CBO TESTIMONY

Statement of
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on
Medicare Payment Policies
for Post-Acute Care

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NOTICE

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Mr. Chairman and Members of the Committee, I appreciate the opportunity to discuss with you the growth in Medicare spending on post-acute care services and options for slowing that growth. Over the past decade, spending on post-acute care services has grown more rapidly than other major components of Medicare spending. That trend is likely to continue unless legislation is adopted to alter the way in which those services are paid for under Medicare, or the extent to which those services are covered by Medicare.

In my remarks today, I will summarize recent trends in Medicare spending on post-acute care as well as projections by the Congressional Budget Office (CBO) for the next decade. I will also discuss some issues that might be considered when designing policies to contain post-acute care spending, and briefly comment on the Administration's proposals.

My discussion focuses on policies that might, in the near term, constrain spending on services from providers in fee-for-service Medicare. Broader strategies to reduce the total cost of the program over the longer term—such as expanding the types of health plans that can participate in Medicare, changing the payment formula to allow the program to benefit from managed care efficiencies, or restructuring Medicare as a defined contribution program—are not addressed. The financing problems facing Medicare over the long term are dramatic, however, and options that focus on adjustments to fee-for-service spending would be insufficient to maintain

the life of the program. CBO's recent report, *Long-Term Budgetary Pressures and Policy Options*, analyzes the broader issues of Medicare restructuring for the long term.

GROWTH IN MEDICARE SPENDING ON POST-ACUTE CARE SERVICES

The Hospital Insurance (HI) program finances most post-acute care services under Medicare. Those services are provided by skilled nursing facilities (SNFs), home health agencies, and specialty hospitals including rehabilitation and long-term hospital facilities. The Supplementary Medical Insurance (SMI) program also finances some post-acute care services, including rehabilitation, pharmacy, and medical supplies. My testimony today will focus primarily on SNF and home health services paid for under the HI program.

Medicare covers SNF services only if the patient had a minimum three-day stay in an acute care hospital before being admitted to the SNF. Coverage of home health care, in contrast, does not require a previous hospital stay, and a substantial proportion of home health visits are provided to patients with chronic conditions. Rehabilitation facilities (both hospitals and separate units) and long-term hospitals also provide post-acute care services, although patients may be admitted directly to

those facilities. The data presented here reflect total spending by each of those providers for both post-acute care and chronic care.

Recent Trends in Spending

In 1995, Medicare spent $29.4 billion on services from post-acute care providers paid on a fee-for-service basis under the HI program (see Table 1). Between 1990 and 1995, HI spending on those services escalated at an average rate of 28.8 percent a year compared with a rate of 10.5 percent for all Medicare benefits and 6 percent for acute inpatient hospital services paid for under the prospective payment system (PPS). Services provided by SNFs and and home health agencies accounted for more than 80 percent of spending under HI on services from post-acute care providers in 1995.

Although the magnitude of spending on post-acute care services under the SMI program is not known with great precision, it appears to be sizeable and growing. In calendar year 1990, for example, intermediaries under SMI paid about $500 million for rehabilitation services. By 1995, that spending had tripled to $1.7 billion.

TABLE 1. OUTLAYS FOR SERVICES FROM POST-ACUTE CARE PROVIDERS UNDER MEDICARE'S HOSPITAL INSURANCE PROGRAM, FISCAL YEARS 1990 AND 1995 (In billions of dollars)

	1990	1995	Average Annual Rate of Growth (In percent)
Skilled Nursing Facility	2.8	9.1	26.6
Home Health Agency	3.3	14.9	35.2
Post-Acute Care Hospital[a]	2.2	5.4	19.7
Total	8.3	29.4	28.8
Memorandum:			
PPS Hospitals	51.6	69.2	6.0
All Medicare Benefits	107.2	176.9	10.5

SOURCE: Congressional Budget Office.

NOTE: PPS = prospective payment system.

a. Includes rehabilitation units, rehabilitation hospitals, and long-term hospitals.

Sources of Spending Growth

Three factors have fueled the rapid growth in spending for post-acute care services. First, a host of legislative actions, court decisions, and regulatory changes during the 1980s significantly expanded Medicare's coverage of post-acute care benefits. Actions were also taken to allow more post-acute care providers, including proprietary home health agencies, to participate in Medicare, and more nursing facilities sought certification under the Medicare program.

Second, establishing the prospective payment system for inpatient hospital services in 1983 transformed both the hospital and the post-acute care industries. Under that system, hospitals are given fixed payments based on the medical diagnosis of their patients rather than on the hospitals' cost of providing services. That shift from cost-based reimbursement gave hospitals an incentive to reduce their costs by discharging patients more quickly into post-acute care services. Retaining a separate payment system for post-acute care services gave providers incentives to increase the use of those services and encouraged hospitals to establish their own post-acute care units.

Third, advances in medical technology expanded the types of services that can be provided in less intensive settings. Technical services such as infusion therapies, which until recently would have been delivered on an inpatient basis only,

are now delivered in SNFs and in the home. Such advances may prevent the need for hospitalization but, in many cases, they lead to a substantial increase in the use of covered services in post-acute settings. New drug therapies, for example, may require only a minimum amount of monitoring by a skilled nurse—perhaps a blood test once a month—which can be done in a patient's home. That monitoring, however, could count as a skilled nursing service under Medicare, enabling a beneficiary to have access to an array of other home health services including personal care (such as assistance with dressing or bathing) provided by aides. (The Administration has recently proposed to eliminate the automatic eligibility for broader home health benefits that is currently available to patients whose only medical need is to have blood drawn periodically.)

Those factors also encouraged more providers to enter the post-acute care market. Between 1990 and 1995, for example, the number of SNFs ballooned by 40 percent and the number of home health agencies grew by an extraordinary 60 percent (see Table 2). In particular, many hospitals established their own post-acute care units. In 1996, three-quarters of all short-term acute care hospitals had at least one post-acute care unit, such as an SNF, rehabilitation unit, or home health agency. The number of freestanding proprietary home health agencies soared as well.

Outlays for both home health and SNF services grew rapidly in recent years. In addition, the number of enrollees receiving care nearly doubled between 1990 and

TABLE 2. NUMBER OF PROVIDERS OF POST-ACUTE CARE SERVICES AND PROSPECTIVE PAYMENT HOSPITALS IN MEDICARE, 1990 AND 1995

Provider	1990	1995	Average Annual Rate of Growth (In percent)
Skilled Nursing Facility[a]	10,572	14,811	7.0
Home Health Agency	5,718	9,147	9.9
Inpatient Rehabilitation Facility	816	1,024	4.6
Long-Term Hospital	87	178	15.4
PPS Hospital	5,527	5,250	-1.0

SOURCE: Congressional Budget Office.

NOTES: Counts are as of December of each year.

PPS = prospective payment system.

a. Counts include swing-bed units in hospitals.

1995 for both home health and SNF services (see Table 3). However, distinct differences in the patterns of service use between those types of providers are apparent.

Aside from the growth in the number of people using services, most of the increased spending for home health is the result of a sharp rise in the number of visits per user. The average patient received twice as many home health visits in 1995 than in 1990. The average cost of a visit, however, grew modestly, reflecting a shift away from skilled nursing visits toward aide visits. Home health under Medicare is increasingly used to compensate for a patient's functional limitations rather than to provide skilled nursing or therapy services.

In contrast, an expanding use of ancillary services, particularly therapy services, and a rise in the number of patients have driven the growth of SNF spending. Unlike routine operating costs, which are paid on a reasonable-cost basis subject to limits, ancillary costs are not subject to limits. Consequently, although the number of SNF days per patient remained fairly constant, total outlays tripled between 1990 and 1995.

TABLE 3. GROWTH IN THE USE OF MEDICARE HOME HEALTH AND SKILLED NURSING FACILITY SERVICES, FISCAL YEARS 1990 AND 1995

	1990	1995	Average Annual Rate of Growth (In percent)
Home Health Services			
Users (Millions of people)	1.9	3.4	12.7
Visits (Millions of visits)	62.8	236.4	30.4
Outlays (Billions of dollars)	3.3	14.9	35.2
Skilled Nursing Facility Services			
Users (Millions of people)	0.6	1.2	14.0
Days (Millions of days)	22.9	40.3	12.0
Outlays (Billions of dollars)	2.8	9.1	26.6

SOURCE: Congressional Budget Office.

Projected Trends in Spending

Under current law, spending for post-acute care services is likely to continue its rapid growth, although not at the startling rates of the past decade. CBO projects that spending for SNF and home health services under fee-for-service Medicare will grow by 9.1 percent a year between 1997 and 2002 (see Table 4). That estimate does not, however, fully reflect the rapid growth of those services. CBO projects that the number of people enrolled in fee-for-service Medicare will decline as enrollment in health maintenance organizations increases substantially over the next decade. Consequently, outlays for SNF and home health services per person enrolled in fee-for-service Medicare will grow by 10.8 percent a year between 1997 and 2002.

POLICY OPTIONS

The rapid growth of Medicare spending on post-acute care services is adding to both the general financing problem facing Medicare and the imbalance of payments and revenues in the HI trust fund that will soon lead to that fund's depletion. Trimming limits under the current cost-based reimbursement system or developing a prospective payment alternative to the current reimbursement system could slow that growth. Other options include tightening Medicare's coverage standards and imposing greater cost-sharing requirements on beneficiaries.

TABLE 4. PROJECTED OUTLAYS FOR SERVICES FROM POST-ACUTE CARE PROVIDERS UNDER MEDICARE'S HOSPITAL INSURANCE PROGRAM, FISCAL YEARS 1997 AND 2002
(In billions of dollars)

	1997	2002	Average Annual Rate of Growth (In percent)
Skilled Nursing Facility	12.8	19.2	8.4
Home Health Agency	19.0	29.9	9.5
Total	31.8	49.1	9.1
Memorandum:			
All Medicare Benefits	207.9	312.4	8.5

SOURCE: Congressional Budget Office.

Developing specific policy options to address those spiraling costs is complicated by the overlaps in functions and services that exist among different types of providers. Financial incentives and changes in the delivery of services have blurred the distinctions between the levels of care furnished by acute care hospitals, post-acute care providers, and long-term care facilities. Not only do post-acute care services substitute for some inpatient treatment, but different post-acute care providers can tender many of the same services. Those factors argue for payment policies that provide comparable incentives across different sites of care.

A similar blurring of the distinction between post-acute care and long-term care has taken place. Home health care has increasingly become a long-term care benefit, with three-quarters of all home health payments in 1994 being provided to patients whose episode of care was at least four months. Many SNF patients also have chronic care needs, and they may cycle through acute, post-acute, and long-term care services covered by both Medicare and Medicaid. Thus, limiting payment for, or use of, particular post-acute care services financed by Medicare could lead to increased federal spending elsewhere.

Payment Options

Most proposals to slow the growth of Medicare spending on post-acute care services focus on payment options. Those proposals generally would tighten current Medicare payment systems in the near term, allowing time to develop alternative payment methods to be put in place in several years.

Tightening current payment systems is perhaps the simplest way to reduce the growth of spending for post-acute care services under HI. Those systems generally pay each provider on a cost-reimbursement basis, subject to a limit (see Box 1). Cost limits could be pared, or they could be imposed where particular costs (such as ancillary services in SNFs) are not now subject to a limit. Although such an approach could be useful in the near term, cost-based payment provides little incentive to reduce the use of health services.

Replacing cost-based reimbursement with prospective payment may be a more promising avenue of reform. Developing a workable payment system that could control growth in the volume of services provided, however, would be complicated. By fixing the payment for a set of related services, prospective payment systems place providers at financial risk for the services they either provide directly or order for patients. Unlike the current payment system, prospective payment can give providers an incentive to hold down their costs. But prospective

BOX 1
POST-ACUTE CARE BENEFITS FINANCED BY THE HOSPITAL INSURANCE PROGRAM

Services provided by skilled nursing facilities (SNFs) and home health agencies account for most Hospital Insurance (HI) payments to fee-for-service providers of post-acute care services—roughly five-sixths of the total in 1995. In addition, the HI program finances inpatient stays in rehabilitation hospitals, rehabilitation units within acute care hospitals, and long-term hospitals.

SNF Benefit. Medicare pays for up to 100 days of SNF care during a spell of illness for beneficiaries who recently have completed a minimum three-day hospital stay and need skilled nursing or rehabilitation services on a daily basis. A copayment equal to one-eighth of the hospital inpatient deductible is required from the beneficiary, beginning on the 21st day of SNF care. That copayment is $95 in 1997.

Medicare pays SNFs separately for routine services, capital costs, and ancillary services. Payments for routine services (which include room, board, and skilled nursing services) are based on facility-specific costs subject to national limits. Payments for capital and for ancillary services (such as physical therapy, occupational therapy, speech therapy, laboratory tests, and pharmacy) are based on the facility-specific costs without limits.

Home Health Benefit. To qualify for the home health benefit, enrollees must be homebound and require skilled nursing care or physical or speech therapy on a part-time or intermittent basis. Beneficiaries may also receive occupational therapy, home health aide services, or medical social services. A previous hospital stay is not required to receive the home health benefit. Medicare reimburses agencies for their costs up to aggregate agency limits, which are based on per-visit cost limits for each type of home health service. The per-visit cost limits are 112 percent of the average cost per visit for free-standing agencies. Limits are calculated separately for urban and rural providers. There is no copayment for beneficiaries.

Rehabilitation and Long-Term Hospital Benefits. Rehabilitation facilities—free-standing hospitals or distinct-part units within acute care hospitals—and long-term hospitals are exempt from the hospital PPS and are paid on a cost basis subject to limits. Patients in rehabilitation facilities require intensive treatment (at least three hours of therapy a day, frequent direct physician involvement and 24-hour rehabilitation nursing). Long-term hospitals provide a wide range of services, including rehabilitation, treatment of ventilator-dependent patients, cancer treatment, and chronic disease care. The average inpatient stay in long-term hospitals must exceed 25 days. For both rehabilitation and long-term hospital benefits, patients are subject to the HI hospital deductible ($760 per spell of illness in 1997) and daily coinsurance for the 61st through 90th days ($190 a day in 1997).

payment systems also encourage providers to increase the number of beneficiaries using services, while minimizing the care provided to those patients.

A prospective payment system would have to be designed carefully to assure that Medicare savings were obtained without jeopardizing access to or quality of care, and without imposing undue financial risk on providers. Important design features include the scope of services covered by prospective payment and the selection of appropriate adjusters to better match payments with the cost of providing treatment.

Scope of Services. In principle, greater program savings would be likely to result from prospective payment systems that pay for a broader range of services over an entire episode of care, rather than more narrowly defined services provided over a limited period of time. A broad definition would encompass more fully the care needed to treat a patient's illness, and would limit the provider's opportunity to receive additional payments by shifting necessary services outside the defined episode.

The most encompassing prospective payment system for post-acute care services would pay hospitals a prospective "bundled" rate to cover both inpatient and all post-acute care, including SNF, home health, and rehabilitation services. Such an approach would encourage more efficient use of services over a broadly defined

episode of care. It would also eliminate the financial incentive that now exists with separate payments for hospitals and various types of post-acute care providers to discharge patients from an inpatient stay to another provider as soon as possible. But bundled payment has been criticized as putting too much control over treatment and financing in the hands of hospitals, and it would not address the growing use of home health services that do not follow an inpatient stay.

Separate prospective payment systems for SNFs, home health agencies, and rehabilitation units have also been proposed. Those systems would encourage individual providers to reduce the cost of services they deliver. But separate prospective payments would introduce a new incentive for post-acute providers to discharge patients to another provider as soon as possible. Shifting patients among post-acute care providers is more likely if, as appears to be the case, the services they offer are close substitutes. Such shifting could adversely affect both the quality of patient care and the savings possible under a new payment policy.

Payments would no longer be tied to the costs of individual providers under a prospective system, and separate billing would be eliminated for some or all of the services and supplies provided. A prospective payment system for SNFs, for example, might cover routine costs (including room and board and routine nursing care), capital costs, and ancillary costs (including therapy services, drugs, and

medical supplies). Payment might be for one day of care or for an episode, such as an uninterrupted stay in an SNF.

Prospective payment systems using smaller units of service, such as days or visits rather than episodes, are not likely to yield substantial program savings. For example, paying home health providers on a per-visit basis would allow providers to increase revenues by reducing the services provided in a visit, necessitating more home health visits.

Even per-episode prospective payment systems—either under a bundling approach or separate prospective systems—might not yield program savings if they were poorly designed. Such systems encourage "cream skimming," in which providers seek out low-cost beneficiaries with few post-acute care needs. The full prospective payment could be substantially greater than the amount that would have been paid under the current cost-reimbursement system, unless the payment was adjusted to reflect the level of the patient's need for services.

If the prospective amount did not accurately reflect the cost of providing care, high-cost patients might face restrictions on their access to providers. Those providers who served sicker patients or who operated in higher-cost areas could risk financial losses even if they were run efficiently, unless appropriate adjustments were made to the payments.

Payment Adjusters. Risks to providers and beneficiaries could be reduced by adjusting payments to match more closely the cost of providing necessary treatment. Although the focus of attention has been on developing case-mix adjusters, which reflect cost variations in the treatment of similar patients, a practical prospective payment system for post-acute care services would probably also require payment adjusters to reflect cost factors that are specific to the institution.

The hospital PPS, for example, uses three kinds of payment adjustments: diagnosis-related groups (DRGs), outlier payments, and hospital-specific adjustments. DRGs adjust the Medicare payment for case mix, assuring that payments are higher for patients needing more expensive care. A DRG payment represents the average cost of treating patients with a given diagnosis. Medicare also makes an outlier payment when a particular patient requires much more extensive services than is typical for his or her DRG. Additional adjustments are made to payment levels to reflect factors that could indicate higher operating costs, such as teaching status or an index of hospital wages in the local area.

Developing an adequate case-mix adjuster for post-acute care services would be complicated, since the need for medical services is only one factor determining the cost of a patient's care. In addition, the functional status of a newly discharged patient and the availability of family support help determine both the type of post-acute care that may be needed and its duration and expense. The more a patient

needs help bathing, walking, or engaging in other activities of daily living, and the less help he or she might have at home from family members, the more likely the need for post-acute care.

Assessing patient needs would be difficult and probably subjective, however, and would be only the first step in designing a case-mix adjuster. The Health Care Financing Administration (HCFA) has worked for some years to develop assessment instruments, including the Uniform Needs Assessment Instrument, the long-term care facility minimum data set, and the Outcomes and Assessment Information Set (known as OASIS).

To develop a case-mix adjuster, data from patient assessment systems would be used to classify post-acute care patients according to the cost of the services they use. HCFA has been testing various case-mix systems over the past decade. Research in the late 1980s, for example, suggested that DRGs might be a basis for adjusting bundled payments for case mix. The Resource Utilization Groups III (RUGs-III) system for SNF services has been tested in the Nursing Home Case Mix and Quality Demonstration that began in 1989. HCFA also continues to develop prototype case-mix adjusters for home health care, but it has not yet determined an appropriate unit of service on which to base a separate prospective payment system.

Developing adequate case-mix adjusters remains a challenge for any proposal to institute prospective payment for post-acute care services. We have to rely on information from current patterns of service use, but those data include both inappropriate use and fraudulent claims. Even if all fraudulent claims could be eliminated from the analysis, the resulting costs of service would potentially be much higher than they would be under a more efficient payment system. One could, for that reason, justify reductions in payments to post-acute care providers even after payment reforms were introduced.

Other Policies

Although prospective payment systems might help constrain expenditures on post-acute care services, those systems alone would not necessarily slow the growth in the number of people using post-acute care. Given the incentives encouraging hospitals under the PPS to discharge patients as soon as possible, the lack of clear and enforceable standards to determine the services that patients should receive opens the door to continued increases in admissions to skilled nursing facilities. Medicare has even less control over the use of the home health benefit, which does not require prior hospitalization and does not require the patient to leave familiar surroundings. As a result of such factors, if providers admit new patients who require only a small

amount of care, prospective payment systems for post-acute care services might not generate savings and could even increase program costs.

The larger policy question, however, is the proper role of Medicare in financing long-term care. Medicare was originally conceived as an acute care insurance program. The home health benefit has been reinterpreted to cover both patients who need true post-acute care and those who need chronic care. Tightening coverage standards would probably restrict that benefit more closely to its original concept. But a reconsideration of Medicare's role might instead lead to expanded coverage of long-term care, if policymakers concluded that the program should provide chronic care benefits.

Imposing a realistic cost-sharing requirement on home health services might be an alternative to cutting back Medicare's coverage of those services. Home health care is the only Medicare service, aside from clinical laboratory services, not subject to cost sharing. Imposing such a requirement could give beneficiaries a greater awareness of the services for which Medicare is being billed. Cost-sharing would also yield some program savings since part of the cost of services would be shifted to beneficiaries.

Whether such a policy would lead to a decline in the use of services depends on whether the new cost-sharing requirement was covered by Medigap and

employer-sponsored insurance. The Congress could prohibit Medigap plans from covering those new requirements, for example, to enforce financial incentives that would discourage use of home health services. Employer-sponsored plans might not cover home health coinsurance, since few of those plans offer any form of home health coverage now. Low-income beneficiaries for whom Medicaid was paying for Medicare cost-sharing requirements would continue to receive that protection.

THE PRESIDENT'S 1998 BUDGET PROPOSALS

The budget the President submitted for fiscal year 1998 includes proposals that would lower spending on services from post-acute care providers paid on a fee-for-service basis under the HI program by $27.6 billion over the next five years, compared with current law (see Table 5). Those proposals are part of a broader package of reductions in spending and expansions of benefits that, on net, would reduce Medicare spending by $82 billion between 1998 and 2002, according to CBO estimates. In addition, the Administration proposes to transfer spending for certain home health visits from the HI program to the SMI program.

TABLE 5. SAVINGS ON POST-ACUTE CARE SERVICES UNDER THE PRESIDENT'S 1998 BUDGET (By fiscal year, in billions of dollars)

Reductions in Payments to Fee-For-Service Providers[a]	1998	1999	2000	2001	2002	Cumulative Savings, 1998-2002
Skilled Nursing Facility	0.1	1.3	1.8	2.1	2.4	7.6
Home Health Agency	1.1	1.4	2.9	3.4	3.9	12.8
Other[b]	0.9	1.2	1.5	1.7	1.9	7.2
Total	2.1	3.9	6.2	7.2	8.2	27.6

SOURCE: Congressional Budget Office.

a. Includes only payments from the HI program.

b. Includes a recalibration of hospital payments when a patient is transferred, a moritorium on new long-term hospitals, and reduced payment updates and capital payments to hospitals exempt from the prospective payment system.

Proposed SNF Policies

The Administration proposes to establish a prospective payment system for SNF services that would make payments on a per-day basis for all costs of SNF services—routine service, ancillary service, and capital costs. Payments would be adjusted for geographic differences in wages and for case mix. The case-mix adjuster is not specified in the proposal, but it is likely to be the RUGs-III system. During a four-year transition period, payments to SNFs would be a blend of the national payment amount and an amount specific to the facility, both of which would be prospectively determined. Those policies would become effective on July 1, 1998.

A per-day prospective payment system might be a practical way of addressing the burgeoning costs of ancillary services in SNF treatment. Unnecessary use of those services during a day of care would be discouraged, although the number of days of SNF care might increase. As noted earlier, SNF payments have been driven by the growth of both ancillary costs and the number of users, with the average number of SNF days per patient remaining fairly stable. However, per-day payment could spark some increase in the average length of stay in SNFs and would not control growth in the number of users.

Although a more inclusive per-episode payment would provide broader incentives to hold down treatment costs, case-mix adjusters would be needed that could reliably predict the variation in those costs for entire episodes. HCFA has focused its efforts, instead, on developing adjusters for per-day payment.

The Administration's proposal would also reduce the annual update to limits on routine service costs by removing the effects of spending growth that occurred between July 1994 and July 1996. In addition, to eliminate fraudulent billing practices, SNFs would be required to bill Medicare for nearly all services their residents receive. Outside suppliers of those services could no longer bill Medicare separately.

Proposed Home Health Policies

The Administration's proposals for Medicare's home health benefit include adjusting the current payment system to slow the growth of spending, introducing a prospective payment system based on those reductions in payments, and making some changes in the way the benefit is administered.

An interim payment system would be established for home health services, beginning on October 1, 1997. That system would pay home health agencies the lesser of actual cost (defined as Medicare allowable costs paid on a reasonable-cost

basis), a per-visit cost limit (based on 105 percent of national median costs), and a new limit that is specific to the agency on annual costs per beneficiary (based on reasonable costs reported by the agency for 1994). The agency-specific limit on per-beneficiary costs is intended to account for the recent rapid growth in the volume of home health visits provided to patients.

A prospective payment system would replace the interim system, beginning on October 1, 1999. The details of that prospective payment proposal, however, are largely unspecified. The unit of service for which payment would be made is not stated in the proposal. Although payments would be adjusted for case mix and labor costs, no specific case-mix adjuster is identified. An outlier policy is proposed, but the details are left to the Secretary of Health and Human Services. Program savings would be the result of a 15 percent reduction in the cost limits and per beneficiary limits that are in effect on the last day before the policy is carried out.

In addition, home health cost limits would be cut by removing the increase in the market basket that occurred between July 1994 and July 1996. Other policies would base payment on the location where services are rendered, not where services are billed. Periodic interim payments would be eliminated when the prospective payment system is put in place. So-called normative standards would establish a basis for claims denials, and the definition of "homebound" would be clarified.

The President's budget also proposes to shift part of home health care from the HI program to the SMI program. Beginning October 1, 1997, the first 100 visits following a three-day hospital stay would be reimbursed under HI. All other visits, including those not following hospitalization, would be reimbursed under SMI. Those latter visits would not be subject to the SMI deductible or coinsurance, and would not increase the SMI premium. About $86 billion in payments would be shifted from HI to SMI. The transfer would have no impact on total Medicare spending, but it would postpone depletion of the HI trust fund. CBO estimates that the Administration's policies, including the home health transfer, would maintain a positive balance in the HI trust fund through 2007.

Other Proposals

Because the number of long-term hospitals has grown rapidly in recent years, the Administration proposes to stop designating new long-term hospitals. Much of that growth is the result of rehabilitation and psychiatric hospitals changing designations to avoid Medicare's more stringent criteria for the coverage of services. In addition, some acute care hospitals have converted part of their facilities into separate long-term hospitals.

Payment rates for non-PPS hospitals would also be reduced. Limits on operating costs would be rebased, and capital payments would be reduced to 85 percent of reasonable costs.

In addition, the Administration would change the payment policy for patients discharged from PPS hospitals to SNFs or non-PPS hospitals. Under current rules, the PPS hospital receives a full DRG payment for those patients, and the SNF or non-PPS hospital also gets its normal payment. The proposal would treat those patients as transfers, with the PPS hospital paid on a per-diem basis up to the full DRG payment.

CONCLUSION

Reining in the spending on post-acute care services in Medicare would be a formidable task. The current payment structure of fee-for-service Medicare fails to give post-acute care providers an incentive to constrain spending, and past actions that broadened the benefit beyond true post-acute care have greatly contributed to the growth of program spending. Within this context, it is difficult to design policy options to slow the growth of spending.

Because the financial incentives facing post-acute care providers are complicated, the effort required to develop a workable new payment system would be substantial. Options that would limit spending by one type of provider could result in a shift of spending elsewhere in the Medicare system, particularly when services offered by other providers are close substitutes. The Administration's proposals represent a first step on what is undoubtedly a long road to payment reform for post-acute care services.