per month by the year 2007 from the current level of $43.80 per months.[47] Two BBA provisions account for this doubling over the next ten years. The first pertains to the share of Part B costs covered by monthly premiums. By law, Part B premiums must cover a set percentage of Part B costs. Since 1983, the share of Part B costs covered by premiums has been set at 25%. Before the BBA, Congress had to renew this provision periodically and it was scheduled to expire in 1998. Despite concerted efforts over the years and during the debate over the Balanced Budget Act to change this figure, Congress adopted the 25% figure and made it permanent as part of the Balanced Budget Act.

Without this amendment, the percentage of Part B costs covered by premiums would have fallen considerably over the next several years. Maintaining this level of premium financing, however, requires an increase in the monthly premium paid by beneficiaries.[48]

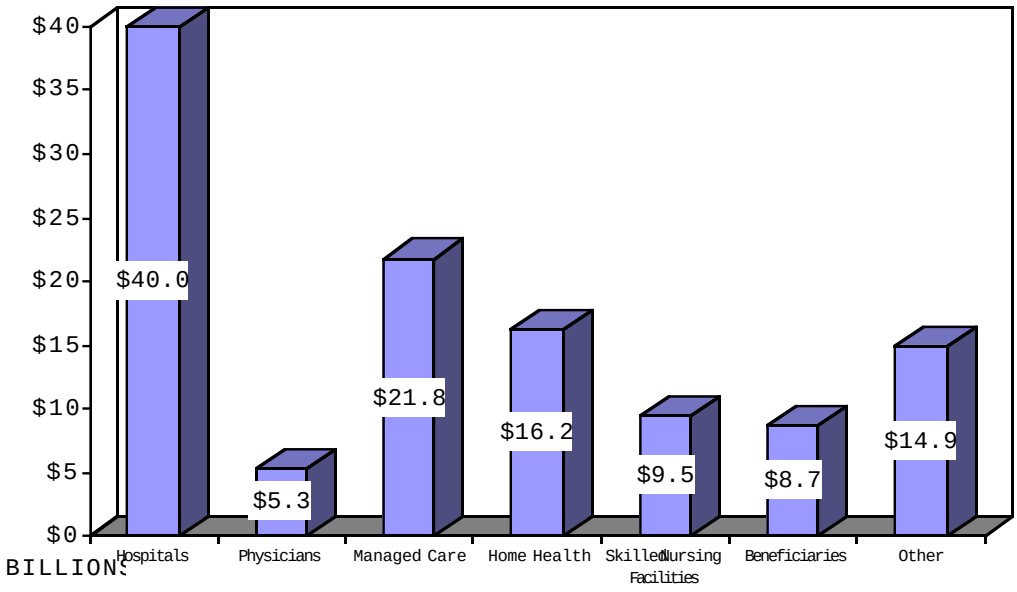
The second provision contributing to the Part B premium increase is the transfer of a significant portion of home health costs from Part A to Part B. This change results in a substantial increase in the total sum upon which the 25% figure is calculated.

TABLE 2: MASSACHUSETTS AND U.S.:
Distribution of Population By Age, 1997

	0-18 yrs	19-64yrs	65-74 yrs	75&over	85+ (1996)
Mass.	25.2%	60.8%	7.2%	6.8%	1.7%
U.S.	27.5%	59.8%	6.9%	5.8%	1.4%

Sources: adapted from Lamphere, Joann, Holahan, Danielle, Brangan, Normandy and Burke, Robin, *Reforming the Health Care System: State Profiles 1997,* Washington, D.C.: AARP Public Policy Institute, 1997. 85+ figure for 1996 taken from Bectel, Robert and Tucker, Natalie Graves, *Across the States 1998: Profiles of Long-Term Care Systems,* Washington, D.C.: AARP Public Policy Institute,1998.

FIGURE 1: REDUCTIONS IN SPENDING FROM BBA BY SECT
FY 1998-2002



Sources: Graph prepared by Stuart Altman, Ph.D., September 25, 1997 and additional information from Moon, Marilyn, Gage, Barbara, and Evans, Alison, *An Examination of Key Provisions Medicare Provisions in the Balanced Budget Act of 1997,* The Urban Institute: September, 1997.

Specified Low Income Beneficiaries

Congress attempted to cushion the effect of the Part B premium increase by shifting the cost of premiums for a limited number of low-income beneficiaries to Medicaid. Medicaid currently pays premiums for individuals who qualify as "Specified Low Income Medicare Beneficiaries" (SLMB). To be a SLMB, a beneficiary's income must fall between 100% and 120% of the federal poverty level (FPL), between $691 and $825 for 1998.[49] The BBA created a capped entitlement program that will pay the full premium for beneficiaries whose incomes fall between 120% and 135% of the FPL. The BBA earmarks $200 million in federal funds for this purpose in 1998. This figure will increase to $400 million by the year 2002. Although states must match this figure with their own funds, the Urban Institute estimates that it will cover only one-quarter of those qualified. If there are funds remaining after this first group has been covered, Medicaid will also pay part of the premium increase for beneficiaries with incomes between 135% and 175% of the FPL. The Urban Institute estimates that this amount will equal approximately $3 in 1999 and increase to only $16 by the year 2002.

Qualified Medicare Beneficiaries

Qualified Medicare Beneficiaries are beneficiaries whose incomes are below 100% of the federal poverty level ($691 for 1998).[50] These individuals are eligible for Medicaid coverage of Medicare cost sharing and Part B premiums. The BBA reduces Medicaid's obligation to pay for cost sharing. If a state Medicaid program's payments to physicians and other providers are less than 80% of Medicare's fees, then the state no longer has to pay the cost-sharing liability. The beneficiary is also free from any obligation to pay these costs. This new rule raises concerns that providers will be reluctant to treat individuals for whom they stand to lose as much as 20% of their fees. [51]

2. NEW PREVENTIVE BENEFITS

The BBA added access to several preventive benefits including mammography, pap smears and pelvic examinations, prostate cancer, colorectal screening, screening for bone mass density and diabetes self management. It also extends HCFA's Influenza and Pneumococcal Vaccination Campaign through 2002. The estimated cost of the new preventive services is $4 billion between 1998 and 2002. The BBA further

requires gradual reductions in the copayment for hospital outpatient services, a change estimated to cost $2 billion between 1998 and 2002. The BBA also directs the Secretary of Health and Human Services to request that the National Academy of Science conduct a study of the feasibility of expanding or otherwise modifying other Medicare benefits.

3. MEDICARE+CHOICE PLAN OPTIONS

A. Medigap and Managed Care Plans in Massachusetts

Massachusetts already had a guaranteed issue, guaranteed renewal Medigap market when the BBA was enacted. Chapter 176K of the Massachusetts General Laws, effective in April of 1994, prohibits carriers from engaging in medical underwriting, and similar practices in the Medigap market. It also requires community rating of Medigap plans with only geographic variation permitted.

Because of federal oversight, Medicare managed care plans and indemnity plans do not operate under identical rules. For example, Chapter 176K requires indemnity carriers to offer up to three standardized benefit plans, but managed care plans are not subject to this requirement. However, indemnity carriers and managed care organizations must offer at least two plans, one with a comprehensive prescription drug benefit and one with no drug benefit. Indemnity plans drug benefits are subject to a $35 quarterly deductible. Managed care plans generally charge a $5-$15 copayment for prescription drugs.

The Massachusetts Medigap market has been in a state of flux for the last several years. Rates in fee-for-service plans such as Blue Cross Medex have increased dramatically, resulting in a substantial enrollment decline. Overall, fee-for-service insurers lost 27% of their enrollment between 1992 and 1997. Conversely, managed care enrollments rose 172% during the same period. The two Massachusetts counties with the highest managed care enrollment were Worcester and Bristol counties.[52]

As of March, 1998, 7 managed care organizations offered Medigap plans.[53] Only two carriers, Blue Cross Blue Shield and the American Association of Retired Persons (AARP) offer traditional indemnity plans.[54] Other indemnity insurers, including Banker's Life, have pulled out of the market.[55] Premiums for managed care plans have stabilized or even fallen in recent years. Premiums for plans being offered for sale as of March, 1998 ranged from $0 for a plan without prescription drugs to $132 for a plan with full prescription drug coverage, depending upon county of residence.[56]

By the end of 1996, 53% of Medicare managed care enrollees had prescription drug coverage, slightly higher than the 51% enrolled in indemnity plans with this benefit.[57] Since 1990, the number of Massachusetts beneficiaries with prescription drug coverage has fallen sharply.[58] In 1996, the Massachusetts legislature created the Senior Pharmacy Program (SPP). This program authorizes a $750 annual subsidy for drug coverage for low-income elders (with incomes less than 150% of the federal poverty level) who lack prescription drug coverage. By March, 1998, 20,000 elders had enrolled in the program.

B. BBA Amendments

New Plans Offered

The BBA changes Medicare to provide beneficiaries with access to a broader array of plans. Prior to BBA, Medicare beneficiaries could either remain in traditional fee for service plans or join managed care plans with a risk or cost contract. Some states permitted a point of service option referred to as "Medicare-Select".

Under the BBA, beneficiaries can still enroll in traditional fee-for-service plans, but they will have more alternatives than in the past. The BBA replaces the existing scheme of risk and cost contracts with Medicare+Choice plans. With the possible exception of provider sponsored organizations (PSOs), these Medicare+Choice organizations must be organized and licensed as risk-bearing entities under state law.[59] No state premium taxes or similar taxes may be imposed on these Medicare+Choice organizations.[60]

Medicare+Choice plans cannot screen or reject beneficiaries on the basis of health status. Medicare+Choice plans will also be subject to consumer protections regarding grievances and appeals, emergency services (the "prudent layperson standard"), disclosure, confidentiality, access, quality of services

pursuant to standards defined by HCFA. Beneficiaries will also be able to appeal to HCFA for an external review. Each plan must also establish and maintain written policies and procedures regarding advance directives. These provisions are similar to current law.

Under the BBA, new Medicare+Choice plans include:

1. "Coordinated Care Plans":

a. HMOs (with or without point of service options);

b. Preferred provider organizations (PPOs),

c. Provider sponsored organizations (PSOs);

2. Private fee for service plans; or

3. Medical savings accounts (MSAs) (Only 390,000 of these will be offered nationally)[61]

4. Religious Fraternal Benefit Society plans.[62]

A POS is a modified managed care plan permitting beneficiaries to go to out-of-network providers paying high coinsurance, usually between 20-30%. The plan covers the remainder. Individuals who prefer the lower cost of managed care plans, but want to maintain their ability to choose a provider, often find the point of service option attractive.[63]

A PPO is a modified indemnity plan that has a network of providers that an insured person can see for less cost than out-of-network providers. There is usually less oversight from the managed care plan in managed care plans, with or without POS options. However, the differences between POS and PPO plans have increasingly blurred, so that consumer must examine the rules for using in and out-of-network benefits carefully.[64]

A provider-sponsored organization (PSO) is the newest form of managed care plan. A PSO is "a public or private entity . . . that is established or organized and operated by a health care provider, or group of affiliated health care providers."[65] Under Medicare+Choice, groups of providers may contract directly with Medicare to provide services to beneficiaries. PSOs manage care themselves, rather than using an insurer. Concerns were raised during the BBA debate that PSOs would serve the lowest-cost beneficiaries creating adverse selection against other plans.[66] To minimize this likelihood, Congress ordered the Secretary to set solvency guidelines rather than leaving standards under traditional states jurisdiction.[67] The standards must ensure that plans have adequate resources to serve all beneficiaries.

The BBA permits HCFA to grant PSOs a 36 month waiver of state licensure laws.[68] However, the PSO must still comply with consumer protection and quality standards as such standards "would apply in a State to the organization if it were licensed under State law . ." [69] HCFA, in turn, can enter into an agreement to permit the State to carry out all monitoring and enforcement activities.[70] No later than December 31, 2001, the Secretary must submit a report on whether the waiver process should be continued.[71]

BBA sanctioned Medical Savings Accounts (MSAs) also may create adverse selection. Medical Savings Accounts are insurance plans with high-deductibles and relatively low premiums. Under Medicare+Choice the maximum deductible will be $6000. Money used to meet the deductible is placed in a separate savings account. Medicare will put the difference between the payment it makes to the Medicare+Choice plan and the MSA premium in the beneficiary's MSA account. The impact of these plans in the Medicare+Choice market may be minimal. Similar to the 1996 Health Insurance Portability and Accountability Act (HIPAA), the BBA mandates that only a limited number (390,000) of MSAs will be offered on a demonstration basis, so enrollment may likely be quite limited.

Religious Fraternal Benefit Society plans may be offered by a church, convention, association or affiliated group of churches.[72] These plans may refuse to offer coverage to individuals who are not church members, but they not condition membership in their church, and hence access to their Medicare+Choice plan, on the basis of health status.[73]

"Congress broadly pre-empted state laws and regulations with respect to Medicare+Choice plans 'to the extent that such law or regulation is inconsistent with such (federal) standards."

Benefits

Except for new preventive services added by the BBA, the Medicare fee-for-service package will remain the same. Congress delegated authority to the Secretary to design benefit packages for Medicare+Choice plans. In so doing, Congress broadly preempted state laws and regulations with respect to Medicare+Choice plans "to the extent that such law or regulation is inconsistent with such (federal) standards."[74] It further preempted state authority in the following three specific areas:

1. Benefit requirements;

2. Requirements relating to inclusion or treatment of providers;

3. Coverage determinations (including related appeal and grievance mechanisms.

These changes represent a shift in authority from the states to the federal governments.

Beneficiaries will have a choice between the traditional Medicare fee-for-service package and a Medicare+Choice plan offered in their geographic area when they first become Medicare eligible. Individuals who do not elect a specific plan at that placed in the Medicare+Choice plan offered by their current carrier.[75] The BBA directs the Secretary to establish procedures for enrollment of current Medicare beneficiaries.[76]

The new Medicare+Choice plans will be available for the first time in November, 1998. Coverage will take effect on January 1, 1999. In 1999, November will be officially designated the time will automatically be enrolled in the original fee-for-service plan, unless they are already in a plan offered by one of the organizations that will offer a new Medicare+Choice plan. In this case, they will be "annual coordinated election" period. During the period from 1998 to 2003, there will be a transition from continuous, year-round open enrollment to the November "annual coordinated election" period. Between 1998 and 2001, new plans will become available in November, but will permit "continuous open enrollment," i.e. beneficiaries will be able to enroll or disenroll in any plan at any time.[77] In the year 2002, continuous open enrollment will end and beneficiaries will be permitted to change plans once during the first six months of the year, i.e. January-June, 2002 and in November.[78]

TABLE 3: TIMELINE FOR ENROLLMENT AND CHANGING COVERAGE MEDICARE+CHOICE

Month	Action	Current Beneficiaries	New Beneficiaries
November 1, 1998, 1999, 2000, 2001	Medicare+Choice Plans Offered Beneficiaries May Buy New Coverage	Continuous Open Enrollment	Continuous Open Enrollment (Initial enrollment under rules determined by HCFA)
January 1, 1999, 2000, 2001	Medicare+Choice coverage takes effect	Continuous Open Enrollment	Continuous Open Enrollment (Initial enrollment under rules determined by HCFA)
January 1, 2002	Medicare+Choice coverage takes effect	Beneficiaries May Switch Coverage Once. from January 1 – June 30, 2002	Beneficiaries May Switch Coverage Once During First 6 Months of Enrollment
November 1, 2002 (Annual, Coordinated Election Period)	Medicare+Choice Plans Offered	Beneficiaries May Switch Coverage	Same rules apply
January 1, 2003, and thereafter	Medicare+Choice coverage takes effect	Beneficiaries May Switch Coverage Once.from January 1–March 31, 2002	Beneficiaries May Switch Coverage Once During First 3 Months of Enrollment
November, 2003 and November of every year thereafter	Medicare+Choice Plans Offered	Beneficiaries May Switch Coverage	Same rules apply

Source: P.L.105-33. This table was compiled upon the author's reading of the Balanced Act. HCFA regulations are pending and may modify the information contained herein.

In subsequent years, this six month time frame will be reduced to three months. Enrollees will be able to change plans only once during the first three months of 2003 and in November. New enrollees will be able to change once during the first three months that they are eligible for Medicare+Choice.[79] *See Table 3,on previous page.*

To protect beneficiaries when continuous open enrollment ends in 2002, there will be several exceptions to the new limits on switching for beneficiaries. For example, there will be an exception for beneficiaries who show that the plan violated a "material provision" of the contract (which may include a failure to provide medically necessary care). The BBA also grants HCFA the authority to determine other "exceptional conditions" under which a beneficiary may switch plans without waiting outside of the designated time periods.[80] How much flexibility beneficiaries actually have in changing plans will depend considerably upon how broadly HCFA interprets these provisions.

Beginning in 1999, the open enrollment period will be the same for all carriers and will take place in November of each year. Coverage in a new plan will take effect on January 1 of the following year. At least 15 days before the November open enrollment period begins, the BBA requires HCFA to mail general information about Medicare to all beneficiaries along with information comparing it to the Medicare+Choice plans available in their area. The BBA also requires HCFA to provide a toll-free number and an Internet site providing information on Medicare+Choice options.

The BBA provides protections for providers who participate in Medicare+Choice plans. These protections include an anti-gag rule provision, limitations on provider incentive arrangements and due process protections in provider participation decisions. Plans must also consult with doctors on issues pertaining to medical management procedures, medical policymaking and quality.

TABLE 4: BBA Amendments: Beneficiary Cost Sharing, Benefits and Plans

Amendment	Potential Provider Impact	Potential Consumer Impact
Part B Premium Increase	Absorb More Unpaid Beneficiary Costs	Increased Out-of Pocket Costs
New Benefits 1) Annual Mammograms; 2) Annual Pap Smears and Pelvic Examinations; 3) Prostate Cancer Screening 4) Colorectal Screening 5) Bone Mass Density Screening 6) Diabetes Self-Management	More Access to Preventive Services	More Access to Preventive Services
New Medicare+Choice Plan Options 1) Managed Care Plans with/without Point of Service Option; 2) Provider Sponsored Organization Plans; 3) Private Fee for Service Plans; 4) Medical Savings Accounts; 5) Religious Fraternal Benefit Societies;	May Increase Enrollment in Non-traditional Medicare plans Potential for Adverse Selection	May Increase Enrollment in Non-traditional Medicare plans Potential for Adverse Selection

Sources: Moon, Marilyn, Gage, Barbara, and Evans, Alison, *An Examination of Key Provisions Medicare Provisions in the Balanced Budget Act of 1997,* The Urban Institute: September, 1997 and P.L. 105-33, The Balanced Budget Act of 1997

B. IMPACT ON HMOS

1. HMO Reimbursement Rates

In recent years, the number of Medicare risk contracts has risen steadily. The payment rate for risk contracts is calculated using a national average rate per beneficiary (the U.S. Per Capita Cost or USPCC). The USPCC is then adjusted for geographic and case mix differences on a county by county basis (The County/U.S. ratio). This adjusted rate is referred to as the Average Adjusted Per Capita Cost (AAPCC). Separate rates are calculated for elderly, disabled and End Stage Renal Disease beneficiaries.

Prior to the BBA, this system was the target of two primary criticisms. The first criticism was that the national average used to calculate the rate was based upon data that included the costs of individuals with high costs and utilization who were not enrolled managed care plans.[81] Many saw these rates as too generous because the inclusion of non-managed care beneficiaries inflated the rate and did not accurately reflect the actual costs of elderly beneficiaries enrolled in managed care plans. The second criticism was that payment rates between counties in different parts of the U.S. varied dramatically. The rate in one urban county in New York was more than three times as high as the rate for a rural county in Louisiana.

In Massachusetts, Suffolk County had the highest payment rate for 1998. Managed care plans in Suffolk County received a total elderly rate of $650.04 for Part A and Part B coverage. The combined rate for disabled beneficiaries in Suffolk County was slightly lower at $643.08. The payments for the county with the lowest rate, Hampshire County, were $411.96 for elders and $367.00 (the statutory minimum under the BBA) for disabled beneficiaries. In FY 1999, rates for all Massachusetts counties will increase by 2%, the minimum increase permitted under the BBA. *See Table 5 below.*

TABLE 5: 1999 MEDICARE+CHOICE MONTHLY CAPITATION RATES FOR MASSACHUSETTS COUNTIES

State County Code	County Name	Aged Rates		Disabled Rates	
		Part A	Part B	Part A	Part B
22000	BARNSTABLE	$288.98	$214.73	$264.72	$197.10
22010	BERKSHIRE	$282.19	$209.69	$262.20	$195.23
22020	BRISTOL	$268.43	$199.47	$221.35	$164.81
22030	DUKES	$347.73	$258.39	$342.71	$255.18
22040	ESSEX	$299.48	$222.54	$261.16	$194.46
22060	FRANKLIN	$244.72	$181.84	$218.56	$162.74
22070	HAMPDEN	$255.84	$190.11	$214.57	$159.77
22080	HAMPSHIRE	$241.07	$179.13	$214.57	$159.77
22090	MIDDLESEX	$339.81	$252.51	$305.91	$227.78
22120	NORFOLK	$328.82	$244.33	$291.41	$216.98
22130	NANTUCKET	$353.67	$262.81	$312.16	$232.44
22150	PLYMOUTH	$316.06	$234.86	$257.72	$191.89
22160	SUFFOLK	$380.39	$282.65	$375.98	$279.96
22170	WORCESTER	$314.54	$233.73	$261.69	$194.86

Source: Health Care Financing Administration. Rates for ESRD beneficiaries are the same throughout the U.S. with each county receiving $1,474.18 for Part A and $2,828.35 for Part B.

2. THE BBA AMENDMENTS

To narrow the gap between counties, the BBA established a floor for those plans at the bottom and restraints on growth that function as the equivalent of a ceiling for plans at the top. For FY 1998, the minimum rate paid to any state will be $367.00 combined for elderly and disabled beneficiaries adjusted by an annual update factor. Plans at the higher end will receive a minimum increase resulting in a rate of 102% of the 1997 AAPCC, but nothing more. The minimum increase will be 102% of the prior year's rate for every year thereafter.

The BBA requires that HCFA calculate a blended rate of national and county factors with the national rate being given more weight every year. Under the original BBA scheme, HCFA was supposed to gradually phase in the blended formula from 90% area-specific/10% national in 1998 to 50% area-specific/50% national in 2002.[82] However, this blended rate was not implemented as planned for 1998 because its cost would have violated budget neutrality and it is uncertain whether or how this scheme will be implemented in the future.[83] Nevertheless, some managed care plans areas with the lowest AAPCC rates have seen meaningful increases and areas with high AAPCC rates have seen their rates of growth diminish.

The AAPCC rate will also be adjusted annually by a "national growth percentage." [84] To calculate the percentage, HCFA will determine the projected per capita rate of growth in Medicare spending and then subtract a specific percentage set in law.[85] For further details regarding rates of growth in future years, *see Table 6 below.* Even with this reduction Medicare spending per capita is still expected to increase by 2.6% for this year.

TABLE 6: NATIONAL GROWTH PERCENTAGE: 1998-2002

Year	National Growth Percentage As % of Medicare Per Capita Rate of Growth (in percentile)
1998	-.8%
1999	-.5%
2000	-.5%
2001	-.5%
2002	0.0% (No Reduction)

Source: Legislative Summary of The Balanced Budget Act , P.L. 105-33. of 1997, P.L. 105-33

To ensure that beneficiaries get sufficient value for the Medicare dollars paid, HCFA compares the Medicare payment rate to an Adjusted Community Rate for individual plans. If the ACR is less than the Medicare payment, then the law requires the plan either to offer additional benefits or lower premiums to beneficiaries. Observers have long believed that the ACR system does not obtain as much value for the beneficiary's dollar as intended. The BBA makes a number of changes to the ACR process to ensure that the ACR rate for each plan "is a more accurate reflection of the benefits actually delivered."[86]

The BBA makes substantial changes to the process for calculating the Adjusted Community Rate (ACR) for individual managed care plans.. The BBA also requires HCFA to develop a better risk adjustment system to account more accurately for the health status of beneficiaries enrolled in Medicare+Choice plans. To implement this risk adjustment scheme, the BBA grants HCFA the authority to collect encounter data, i.e. information regarding diagnoses and services provided, from all sites of care.[87]

The managed care plans also lost a portion of their rate for GME payments in the BBA. These payments will be reallocated to hospitals. This change is also being phased in between 1998 and 2002. This latter provision will reduce payments to managed care plans by an estimated $4 billion dollars per year.

3. POTENTIAL HMO IMPACT OF THE BBA

The new Medicare+Choice plans created by the BBA will be introduced into a market already in transition. These new plans may be attractive to individuals seeking relief from the rising cost of the traditional fee-for-service Medicare plans. They may accelerate the trend away from the traditional fee-for-service Medigap plans. If HMOs introduce plans with point-of-service options, the flexibility of this benefit, combined with the lower premium, may entice beneficiaries who had stayed in Medigap plans to guarantee choice of provider.

Managed care plans may also encounter competition from Medicare+Choice PSOs. There are providers in Massachusetts with sufficient resources to form PSOs. On the other hand, the uncertainty of how and by whom PSOs will ultimately be regulated may dampen the enthusiasm of some parties who might otherwise be eager to enter this new market.

Another uncertain issue is whether the changes in the AAPCC, combined with the new Medicare+Choice options like PSOs, will increase managed care penetration in low enrollment counties in Western Massachusetts and the Islands. When this Issue Brief went to print, HCFA had not yet issued the final Medicare+Choice regulations, and it was still reviewing the filings made by the HMOs with existing plans. For this reason, it is difficult to assess whether Medicare+Choice will improve the range of options available in areas such as Berkshire, Hampshire, and Dukes counties.

Because MSAs will be sold in such limited numbers, their impact on the market is difficult to assess at this time. The MSA demonstration pursuant to the Health Insurance Portability and Accessibility Act of 1996 (HIPAA) has had limited success. It is also difficult to assess the likelihood that companies will introduce private-fee for service plans in a market where managed care has been gaining market share and consumers have been dropping their traditional fee-for-service Medigap coverage.

Adverse selection is a concern to many parties. The introduction of a variety of plans could segment the market in a way that isolates beneficiaries with the greatest health needs and the lowest incomes. HCFA does not have identical authority to prescribe benefit packages for all of the plans. Private fee for service plans and MSAs have more flexibility to formulate benefit packages.[88]

The BBA has already created confusion in this market because its timeline for the regulatory scheme governing the Medicare+Choice plans. It requires carriers to submit plan information regarding benefits and premiums for HCFA's approval no later than May 1.[89] However, the BBA did not require HCFA to issue its standards for the benefit packages and premiums until June 1, 1998.[90] Carriers were thus forced to submit their proposals without knowing whether they would meet the new requirements or how their offerings would compare to those of their competitors.

"The new Medicare+Choice plans created by the BBA will be introduced into a market already in transition."

The BBA has created further confusion because of its potential to disrupt the benefits scheme created by Chapter 176K, the Massachusetts Medigap statute. Under Chapter 176K, the primary function of the standardized benefits packages in the indemnity market and the "all or nothing" drug benefit scheme in both the indemnity and managed care markets was to minimize adverse selection between plans. In recent years, the medical profession has increased its reliance on drug therapies in lieu of more methods such as surgical intervention.[91] Therefore, the importance of this benefit for seniors continues to rise. One of the law's long-term goals was to ensure that all beneficiaries have access to a meaningful prescription drug benefit. By granting HCFA the authority to issue benefit standards that supercede these state laws, the BBA has generated uncertainty regarding its market's future. How policymakers resolve the drug coverage dilemma will have a considerable impact on elders.

A critical factor in the implementation of the Medicare+Choice scheme will be the timing and quality of the information available to beneficiaries. During the first year, the BBA requires HCFA to mail extensive information on each Medicare+Choice plan's benefits, cost-sharing and premiums along with information related to quality and performance, if available, to each beneficiary at least 15 days before the annual coordinated election period in November.[92] Given the short timeline and the enormity of the task, getting an effective consumer information effort up and running will be no small matter. Similar logistical difficulties may also limit the effectiveness of carrier advertising. Marketing materials must be submitted to HCFA at least 45 days before dissemination.

Consumers, providers and policymakers will have to rethink strategy at the state level to determine how to most respond to these changes effectively. Strategies may range from working closely with HCFA to ensure that the concerns of Massachusetts beneficiaries and providers are taken into account to reshaping state initiatives such as the Senior Pharmacy Program to fill in whatever gaps may be remain when federal policy is finalized. New strategies such as premium subsidies or drug reinsurance pools may need to be revisited to provide adequate protection to Massachusetts seniors and people with disabilities.

TABLE 7: BBA Amendments Affecting HMOs

Amendment	Potential Provider Impact	Potential Consumer Impact
Changes to Rate Methodologies 1) AAPCC 2) Updates 3) ACR 4) Risk Adjustment	Reduced Revenues	Increased Premiums/Reduced Benefits Over Time
Reallocates GME Payments from Managed Care Plans to Hospitals	Reduced Revenues	Increased Premiums/Reduced Benefits Over Time

Sources: *Report to the Congress: Medicare Payment Policy, Medicare Payment Advisory Commission* (MedPac Report), Volume 1, Recommendations MedPac Report, Vol. 1, pp. 13-47.

C. HOME HEALTH SERVICES

1. BACKGROUND

Massachusetts has approximately 196 home health agencies.[93] Approximately 65% are non-profit VNAs and similar agencies, 25% are proprietary (for-profit) agencies and 10% are owned by a government entity, usually a city or county agency. Forty-two Massachusetts home health agencies are affiliated with hospitals.[94] These agencies served 119,000 Medicare beneficiaries in 1995, the last year for which complete HCFA data is available.[95] According to the Part A intermediary, approximately 83 of these agencies were formed on or after January 1, 1994.[96] Massachusetts' home health agencies served a higher percentage (14%) of the state's Medicare beneficiaries than the national average of 10%.

a. Eligibility Criteria

To receive Medicare home health services, a beneficiary must meet the following criteria: 1. S/he needs "intermittent" skilled nursing care, or physical or speech therapy. 2. S/he is "homebound".[97] 3. A physician in writing certifies the need for services. 4. The care is provided by, or through arrangements with a Medicare certified provider.[98] Medicare beneficiaries who meet these requirements are eligible for "part-time or intermittent skilled nursing and home health aides," physical, speech and occupational therapy, and medical social services.[99]

b. Expenditures

Nationally, home health expenditures "have more than doubled as a share of the total Medicare budget" with "annual average increases of more than 28 percent per beneficiary . . . between 1990 and 1996".[100] According to a report published by the Kaiser Foundation, "Medicare spending for home health services increased during this period of time because of two key factors:

1. the rise in both the absolute number and in the proportion of Medicare beneficiaries receiving home health services; and,

2. the increase in the number of home health visits per home health user."[101]

The actual cost per unit of service (in this case, visits) has contributed much less to the growth in home health spending than it has to growth of other Medicare expenditures.[102] These increases were in turn driven by a number of factors including the relaxation of the home health eligibility and coverage requirements, such as the 1980 repeal of the three day prior hospital stay requirement, along with less stringent regulatory oversight.

Other trends in health care delivery and payment played a substantial part in causing these increases as well. Medicare's transition to hospital prospective payments based upon diagnosis-related groups (DRGs), reduced the lengths of hospital stays. At the same time, the number of nursing home residencies also fell, as did nursing home lengths of stay. These factors, combined with advances in medical technology and practice, increased reliance upon home care dramatically.[103] In addition, proprietary (for-profit) agencies began entering the traditionally non-profit home health market in

substantial numbers. Between 1990 and 1995, the number of proprietary agencies across the country had grown by 60%.[104]

c. Fraud and Abuse

In 1995, the Clinton Administration responded to concerns regarding "fraud and abuse" by launching "Operation Restore Trust." As part of this initiative, HCFA increased home health agency audits, claims reviews and other anti-fraud measures in five states that together accounted for 40% of Medicare payments: California, New York, Florida, Texas and Illinois.[105] In 1997, HCFA expanded this initiative to other states, including Massachusetts. No fraud and very little "abuse" have been uncovered in Massachusetts. Anecdotally, however, these audits have had a chilling effect on the industry. Providers are now more cautious when they interpret eligibility and coverage requirements for fear that they will be challenged by HCFA and forced to repay any alleged overpayments.[106]

There is evidence that the rate of growth for Medicare home health expenditures has begun to decline in the last 2-3 years. Growth from 1995 to 1996 was 9% and the most recent Congressional Budget Office estimates indicate that between 1996 and 1997, home health outlays increased by 4.8%.[107] Some cite these figures to assert that the IPS was unnecessary to achieve the desired savings.[108]

d. Service Delivery

Massachusetts home health agencies have been delivering care for relatively low costs per visit. The average cost per visit in Massachusetts was $50 per visit or 19% below the national average. This figure reflected a general trend among New England states, except Rhode Island, toward lower average costs per visit.[109]

Massachusetts, along with Connecticut, did not follow the trend of most New England States toward lower than average Medicare payments per user of home health services. Massachusetts home health agencies have slightly higher Medicare costs per user than the national average.[110] Massachusetts's payments per user were 5.7% higher than the national average, ranking it at 13th among the 50 states in average Medicare payments per user for 1995.[111] *See Table 8, below.* The Commonwealth has been trying to reduce the use of Medicaid-funded nursing home admissions and to maximize use of the federally funded Medicare program rather than the partially state-funded Medicaid program. For example, between 1995 and 1996, the number of nursing home residents dropped by nearly 4%.[112] This policy may explain Massachusetts' slightly higher than average number of home health visits.

Massachusetts had a relatively high number of visits per user of home health services, ranking 9th in the United States with 94.3 visits per patient per year as compared to the national average of 72.3 visits per year. This relatively high rate of visits may be linked to state efforts to reduce nursing home admissions and minimize Medicaid expenditures. In addition, the relatively high rate of visits and the slightly above average rate of overall payments per user also may be related to the high proportion of Massachusetts elders who are 75 and older.[113]

The Medicaid program also provides home health services to beneficiaries. In many cases it provides these services in conjunction with the Executive Office of

TABLE 8: MASSACHUSETTS, NEW ENGLAND & US HOME HEALTH CARE DATA

	# of Patients (1,000's)	Average Payment Per Visit	% Above or Below Nat'l. Average	Average Payment Per User	% Above or Below Nat'l. Average
Connecticut	57	$60	-3.0%	$4,770	6.6
Massachusetts	119	50	-19.0	4,730	5.7
Rhode Island	19	64	3.0	4,037	-9.7
Maine	22	53	-15.0	3,717	-16.9
New Hampshire	17	50	-19.0	3,057	-31.7
Vermont	12	45	-28.0	3,030	-32.3
New England	246	53	-15.0	4,400	-1.6
U.S.	3,430	62	—	4,473	—

Source: *The New England Journal, citing the Health Care Finance Administration and the Wall Street Journal,* January 7, 1998, p. NE1

Elder Affairs pursuant to the 2176 Home and Community-Based Waiver. For elders who need less skilled care, Massachusetts also provides homemaking and personal care assistance through its network of thirty home care agencies.[114]

2. THE BBA HOME HEALTH AMENDMENTS

a. Home Health Benefits: The Interim and Prospective Payment Systems

Due to its expansion since the late 1980's, Medicare's home health benefit has become an integral part of the current effort to slow the growth in Medicare spending, ease the financial pressures on the Medicare Hospital Insurance Trust Fund, and balance the federal budget. The BBA made several major changes to the financing and payment of home health care services. The total estimated savings from these changes were approximately $16.2 billion.[115] According to the Massachusetts Home & Health Association, Massachusetts agencies are expecting cuts of $100 million in the coming year.[116]

Prior to the BBA, home health agencies were reimbursed according to a cost-based formula. Many observers criticized this system for not providing incentives to minimize costs: "since an agency's payment limit increased with the number of visits, it had no reason to curb volume as long as the average cost per visit did not exceed the average limit."[117]

As of the beginning of the federal fiscal year on October 1, 1997, the BBA required home health providers to begin a transition from the retrospective cost-based reimbursement system to an interim payment system (IPS) with the ultimate goal of implementing a prospective payment system (PPS) similar to the one operating in hospitals since the mid 1980's. Under the IPS, the cost-based system continues "subject to modified and tighter limits."[118] This system took effect on October 1, 1997. The PPS will take effect on October 1, 1999. For details regarding both the pre-BBA and post-BBA interim and prospective payment formulas, see table 9 below.

TABLE 9: Comparison of Pre-BBA and Post-BBA Home Health Payment Systems

Formula	Amendment
Pre-BBA Formula	Payments to home health agencies were equal to 112% of the mean national costs for that type of visit.
Post-BBA Formula Interim Payment System (IPS) 10/1/97-9/30/99	Under the new methodology, a home health agency will receive the lesser of two amounts calculated using the following methodologies: 1) a payment based upon 105% of median national costs; or, 2) a capped payment, adjusted for geography and case mix This "per beneficiary limit is a blended amount based on 75% of the agency's costs per beneficiary and 25 percent of the average cost per beneficiary in its census region, using 98% of a base year's costs."[i] This capped amount is then multiplied by the agency's unduplicated census count..[ii]
Post-BBA Formula Prospective Payment System (PPS) 10/1/99 and thereafter	To determine the new prospective payment methodology, HCFA will have to consider several issues, including the following factors: 1) the units of service upon which the prospective payment will be based; 2) the standard prospective payment amount for that unit of service; 3) the geographic adjustment for wage levels; 4) case mix adjustments; and, 5) an outlier adjustment, i.e. an adjustment for certain high cost cases.[iii]

i Komisar and Feder, at p. 10.
ii P.L. 105-33, Section 4602(c).
iii Komisar and Feder, at p. 11.

Sources: Komisar, Harriet L. and Feder, Judith, *The Balanced Budget Act of 1997: Effects on Medicare's Home Health Benefit and Beneficiaries Who Need Long-Term Care,* Washington, D.C.: Institute for Health Care Research and Policy, Georgetown University, February , 1998, pp. 10-11 and P.L. 105-33, Section 4602(c).

Under the IPS, HCFA sets caps per beneficiary based upon costs incurred during federal fiscal year 1994, known as the base year. This formula accounts for inflation in home health costs by permitting a rate update based upon the "home health market basket, a national index of growth in input costs of home health agencies, such as wages and utility expenses."[119] This formula applies only to agencies that operated in their current form during FY 1994. Newer agencies that were "created, merged or changed owners after October 1, 1993 . . . will receive a per beneficiary cap based solely on national experience, (the median of these limits applied to other home health agencies) adjusted for inflation."[120]

The Secretary of Health and Human Services has wide discretion to establish the parameters for the PPS which will take effect on October 1, 1999. On January 2, 1998, the Secretary published interim rules and on March 31, 1998, she published final rules regarding this formula with a comment period. Although permanent rules were expected on June 1, 1998, they were still not published when this issue brief went to press. In fiscal year 2000, the BBA requires a 15% reduction in the cost-based and per beneficiary limits, regardless of whether the new PPS is ready for implementation.

b. Definitions

To receive home health services, a beneficiary must require "part-time or intermittent" care. Prior to the BBA, these terms were defined only in HCFA regulations, not in statute. The BBA codified the definition in statute. "The new (statutory) definitions differ somewhat from the previous regulatory definitions and practices."[121]

Individuals who need certain skilled services on an "intermittent" basis are eligible for home health services. The new BBA definition of "intermittent"[122] makes more beneficiaries eligible for home health services.

Eligible beneficiaries may receive "part time or intermittent services." The new BBA definition of this term narrows the scope of reimbursable skilled nursing and home health aide services. According to a HCFA bulletin, it permits less flexibility in the number of hours of service that certain beneficiaries may receive per day.[123,124]

The BBA also modified the definition of "skilled services" necessary to qualify for home health services. Prior to the BBA, "venipuncture", the drawing of blood, was considered a skilled service that alone justified a home health visit. The BBA changed this provision so that venipuncture alone no longer justifies home health services.

c. Fraud and Abuse

The Act contained several fraud and abuse provisions to reinforce the efforts of HCFA auditors who had already stepped up their reviews of home health agency practices. These measures were included to reinforce the efforts of its auditors and other agency personnel involved in Operation Restore Trust.

d. Surety Bonds

The BBA requires home health agencies, along with certain other providers, to post a surety bond of at least $50,000 or 15% of the annual amount they receive from the Medicare or Medicaid Program.[125] Agencies must also post a similar, but separate, bond for Medicaid. The surety bond serves as a guarantee that the agency can repay HCFA in the case of overpayment. Smaller agencies, particularly non-profit Visiting Nurses Associations, have had difficulty meeting these new requirements.[126] The Secretary may also impose similar bonding requirements on Part A providers, suppliers or similar persons. The BBA also imposes a minor, but meaningful, change requiring that payment limits be based upon the location of the service provided, not the site of the home health agency's billing office.[127]

e. Other BBA Amendments to the Medicare Home Health benefit

Transfer of certain payments to Part B: Home health services were originally designed to be provided only after a beneficiary hospital discharge. For this reason, reimbursement for all home health services was historically provided under Part A. To relieve the pressure on the Part A Trust Fund, the BBA reallocates a portion of home health costs to Part B. For the first time, "(h)ome health visits that are not related to an earlier three-day hospital stay or that follow at least 100 visits subsequent to a stay will be financed from Part B."[128]

Prohibition of Self Referral: Some hospitals have home health agencies of their own or in partnership with other entities. To reduce fears about competition for beneficiaries who are being discharged from a hospital to home health services, the BBA prohibits hospitals

from limiting referrals of their patients to hospital affiliated home health agencies. These beneficiaries are often seen as desirable, short-term, low-cost patients. To facilitate enforcement of this provision, the BBA requires hospitals to disclose information about referrals to "entities in which the hospital has a financial interest."[129]

Commission to Evaluate "Homebound" Definition: Much controversy has surrounded the interpretation of the term "homebound." Some observers believe that it should be amended to reflect the original intent of the program to serve only individuals who cannot leave the home to receive medical treatment. The BBA directs a commission to examine this definition and make recommendations.

3. IMPACT OF THE BBA HOME HEALTH AMENDMENTS

Recent research suggests that the IPS and the PPS jeopardize the health and well being of high utilizers of home health care services in Massachusetts and the nation. These new payment systems also have serious implications for the Commonwealth's budget.

Some research has projected how these changes will affect beneficiaries and who are most vulnerable. In their study of national data, Komisar and Feder report that:

> "Beneficiaries with the highest levels of use are likely to be affected the most by the changes in the delivery of home health. They will be especially affected not only because home health services play a large role in their health care, but also because policy changes (both the interim system and the PPS) will create incentives for agencies to reduce high volume episodes."

These researchers note that most high home health users "do not appear to be using Medicare's home health benefit solely or predominantly for long-term care. Rather, most appear to have multiple-often-complex-medical needs, requiring a range of acute and long-term care services."[130] Because the greatest growth in home health is from the increase in the average number of visits per client, the number of visits is likely to be the first area in which agencies reduce volume. The relatively high average number of visits by Massachusetts home health agencies, combined with the large proportion of Massachusetts elders over 75 and over 85, suggest that a significant number of Massachusetts clients may fall into this high risk group.

Although there have been no statistical analyses of the impact as yet, anecdotal accounts of frail elders, children, and adults with disabilities losing their home health services or receiving drastic cuts in service have been receiving substantial press coverage. Stories have appeared regarding the impact of these cuts in diverse communities such as Lowell, Lawrence, Quincy, and Arlington.[131] Testimony at a hearing before the Joint Committee on Health Care indicated that the problem is not just confined to the Eastern half of the state, but affects individuals and families in Central and Western Massachusetts communities such as Milford, Worcester, and Springfield as well.[132]

State-funded programs have begun to report cost shifting of Medicare home health expenditures to their budgets. In testimony before the Joint Committee, Massachusetts Division of Medical Assistance Assistant Commissioner Elizabeth Greene stated that some dually eligible individuals will turn to Medicaid's community based programs for assistance. [133] She indicated that these changes increase risk of institutionalization. Some will continue to receive services at home. "Others, however, are likely to end up in nursing homes."[134]

The Massachusetts Association of Home Care Programs/Area Agencies on Aging report a sharp increase in the growth of home care caseloads during the first three months of 1998. Prior to the the Medicare home health changes, the estimated caseload increase had been 40 cases per month. This figure grew to 303 in February. The Mass Home Care Association has predicted that, based upon current trends since the passage

"Recent research reveals that the IPS and the PPS jeopardize the health and well being of high utilizers of home health care in Massachusetts and around the country."

"… some individuals who are dually eligible for Medicare and Medicaid will likely turn to the state's Medicaid community based programs for more assistance."

of the BBA, the average monthly increase in caseload could rise as high as 140 cases per month. [135]

HCFA and other sources suggest confusion as a reason for these cutbacks.[136] Beneficiaries are disadvantaged because of the difficulty in pursuing an appeal. One problem is that Medicare will not pay for services during an appeal. To continue receiving services while the appeal is pending, the beneficiary must pay out-of-pocket. Further, a favorable decision applies only to the prior period and not to a new episode of care. The beneficiary, thus, may have to pursue multiple appeals. Although most individuals who pursue appeals ultimately win them, the benefit of challenging a service denial may be limited.[137]

Agencies also have limited information about the extent of the cutbacks and the rules under which they operate. "HCFA lacks readily available data to calculate the per-beneficiary limit . . . in the interim, agencies have completed up to six months of the cost reported period without knowing the applicable per-beneficiary limit."[138] In addition, agencies will not submit final cost reports until 1999, thus feedback from HCFA on the reasonableness of their costs will be unavailable for some time. Agencies formed since 1994 may be particularly vulnerable.[139] The Medicare fraud and abuse audits add an additional element of uncertainty to the equation.

Agency staff have borne a substantial portion of the costs of the cutbacks through staff layoffs in some agencies and and loss of benefits in other agencies.[140] Some organizations, such as the Massachusetts Easter Seals Society which serves children with disabilities, are discontinuing home health services altogether.[141]

Several approaches are possible to address these problems. One is to accept the current rules and assist beneficiaries, their families and agencies to adapt to them by increasing state funding for home health, home care and nursing home services. Such increases may be necessary in any case, but efforts to modify the new payment scheme may minimize additional state expenditures. Whether to focus on the interim payment system currently in place or on the prospective payment system to take effect on October of 1999 is an important strategic question. Senator Edward Kennedy and Representative James McGovern have filed legislation to delay PPS implementation and to update the base year upon which it is calculated. However, further reductions of 15% will take place whether or not a PPS is in place at that time.

Another strategy would be to focus on questions regarding units of service and other matters that will form the foundation of the PPS in years to come.[142] Still another approach, which could be pursued simultaneously with those described above, is to strengthen beneficiaries' appeal rights. Underlying this debate, however, is the fundamental question of who will receive and who will pay for home health care services.

Interested parties could either pursue this approach through working closely with HCFA in defining appropriate rules under the new law or turning to Congress to change the rules set down in the BBA. The appeals process could be modified to ensure that beneficiaries continue to receive Medicare-reimbursed services pending the outcome of their appeals. Another important change to the appeals process would make appeal decisions binding on a prospective, as well as retrospective, basis, to enable beneficiaries to obtain a certain level of services for a specified period of time into the future.

TABLE 10: BBA HOME HEALTH AMENDMENTS

Amendment	Potential Provider Impact	Potential Consumer Impact
New Payment Systems 1) Interim Payment System (IPS) (10/1/97 – 10/1/99) 2) Prospective Payment System (PPS) (10/1/99 and thereafter)	Reduced Revenues Layoffs/Other Staffing Changes Closure of Some Agencies	Increased Reductions/Denials in Service Agency layoffs/Staffing Changes Increased Reliance Upon Family Cost Shifting to States - Medicaid/Home Care
Definitions 1) "Intermittent" – Eligibility 2) "Part-time or intermittent"-Scope 3) "Venipuncture" – Eligibility	More Individuals Eligible, but Narrower Scope of Service	More Individuals Eligible, but Narrower Scope of Service
Fraud and Abuse	Agencies More Conservative Eligibility and Scope Decisions	Agencies More Conservative in Decisionmaking Regarding Eligibility and Scope
Surety Bonds	Smaller, non-profits have difficulty qualifying. Increased Costs. Barrier to Market Entry	Smaller, non-profits have difficulty qualifying. Increased Costs. Barrier to Market Entry
Transfer of Certain Home Health Payments from Part A to Part B	Increases longevity of Part A Trust Fund Increases Part B Premiums	Increases longevity of Part A Trust Fund Increases Part B Premiums
Prohibition on Self-Referral by Hospitals	Reduces Competitive Advantage of Hospital-owned Home Health Agency for short-term, post-acute, rather than chronic, patients	Reduces Competitive Advantage of Hospital-owned Home Health Agency for short-term, post-acute, rather than chronic, patients
Commission on Homebound Definition	May Further Restrict Eligibility and Reduce Revenues	Reduces Competitive Advantage of Hospital-owned Home Health Agency for short-term, post-acute, rather than chronic, patients

Source: Information for table derived from Komisar, Harriet L. and Feder, Judith, *The Balanced Budget Act of 1997: Effects on Medicare's Home Health Benefit and Beneficiaries Who Need Long-Term Care,* Washington, D.C.: Institute for Health Care Research and Policy, Georgetown University, February , 1998.

D. ACUTE CARE HOSPITALS IN MASSACHUSETTS

1. BACKGROUND

Eighty-five hospitals in Massachusetts are reimbursed under PPS.[143] Approximately 40 of these provide graduate medical education. These teaching facilities tended to be large urban hospitals that receive Disproportionate Share (DSH) as well as GME payments. At least 31 hospitals provided a substantial amount of free care or had a high volume of Medicaid patients. The Division of Health Care Finance and Policy noted the diversity in size and other characteristics among these hospitals. Of the 74 hospitals for which it obtained reliable data, "18 had less than 100 beds, 25 had between 100 and 200 beds, and 31 had over 200 beds."[144] The smaller hospitals tend to be community hospitals that do not receive GME or DSH payments. Despite some inroads by for-profit corporations, most Massachusetts hospitals remain non-profit entities.

The hospital industry in Massachusetts has undergone substantial changes during the 1990s. In 1991, the Legislature repealed the rate-setting system that had governed the state's hospitals for many years, creating a more competitive environment.[145] Combined with the growth of managed care and pressure from both public and private payers to reduce costs, hospitals began to focus on cost reductions and increased economies of scale, as well as mergers and consolidations. Hospitals also entered new markets such as home health and, by establishing transitional care units (TCUs), entered the sub-acute skilled nursing facility market as well. As a result, they will also feel the effects of BBA changes to these sectors.

In 1997, in response to concerns regarding hospitals' ability to pay the costs of free care in this competitive environment, the Legislature enacted Chapter 47 of the Acts of 1997 to broadens the financing of free care by requiring insurers to pay an assessment to the Uncompensated Care Pool and by increasing state contributions.[146]

Medicare pays for more than 40% of all hospital discharges in Massachusetts. Medicare is most significant for small, community-based, non-teaching hospitals that admit a greater proportion of elderly patients. In these hospitals, Medicare payments comprise roughly 60% of total inpatient service revenue. In the larger, urban teaching hospitals, Medicare payments made up less than 50% of inpatient service revenues. Medicare covered about 35% of all hospital outpatient claims in 1996.

Hospital payments account for about 44 percent of all Medicare expenditures and represent almost 30 percent of the proposed (federal budget) savings over five years (1998 through 2002). Half of these savings are from reductions in the update factors for prospective payment system (PPS) hospitals.[147] Since Congress first enacted the prospective payment system in 1983, hospitals have received set operating and capital payments for each Medicare beneficiary discharged. Both operating and capital payments are adjusted by factors related to geographic differences in the cost of inputs (such as those for labor, supplies or capital assets) and the Diagnosis Related Group (DRG) of the individual patient. A hospital also receives additional payments for extremely high cost cases (outliers). Payments to teaching hospitals are further adjusted for indirect medical education (IME) costs. Hospitals that provide large amounts of care to low-income patients receive disproportionate share adjustments.[148]

2. BBA ACUTE HOSPITAL AMENDMENTS

a. PPS Payments

Each year, PPS payments are updated to reflect expected inflation in hospital input as measured by the hospital market basket index.[149] The hospital market basket index is an index of the annual change in the prices of goods and services that providers (in this case, hospitals,) use for producing health services. With the exception of one year, the update had been set at 2.1% below the hospital market basket index since 1986. Without the BBA, it would have been set equal to the hospital market basket index for future years. The BBA freezes the update factor at zero (0%) for 1998, meaning that acute care hospitals will receive an update equal to the market basket index for 1998. For details on the amount of updates for future years, see the table below. The Balanced Budget Act provides "temporary relief from these reductions for "non-teaching, non-disproportionate share" hospitals by permitting a .5% increase in the update for discharges during FY 1998 and .3% for 1999. After FY 1999, these hospitals will be subject to the same prospective payment update as all acute-care hospitals.[150]

TABLE 11: AMOUNT OF UPDATE RELATIVE TO MARKET BASKET, 1998-2002

Year	Update as % of Market Basket Index Teaching/DSH Hospitals	Update as % of Market Basket Index Non-Teaching/Non-DSH Hospitals
1998	0%	.5%%
1999	-1.9%	.3%
2000	-1.8%	-1.8%
2001	-1.1.%	-1.1.%
2002	-1.1.%	-1.1.%

Source: The Balanced Budget Act of 1997, P.L. 105-33, Section 4401(a) and Section 4401(B).

b. Change in Rules for Patient Transfers to Sub-Acute Settings

The BBA sets new payment rules for beneficiaries with certain diagnoses who are discharged from a PPS hospital to sub-acute settings such as PPS-excluded hospitals, transitional care units within a hospital and freestanding skilled nursing facilities, a home health agency or other post-discharge services. The BBA

orders the Secretary to identify 10 DRGs associated with a high volume of discharges to sub-acute settings.[151] Hospitals will receive a lower payment for those beneficiaries than it would have under the prior system. According to the Urban Institute, "this policy is intended to correct for falling hospital costs associated with higher use of post-acute providers."[152]

c. Changes to GME Payments

The BBA makes several changes to the GME program. It reduces the IME adjustment to prospective payments by 29% over a five-year period.[153] It begins by reducing IME payments to hospitals from 7.7% in 1997 to 7.0% in 1998. The adjustment will continue to fall until it reaches a permanent rate of 5.5% in the year *2001.[154] See table 12 below.*

TABLE 12: IME TEACHING ADJUSTMENT FACTOR: 1998-2002

Year	IME Teaching Adjustment Factor (in percentile)
1998	7.0%
1999	6.5%
2000	6.0%
2001	5.5%
2002	5.5%

Source: Legislative Summary of The Balanced Budget Act of 1997, P.L. 105-33

To address concerns regarding physician oversupply, particularly specialists, the BBA imposes "hospital-specific" caps on the number of residents in each teaching hospital when calculating IME and direct medical education payments.[155] It places additional limits on the ratio of residents to patient beds for IME payment purposes. In response to the trend toward outpatient care, the BBA permits hospitals to include residents who practice in outpatient settings in their IME calculation provided that the hospital prove that it pays the bulk of the their training costs.[156]

To encourage teaching hospitals to reduce voluntarily the number of residents, the BBA extends a program of incentive payments first tested in 1997 in a demonstration project in New York to the entire country. As long as they maintain the same level of primary care training, hospitals that agree to reduce their overall residency programs by 20-25% between 1998 and 2002 will receive payments to cushion the loss of payments for those slots.

For the first time, the BBA authorizes hospitals to receive IME and direct medical education payments for every Medicare+Choice patient they discharge. Teaching hospitals did not receive IME or direct medical education payments for managed care beneficiaries in the past. These additional payments will be phased in between 1998 and 2002. According to some analysts, these payments may ensure access to teaching hospitals for beneficiaries in managed care plans.[157] Also, the BBA permits direct medical education payments to non-hospital providers according to a formula developed by the Secretary. It further establishes a special commission to evaluate current Medicare GME payments and develop recommendations for additional reforms.[158] In response to fraud and abuse allegations, the BBA directs the Secretary to conduct a study in variations in overhead costs and supervisory physician components between hospitals.[159]

d. Disproportionate Share Hospital (DSH) Payments

Disproportionate Share Hospital (DSH) payments are adjustments to a hospital's prospective payments to compensate for serving a relatively large volume of low-income patients.[160] Medicaid also makes DSH payments to some hospitals. Between fiscal years 1998 and 2002, Medicare DSH payments will be reduced by 1% per year. Starting in 2003, there will be no further reductions. For more detail on the reductions, *see table 13 below.*

TABLE 13: REDUCTIONS IN DSH PAYMENTS, 1998-2002

Year	Reduction in DSH Payments (in percentile)
1998	-1%
1999	-2%
2000	-3%
2001	-4%
2002	-5%

Source: The Balanced Budget Act of 1997, P.L. 105-33, Section 4403(a)

2. POTENTIAL IMPACT OF THE BBA ACUTE HOSPITAL AMENDMENTS

Prior to the BBA, the PPS profit margin for Massachusetts acute hospitals has been substantially lower than the national average. In 1994, the PPS profit margin was less than one-tenth of one percent. This figure dipped to a negative -1.4% in 1995 and then rebounded to 2.0% in 1996.[161] Overall profit margins for these three years were positive, suggesting that hospitals were able to compensate for low Medicare returns with revenues from other, primarily private, insurers.

The State's Division of Health Care Finance and Policy reports that "The BBA is predicted to reduce Medicare payment to the Massachusetts PPS sector as a whole by 1.4 billion over the next five years, 10% less than projected revenues of $12.9 billion under previous draft regulations."[162] As a result, all hospitals are anticipated to see reduced profit margins and some will incur losses. The DHCFP suggests that "(a)n individual hospital's ability to cross-subsidize its Medicare-funded admissions from patients with private insurance will be an important factor in determining the extent to which the Medicare cutbacks by the BBA can be absorbed . . ." by Massachusetts hospitals.[163] The Division's report notes substantial disparities between the ability of community hospitals and large teaching hospitals to do so.

Disparities also exist between teaching hospitals that receive DSH funds and community hospitals without DSH support. On average, the community hospitals lost money on Medicare patients while the teaching hospitals made a small profit. The overall profit margins showed an average of -3.8% for community hospitals and an average gain of 5.1% for teaching facilities.[164] The BBA changes to PPS may exacerbate the existing disparities.

While some hospitals will attempt to shift costs to other payers, including Medicaid, small community hospitals will face additional pressures "to consider options of merger, affiliation, acquisition, conversion or even closure, with serious implications for access to health care in smaller towns far away from urban centers."[165] As noted in the next section, hospital transitional care units will also be adversely affected by the BBA's changes to the Medicare nursing facility payment system. For some hospitals with sufficient resources to form Medicare provider service organizations (PSOs), the BBA may provide some benefit that will offset the losses from their traditional business.

TABLE 14: BBA Amendments Affecting Hospitals

BBA Amendments	Potential Provider Impact	Potential Consumer Impact
1) Changes to Prospective Payments a) Reduced PPS Updates b) Reduced IME and DSH payments c) Changes to Payments for Transfers 2) Increased GME payments for Medicare+Choice Enrollees. 3) Changes in Direct GME to Reduce Number of Residents. 4) Reimbursement for Residents in Outpatient Settings.	May Affect Discharge Policy Increased Industry Consolidation Less Financial Stability, Particularly for Community Hospitals Reduced Revenue from Transitional Care Units and Possible Closure May Offset Revenue Reductions from Other PPS Changes	May Affect Discharge Timing and Setting May Affect Discharge Timing and Setting Less Choice Regarding Provider and Location of Provider

Sources: *Report to the Congress: Medicare Payment Policy, Medicare Payment Advisory Commission* (MedPac Report), Volume 1, Recommendations, pp. 51-68, *The Impact of the Medicare Provisions in the Balanced Budget Act of 1997 on Massachusetts Health Care Providers, Consumers, and Medicaid: A Report to the Senate Committee on Ways and Means, House Committee on Ways and Means and Joint Committee on Health Care*, May 1998.

E. PPS -EXCLUDED HOSPITALS IN MASSACHUSETTS

1. BACKGROUND

There are 51 specialty hospitals (children's, cancer, rehabilitation, psychiatric, chronic and state-run facilities.) that are eligible for PPS-excluded status in Massachusetts.[166] There are also two types of distinct-part units in acute care hospitals (rehabilitation and psychiatric.)[167] that receive similar treatment. In 1996, Medicare revenue to these hospitals totaled over $246 million. In that same year, Medicare patients accounted for 61% of the occupancy in the rehabilitation units and 44% of the occupancy in the psychiatric units.[168]

These hospitals have been subject to the same trends as acute-care hospitals. For example, "(t)he rapid changes in the financing of health care are now spilling over to the once-shielded rehabilitation industry"[169] In response to pressure from payers, particularly managed care organizations, rehabilitation hospitals have cut staffing and significantly decreased average lengths of stay.[170] Consolidation has increased and large-scale for-profit chains have emerged as significant players in this market.[171] These same trends have also caused substantial downsizing and shortened lengths of stay in psychiatric hospitals.

2. THE BBA AMENDMENTS AFFECTING PPS-EXCLUDED HOSPITALS

PPS-excluded hospitals receive payments referred to as "TEFRA" payments.[172] Medicare pays the hospital the lesser of the amounts yielded by two different formulae, either the facility's average costs per discharge or its "target amount"— its costs per discharge in a base year updated to the current year.[173] The BBA changes were designed to level the playing field for old and new facilities that received payments under this scheme.[174] Prior to the BBA changes, new facilities appeared to be at an advantage, fueling the growth of new facilities and contributing to poorer financial performance among older facilities.[175]

Medicare payment updates reflect increases in the cost of inputs and improvements in medical technology. To minimize discrepancies between facilities, the BBA requires that Medicare implement a facility-specific formula for updates, with higher updates permitted for providers whose costs exceed their targets. Older facilities (those excluded from PPS before 1991) may choose a more recent base year from which to calculate their target amounts.[176] Three types of facilities with the highest target amounts (psychiatric hospitals and units, rehabilitation hospitals, and long-term care hospitals) will be subject to caps. These caps are set at the 75th percentile of fiscal year 1996 target amounts, adjusted for inflation.[177]

"The rapid changes in the financing of health care are now spilling over to the once-shielded rehabilitation industry."

The BBA contains provisions to assist long-term care hospitals and rehabilitation facilities in making the transition to PPS. The BBA requires that the Secretary submit a prospective payment proposal for long-term care hospitals to Congress by October 1, 1999. Rehabilitation facilities must begin to use a prospective payment system as of October, 2000.[178]

3. POTENTIAL IMPACT OF THE BBA CHANGES AFFECTING PPS-EXCLUDED HOSPITALS

Changes to Medicare's payment method for these hospitals may cause Medicaid to modify its reimbursement policies for these facilities, leading to a reduction in revenues from both programs. According to the State Division of Health Care Finance & Policy, "(t)hese facilities may experience a significant total reduction in revenue, which may translate into reductions in staffing, efforts to improve efficiency of service delivery and efforts to shift costs to other payers."[179] The Division predicts that chronic and rehabilitation hospitals "will inevitably resort to shortening lengths of stay in their facilities, thus putting greater pressure on skilled nursing facilities and home health care alternatives. Psychiatric facilities will also be pressured to discharge patients into the community at much faster rates."[180] These practices raise concerns regarding quality of care; the added pressure from the BBA changes may exacerbate these problems, particularly "for the patient with relatively greater complexity of care."[181]

TABLE 15: BBA Amendments and Non-PPS Hospitals

BBA Amendments	Potential Provider Impact	Potential Consumer Impact
1) Changes to Payment Formulas	Old and New Facilities on More Even Footing	May Affect Discharge Timing and Setting
2) New Prospective Payment System for Rehab. Hospitals in Future	Increased Industry Consolidation	Less Provider Choice
3) Future Prospective Payment for Long-Term Care Hospitals		

Sources: *Report to the Congress: Medicare Payment Policy, Medicare Payment Advisory Commission* (MedPac Report), Volume 1, Recommendations, pp. 51-68, *The Impact of the Medicare Provisions in the Balanced Budget Act of 1997 on Massachusetts Health Care Providers, Consumers, and Medicaid: A Report to the Senate Committee on Ways and Means, House Committee on Ways and Means and Joint Committee on Health Care*, May 1998.

F. SKILLED NURSING FACILITIES IN MASSACHUSETTS

1. BACKGROUND

The skilled nursing facility industry in Massachusetts includes many non-profit and for-profit entities. Eighty-eight percent of these facilities are certified to accept Medicare beneficiaries. Medicare limits the amount of nursing facility coverage it reimburses, covering the first 100 days of treatment in a nursing facility. In addition, it pays for nursing and rehabilitative services, but does not cover custodial care. As a result, Medicare beneficiaries in nursing homes are usually cared for in a separate unit where their medically intensive needs are attended to by a more highly skilled staff. Once an individual exhausts Medicare coverage, s/he will either pay privately until able to make the transition to Medicaid or transfer directly to Medicaid immediately, depending upon his/her financial circumstances.

"Although Medicaid remains the largest payer of nursing facility services, Medicare costs and utilization have risen sharply in recent years."

Although Medicaid remains the largest payer of nursing facility services, Medicare costs and utilization have risen sharply in recent years. Medicare payments to skilled nursing facilities rose from $43.2 million in 1990 to $363.2 million in 1996.[182] Hospital created transitional care units (TCUs) specifically to serve post-acute patients such as Medicare beneficiaries. As a result, Medicare revenues constitute a large portion of the overall revenues of these units. According to the Division of Health Care Finance & Policy, "(t)he Medicare reimbursement system has encouraged the growth and expansion of the hospital-based TCU market. In 1992, there were 5 hospital based TCUs in Massachusetts. In 1997, the number had grown to 36."[183] The Division also notes that not-for-profit free-standing facilities also serve, "on average, a higher proportion of Medicare beneficiaries" than in the past.[184]

2. THE BBA AMENDMENTS AFFECTING SKILLED NURSING FACILITIES

The BBA requires HCFA to submit a proposal by May 1, 1998 for a prospective payment system for skilled nursing facilities. Under current law, skilled nursing facilities are paid a per diem rate, "based on facility-specific per diem costs, subject to national average caps,"[185] except for certain ancillary services, e.g. physical therapy. Increases in ancillary costs have fueled a substantial increase in the cost of skilled nursing facility services, causing them to rise from 1% of total Medicare expenditures in 1984 to 6% in 1996. The implementation of PPS is intended to stem this growth by providing a fixed payment for both routine and ancillary services. This new system will also require substantial improvements in the data collection of skilled nursing facilities and significant changes in their billing procedures, including a transition to consolidated billing.

3. POTENTIAL IMPACT OF THE BBA ON SKILLED NURSING FACILITIES

These new policies likely will cause Medicare nursing facility admissions to stabilize or decline.[186] In addition, the BBA will encourage skilled nursing facilities to reduce costs, particularly those associated with ancillary providers. The new consolidated billing system and the information collection it requires will increase administrative burdens and expenses to the facilities. Large for-profit entities with multiple facilities may manage these changes more easily than smaller, independent facilities.[187]

"It is likely that some hospitals will choose to exit the TCU market completely, resulting in closures of TCUs. If this occurs, admissions to freestanding skilled nursing facilities and rehabilitation hospitals will increase."

Transitional Care Units will be particularly affected because of their high level of dependence on Medicare. Many TCUs are relatively new and the BBA's PPS formula permits less transition time to the new payment system for new facilities than for old ones. Also, under the new PPS rules for acute hospitals, individuals with one of 10 diagnoses will now be considered "transfer" patients when they move to a post-acute facility. TCUs will no longer receive a separate payment for these beneficiaries, but instead reimbursement will be included under the hospital's original DRG-based prospective payment. This change will lead to a reduction in transfers from hospitals to TCUs. For this reason, it "is likely that some hospitals will choose to exit the TCU market completely, resulting in closures of TCUs. If this occurs, admissions to freestanding skilled skilled nursing facilities and rehabilitation hospitals will

TABLE 16: IMPACT OF THE BBA ON SKILLED NURSING FACILITIES

BBA Amendments	Potential Provider Impact	Potential Consumer Impact
1) New Prospective Payment System and Consolidated Billing	Reduced Revenues/ Stabilization or Decrease in Medicare Admissions Reduced Ancillary Services Greater Administrative Burdens More Consolidation	More Access for Beneficiaries with Certain Conditions and Less Access for Others

Source: *The Impact of the Medicare Provisions in the Balanced Budget Act of 1997 on Massachusetts Health Care Providers, Consumers, and Medicaid: A Report to the Senate Committee on Ways and Means, House Committee on Ways and Means and Joint Committee on Health Care,* May 1998.

increase," notes the DHCF&P.[188] As a result, the number of individuals discharged to the care of home health agencies, hospital owned or not, may increase.

Conversely, BBA reductions in home health payments may lead to increased nursing home admissions. An expansion in admissions will likely lead to further growth in Medicaid costs.[189] The the methodology which HCFA is likely to choose to implement the new PPS, referred to as "RUGS-III, may also increase incentives to admit beneficiaries with certain needs, e.g. "complex rehabilitation," in lieu of individuals with cognitive impairments for whom reimbursement is less favorable.[190] On the other hand, beneficiaries may benefit from improvements in quality control made possible by the new information systems accompanying the new PPS system.[191]

G. PHYSICIANS IN MASSACHUSETTS

1. BACKGROUND

The practice of medicine has undergone a dramatic shift in the last two decades. "With the growing prevalence of managed care has come greater third-party influence on physicians' clinical decisions, to achieve efficient and high-quality health care."[192] As managed care now comprises approximately 40% of the market, physicians' autonomy and their incomes have been reduced. They have succeeded to some degree in limiting the authority of managed care plans over them. In 1996, the Massachusetts Legislature passed an anti-gag rule provision reinforcing provider's ability to counsel their patients freely regarding their care.[193]

Massachusetts physicians have historically been subject to certain restrictions when treating Medicare patients. For example, they are prohibited from balance billing Blue Cross and Blue Shield subscribers. They have also had a higher than average percentage of their elderly patients in managed care. They are paid according to the Medicare fee schedule. "Components of the fee schedule address the three types of resources used to provide services: physician work, practice expense and malpractice insurance expense."[194] Rates paid for practice expense and malpractice insurance are based upon historical charges, however the physician work component is based upon an assessment of resources used to provide physician services. The sum of these three components is then converted to a dollar value by a conversion factor that is updated annually.

2. BBA CHANGES AFFECTING PHYSICIANS

The BBA changes to the Medicare fee schedule for physicians are estimated to save $5.3 billion between 1998 and 2002. The BBA makes three major changes to physician payments: 1. Establishing a single conversion factor; 2. Replacing the "volume performance standard" with a "suitable growth rate formula"; 3. Delaying the use of the revised physician expense methodology for 1 year and then phases it in over three years.[195]

3. POTENTIAL IMPACT OF BBA ON PHYSICIANS

The overall effect of these changes will be to reduce payments for some services ranging from radiology to coronary artery bypass grafts. However, the BBA increased payments for the majority of services.[196] Given the likely benefit to many physicians, there has been little public discussion of these changes here in Massachusetts. This may change over time and it will be important to monitor beneficiary access to services that were subjected to cuts.[197]

Another, little known provision permits beneficiaries to opt out of Medicare and contract privately with a physician. However, any physician who enters into such a contract is barred from the Medicare program for a two year period. This BBA provision is undesirable to most physicians. Therefore, few physicians are likely to adopt such arrangements.[198]

"The overall effect of these changes will be to reduce payment for some (services)… However, the BBA increased payments for the majority of services."

TABLE 17: IMPACT OF THE BBA ON MASSACHUSETTS PHYSICIANS

BBA Amendment		
Changes to Payment Formulas	More Revenue for Primary Care Providers and Some Specialists and Less Revenue for Other Specialists	Increased Access for Some Services and Less Access for Others May Increase Provider Choice
Medicare+Choice PSOs.	Easier to Form PSOs. Physicians may benefit from the BBA's provisions regarding PSOs. Those networks with the resources to bear this level of risk may have a substantial market awaiting their entry.	Increased Access for Some Services and Less Access for Others May Increase Provider Choice

Source: *The Impact of the Medicare Provisions in the Balanced Budget Act of 1997 on Massachusetts Health Care Providers, Consumers, and Medicaid: A Report to the Senate Committee on Ways and Measn, House Committee on Ways and Means and Joint Committee on Health Care,* May 1998.

III. CONCLUSION

The Balanced Budget Act served not only as a means of balancing the federal budget, but also as a window of opportunity for those seeking fundamental reform of the Medicare program as we know it. Depending upon how its provisions are implemented, many of these changes could result in beneficiaries obtaining considerably different levels of coverage from the Medicare program.

Even though it reinforces choice at the beneficiary level, the BBA reduces state autonomy by appropriating to the federal government a great deal of authority over the insurance market that had traditionally been the province of the states. It also reinforces a wave of consolidations that has swept the health care industry without a clear policy of how beneficiaries' access to care will be preserved. By reducing home health payments, it reversed recent federal policy and reaffirmed Medicare's original short-term, acute care orientation, a step which may ultimately be paid for by the states. These reductions shifted substantial costs for long-term, chronic care to the states, to beneficiaries and to their families, diminishing their ability to balance their own budgets.

Over the next few years, these stakeholders will be seeking to regain their equilibrium with greater costs to bear and less authority at their disposal.

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89 P.L. 105-33, Section 1854(a)(1).

90 P.L. 105-33, Section 1856(b)(1).

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118 *Ibid*.

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122 "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 period of up to 21 days (with extensions in exceptional circumstances when the need for additional care is finite and predictable)." *Ibid*.

123 "skilled nursing and home health aide services any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a cases-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week)." Komisar and Feder, at p. 12.

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