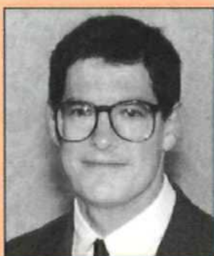
One Year Later: The BBA Hits Catholic Healthcare

BY FELICIEN "FISH" BROWN

Just a little more than a year ago, on August 5, 1997, the president signed into law the Balanced Budget Act of 1997 (BBA). The act contained substantial budget reductions and payment system changes for hospitals, health plans, nursing facilities, and other providers. Since then, Congress and the president have moved on to other challenges, from campaign finance reform to tobacco controls and managed care patient protections to proposed tax cuts. And it seems that each month, news on the federal budget gets better and better, with a projected *surplus* of $63 billion for fiscal year 1998 and a $1.5 trillion surplus over the next 10 years.

Now, the Health Care Financing Administration (HCFA) is in the thick of implementing the many Medicare provisions in the BBA, and providers are trying to adapt to the new reality. Some changes have already taken effect, while others will not be implemented until the year 2000 or later. In addition to the budget reductions in Medicare, providers face new payment systems, reporting and billing requirements, and new responsibilities that HCFA hopes will improve quality of care.

The Congressional Budget Office (CBO) estimates that the BBA will reduce Medicare spending by $116 billion over a five-year period. To get a better sense of how the changes would affect Catholic healthcare in particular, CHA asked members to provide us with system-specific and/or hospital-specific estimates. The dollar impact on 10 Catholic systems representing about 230 hospitals is estimated to be a $300 million reduction in FY 1999 alone. And this represents an underestimate—because most systems had already accounted for anticipated Medicare reductions in their financial planning and therefore did not show the full effect relative to what Medicare payment rates would have been absent the BBA. Also, many systems were not able to estimate the impact of specific BBA provisions (e.g., new prospective payment systems [PPSs]) because they did not have enough information.



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Using a consistent, albeit perhaps rough, measure of the dollar impact on hospital financial position, the $300 million in FY 1999 Medicare payments for 10 Catholic systems represent on average 2 percent of net patient revenues and 50 percent of net operating income. That sounds like quite a loss. But the congressional advisory group known as the Medicare Payment Advisory Commission (MedPAC) has a different message. MedPAC estimates that hospitals will have Medicare inpatient PPS margins of more than 15 percent this year *and* maintain these until the year 2002. These margins are less than the 24 percent margin that MedPAC forecasted for 2002 prior to the BBA cuts, but the margins are still higher than any year since inpatient PPS implementation in 1984. Why? Hospitals became better at managing costs in the 1990s in response to pressure from managed care plans, which are increasingly calling the shots. Lower overall inflation helped bring costs down as well. In 1994 and 1995, operating costs per Medicare case actually declined.

Following is a brief update on the status and impact of BBA changes in five payment areas—hospital inpatient and outpatient, home health, skilled nursing facilities, and Medicare+Choice. Before diving into the details, we should review the federal government's implementation process. After legislation is enacted, HCFA writes regulations interpreting the changes based on input from internal lawyers and policy experts, as well as formal comments from outside groups and affected providers. HCFA then issues more detailed program memoranda and answers to frequently asked questions, and Medicare intermediaries and carriers put out their own notices and work with providers to implement the program changes.

Rarely does this process operate smoothly or quickly, even less so now as HCFA attempts to implement the many BBA changes simultaneously. That is why Congress is increasingly exercising

its constitutional oversight responsibility, with committee hearings, meetings with HCFA staff, and a snowstorm of letters this past summer between individual members of Congress and HCFA Administrator Nancy-Ann Min DeParle. Throw into the mix heightened concern about the potential catastrophe of the year 2000 computer glitch, and you have a veritable gumbo of BBA implementation activity of which Chef DeParle cannot possibly know all the ingredients.

HOSPITAL INPATIENT PAYMENTS

On August 6, 1998, HCFA published its final rule on hospital inpatient PPS rates for FY 1999. The large majority of hospitals will receive a 0.5 percent increase in base payments, a 1.9 percentage point reduction from the market basket. The federal rate for inpatient capital will be 1.76 percent higher than the previous year.

For hospitals, CBO estimates that the BBA's changes in Medicare inpatient PPS updates ($2.4 billion in FY 1999 and a total of $17.1 billion for FY 1998-2002) have a larger dollar impact than any other BBA provision. The update changes alone appear to account for about one-third of Medicare reductions to hospitals, according to CBO estimates. Data from some Catholic systems bear this out as well. CBO estimates that the inpatient capital reduction accounts for between 10 percent and 15 percent of total BBA reductions for hospitals. Catholic systems found the capital cuts to be even more significant, accounting for 20 percent to 25 percent of the total impact.

In addition, the HCFA inpatient regulation explained the new "transfer" provision that pays hospitals less for certain discharges (10 DRGs) to a postacute provider. CBO's estimated Medicare savings due to the "transfer" provision are small in relation to the overall cuts, just $0.1 billion in FY 1999 and $1.3 billion over five years. But the dollar estimate does not account for the many hours spent by hospital administrators trying to understand and adapt to the new transfer changes. Meanwhile, lurking in the background is HCFA's authority, without having to go back to Congress for permission, to expand the number of DRGs subject to the lower transfer payment amount.

HOSPITAL OUTPATIENT PAYMENTS

The BBA called for several changes in Medicare hospital outpatient payments, including percent reductions in operating and capital rates, a gradual reduction in the so-called formula-driven overpayment (FIDO), and a new outpatient PPS system. The first two measures are under way, and the PPS regulation was expected to be published by HCFA in August 1998. The regulation will provide more information on HCFA's classification system for ambulatory visits (ambulatory care procedure codes, or APCs), whether HCFA will lower payment rates in anticipation of hospital behavioral changes, and other important decisions that could increase the dollar impact on hospitals.

CBO estimated that total hospital outpatient changes would reduce Medicare payments by $1.9 billion in FY 1999 and by $7.2 billion over five years. This reduction accounts for 15 percent to 20 percent of the total hit on hospitals, a percentage consistent with that reported by Catholic systems.

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HOME HEALTH

The BBA reduced home health payments by a CBO-estimated amount of $2 billion in FY 1999 and $16 billion over five years. On August 11, 1998, HCFA published the FY 1999 payment limits, which already have been blamed for forcing closure of hundreds of home health agencies. HCFA made one change in the interim payment system (IPS) implementation, a change encouraged by the Catholic Health Association (CHA) and other organizations. HCFA will not require agencies purchased since 1994 to be considered new providers, which are paid at the national, and mostly lower, rate. Catholic system estimates of the dollar effect of home health changes range widely, probably reflecting the extent to which each system owns home health agencies, as well as the geographic area in which its agencies are located.

Congress is considering changing the "blend" in IPS payment rates to make payments more equitable within a region and nationally. Areas such as the Midwest and Northeast, which currently have lower home health payment rates, would benefit from a congressional change in the "blend," while the South and West would lose. It is less likely that Congress will delay IPS implementation or eliminate the 15 percent additional home health reductions scheduled for the year 2000. These changes would increase federal spending or have to be offset by establishment of a Medicare beneficiary copayment, approaches which the Clinton administration has rejected.

HCFA is currently developing a home health PPS system which the BBA requires to be implemented in October 1999. Blaming the year 2000 computer problems, HCFA has already conceded that it will not meet the deadline.

SKILLED NURSING FACILITIES (SNFs)

Outside comments to HCFA on its regulation that implements the new SNF PPS system mandated by

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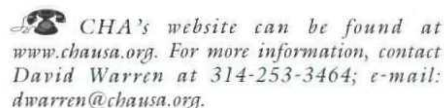
dards and waiver requirements for provider-sponsored organizations. Your boss wants a summary of the matter on her desk by the end of the day. You could (a) spend hours making phone calls to Washington, DC, hoping to talk to a live human being who can tell you the phone number of the office that actually has the information you need, (b) use one of many Internet search engines, trying combinations of key words that might yield a list of fewer than 100 possibly relevant documents, or (c) go to the Public Policy section of CHAusa and, with a click of your mouse, find the complete text of the *Federal Register* notice.

That is just one example of the advocacy materials literally at your fingertips on CHAusa. If you need information about an issue that affects the Catholic health ministry, you will find it on CHAusa. You will find it there because CHAusa is more than an electronic bulletin board. It is an active tool used constantly by CHA staff to provide members with advocacy leadership.

And Many Other Information Resources

If I had the space and time, I could cite many more examples of CHAusa's resources, including the long-term care area, spiritual guidance and inspiration for mission leaders, and forums where sponsors can talk about their future roles. Even a service as small as routing a specific question via e-mail to the "webmaster" (me) can make a difference to you. It's far more economical—and surprisingly quicker—than a phone call.

CHAusa is a nexus for everything CHA does. It is the online library of CHA resources. Not a static enterprise, it changes, grows, and evolves. And it is very much member driven, because CHAusa is about what you do: working for a vital Catholic health ministry. □


CHA's website can be found at www.chausa.org. For more information, contact David Warren at 314-253-3464; e-mail: dwarren@chausa.org.

HEALTH POLICY

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The BBA was supposed to encourage higher Medicare+Choice enrollment, not reduce it.

the BBA are due in September 1998. CHA is currently surveying Catholic hospitals and SNFs regarding the regulation and will respond to HCFA before the comment period deadline. CBO estimated Medicare savings of $1.3 billion in FY 1999 and $9.5 billion over five years. HCFA now says that the SNF PPS will actually save the federal government even more, a total of $12.6 billion over five years.

Most Catholic systems responding to the CHA survey did not estimate the impact of the SNF PPS and/or do not own a SNF. Two Catholic systems estimated that the change would be substantial, accounting for about 20 percent of the total impact of the BBA. CHA and other groups are exploring the possibility of legislative changes—for example, maintaining a pass-through for nontherapy ancillary costs, creating an outlier system, and establishing demonstrations for unique SNFs serving higher-acuity patients.

Medicare+Choice

HCFA is currently seeking comments on its Medicare+Choice regulation, a voluminous document containing numerous requirements for health plans and hospitals. CHA will submit comments and recommendations to HCFA before the September 24, 1998, deadline. The estimated CBO savings from Medicare+Choice ($2.2 billion and $21.8 billion over five years) are due to a reduction in payment rates. A BBA provision designed to make Medicare payments to health plans more equitable across the country ("blend") has not yet been implemented because of a minimum 2 percent payment increase for all plans and a budget-neutral requirement. HCFA is not likely to begin implementing the "blend" until the year 2000 or 2001.

The past two months have seen large Medicare HMOs—Pacificare, Oxford, Anthem, and United—cut back or eliminate their Medicare enrollment in certain counties across the United States. Other health plans have decided to stay in place but will cut back on extra benefits beyond the standard Medicare package, increase beneficiary premiums, or both. Researchers still believe that Medicare overpays managed care plans because their enrollees are healthier and have lower costs. The BBA requires HCFA to develop a risk-based adjustment to payment rates to account for these differences. In the future, Congress and HCFA will be monitoring closely how the BBA payment changes for Medicare+Choice plans affect the number of Medicare beneficiaries enrolling in managed care. In short, the BBA was supposed to encourage higher enrollment, not reduce it.

For now, the handful of Catholic-sponsored Medicare managed care plans have not announced major changes. It is too early to tell just how Medicare+Choice and the many other BBA changes will affect Catholic healthcare, but amid the many payment reductions there are also expansions in service. The first provider-sponsored organization to obtain a federal waiver was at St. Joseph Healthcare in Albuquerque, owned by Catholic Health Initiatives. And SSM Health Care in St. Louis recently announced that it will purchase a home health agency that did not want to continue to operate at the lower Medicare rates. □