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Medicare Beneficiary Access to Care: The Effects of New Prospective Payment Systems on Outpatient Hospital Care, Home Health Care, and Skilled Nursing Facility Care

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ABSTRACT

The Balanced Budget Act of 1997 (BBA 97) required that prospective payment systems replace retrospective cost-based reimbursement systems for Medicare beneficiaries receiving care in hospital outpatient departments, from home health care agencies, and in skilled nursing facilities. These new payment systems either have reduced or are predicted to reduce payments to providers, some of whom say that beneficiaries will face restricted access to care either because they will be turned away or because facilities or agencies will be forced to close. Investigators have found little evidence that beneficiaries have been denied care, although federal analysts have recommended that if further evidence emerges indicating unmet care needs, Congress might make targeted modifications to the new payment systems for patients with exceptionally costly conditions. This report will be updated when new information becomes available or when there is congressional action.

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Summary

Prior to the Balanced Budget Act of 1997 (BBA 97), Medicare paid for hospital outpatient department (HOPD) services, home health care, and care in skilled nursing facilities (SNFs) mostly on a retrospective, cost-reimbursement basis. The BBA 97 replaced those procedures with prospective payment systems (PPSs) under which provider payments are predetermined, fixed amounts. Some say these new payment systems have reduced payments to providers, or will do so in the future, resulting in beneficiaries not getting needed care. Others say denial of care cannot be documented and that overall payment reductions reflect changed economic conditions and effective anti-fraud measures. However, analysts have reported to Congress that if evidence emerges regarding care access problems for the sickest patients, limited, targeted payment exceptions or increases might be warranted.

The PPS for hospital outpatient departments will not be implemented until after the start of 2000; thus, it has not yet had any effect. Some of those commenting on proposed rules that were open for comment from September 8, 1998 through July 30, 1999, say that payments might be inadequate for procedures with bundled payments for such things as blood products or chemotherapy drugs. Certain low volume, rural hospitals might realize the largest reductions; data problems make evaluation of payments to cancer hospitals problematic. The proposed rules sought suggestions about ways to address bundled payment, rural hospital, and other issues.

The hospital industry also claims that the law unintentionally reduces payments to hospitals below pre-BBA levels because of an alleged flaw in the formula determining beneficiary copayment amounts. They say that the new system was intended to be budget neutral with regard to hospital revenues; others say budget neutrality was intended to apply only to the government's costs.

The BBA required development of a home health PPS, but Congress sought immediate curbs on home health care spending by establishing an interim payment system effective in 1997 that has substantially reduced Medicare payments to some home health agencies (HHAs). Despite claims that beneficiary access to home care was being impaired due to closure of 14% of HHAs between October 1997 and January 1999, the General Accounting Office found no conclusive evidence of reduced access and termed the reduction in the number of agencies a "market correction" in response to an oversupply of HHAs.

The PPS for Medicare payments to SNFs began in July 1998. Although hospital discharge planners do not report that they cannot place beneficiaries requiring SNF care, some analysts say that the daily payment rates may be inadequate for patients needing extensive skilled nursing care, medications, or laboratory services. HCFA officials are monitoring the new system and say that changes might be made to some of the payment groups for very ill patients but that the law requires any payment increases to be offset by decreases in other payment groups.

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Most Recent Developments

The Consolidated Appropriations Act, 2000, enacted November 29, 1999, (P.L. 106-1113) increases Medicare payments to HOPDs, HHAs, and SNFs and modifies other provisions of BBA 97. See CRS Report RL30347, *Medicare, Medicaid and State Children's Health Insurance Program (SCHIP): Changes to Balance Budget Act of 1997 (BBA 97, P.L. 105-33) Provisions* for a summary of the Medicare and Medicaid provisions.

HOPDs. The new law (a) requires until January 2000 that additional payments above and beyond the PPS payment designated for a case be paid for certain drugs, biologicals, and devices, and, for 2 to 3 years, provides additional payments for certain high cost patients (these payments must be "budget neutral" meaning offsets must be made elsewhere in the PPS so that there is no net cost to Medicare); (b) limits the cost range of items or services that are included in any one PPS category; (c) requires the Secretary to review the PPS groups and amounts annually and to update them as necessary; (d) through 2003, limits the reduction in Medicare payments individual hospitals experience due to the PPS; (e) provides special payments until 2004 for small, rural hospitals to ensure that they receive no less under the outpatient PPS than they would have received under the prior system and provides the same protection permanently for cancer hospitals; (f) limits beneficiary copayments for outpatient care to no more than the amount of the beneficiary deductible for inpatient care; (g) requires that the pre-PPS payment base used to determine the budget neutrality of Medicare PPS payments include beneficiary coinsurance amounts as paid under the pre-PPS system (i.e., 20% of hospital charges).

The Congressional Budget Office (CBO) estimates that these changes in payments to HOPDs will cost \$5.2 billion over 5 years and \$11 billion over 10 years.

HHAs. The new law (a) provides \$10 per beneficiary to offset costs for collecting OASIS data; (b) delays the 15% reduction in home health payments until 12 months after implementation of the PPS but, within 6 months of implementation, requires the Secretary to assess the need for any reductions; (c) increases per beneficiary limits by 2% for older agencies; (d) revises the amount of required surety bonds; (e) excludes durable medical equipment from consolidated billing.

CBO estimates that these changes in payments to HHAs will cost \$1.3 billion in the first 5 years, largely from delay of the 15% reduction.

SNFs. The new law (a) from April 1, 2000, until October 1, 2000, increases per diem payments by 20% for 15 SNF PPS payment categories (Resource Utilization Groups, "RUGs"); (b) permits payment under the federal PPS rate for agencies for which it is more advantageous than under the transition rates which include a factor reflecting individual SNF cost experience; (c) provides for additional payment beyond the designated PPS rate for ambulance services for dialysis patients and for specific chemotherapy items and services, radioisotope services, and prosthetic devices; (d) until October 1, 2001, fixes PPS per diem rates at 50% of the facility-specific rate and 50% of the federal rate for facilities in which 60% of the patients are immunocompromised.

CBO estimates that these changes in payments to SNFs will cost \$2.2 billion in the first 5 years.

Introduction

The federal Medicare program finances health insurance coverage for about 39 million disabled individuals and elderly persons age 65 or over nationwide. Currently, about 84% of beneficiaries participate in Medicare's traditional fee-for-service program under which they obtain care from a physician, provider, or facility of their choice, and Medicare makes a payment on their behalf. Under the Medicare+Choice program, about 14% of beneficiaries participate in managed care plans, generally health maintenance organizations (HMOs), for which Medicare makes a monthly predetermined fixed payment per enrolled beneficiary.

The Balanced Budget Act of 1997 (BBA 97) sought to achieve savings for certain Medicare-covered services under the fee-for-service program by changing the way Medicare pays for those services. Prior to the changes made in BBA 97, Medicare paid for most hospital outpatient department (HOPD) services, home health care, and care in skilled nursing facilities (SNFs) on a *retrospective*, cost-reimbursement basis. The BBA 97 required that those reimbursement systems be replaced with *prospective* payment systems (PPSs) under which provider payments are some form of predetermined, fixed amounts for which future increases are limited by provisions specified in law. These new payment systems have reduced or, critics predict, will reduce Medicare payments to some HOPDs, home health agencies (HHAs), and SNFs, generating allegations that beneficiaries will face problems with access to care. On those grounds, representatives of the provider industry are seeking revisions to the BBA law to increase Medicare payments. This report discusses the new prospective payment systems and care access issues.¹

¹ CRS Report 97-802, *Medicare Provisions in the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33)*, by Jennifer O'Sullivan et al., details Medicare payment systems pre-BBA and describes the BBA savings provisions. It includes background information on Medicare and serves as a reference document for this report. In addition, CRS Report RS20238, *Trends in Medicare Spending After the Balanced Budget Act*, by Hinda Ripps Chaikind, documents

Prospective Payment Systems: An Overview²

Background. Historically, Medicare has based payments to health care providers on some measure of reasonable costs which are reimbursed retrospectively. Retrospective cost reimbursement systems have been criticized for their complexity, unpredictability, and lack of incentives for providers to maximize efficiency and contain costs. In contrast, prospective payment systems are comparatively easily administered, allow costs to be predicted more accurately, include mechanisms for containing rates of increases, and strengthen providers' incentives for efficiency.

Prospective payment systems can take a variety of forms with different approaches being appropriate for different types of care or settings. Determination of exactly how much to pay is a key factor in designing a PPS because Medicare buys health care and health care products in private markets. Payment amounts should reflect market prices in order to ensure beneficiary access to quality care while simultaneously minimizing program and taxpayer costs. For instance, if Medicare's payments were significantly lower than market rates, providers might serve only those patients who needed little or inexpensive care and avoid others, a practice known as "risk selection." Payments that were relatively high could create an incentive for providers to deliver unnecessary care.

Another key factor in the design of a PPS is the unit of payment. Different units of payment are appropriate for different settings. For example, the hospital inpatient PPS is referred to as a "discharge based system" because the unit of payment is an entire hospital stay for a specified diagnosis. For other types of care, payments might be based on individual medical procedures such as would be appropriate for a visit to a physician or an ambulatory care facility. Payments might be based on a daily rate when an individual receives care on an ongoing basis over several days. Another unit of payment might cover all care given during an episode or spell of illness.

One of the most important concepts underlying any PPS is that the payments made by Medicare to providers are based on typical, average costs for a service provided in a specific setting. PPS amounts paid by Medicare are not intended to reimburse the provider for costs incurred by or attributable to any individual patient.

Inpatient Hospital PPS. The PPS for inpatient hospital care (Part A of Medicare) was implemented in 1983. Under that system, hospitals receive predetermined, fixed payments per hospital admission. Payments are determined by a patient's diagnosis and the groupings of costs associated with treatment for an average patient with that diagnosis. This is known as the diagnosis related group (DRG) system. A hospital receives the same amount whether a patient is discharged

¹ (...continued)

spending reductions that have occurred in various components of Medicare since the original estimates in 1997.

² For a detailed discussion of design issues pertaining to prospective payment systems, see Medicare Payment Advisory Commission. *Report for Congress: Medicare Payment Policy*. March 1999. p. 3-24. (Hereafter cited as MedPAC, *Report to the Congress: Medicare Payment Policy*)

earlier or later than average. The payment is fungible in that hospital “savings” from early discharges can be applied to the cost of care for patients whose stay is longer than average. Thus, even if a patient’s care is very costly compared with the norm for his or her DRG, the hospital can finance that patient’s care with funds it received for other patients whose care was less costly than the norm. The hospital also has an incentive to provide care efficiently so that its costs do not exceed the average.

Physician PPS. Physicians and certain other practitioners participating in the fee-for-service Medicare program are paid under Part B of Medicare according to a fee schedule required by 1986 legislation and implemented in 1992. A fee schedule, which is a kind of PPS, is a listing of payable fees for specified procedures and services in specified settings. All physician care is paid under a fee schedule regardless of the setting in which it is provided.

Hospital Outpatient PPS. The PPS that the Health Care Financing Administration (HCFA) designed for HOPD services is a fee schedule under which the facility is paid a specified sum for each of the hundreds of different procedures that are carried out in that setting. Implementation is scheduled for early in 2000. An important issue in the fee schedule design for HOPDs is the extent to which costs for ancillary goods and services are included in the payment for the main procedure. Inclusion of ancillary services in one overall payment is sometimes referred to as “bundling” or “packaging.” Ancillary services that might be bundled into a major service payment include such things as anesthesia, laboratory tests, and certain diagnostic tests. Inclusion or exclusion and separate payment for ancillary services might be based on whether the service is integral to the main service or merely related to it. For procedures such as infusion therapy or chemotherapy in which administration of drugs is the main service, the price of the drug may be bundled into the fee schedule amount or, in some cases, paid separately. Separate payment might be provided if the price of the drug or other item is highly variable or unpredictable as it might be for a product that is new on the market. In general, the fee schedule proposed by HCFA uses relatively little bundling of ancillary service costs into the payment for the main service.

Home Health Care PPS. The BBA requires HCFA to establish a PPS for home health care, but the law did not specify the unit of care for which home health PPS prices would be set, leaving that decision up to the Secretary of Health and Human Services (HHS). Although the details of the home health PPS are not yet available (implementation is scheduled for October 1, 2000), HCFA officials have announced that payment under the new system will be based on an episode of illness. Thus, HHAs will receive a specified payment per beneficiary episode of care. Those payments will be adjusted for patient characteristics and the resources the patient is expected to use (referred to as a “case mix” adjustment). HCFA had considered using a home health visit as the PPS unit, but a demonstration project showed that it did not include incentives to control the volume of services and would not adequately contain costs compared with the existing system. Instead, research has focused on defining an episode of care for which payment would cover a given number of days of care.

Skilled Nursing Facility PPS. The PPS for SNFs (implemented mid-1998) is based on a per diem unit of care, meaning the facility receives a fixed payment for each Medicare-covered day a beneficiary spends in a SNF. The amount of the

payment is based on the cost of the resources the patient is likely to use per day. Patients are classified into resource utilization groups, or “RUGs,” for purposes of defining the specific payment for each covered day. This classification system serves as the case-mix adjustment for the SNF PPS. For example, patients needing mostly physical therapy or speech therapy of different intensities use different kinds and amounts of resources from patients needing such things as skilled nursing care, intravenous medications, extensive laboratory testing, or use of a respirator. There was, and continues to be debate about whether the SNF PPS should provide fixed payments per day or whether it would be preferable to establish a discharge-based system under which the payment would be a fixed amount per SNF stay. However, the clinical and other factors that are related to and predictive of length of stay are not yet well documented or understood; thus, the per diem approach has been adopted.³

Hospital Outpatient Departments

Pre-BBA 97 Payment System. Medicare payments to hospital outpatient departments rose at an annual rate of over 12% from 1983 to 1997 and increased from 7% to 20% as a share of all Medicare payments to hospitals. Much of this growth resulted from an increase in the volume of services provided in HOPDs, including volume increases attributable to advances in medicine and technology permitting procedures formerly restricted to the inpatient hospital setting to be provided safely on an outpatient basis. During this period when the volume of outpatient care was growing, HOPDs were paid under a complex cost- and charge-based reimbursement system that had evolved “into an intricate patchwork of different mechanisms, each aimed at specific services or specific classes of hospitals.”⁴ Because of the complex, unwieldy nature of the cost reimbursement system for hospital outpatient care and its lack of incentives for efficiency and cost controls, Congress directed the Secretary of HHS to develop a PPS for HOPD services as long ago as the Omnibus Budget Reconciliation Act of 1986.

As HOPD costs were rising, so were costs to beneficiaries for their coinsurance for HOPD procedures. Beneficiaries are responsible for paying 20% of Medicare’s approved charges for most Part B services. However, for HOPD care, beneficiaries are billed 20% of the *hospital’s charges* rather than 20% of the *Medicare-approved amount*. This occurs because Medicare’s payment for a hospital outpatient procedure under the complex formula involving a blend of cost and charge reimbursements is normally not determined until long after the service is rendered. This system not only “overcharges” beneficiaries because hospital charges are substantially higher than Medicare-approved amounts, but also results in some hospitals being “overpaid” by Medicare because the full amount some beneficiaries paid when they received the care (20% of charges) is not subtracted when Medicare’s share of costs are computed. This situation is referred to as the “formula-driven overpayment.”

BBA 97 Changes. In BBA 97, Congress eliminated the formula-driven overpayment effective at the start of FY 1998. The Act also directed the Secretary

³ Ibid., p. 7.

⁴ Ibid., p. 102.

of HHS to implement the HOPD PPS in 1999. On September 8, 1998, HCFA published PPS proposed regulations for comment. However, HCFA subsequently delayed implementation of the outpatient PPS until after the start of the year 2000 in order to accommodate resolution of "year-2000" data processing problems and extended the public comment period on the proposed regulations through July 30, 1999. Thus, Medicare has not yet begun paying HOPDs under the PPS.

The PPS that HCFA designed for outpatient care is a fee schedule which covers a hospital's facility and non-physician personnel costs; physicians are paid separately under a Medicare physician fee schedule. The HOPD fee schedule is a set of flat payments that Medicare will pay for specified procedures carried out in HOPDs, and there are many hundreds of these scheduled amounts that are adjusted for costs attributable to factors such as regional wage variations. The effects on hospital revenues will differ among hospitals and procedures, reflecting different hospital outpatient caseloads. The potential unevenness of the effects of the PPS has prompted concerns about the adequacy of Medicare payments under that system for certain kinds of outpatient procedures and for certain hospitals.

For instance, providers say the payments would not cover adequately the costs of procedures requiring blood transfusions and use of blood products and certain cancer treatments, particularly those for which costly chemotherapy drugs are used. Cancer hospitals are concerned that their payments for Medicare outpatients would be inadequate.⁵ Low-volume, rural hospitals are concerned that the new payment system would cause disproportionate reductions in their revenues because they serve a large proportion of their patients on an outpatient basis, and Medicare beneficiaries constitute a larger share of their outpatient caseloads than other hospitals. Teaching hospitals also say their costs would not be covered adequately because of their higher than average costs.⁶ Some hospital officials say that if their Medicare resources are reduced substantially under the outpatient PPS, beneficiaries with high-cost needs might be turned away; others say they may close their outpatient departments.

HCFA is aware that the effects of the new system are uneven among providers compared with their payments under the prior system. To estimate the effects of the new system on different hospitals, HCFA carried out a computer simulation of payments to hospitals under the PPS and compared those payments with each hospital's costs and pre-PPS payments. Based on that analysis, HCFA noted in the proposed regulations that the estimated reductions in Medicare payments under the PPS could be larger for rural hospitals than for others, and could be largest for low volume rural hospitals that are the sole provider for the community. The regulations seek comments on phasing in the new system for those hospitals as a way to alleviate the impact, although critics in the industry say that whether the system is implemented sooner or later, the eventual effects would be the same.

⁵ Cancer hospitals are those extensively involved in treatment for and research on cancer. There are currently 10 cancer hospitals.

⁶ MedPAC reports that it has been unable to substantiate the claim that teaching hospitals would be disproportionately harmed by the outpatient PPS. HCFA noted in the proposed regulations that the simulation analysis showed that effects of the PPS on teaching hospitals were small and in some cases not statistically significant.

With regard to chemotherapy drugs, the regulations provide for “unbundled” reimbursement for some specific chemotherapeutic agents; that is, the cost of the drugs would be reimbursed separately from the other costs of the chemotherapy procedure. The regulations asked for information on additional chemotherapy drugs that are exceptionally costly and that perhaps should be reimbursed separately.

The regulations also discuss possible large reductions in payments to cancer hospitals. However, because the procedures these hospitals use for reporting costs under the pre-PPS system are somewhat different from other hospitals, HCFA noted that the comparisons of the pre-PPS costs and payments for these hospitals with the simulated effects of the PPS were likely to be inaccurate. Agency analysts are continuing to study the data, and HCFA will adjust the rates for these hospitals if the analysis indicates such adjustments would be appropriate. The regulations also asked for comments on phasing in the new system for cancer hospitals as a way to moderate its impact.

HCFA officials say that comments describing payment inadequacies or other problems with the PPS proposed regulations will be reviewed and taken into consideration when they write the final regulations. Although many of the concerns about the HOPD PPS may be addressed through regulation and would not require congressional action, changes to the fee schedule that would increase Medicare spending would be outside of HCFA’s regulatory authority because the law requires the new system to be budget neutral to the government, meaning that total Medicare payments may not exceed an amount targeted to replicate payments under pre-PPS law. Nevertheless, the PPS for outpatient care has not been implemented yet, and, thus, it is not possible to assess any effects on beneficiary access to care. However, elimination of the formula-driven overpayment has reduced some hospitals’ Medicare payments.

Beneficiary Coinsurance for HOPD Services. As noted above, Medicare beneficiaries usually pay more than 20% of the Medicare-approved amount for HOPD services and may pay as much as 50% or more.⁷ Because there is no limit on the amount of a hospital’s charges, some analysts were concerned that beneficiaries might eventually be billed for an amount equal to 100% of the Medicare-approved charge for a service if Congress did not change the law. (In most cases, beneficiaries have “medigap” insurance policies that cover their Medicare coinsurance costs; thus, their insurance pays the higher amount, but the costs of those policies reflect the high coinsurance rates for hospital outpatient care.)

In BBA 97, Congress sought to bring beneficiary cost sharing for outpatient hospital services gradually into line with that required for other Part B care by freezing the *dollar amount* hospitals may charge beneficiaries for each type of HOPD procedure at 20% of the median of *all hospital outpatient charges* in 1996 (pre-PPS), updated to 1999 (or the year the PPS is implemented). (The median charge for each

⁷ For example, assume the charge for an endoscopy for a suspected stomach ulcer at a HOPD is \$2,000. Under current law the hospital would bill a beneficiary \$400, or 20% of the charge. However, Medicare may subsequently approve charges of only \$1,600; thus, the beneficiary would have paid 25%.

procedure is the amount below which 50% of all charges fall and above which 50% fall.) This provision will go into effect when the PPS is implemented. Over time, after implementation of the PPS, the “frozen” dollar amounts hospitals may charge beneficiaries will come to equal 20% of Medicare’s approved amount under the PPS, and Medicare’s fee schedule payment will be 80%. This would occur because PPS payments are to be updated annually by a factor defined in law. However, the MedPAC estimated that it could take up to 40 years for beneficiary payments to equal 20% of Medicare approved amounts under the PPS.⁸

The BBA 97 (Section 4523) specifies that the “conversion factors” used to establish the fee schedule dollar amounts for different procedures under the outpatient PPS be calculated so that the aggregate amount of payments to HOPDs in the first year of implementation of the PPS (originally set for 1999) would equal the sum of (a) the estimated amount that Medicare would have paid hospitals under the old system in 1999 (or the first year of operation of the PPS), plus (b) the estimated amount of beneficiary copayments to hospitals computed as 20% of the national median of HOPD charges, by type of service, during 1996 (updated to 1999).

Pegging Medicare’s aggregate share of payments under the PPS at the amount that would have been paid without the PPS makes the new system “budget neutral” with regard to the *government’s share* of payments to hospitals. However, hospitals would receive less in total than they would have received under the pre-PPS system because beneficiary copayments that are pegged to *median charges* are less in the aggregate than the amount beneficiaries would have paid under the old system. HCFA estimates that total payments to HOPDs under the PPS will be 3.8% less than they would have been without the PPS, and this reduction is attributable to the reduction in the beneficiary copayment. (If beneficiary copayments had been pegged at 20% of the *average* charges, the aggregate sum of payments to hospitals from Medicare and from beneficiaries would have been closer to the total amount hospitals would have received without the PPS in 1999.)⁹

Thus, hospitals say they are being required to accept lower compensation for their services than they had anticipated based on their perception that the new PPS was to be budget neutral with regard to their total payments for Medicare beneficiaries in the first year of the PPS. They say that this situation amounts to greater “savings” than Congress intended. (It should be noted that any “savings” from lower payments to hospitals from this provision accrue to beneficiaries or Medigap plans, not to the government.)¹⁰

⁸ Medicare Payment Advisory Commission. *Report to the Congress: Medicare Payment Policy, Volume I: Recommendations*. March 1998. p. 80.

⁹ Part II, U.S. Dept. of Health and Human Services, HCFA, 42 CFR part 409 et al. *Federal Register*, v. 63, no. 173, September 8, 1998. p. 47598.

¹⁰ Some representatives of the insurance industry have advocated that Congress mandate a reduction in Medicare beneficiary HOPD copayments to 20% of the approved amount under the new fee schedule as soon as it is implemented. This reduction in beneficiaries’ share of outpatient costs would reduce the insurance carriers’ Medigap plan liabilities, and, presumably, Medigap premiums. However, it would create a larger reduction in hospital

(continued...)

HCFA officials say that the law does not authorize the agency to spend money to make up to hospitals the difference caused by basing beneficiary payments on 1999 median charges and that legislation would be needed to authorize such increased payments;¹¹ others in the hospital industry disagree. If Congress passed legislation providing increased funding to hold hospitals harmless from reductions in beneficiary payments, it would trigger “pay-go” budget rules, and offsetting reductions or revenue increases would be required. If payments to hospitals were increased without legislation, the Congressional Budget Office (CBO) would not score any budget costs, but would increase Medicare/HOPD spending in its baseline estimates for “current law.” However, HCFA officials say legislation is required.

Home Health Care

Pre-BBA 97 Payment System. Home health services covered by Medicare include intermittent skilled nursing care or home health aide services as well as physical therapy, speech pathology, occupational therapy, and medical social services. Services must be carried out under a plan of care prescribed and reviewed by a physician. Medicare spending for home health care in 1988 totaled \$2.0 billion. By 1994 it had increased to \$13.3 billion, and by 1996 it was \$17.5 billion, for an average annual increase of 31% since 1988. This spending growth was largely due to growth in the number of beneficiaries served and in the number of home visits provided to each beneficiary qualifying for the benefit. In addition, the supply of HHAs grew at about 9% per year during most of the 1990s.¹²

An important event in the history of the Medicare home health benefit was settlement of a class action lawsuit in 1989. Many believe that much of the increase in home health spending that occurred from 1989 to the early 1990s was brought about by HCFA’s liberalizing its guidelines pertaining to eligibility and benefit coverage as a result of that suit, and the program’s payment rules imposed no effective limit on the volume of services for which it would provide reimbursement. Commentators pointed out that the rapid increases in the volume of home health visits that occurred in a relatively short period of time could not be explained by rapidly increasing rates of ill health among the Medicare population. For example, in 1988, 1.58 million Medicare beneficiaries were home health patients and received an average of 23 home health visits; in 1993, 2.86 million beneficiaries received an average of 59 home health visits.

¹⁰ (...continued)

revenues than will occur under the PPS with beneficiary copayments pegged at 20% of median charges and phased down to 20% of approved amounts.

¹¹ Neither CBO nor the Administration has published an estimated cost for making up the difference to hospitals. Estimates prepared by the hospital industry indicate that their “loss” might total about \$850 million per year, or \$4.5 billion over 5 years.

¹² Medicare Payment Advisory Commission. *Report to the Congress: Selected Medicare Issues*. June 1999. p. 112. (Hereafter cited as MedPAC, *Report to the Congress: Selected Medicare Issues*)

Prior to the changes made by the BBA 97, Medicare reimbursed home health agencies for the lesser of (a) their reasonable costs, or (b) a limited amount per visit, applied in the aggregate. The per visit limit was set at 112% of the national average cost, which was calculated separately for each type of service (nursing, therapy, etc.). It was based on costs for free-standing agencies (i.e., agencies not affiliated with hospitals) and varied according to whether an agency was located in an urban or rural area and according to wage level differentials from area to area. Per-visit cost limits were updated annually by applying a market basket index to base year data derived from home health agency cost reports. These limits, however, were applied to aggregate agency payments; that is, an aggregate cost limit was set for each agency equal to the sum of the agency's limit for each type of service multiplied by the number of visits of each type provided by the agency.

This cost-based reimbursement system was criticized as providing few incentives for home health agencies to maximize efficiency or control the volume of services they delivered because HHAs were paid for every visit their workers made.

BBA 97 Changes.¹³ The BBA 97 required that a PPS be implemented for home health care beginning in 1999 and required that the PPS be designed to reduce home health payments by 15%. It specified that the 15% reduction was to go into effect even if the PPS were not ready for implementation in 1999. P.L. 105-277, the Omnibus Consolidated and Emergency Supplemental Appropriations Act for Fiscal Year 1999, postponed both the PPS implementation and the 15% reduction from October 1999 to October 1, 2000. Should the PPS not be implemented at the start of October 2000 as currently planned, payment limits to HHAs will be reduced by 15%, and when the PPS is subsequently implemented, it will be budget neutral compared to the interim payment levels with the 15% reduction. Thus, the 15% reduction occurs only once.

As currently planned by HCFA, the home health PPS unit of payment will be a patient's episode of illness, with payments adjusted to reflect patient characteristics and care needs.¹⁴ Payments to HHAs will be bundled to include most of the supplies and equipment, including durable medical equipment, needed during a patient's course

¹³ In addition to changing the payment system, other BBA home health provisions included: requiring claims to include a physician identifier; elimination of eligibility based solely on needing a skilled nurse to draw blood; revision of the definitions of "part-time" and "intermittent" for purposes of establishing eligibility for care by a skilled nurse and home health aide; transferring from Part A to Part B payments for home health visits that are not part of the first 100 visits following a hospitalization; requiring home health workers to report their activities during a visit in 15-minute intervals; extending savings from a July 1994 through June 1996 freeze on home health cost limit updates. It also required a study of the definition of "homebound" and a study to establish normative guidelines for the frequency and duration of home health services. The Health Insurance Portability and Accountability Act (HIPAA) included civil money penalties for physicians who falsely certify that a beneficiary needs home health care, a provision some say has had a chilling effect on physician referrals.

¹⁴ The BBA authorizes up to 5% of payments to be used to reimburse HHAs for care for "outlier" cases, that is, patients with extensive care needs, although a budget neutrality requirement in the law specifies that aggregate payments must be reduced to offset those higher payments.

of care, although HHAs often arrange to have such items provided through an outside vendor. When the PPS is implemented, equipment and supply vendors will not bill Medicare directly as they often do under current law but will bill the HHA and be paid by it. This bundling is sometimes referred to as the “consolidated billing” feature of the home health PPS.

The Interim Payment System. Because of concern about the rapidly rising costs of Medicare home health reimbursements due to an increasing volume of services, Congress included in the BBA 97 an “interim payment system” (IPS) for Medicare home health care in order to achieve immediate Medicare spending reductions prior to implementation of the PPS. This interim system was effective for HHA cost reporting periods starting on or after October 1, 1997, and is to remain in effect until the PPS is implemented in October, 2000.

The IPS achieves cost savings by establishing a new methodology for limiting aggregate annual Medicare payments to individual HHAs. Under this procedure an agency receives payments totaling the least of three amounts (pre-IPS payments were the lesser of the first two of these amounts):

- (a) the agency’s reasonable costs; or
- (b) payments determined under the per visit limits, with the limit set at 106% of the national median cost per visit by service type (pre-IPS limit was 112% of the national average cost per visit)¹⁵; or
- (c) aggregate payments under a new formula based on *per beneficiary limits*.

HCFA estimates that 79% of HHAs are subject to the new per beneficiary limit; the others receive less under the reasonable cost or per visit limit. Determining an agency’s aggregate Medicare payment limit under the new per beneficiary formula includes four steps:

- (1) Divide the total payments the agency received from Medicare for cost reporting periods ending in FY1994 by the number of Medicare patients it served that year to get an average amount per beneficiary (certain cost and wage updates are applied);
- (2) reduce that average amount per beneficiary to 75% of the full amount;
- (3) add a sum that is 25% of the average Medicare per-beneficiary costs of all agencies in the same census region to get a new average cost per beneficiary;

¹⁵ P.L. 105-277 increased the limit from 105% of the national median cost of a service (estimated at the time of BBA enactment to be about 98% of the mean) to 106% of the median.

- (4) multiply the agency's average cost per beneficiary from step three by the number of Medicare patients the agency is serving in the current year or cost reporting period. The result is an aggregate annual payment limit that an agency is held to for serving all its Medicare patients in a cost reporting period under the IPS.

If an agency's average costs for its patients are lower than others in the region, it benefits from the sum that is added based on the average regional per-beneficiary limits; if an agency's costs are higher than others in the area, it loses money from the regional component of the formula.¹⁶ This regional component of the formula also decreases the disparities that existed among agencies' costs per beneficiary.

The per beneficiary aggregate limit does not restrict the amount an HHA can spend on any individual beneficiary. It is simply a technique for arriving at an aggregate budget amount for an agency's Medicare patients. However, many HHAs have misunderstood how this limit works, and there are reports that some agencies ended care to beneficiaries when the cost reached the amount of the per beneficiary payment (i.e., the amount arrived at by step three above).

Congress based the per beneficiary calculation on 1993-1994 levels of operation in order to discount the large volume growth that still appeared to be occurring after that year (program costs grew by nearly 22% from 1994 to 1995). Using FY1994 as the base year causes agencies that had increased their costs per patient since then (generally by increasing the number of visits per patient) to have a larger reduction in their Medicare revenues under the IPS than agencies that had maintained relatively constant average costs per beneficiary. Some in the industry said that this effect is unfair to agencies that had low average patient costs in 1994 but that since then had incurred an increase in the number of very ill and costly patients needing more than the average number of visits required by their typical patient in 1994. Others say that even if their caseload now is similar to that served in 1994, the payment formula does not provide inadequately for agency cost increases since then. They say some agencies are being forced to reduce their staff and therefore their capacity to provide home care and allege that beneficiary access to care has been reduced.

Responses to the Interim Payment System. Representatives of the home health industry claimed that (a) the IPS was limiting HHAs' ability to provide necessary care; (b) agencies with low average costs per beneficiary in the FY1994 base period were realizing the severest reductions; and (c) these older agencies were being paid inequitably in comparison with newer agencies because agencies that had not been in business long enough to have had a cost reporting period ending in FY1994 were assigned a per beneficiary limit equal to the national median.

To address these concerns, in 1999, Congress modified the IPS formula to increase per visit limits for HHAs from 105% of the median to 106% and increased payments to agencies whose per beneficiary limits under the IPS were less than the

¹⁶ The per-beneficiary limit for new HHAs that were not in operation in 1994 is set at the national median amount.

national median per beneficiary limits. The per beneficiary limits for older agencies were increased by one-third of the difference between the agency's per beneficiary limit and the national median of per beneficiary limits. (These changes were included in P.L. 105-277, the Omnibus Consolidated and Emergency Supplemental Appropriations Act for Fiscal Year 1999.)

These modifications to home health payments were estimated to increase Medicare payments to 65% of HHAs. The Act also moved the 15% reduction to coincide with implementation of the PPS on October 1, 2000. The estimated total cost was \$1.65 billion over 5 years, about \$750 million of which came from delaying the 15% reduction.)

Congress asked the General Accounting Office (GAO) to investigate the effects of the IPS on beneficiary access to home health care.¹⁷ The GAO analyzed data on home health care utilization patterns before and after implementation of the IPS and conducted interviews with hospital discharge planners and other "stakeholders" in communities in which there had been a substantial number of HHA closures. In a report issued in May, 1999, the GAO found that, although 14% of HHAs closed between October 1, 1997 and January 1, 1999, over 9,000 HHAs were still in business, about the same number in operation in 1996. Forty percent (40%) of the agencies that closed were in three states (Louisiana, Texas, and Oklahoma) where recent growth in the number of HHAs had been high. The majority of HHA closures were in urban areas where large numbers of agencies were still providing care. Characteristically, the HHAs that closed were small agencies that had been providing over 40% more visits per beneficiary than those that remained open, and many had been losing patients before implementation of the IPS. GAO termed the reduction in the number of HHAs a "market correction in response to an oversupply of HHAs" and noted that the IPS achieved its goal of reducing costs attributable to unnecessary utilization of home health care.

Because the payment limits imposed by the IPS induce agencies to balance the number of expensive patients against the number of inexpensive patients they serve in order to stay within their total Medicare payment limit, questions remain about whether the IPS also creates incentives for HHAs to refuse to serve beneficiaries with the most serious medical needs and who require extensive home health visits. A home health agency might refuse to accept certain expensive patients if it were concerned that the balance of patients in its caseload would be tipped too far toward costly cases and result in expenditures exceeding the agency's total funding limit.

In its June 1999 report, MedPAC addressed the possibility that, as long as the IPS is in effect, potentially costly home health care beneficiaries might not find the care they need. The report recommends:

If the Congress is not confident that the Secretary can implement a prospective payment system for home health services by 2000, then it should explore the

¹⁷ U.S. General Accounting Office. *Medicare Home Health Agencies: Closures Continue, With Little Evidence Beneficiary Access Is Impaired*. GAO/HEHS-99-120, May 1999. Washington, 1999.

feasibility of establishing a process for agencies to exclude a small share of their patients from the aggregate per-beneficiary limits. Such a policy should be implemented in a budget-neutral manner.¹⁸

HCFA officials say that the home health PPS is on schedule for implementation in October 2000.

In January 1998, CBO projected 10-year BBA home health care savings of almost \$75 billion; their March 1999 re-estimate includes an additional \$56 billion in savings. The original CBO estimate reflected an annual rate of growth in home health spending of 8.3% a year over 10 years, but the revised estimate shows an annual increase of 5.6% a year. (Under old law, in the early 1990s, Medicare home health spending had been growing at rates of between 20% and 30% a year.) However, CBO's revised estimates reflect changes in their underlying economic assumptions as well as revised estimates of the effects of the BBA.

Data on Medicare home health spending reported by HCFA indicated a 6.3% decrease from \$17.6 billion in FY1997 to \$16.5 billion in FY1998, which was approximately the first year of operation of the IPS. However, agency officials caution that reduced Medicare payments for home health care in 1998 reflect an intensified case review process HCFA required claims processors to implement along with the IPS.¹⁹ As a result of that intensified review, federal disbursements to HHAs slowed with the apparent effect of reducing payments, but HCFA expects that, in time, the payments will be made and spending totals for FY1998 will show an increase.

Skilled Nursing Facilities²⁰

Pre-BBA 97 Payment System. Before enactment of the SNF PPS in mid-1998, Medicare paid for most SNF care on a reasonable cost (as defined by the program) retrospective basis. Despite the imposition of limits on certain reimbursable costs, cost-based reimbursement has been cited as one of the reasons for significant growth in SNF spending since 1989. Spending increased from \$3.5 billion in 1989 to \$11.7 billion in 1996, for an average annual rate of growth of 19%. Payments in 1998 totaled \$13.8 billion. Growth in SNF spending can be explained largely by the increasing number of persons qualifying for the benefit and increases in reimbursements per day of care. Numbers of persons served had nearly doubled since 1989, reaching 1.63 million persons in 1998. Average payments for care had grown from \$117 per day in 1989 to \$262 per day in 1998.

For Medicare reimbursement purposes, the costs SNFs incur for providing services to beneficiaries are divided into three major categories: (1) routine services

¹⁸ MedPAC, *Report to the Congress: Selected Medicare Issues*, p. 112.

¹⁹ It also reflects more intensive fraud and abuse detection activities that have targeted home health agencies, among other providers.

²⁰ Medicare pays in full for 20 consecutive days of SNF care, and beneficiaries pay a copayment for days 21 through 100.

costs that include nursing, room and board, administration, and other overhead (these costs were subject to certain limits per day); (2) ancillary services, such as physical and occupational therapy and speech language pathology, laboratory services, drugs, supplies and other equipment; and (3) capital-related costs, including net depreciation expense, taxes, lease and rental payments, improvements that extend the life or increase the productivity of assets, net interest expense, etc. Ancillary service and capital costs were both paid on the basis of reasonable costs and neither were subject to limits. Increases in ancillary service reimbursements explain much of the per diem payment growth during the 1990s.

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

BBA 97 Changes. The PPS described in the BBA 97 reflects the Resource Utilization Group (RUG) design HCFA developed over several years and tested on a demonstration project basis. The RUG system requires SNFs to categorize their Medicare patients according to 44 hierarchical groups. The SNF PPS provides facilities a fixed amount per day per patient (a “per diem” payment), with the amount of the payment determined by the RUG into which the patient is classified. This RUG classification system serves as the case-mix adjustment that is used to relate program payment to individual patient characteristics and resource use. The BBA 97 requires that the new system be phased in over 3 years starting July 1, 1998 (or the first date thereafter on which a SNF started a new annual cost reporting period). During this phase-in period, part of the per diem payment to each SNF is based on the facility’s historical costs (the “facility specific” component of the PPS), and part is based on the new federal per diem prospective payment.²¹

The BBA 97 instructs the Secretary how to (a) compute average per diem payment rates using Medicare-approved SNF costs in 1995 as the base year; (b) adjust the average rates for facility case-mix and geographic differences; and (c) update the per diem rates for years after 1995. This methodology aims at setting the PPS per diem payments to reflect overall average pre-PPS Medicare costs in order to achieve budget neutrality for the new payment system when it is first implemented; moreover, the law specifies limited updates to payments under the RUG system in future years.

An issue some have raised regarding the current design of the RUG system is the adequacy of payments for patients with multiple problems requiring skilled nursing

²¹ During the 3-year phase-in period starting in 1998, a SNF receives per diem rates that are a “blend” 75% the facility-specific rate and 25% of the federal per diem rate, and the proportions of facility-specific rate to federal per diem rates shifts annually by 25 percentage points until the federal PPS rate equals the full payment.

care (“high acuity patients”) and patients who need extensive “ancillary nontherapy services.” These services include such things as intravenous feedings and intravenous medicines, tracheostomy care, laboratory tests, use of a ventilator/respirator, imaging services, and care for surgical wounds or open lesions requiring special supplies and medicines. The costs of these services can be ascribed directly to individual patients.²² Industry spokespersons say that the PPS provides inadequate compensation for these costly Medicare patients and will place SNFs at increasing financial risk if they serve them. They say SNFs may refuse to accept patients that appear to be high cost risks, end participation in Medicare, or perhaps close altogether. Further, the nursing home industry claims that, in general, the PPS has reduced their payments below the original estimates and that the result eventually, if not immediately, will be restricted beneficiary access to care.

Many do not agree that nursing homes will be as adversely affected as the industry is predicting or that beneficiary access to care has been or will be substantially impeded. For instance, the original 10-year savings projections from the BBA SNF provisions were \$41 billion, and the CBOs re-estimate in March 1999 showed an additional \$6 billion in savings over 10 years. However, the CBO re-estimate reflects many factors, including the improved economy, lower inflation, and heightened efforts by HCFA to reduce fraud and abuse which have resulted in a decline in incorrect payments.

Other observers point out that Medicare payments to SNFs account for only approximately 10% on average of a SNFs total revenue. SNFs generally provide care for a large share of non-Medicare patients and therefore are not so financially dependent on Medicare revenues that their financial viability and, consequently, Medicare beneficiary access to care could be jeopardized by the new Medicare payment system. Medicare covers only up to 100 days of SNF care (including the days for which beneficiaries are responsible for a copayment), and, on average, those qualifying for the SNF benefit receive 32 days of covered care (1998); thus, these Medicare beneficiaries are not long-term care patients who might drain facility resources for months or years. They say, further, that, like all prospective payment systems that compensate health care providers for care to Medicare beneficiaries by the use of predetermined, fixed sums, the payments to the provider are intended to pay the provider for its Medicare beneficiary costs *on average*. That is, although the payment is fixed, a facility’s actual costs may be above or below that amount for an individual patient. The goal for the facility is to incur costs that, over time, do not exceed the PPS average amounts.

At the end of August, 1999, the HHS Office of Inspector General (OIG) published the findings of a survey of the SNF placement experience of 180 hospital

²² In the Explanatory Statement of the Conference Report on BBA 97, conferees included “intent” language that the Secretary develop for the new system case-mix adjusters that reflect the medication therapy needs of SNF patients, suggesting that the Secretary should consider the results of studies conducted by independent organizations, including those which examine appropriate payment mechanisms for medication therapy under the SNF PPS. Although “intent” language does not have the force of law, it can influence policy by carrying an implication of statutory action if the “intent” is not carried out.

discharge planners in eight states.²³ The OIG also compared Medicare data on SNF placements before and after implementation of the PPS. The survey and analysis found no serious placement problems and no indication that Medicare patients could not be placed at all. The Medicare data showed a recent increase in the number of Medicare-certified SNF beds (a key factor in access to care) and did not show any change in where patients were being placed or in the types of patients who were being placed. Planners did note that patients with clinically complex care needs were difficult to place, but did not report that they could not be placed. They also noted that the admissions practices of some nursing homes had changed and that SNFs were requiring more detailed clinical information about patients and were visiting the hospital more frequently to evaluate patients. The report emphasizes that it is an early assessment of the PPS, but that as of the first 5 months of 1999, there was no direct evidence that Medicare patients were unable to receive needed SNF care.

Nevertheless, the system has been in effect only since July 1998, and for some SNFs, implementation began later. If further monitoring suggests that SNFs are avoiding beneficiaries with complex needs and are unable to reallocate their resources to cover them, there might be a need for special payment classifications or reimbursement rates in order to ensure beneficiary access. For instance, if hospital discharge planners were to find that the SNFs in the areas in which their patients lived were accepting only a limited number of complex care patients thereby requiring them to place patients in facilities distant from their homes and families, or if hospitals were forced to keep individuals who might be ready for discharge to a SNF as in-patients longer than necessary, some change to the RUG system might be warranted. Although there are reports of instances in which distant placements and prolonged hospitalization have occurred, the extent of such situations has not yet been documented, and the HHS OIG investigation did not find such problems to be widespread.

At HCFA's request, a contractor is reviewing the RUG system for refinements necessary to assure that payments are adequate for complex care patients. In addition, the BBA 97 requires the Secretary of HHS to establish a medical review process to examine the effects of the PPS/RUGs, focusing in particular on patients with nonroutine needs. The medical review process is being carried out by peer review organizations under contract with HCFA and will focus on indicators of access and care quality as the new system is phased in.²⁴ They are charged with recommending changes to the system if access and quality problems are identified.

Legal Authority for RUG Regulations. Because the law specifies neither the patient care utilization needs that define each of the RUGs nor the amounts payable for each group, and because these groups and definitions are set forth in regulation, some have asked whether the Secretary has the authority to increase the number of RUG categories and/or to redefine certain categories to pay different amounts for patients with higher costs.

²³ 23 U.S. Dept. of Health and Human Services. Office of Inspector General. *Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities*. OEI-02-99-00400, August 1999. Washington, 1999.

²⁴ MedPAC, *Report to the Congress: Medicare Payment Policy*, p. 86.

HCFA officials take the position that the agency does not have the authority to make changes to the PPS/RUGs as promulgated in regulations on May 12, 1998, if such changes would cause the payments to deviate from the objective of the BBA 97 to establish a budget neutral system of payments that reflects, on average, 1995 costs and specified adjustments and updates. According to HCFA, adding new RUGs or refining existing RUGs in such ways that costs would be increased for certain categories of patients would have to be offset by decreases in costs for other categories in order to keep the entire system of payments at the overall average, adjusted pre-PPS Medicare cost level targeted in the law.

The statute appears neither to preclude the Secretary from changing the number or composition of RUG categories nor require such changes. Broad discretion has been granted to the Secretary to develop a payment system for SNF care. The applicable standard of review that a court would use in assessing the legality of the Secretary's regulations implementing the RUG/PPS is set forth in the Administrative Procedure Act (APA). The APA requires the reviewing court to "hold unlawful and set aside agency actions, findings and conclusions found to be (1) arbitrary, capricious, or which constitute an abuse of discretion, or otherwise not in accordance with law...."²⁵ As a practical matter, in cases such as this, where Congress has vested considerable discretion in an agency head to implement a statutory program, the courts usually defer to the agency's interpretation of its own enabling legislation. In according such deference, a court would assess the interpretive components of the rule to be sure that they represented a permissible construction, but this appraisal is necessarily a limited one.²⁶

Congressional Review

On June 10, 1999 the Senate Finance Committee conducted a hearing on Medicare spending under the BBA 97. Witnesses included representatives of the health care industry as well as officials from federal agencies, including the CBO, the GAO, MedPAC, and HCFA. Industry representatives expressed concern that they would be unable to continue to serve Medicare beneficiaries adequately if the new payment systems were not liberalized. However, the federal witnesses suggested that Congress should not increase Medicare funding without more specific information about whether the BBA 97 has reduced payments to providers more than expected and harmed beneficiary access to care. According to the CBO, although Medicare spending over the next 5 years has dropped by almost 10% since first estimated in 1997, factors other than the budget act are likely to be responsible for the spending declines, including federal efforts to reduce fraud and abuse and delays in paying providers under the new payment systems. Although the federal witnesses did not advocate revamping the BBA 97, some suggested that, if warranted by further evidence, targeted adjustments might be appropriate for some hospital outpatient departments or procedures and for HHAs and SNFs caring for very ill patients.

²⁵ 5 U.S.C. § 706(2)(B).

²⁶ *Rust v. Sullivan*, 500 U.S. 173, 184 (quoting with approval the Court's holding in *Chevron U.S.A. v. Natural Resources Defense Council*, 467 U.S. 837 (1984)).