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ISSUE BRIEF

Implementing the BBA: The Challenge of Moving Medicare Post-Acute Services to PPS

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A discussion featuring

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Moving Medicare Post-Acute Services to PPS

The Medicare prospective payment system (PPS) has been the federal government's primary mechanism for helping control Medicare outlays since 1983, when the Social Security Amendments mandated diagnosis-related-group (DRG) rates for inpatient hospital services. When Congress drafted the Balanced Budget Act of 1997 (BBA)—seeking savings in Medicare for a five-year period, among other provisions—it provided for skilled-nursing-facility (SNF), medical rehabilitation, and home health services to go under PPS as well, according to staggered deadlines. Since the BBA became law, the Health Care Financing Administration (HCFA) has been negotiating an obstacle course as it has moved to place these post-acute services under PPS.

From a systems point of view, it makes sense to have the same payment rationale for services that sometimes are provided in the same setting. For example, a person who has had a stroke may receive physical therapy—traditionally part of medical rehabilitation—in a nursing home, rehabilitation unit, or home setting. At the same time, finding one type of payment system that takes into account the variations in patient illness and disability, desired outcomes, and need for services is difficult. Advocates for post-acute services have been quick to point out the differences and the problems. Moreover, during the 1990s, a new lobby—representing, for the most part, for-profit providers that offer sub-acute services for medically complex patients in institutional settings that do not fit HCFA's definitions—has weighed in, seeking both recognition for covered services and differentiation from other post-acute care.

Nonetheless, with private payers and state Medicaid programs well on the way to managed care, Medicare faces the challenge of rationalizing its traditional fee-for-service program into managed financial arrangements. In addition to requiring HCFA to include Medicare Part A SNF, medical rehabilitation, and home health in PPS, the BBA mandated the agency to develop—as an option for Medicare beneficiaries—Medicare+Choice, in part a program of “coordinated care” under which Medicare (under a new Part C) pays managed care organizations to provide defined services. The law also established a new Child Health Insurance Program for HCFA to administer jointly with the Health Resources and Services Administration. Coincidentally, HCFA is responsible for seeing that Medicare, the

largest health program in the nation, is Year 2000 (Y2K) compliant. Added together, these provisions strain a staff that has not grown proportionally with its implementation duties.

This Forum session will examine the challenge of putting SNF, medical rehabilitation, and home health services under PPS. It will look at the health delivery and financing reasons for doing so, the progress HCFA has made to date, and the problems that have arisen (including some adverse impacts on SNF, medical rehabilitation, and home health services that Congress and HCFA, to the extent that it is able to, are seeking to address).

BACKGROUND

Medicare changes—whether reductions in payments to providers; inclusion of SNF, medical rehabilitation, and home health in PPS; or establishment of Medicare+Choice—were crucial parts of the budget agreement between President Clinton and Congress that led to enactment of the BBA. Aimed at reducing Medicare's rates of increase through 2002, the amendments to Title XVIII required HCFA both to make traditional fee-for-service Medicare more cost-effective and to continue the task—started in 1983—of moving Medicare away from cost-based reimbursement. While DRGs for hospital inpatient services under PPS are discharge-based (depending upon mean days of

ISSUE BRIEF/No. 743

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services per diagnosis, with outlier payments for a small percentage of anomalous cases), the PPS systems for the post-acute services are not. The BBA prescribed a per diem basis for SNF and medical rehabilitation care and asked the secretary of the Department of Health and Human Services to recommend the unit of service for home health (although the BBA said that it had to be case-mix-adjusted).

Specifically, the BBA mandated the following for post-acute services:

- Phase-in of a PPS system for SNFs (covering routine, ancillary, and capital costs for services provided to Medicare Part A beneficiaries) beginning with provider cost-reporting periods starting on or after July 1, 1998, a deadline which HCFA met.
- Implementation of a PPS system for medical rehabilitation hospitals and units by October 1, 2000.
- Development of a case-mix-adjusted PPS for home health services by October 1, 1999, a deadline delayed until October 1, 2000, by the Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1999.

The BBA also made some other changes that have affected post-acute services:

- Under Medicare Part A, for ten DRGs, treatment of qualified discharges from an acute- to a post-acute-care setting within three days of patient discharge as transfer cases (with forfeiture by the hospital of part of the full DRG payment if the patient's stay is shorter than the mean length of stay for the DRG).
- Under Medicare Part B, capping of occupational therapy services at \$1,500 per year per Medicare beneficiary and joining of speech-language pathology and physical therapy services under another annual \$1,500 cap per beneficiary (that is, three service categories and two caps).

While the latter two changes are not the topic of this session per se, they have affected Medicare payments to hospitals (in the case of the transfer policy) and to SNFs, medical rehabilitation hospitals and units, and home health providers and have become enmeshed in PPS discussions of post-acute services.

SNF PPS—PLEAS FOR 'REFINEMENT'

Medicare beneficiaries qualify for SNF benefits if they have been hospitalized for at least three days, enter an approved SNF setting within 30 days of discharge,

and meet certain diagnosis and treatment plan requirements. If they qualify, their Medicare-covered SNF costs are paid completely the first 20 days. They pay up to \$96 per day for the next 80 days and Medicare pays the remaining allowable costs. A benefit period consists of 100 days, the maximum that Medicare covers.¹

SNF services went from \$4.2 billion, serving 757,000 Medicare beneficiaries, in 1992 to an estimated \$11.5 billion, serving 1.14 million persons, in 1996—for an average annual increase of 28.8 percent in payments and 10.7 percent in people served. The large increase mainly resulted from a rise in the average payment per day from \$152 to \$286 during the period.²

Phased in over three years, a PPS system for SNFs went into effect for cost reporting periods beginning on or after July 1, 1998. Previously, SNFs had been paid on a reasonable-cost basis or through low-volume prospectively determined rates. HCFA published an interim final rule in the May 5, 1998, *Federal Register* for the new system and is planning to disseminate a final regulation this summer. In the interim rule, HCFA established federal rates, based upon allowable costs from fiscal year (FY) 1995 cost reports, for each admission. It adjusted the per diem payments for each admission by case mix, using 44 Resource Utilization Groups, called RUGs III. It also adjusted the payments to reflect geographic variation in wages, using the hospital PPS area wage index. The per diem payments can change daily based upon patients' classifications as determined by a highly intensive minimum data report generated by the SNF. Through FY 2001, the federal rates will be blended with facility-specific payments to ease SNFs into the payment system.³

Because of Medicare's limitation on number of days covered in a SNF, the program is significantly less important than Medicaid as a payer for long-term-care services. According to industry figures, Medicare beneficiaries make up about a fifth of nursing home patients at any one time. They tend, however, to have greater severity of illness and to consume more resources. Because nursing homes vary in the proportions of Medicare patients they treat, the impact of the new per diem PPS system depends in large part upon a given nursing home's payer mix. (It is important to note that some of the Medicare patients in SNFs are dually eligible for both Medicare and Medicaid; while Medicaid pays for the nursing home stay, Medicare picks up the costs [under Part B] of occupational and physical therapy and speech-language pathology.)

Although the savings for the SNF provisions in the BBA were estimated at approximately \$9 billion over

the legislation's five-year span, some in the industry contend that the savings could amount to \$7 billion more. The Congressional Budget Office (CBO), which made the original savings estimates, maintains that its figures are pretty much on target.⁴ Some contest CBO's baseline, however, because of disagreement over whether savings from Medicare Part B rehabilitation services provided SNF patients should be counted.

However, there is no doubt that some nursing homes are experiencing declines in revenue. In April, Standard & Poor's (S&P) lowered the bond ratings of several major nursing home operators with high debt loads. In doing so, it expressed concern about the effects of the SNF PPS on the firms.

There are approximately 16,800 nursing homes in the United States. In 1998, Beverly Enterprises, a for-profit, ranked first, with 562 facilities and 62,293 beds. Mariner Post-Acute Network, also a for-profit (the result of a merger between Mariner Health Group and Paragon Health Network), was second, with 428 facilities and 50,471 beds. Sun Healthcare Group, Integrated Health Services, and HCR Manor—all for-profit—ranked third, fourth, and fifth. Evangelical Lutheran Good Samaritan Society was the largest not-for-profit, with 223 facilities and 17,356 beds (ranking it 8th in units and 11th in beds).⁵ Some health care systems also operate one or more SNFs, but they rank well below the long-term-care systems in number of units and of beds. Most of the rest are “mom and pop” operations.

Represented by the American Health Care Association and American Association of Homes and Services for the Aging (depending upon whether they are for- or not-for-profit), the nursing homes have charged the RUGs III groups as not being “refined enough” for fair payment. They contend that the criticism particularly applies to persons with medically complex conditions as well as those needing a significant number of drugs and supplies.

Sens. Pete Domenici (R-N.Mex.) and Jeff Bingaman (D-N.Mex.) have taken the lead in the Senate in asking HCFA to revise the SNF rules. At an April 22 hearing of the Senate Budget Committee, which Domenici chairs, the senator told Donna Shalala, secretary of the Department of Health and Human Services (DHHS), that the SNF PPS is having a greater adverse impact than expected. Warning that some nursing homes may have to close their doors, he and other senators expressed concern about the potential harm to beneficiaries as a result. He and Bingaman have drafted a letter to the secretary seeking changes and are gathering signatures from other senators.⁶

HCFA has been sympathetic, as reflected in comments by HCFA officials at a town hall meeting (held at the urging of House Ways and Means Committee Health Subcommittee Chairman Bill Thomas [R-Calif.]) in Baltimore on April 23 and by the DHHS secretary at the May hearing. The agency, which is working with the industry to get updated information on the effects of the new payment system, nonetheless is waiting for data to assess the situation. Among the changes it is considering is development of a new RUGs system or adjustment of the current one to make it more sensitive to a range of severity levels and resource needs. While the final SNF rule to be issued this summer offers an opportunity for revision, HCFA indicates that Y2K activities and constraints make it difficult to make systems revisions to refine the RUGs system before the October 1, 2000, update.

MEDICAL REHABILITATION PPS—RUGS VS. FIM-FRG

Medicare is the largest single payer for inpatient rehabilitation services. In 1996, rehabilitation hospitals and units treated over 450,000 patients, 70 percent of whom were Medicare beneficiaries. Patients treated in the inpatient rehabilitation setting must be capable of undergoing, and likely to improve functionally from, receiving approximately three hours of therapy daily. Medicare requires that at least 75 percent of a rehabilitation facility's patients be admitted for care for one or more of 10 specified neurological, musculoskeletal, or burn conditions. The most common diagnoses of beneficiaries admitted to rehabilitation facilities, though, are stroke, hip fracture, and major joint reattachment procedures such as hip replacement. Those diagnoses describe more than half of beneficiaries in rehabilitation facilities.⁷

When Congress provided for establishment of the PPS system under Medicare Part A in 1983, it exempted inpatient medical rehabilitation services. Those services remained under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), which capped or set limits on them.⁸ At the end of the 1980s and during the first half of the 1990s, medical rehabilitation services grew rapidly. “Aggregate Medicare payments to rehabilitation hospitals and units combined more than doubled between 1990 and 1994, from \$1.9 billion to \$3.9 billion.” Moreover, “between 1986 and 1995, the number of rehabilitation hospitals and distinct-part units grew, respectively, by 11.2 percent and 6.6 percent annually.”⁹

Since 1983, rehabilitation providers and others in the health community had an ongoing debate on whether or not inpatient services should go under PPS, a debate

that was settled by Congress's BBA direction to DHHS to implement a PPS system by October 1, 2000. The ongoing debate had, in part, been based on how medical rehabilitation services could be put under PPS—what the measure of services would be. The latter debate is still continuing, primarily focusing on whether medical rehabilitation should be a case-mix classification system like the RUGs III used for SNF services or a functionally based system such as the Functional Independence Measure Function-Related Groups (FIM-FRGs) used by many rehabilitation providers to assess quality of care. FIM-FRGs consist “of patients with similar clinical characteristics and resource use, as measured by length of stay.”¹⁰

Confusing the situation is payment under Part B for services provided in outpatient rehabilitation facilities and for services given by medical rehabilitation practitioners. The latter include physicians (the specialty is psychiatry, although orthopedists and other specialists offer services as well), occupational therapists (who deal with small muscle groups), physical therapists (who specialize in larger muscle groups), and speech-language pathologists (who work with speech, hearing, and language problems). The \$1,500 per year cap on occupational therapy services, as one category, and on speech-language pathology and physical therapy services, as another category, comes under Part B. It refers to payment to practitioners rather than to institutional settings, which is the focus of Part A. Further confusing the matter is the blurring of the distinction between freestanding or hospital-based medical rehabilitation and SNF (and, to a lesser degree, the home) venues as settings in which occupational therapy, physical therapy, and speech-language pathology services are given.

The largest health care system that operates rehabilitation hospitals is HealthSouth Corporation, which had 129 facilities in 28 states in 1998. A comparison with number two and number three give an idea of HealthSouth's size: in 1998, Sun Healthcare Group operated nine hospitals in six states and the Catholic Health Care Network had two in one state.¹¹ While the medical rehabilitation field has consolidated, with HealthSouth the major operator, some contract rehabilitation organizations, such as Excellcare in the Chicago area, have gone out of business, because SNFs and other post-acute providers are no longer contracting for rehabilitation services to the extent that they were before enactment of the BBA.¹²

The major PPS issue is what system HCFA should adopt for medical rehabilitation services that are

provided under Medicare Part A. The assumption that has been drawn from HCFA's articulation of its post-acute care approach is that it will select a resource-based case-mix system like RUGs III, which the agency views as limiting incentives for providers to keep patients for short stays and to discharge them to other settings. HCFA also is responsible for coordinating the medical rehabilitation PPS with the SNF PPS, which would be easier with similarly based systems, especially since the distinctions between SNF and medical rehabilitation care for some of the same diagnoses have faded over time.

MedPAC and an array of industry groups, including the American Hospital Association, are recommending adoption of FIM-FRG. MedPAC told Congress: “The Secretary [of DHHS] should develop a discharge-based PPS for rehabilitation patients based on the FIM-FRG classification system. Policies to address transfers and short-stay outliers would be necessary components of such a system.” In doing so, MedPAC expressed doubts about the sample size of HCFA's study of rehabilitation staff time that paved the way for its modification (for medical rehabilitation) of the per diem PPS implemented for SNFs. (HCFA is currently sponsoring a study to test the modified instrument on 2,000 rehabilitation patients.) MedPAC also showed concern about the “tight time frame during which HCFA aims to develop the new PPS” for medical rehabilitation.¹³ Backing MedPAC's recommendation, the AHA said in House Ways and Means Committee testimony: “Rehabilitation PPS payment should be based on a patient's ability to function independently, measurements that are much better tied to the mission of medical rehabilitation than RUGs.”¹⁴

With nearly a year and a half to go before HCFA is mandated to begin phasing in a PPS for medical rehabilitation, the agency has contractors looking at the issues and is consulting with various stakeholders. In addition to the inpatient PPS, HCFA is responsible, under the BBA, for a study from the DHHS secretary to Congress (no later than January 1, 2001) on a revised coverage policy of occupational therapy services and of physical therapy services in outpatient settings based upon classification of patients by diagnosis and prior service use. For patients, such as “patients recuperating from strokes, amputation, and head trauma, as well as those grappling with degenerative diseases such as Parkinson's and multiple sclerosis” featured in a May 10, 1999, *Washington Post* article,¹⁵ the Part B caps seem to be the biggest issue, one that is carrying over to the Part A PPS debate.

HOME HEALTH PPS—EAGERLY AWAITED DUE TO INTERIM SYSTEM

Medicare defines home health services as “part-time or intermittent SNF, physical therapy, medical social services, medical supplies, and some rehabilitation equipment [that] may be paid for in full by Medicare” when a patient is “confined at home.” A physician must prescribe the services.¹⁶ Between 1989 and 1995, home health was the fastest growing component of Medicare. “Annual expenditures for the benefit jumped from \$2.6 billion to \$16 billion, an average annual increase of 35 percent.” The increase was attributed in part to changes in the health marketplace as a result of the inpatient hospital PPS, resulting in the discharge of sicker patients, and a court decision that struck down HCFA’s narrow definition of home health. The number of home health providers expanded, as did visits. In 1996, approximately 10 percent of Medicare beneficiaries received home health services. The General Accounting Office (GAO), in a March 1996 report, *Medicare: Home Health Utilization Expands While Program Controls Deteriorate*, accused HCFA of having virtually no controls at all.¹⁷

Congress originally wanted a case-mix-adjusted PPS for home health services by October 1 of this year, the deadline in the BBA. Due to Y2K and other problems, the deadline was pushed back to October 1, 2000. However, the BBA, which targets more than \$16 billion in savings for home health through 2002, mandated an interim-payment system until a PPS is implemented. The interim system has proven to be highly unpopular. Under it, since October 1, 1997, home health agencies have been “paid their costs subject to the lower of an aggregate per visit limit or an aggregate per beneficiary limit.”¹⁸ Moreover, if the agencies’ expenses in providing services are less than the cost limit, they cannot keep the difference. However, they receive no additional reimbursement if their expenses exceed the limit. Also, older agencies tend to have lower per patient caps than newer agencies.

Because the payment schedule adjusts for severity of illness only in terms of an agency’s own historical practices (that is, the case mix in its base year), agencies that have moved to higher acuity patients since then have felt disadvantaged. Initially adding to their angst was a provision in the BBA that provided for the aggregate per visit limits to ratchet down. Last fall, Congress—responding to a strong lobbying effort—amended the law to prevent the additional cuts.¹⁹ Congress funded the change with a tax provision affecting casino jackpot and lottery winners, as well as by reductions in the home health “market basket” of

goods and services upon which increases in payments to home health agencies are gauged.²⁰

An analysis of the implications of the BBA for home health—prepared by the Center for Health Policy Research for the Home Care Coalition—contends that “the sickest patients will experience the most problems. This is because the payment methodology creates perverse incentives in the way it attempts to control utilization.” The report also predicts that “efficient providers of care for very ill patients may have to reduce necessary services, serve a healthier clientele, or leave the market.” In addition, the report indicates that, because “the interim payment system substitutes an agency-specific total payment methodology for a national payment methodology, while locking in historic differences in practice patterns,” it will be “more difficult to move to a final PPS methodology.” The center suggests (a) a moratorium on the interim system, coupled with an accelerated move to a case-mix-adjusted PPS system; (b) adoption of “an interim episode-based PPS system”; (c) implementation of “an interim simplified risk-adjusted payment system” based on four categories of illness (“post-acute, unstable medically complex, stable acute management of chronic illness, and high intensity long-term medically complex”); (d) selection of “a two-level per beneficiary cost-limit based on short-stay or long-stay designations”; and (e) “reexamination of eligibility and coverage changes included in the BBA.”²¹

The GAO has done two surveys to monitor the issue of access to care, a limited survey at the end of last year and a more detailed survey submitted in May to the requesting congressional committees. The GAO found that, overall, the changes in utilization followed the expectations implied in the statutory provisions. It did not find access problems generally, though it implied that there might be difficulties in some high-need cases.

MedPAC, in its March 1999 *Report to Congress*, criticized the interim payment system for not recognizing agencies’ current patient mix.

Ideally, a PPS creates appropriate incentives by adjusting the payment rates to reflect the relative costs of serving different types of patients. Designing such a system has not been easy, however, because users of home health services have extremely diverse needs.

In addition to recommending implementation of a PPS for home health, MedPAC urged Congress and DHHS to

explore additional methods to ensure appropriate use of home health services. These include clearly defining home health eligibility and coverage guidelines, requiring an independent needs assessment for beneficiaries making extensive use of home health care,

standardizing coding for home health visits, and implementing beneficiary cost-sharing.²²

A recent survey of the home health industry by Modern Healthcare had mixed results because of low response. Integrated Health Services was first, with seven million visits in 1997. However, it sold its home health division early this year. (HealthSouth ended its home health operations late last year and Columbia had sold most of its agencies by the start of 1999.) Medshares was next, with nearly three million visits. Home Health Corporation of America and In Home Health were next, each with more than a million. Approximately 1,200 home health agencies are said to have closed since enactment of the BBA as a result of the interim system.²³

KEY QUESTIONS

Whether the post-acute payment policy changes restrain the growth of the services' costs without restricting beneficiaries' access to services is a major question, one posed by Barbara Gage, Ph.D., in an unpublished paper for the Commonwealth Fund on the impact of the BBA on post-acute utilization. In the paper, Gage indicates that the purpose of each post-acute PPS is to

limit the growth in expenditures by giving providers the incentive to manage the costs associated with the unit of payment. Where SNF and rehabilitation facility patients have fairly complex medical needs, their average cost per stay can be predicted and fair payment rates can be based on either a discharge or a per diem basis.

She contends, however, that, "because home health patients are less medically complex, their treatments and average costs may be less predictable."²⁴ (NHPF will hold a meeting July 13 on the impact of the BBA on home health agencies and access to home health services.)

Following are questions that the July 7 session will explore:

- What are the advantages of placing post-acute health services under PPS? What are the disadvantages?
- What is behind the confusion over savings estimates and savings claims for the BBA PPS post-acute service provisions? The BBA provisions themselves? The definitions of the services, especially medical rehabilitation? Crossover from Part A to Part B?
- What impact has the development of "sub-acute services" had on provision and payment of post-acute care?
- What were the rationales behind BBA provisions to coordinate SNF and medical rehabilitation PPS

systems, restrict payment for certain transfer cases, and cap occupational therapy services (under a \$1,500 limit) and speech-language pathology and physical therapy (combined under another \$1,500 limit)?

- How do the numbers of SNF, medical rehabilitation, and home health providers correlate with the numbers of Medicare beneficiaries who need those services?
- How big a factor is Y2K in the timing of BBA PPS implementation?
- What changes is HCFA considering for the final rule on SNF PPS?
- What are the pros and cons of adopting RUGs for medical rehabilitation PPS? Of choosing FIM-FRG instead?
- What is the status at HCFA of the medical rehabilitation PPS?
- Has opposition to the interim payment system for home health quieted since Congress reduced the cuts in payment last fall?
- What is the status at HCFA of the home health PPS?
- What are the rationales for MedPAC's recommendations on the implementation of PPS for SNF, medical rehabilitation, and home health services?
- Can Medicare develop a PPS that includes all providers, regardless of ownership and type?

THE FORUM SESSION

This Forum session will explore the BBA's inclusion of Medicare SNF, medical rehabilitation, and home health services in PPS. It will look at these services from a systems point of view, relative to the adoption of the Medicare hospital inpatient PPS in 1983. It will examine the challenges HCFA faces in implementing the BBA PPS provisions for the post-acute services; the effects upon the services, as given to Medicare beneficiaries by different types of providers; and recommendations for changes in the services' delivery and financing.

Thomas Hoyer, director of the Chronic Care Purchasing Group, Center for Health Plans and Providers, Health Care Financing Administration, will open the session with a discussion of the challenges HCFA is confronting in implementing the BBA PPS provisions. Director of the Bureau of Policy Development's Office of Chronic Care and Insurance Policy before HCFA's recent reorganization, he has worked for the agency and its predecessor organizations since 1972.

William T. Smith, Ph.D., will address the effects of post-acute payment systems on beneficiaries. He is president and chief executive officer of Aging in America, a multi-faceted social agency serving the elderly, and Morningside House, a 386-bed SNF with a long-term home health care program and two adult day health care programs (one in the Bronx and the other in Westchester) for persons with Alzheimer's Disease. He has been in the field of social work since 1971, with the last 20 years dedicated to the field of gerontology.

Gerben DeJong, Ph.D., also will look at the effects of post-acute payment systems on beneficiaries, with special focus on medical rehabilitation. He is the director of the National Rehabilitation Hospital Research Center. In this capacity, he serves as the director of the center's Research and Training Center on Managed Care and Disability. He is also a professor in the Department of Family Medicine and an adjunct professor in the Georgetown Public Policy Institute at Georgetown University. Earlier, he was a senior research associate and associate professor in the Department of Rehabilitation Medicine at Tufts University School of Medicine.

Murray Ross, Ph.D., will address recommendations for changes in BBA PPS implementation, especially from the point of view of MedPAC. Executive director of MedPAC since early 1998, he previously was chief of CBO's Health Costs Estimate Unit. In that position, he supervised preparation of baseline spending projections and cost estimates for Medicare and Medicaid, as well as for other federal civilian health programs. Earlier he worked on a variety of health care reform and income security issues for CBO's Health and Human Resources Division.

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