CHAPTER 6

Financial performance and payment update for facilities exempt from prospective payment

RECOMMENDATION

6A The Secretary should increase the target amount update formula for fiscal year 2001 by up to 0.3 percentage points above the market basket amount.

CHAPTER 6

Financial performance and payment update for facilities exempt from prospective payment

In this chapter

- Overview of the payment system and policy changes
- Financial performance under Medicare
- Updates to target amounts

The Medicare operating margins of inpatient facilities exempt from prospective payment dropped sharply in 1998 in response to the Balanced Budget Act of 1997. For the largest groups of these facilities (long-term, psychiatric, and rehabilitation providers), declines ranged from 4 to 7 percentage points. In contrast, before implementation of the Balanced Budget Act, substantial drops in length of stay, along with less restrictive conditions for new facilities entering the system than for older facilities, produced large increases in exempt facilities' margins from 1990–1997. The provisions of the Balanced Budget Act not only recouped some of the financial gain resulting from falling lengths of stay, but also narrowed the gap in margins between new and old facilities. The Commission recommends a range for the payment update for facilities exempt from prospective payment that extends modestly beyond the expected rate of inflation in hospital input prices, reflecting an increment for cost-increasing drugs and other technological advances.

Facilities exempt from prospective payment make up a diverse group of providers. However, they are treated similarly under Medicare payment policy because the Health Care Financing Administration (HCFA) implemented the prospective payment system (PPS) for inpatient care before researchers were able to develop case-mix classification systems that accounted for the differences in these facilities. The three largest PPS-exempt providers are slated to move to prospective payment by FY 2003.

To provide a context for discussing the target amount update for PPS-exempt facilities for FY 2001, this chapter describes selected characteristics of PPS-exempt facilities, payment policy before the Balanced Budget Act of 1997 (BBA), payment changes enacted by the BBA and Balanced Budget Refinement Act of 1999 (BBRA), and pre- and post-BBA financial performance of PPS-exempt facilities. The chapter then presents the Commission's recommendation on the FY 2001 update.

Provider characteristics

Approximately 2,100 psychiatric, 1,100 rehabilitation, 200 long-term, 70 children's, and 10 cancer facilities now qualify for exemption from the prospective payment system (PPS) for inpatient care. The majority of Medicare payments to PPS-exempt providers are dispersed to psychiatric, rehabilitation, and long-term facilities. Table 6-1 describes the criteria for the different categories of PPS-exempt facilities.

The classes of PPS-exempt providers differ on a variety of measures, including length of stay and Medicare costs per discharge and per day (Table 6-2). Medicare length of stay has been the longest and costs per discharge the highest for long-term hospitals, compared with the other types of PPS-exempt facilities. In 1998, length of stay in a long-term hospital was 28 days and costs per discharge were $16,957. That same year, costs per discharge were $6,127 for psychiatric facilities—the lowest costs of the five types of PPS-exempt facilities. Although costs per discharge were higher for long-term hospitals than for rehabilitation facilities, costs per day were about the same for the two groups. Costs per day in children's and cancer hospitals' were $1,366 and $1,000, respectively, in 1998. This was substantially higher than costs per day for the other PPS-exempt facilities; however, cancer and children's hospitals have shorter lengths of stay.

The classes of facilities also vary in size; cancer hospitals are the largest and rehabilitation facilities the smallest. With the exception of rehabilitation facilities, average facility size shrank during the 1990s. From 1990–1998, average bed size for cancer hospitals decreased from 233 to 218 beds per facility, children's hospitals from 139 to 115 beds, long-term hospitals from 121 to 75 beds, and psychiatric facilities from 71 to 45 beds. Bed size remained relatively constant for rehabilitation facilities, at about 32 beds per facility. During this same period, occupancy rates declined for long-term, psychiatric, and rehabilitation facilities, but increased for cancer and children's hospitals.

In addition, PPS-exempt providers differ in terms of their Medicare share of discharges. From 1990–1998, Medicare penetration increased for all of the PPS-exempt providers except children's hospitals. During this period, Medicare discharges increased from about 60 percent to 68 percent of the total for rehabilitation facilities and from 40 percent to 67 percent for long-term hospitals. Medicare's share of patients at psychiatric facilities grew from 24 percent in 1990 to 39 percent in 1998, with the most pronounced growth in psychiatric units of acute care hospitals. Medicare's share of patients in the 10 PPS-exempt cancer hospitals increased from 20 percent in 1990 to 31 percent in 1998. Children's hospitals' share of Medicare discharges has never been greater than 1 percent. ■

Overview of the payment system and policy changes

From Medicare's inception until 1983, all hospitals that treated Medicare patients were reimbursed for their Medicare-allowable costs on a retrospective basis. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) modified retrospective reimbursement by setting limits on payment per discharge and providing penalties or rewards depending on whether cost per discharge was above or below, respectively, the facility's limit or target. Congress initially intended for TEFRA payment policy to remain in effect for three years. However, the Social Security Amendments of 1983 modified and extended TEFRA while creating a PPS for acute inpatient care. During the phase-in of the PPS, the hospitals covered by it received a blend of prospective payment and modified TEFRA rates. Certain classes of facilities were excluded from the PPS, however, because the types of cases they treated did not allow for accurate prediction of resource costs. These PPS-exempt facilities continued to be reimbursed according to the modified TEFRA rates.

Original payment system

Medicare provides payments for both operating and capital costs. Until HCFA implemented the BBA, PPS-exempt facilities received a base operating payment for each discharge, equal to the lesser of current operating costs or

TABLE 6-1 **Criteria for exemption from the acute-care prospective payment system, by facility type**

Facility	Criteria
Psychiatric hospitals and units	• Patients have psychiatric principal diagnoses and require treatment that can be provided only in an inpatient setting. • The facility is under the supervision of a board-certified or board-eligible psychiatrist and has a director of psychiatric nursing services. • The facility provides psychological, social, and therapeutic services commensurate with patient needs. • Procedures exist for ongoing patient assessment and treatment plan evaluation.
Rehabilitation hospitals and units	• At least 75 percent of the inpatient population requires intensive rehabilitation for 1 or more of 10 specified classes of neurological conditions, muskuloskeletal conditions, or burn injuries. • Multidisciplinary staff are on site. • Procedures exist for preadmission screening and ongoing patient evaluations.
Long-term hospitals	• The average length of stay is longer than 25 days.
Children's hospitals	• The majority of inpatients are younger than 18.
Cancer hospitals	• The facility was recognized by the National Cancer Institute as a comprehensive cancer center or clinical cancer research center as of April 20, 1983. • The facility was recognized by HCFA as a cancer hospital on or before December 31, 1990. • The facility is organized primarily for cancer research or treatment, and at least 50 percent of total discharges have a principal diagnosis of neoplastic disease.

Note: HCFA (Health Care Financing Administration).

Source: MedPAC review of HCFA Provider Reimbursement Manual, Part I.

historical operating costs trended forward by an inflation factor. Each facility's historical operating cost amount—its target—is established during that facility's base year. A hospital's base year is designated as its second full cost-reporting period as an exempt facility, while the base year of a distinct-part unit (for example, a psychiatric unit of an acute-care hospital) is its first cost-reporting period. Target amounts are updated annually. In addition to base payments per discharge, PPS-exempt facilities receive bonus payments if their operating costs are less than their targets and relief payments if their operating costs are more than 110 percent of their targets. Capital payments have not been subject to limits.

Changes resulting from recent legislation

The BBA and BBRA made major changes in the way Medicare pays facilities exempt from prospective payment. These changes include linking updates to financial performance for all PPS-exempt facilities, capping target amounts, and mandating conversion to prospective payment for rehabilitation, psychiatric, and long-term facilities.

The BBA legislation set the FY 1998 update for all PPS-exempt facilities at zero, and linked payment to financial performance for FY 1999–2002 by specifying a formula to update the PPS-exempt target amounts. The primary intent of this linking was to address payment inequities between older and newer facilities. The formula provides a smaller update for facilities with costs less than their targets, and a larger update to facilities with costs greater than their targets. If a facility's costs are less than 66 percent of its limit, it will receive an update of zero. If its costs are between 66 percent and 100 percent of its ceiling, the facility will receive an update equal to the market basket minus 2.5 percentage points. Given the current market basket forecast of 3.1 percent for PPS-exempt providers in FY 2001, a facility in this category would receive an update of 0.6 percent. The update for a facility with costs exceeding its target by less than 10 percent will be the market basket minus 0.25 percent for each percentage point that costs are less than 10 percent above the limit. If a facility's costs exceed its ceiling by 10 percent or more, it will receive an increase equal to the market basket (Figure 6-1).

The BBA introduced several other significant changes to the TEFRA system. First, it established caps for target amounts for psychiatric, rehabilitation, and long-term facilities. Payments to these facilities are now based on the least of a facility's actual costs, target amount, or cap. National caps were set at the 75th percentile target amount for each class of provider for FY 1996, inflated to the current year. Children's and cancer hospitals were excluded from the caps; they continue to be paid the lesser of their current costs or historical costs trended forward by an inflation factor. Second, limits for facilities receiving their first Medicare payment on or after October 1, 1997, for each of their first two cost-reporting periods, were set at 110 percent of the 50th percentile payments for established facilities in each provider class in FY 1996, adjusted each year for inflation. Third, the BBA required HCFA

TABLE 6-2

Selected characteristics of facilities exempt from the acute-care prospective payment system, fiscal year 1998

Type of facility	Number of facilities	Average bed size	Medicare share of discharge	Medicare length of stay (days)	Medicare costs per discharge	Medicare costs per day
Psychiatric	2,119	45	39%	12.5	$6,127	$490
Rehabilitation	1,097	32	68	15.3	9,358	612
Long-term	207	75	67	27.9	16,957	607
Children's	71	115	0*	7.2	9,852	1,366
Cancer	10	218	31	7.3	7,255	1,000

Note: 1998 cost report data are about 50 percent complete. Data presented here are in aggregate form (weighted by facility revenue). In prior years, MedPAC reported mean values (each hospital weighted equally).
* Children's hospitals' share of Medicare discharges is less than 0.5 percent.

Source: Number of facilities is based on December 1998 HCFA survey and certification data. All other figures are based on MedPAC analysis of Medicare Cost Report data from HCFA.

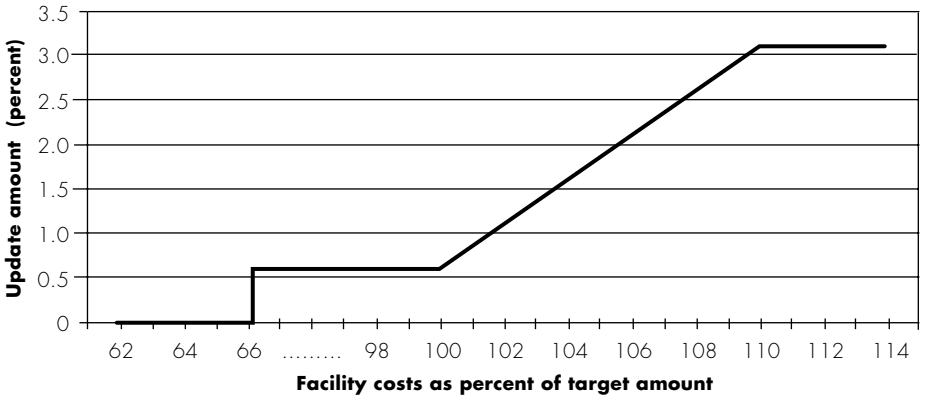
to implement a PPS for rehabilitation facilities by October 1, 2000, and to develop a proposal for a PPS for long-term hospitals.[1] In addition, capital payments to rehabilitation, psychiatric, and long-term hospitals and psychiatric and rehabilitation units were cut by 15 percent.

The BBA also changed the bonus system to include two possible payments to facilities for which costs are less than targets. The first is equal to 15 percent of the amount by which a facility's target exceeds its costs, up to a maximum of 2 percent of its limit. The second, called the continuous improvement payment, rewards improved productivity. It is equal to the lesser of 1 percent of the target amount or one-half the amount by which a facility's current costs are less than its prior year costs, after adjustment for inflation. The continuous improvement payment cannot exceed 1 percent of the facility's limit.

Legislative provisions of the BBRA mitigated some of the effects of the BBA. For example, the BBRA increased the maximum amount of the continuous bonus payments to long-term and psychiatric facilities to 1.5 percent of a facility's limit in FY 2000 and 2 percent in FY 2001. Two additional provisions reflect Commission recommendations from March 1999. First, the BBRA requires an adjustment to the labor-related portion of the 75 percent national cap on payments to TEFRA facilities. This adjustment reflects differences between the wage-related costs in the hospital's area and the national average of such costs within the same class of hospitals for cost-reporting periods beginning on or after October 1, 1999. Second, the BBRA requires the Secretary to report on a per-diem based PPS for psychiatric facilities and, by October 1, 2002, to implement this system. The BBRA also requires a discharge-based PPS for long-term hospitals by October 1, 2002, although HCFA predicts that prospective payment for psychiatric and long-term facilities will not be implemented before 2004.

FIGURE 6-1

Target amount update formula, fiscal years 1999–2002



Note: Beginning in FY 2001, rehabilitation facilities will be paid a blend of the PPS and PPS-exempt rates.

Source: MedPAC analysis of update formula in the Balanced Budget Act of 1997, assuming a market basket of 3.1 percent.

1 The Commission's recommendation for updating target amounts will only affect rehabilitation facilities during the two-year phase-in of a new case-mix adjusted PPS, beginning October 1, 2000. During the phase-in, facilities will be paid a blend of PPS and PPS-exempt rates.

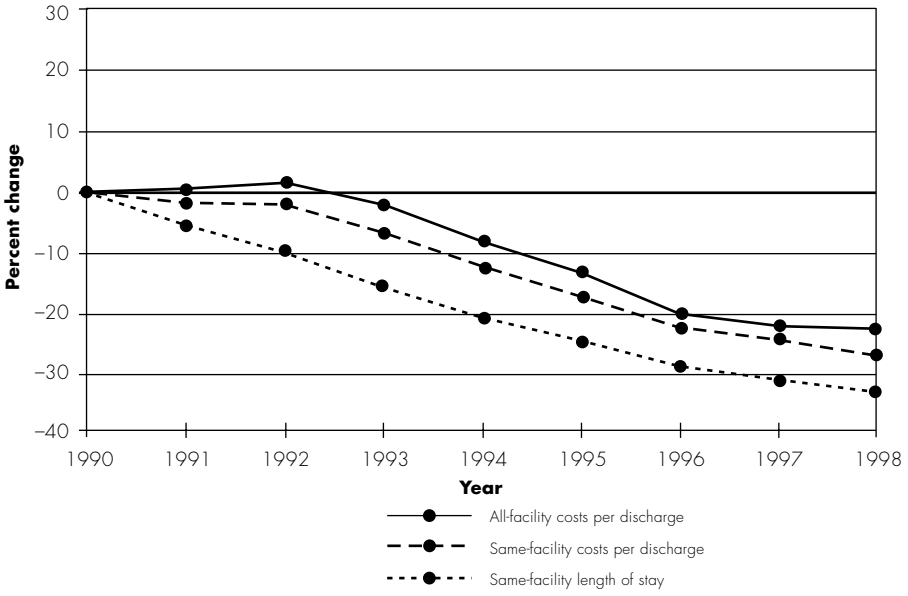
Financial performance under Medicare

Performance information provides context for the Commission's update decision. Two important indicators of financial performance—costs per discharge and Medicare margins—reveal that the BBA and BBRA changes in Medicare payment policy had greater effects on rehabilitation, psychiatric, and long-term facilities, compared with cancer and children's hospitals. This differential effect is reflected in the operating margins of these three classes of facilities, which declined precipitously in 1998. Before 1998, operating margins increased substantially due to declining lengths of stay and the entry of new facilities, which the TEFRA payment system treated more favorably than it did older facilities.

Given that most of Medicare's payments to PPS-exempt facilities are to rehabilitation, psychiatric, and long-term facilities, the Commission's discussion of financial performance for PPS-exempt facilities focuses on these groups. Additional trend and distribution data (10^{th}, 25^{th}, 50^{th}, 75^{th}, and 90^{th} percentiles) for all five classes of PPS-exempt facilities are included in Appendix C.

FIGURE 6-2

Cumulative change from 1990 in Medicare length of stay and real costs per discharge, rehabilitation hospitals and units, fiscal years 1990–1998



Note: 1998 cost report data are about 50 percent complete. Same-facility analysis (same facilities compared for 1990 and 1991, 1991 and 1992, and so forth) eliminates the effect of the entry of new facilities on the measured annual changes in length of stay and cost per discharge. Analysis of all facilities, in contrast, accounts for the cost-increasing effect of the entry of new facilities each year. Medicare costs per discharge are adjusted for inflation using the GDP implicit price deflator.

Source: MedPAC analysis of Medicare Cost Report data from HCFA.

Costs per discharge

Real costs per discharge over a series of two-year periods—for example, 1990–1991, 1991–1992, and so on—declined markedly from 1990–1998.[2] A key determinant of this trend was declining lengths of stay. Furthermore, when analysis was not limited to two-year cohorts, thereby accounting for the entry of new facilities each year, real costs were higher. We developed an analysis to highlight the effects of these two factors separately (Figures 6-2, 6-3, and 6-4).

Same-facility analyses, based on a series of two-year periods, suggest that the decline in real costs per discharge for psychiatric, rehabilitation, and long-term facilities that occurred during the 1990s has been driven primarily by large declines in length of stay. Although the decline in length of stay was slightly greater for psychiatric than rehabilitation facilities, real costs per discharge decreased more for rehabilitation providers. Psychiatric facilities' lengths of stay plummeted by 33 percent and costs per case fell by 20 percent during 1990–1997, while length of stay and costs per discharge declined by 31 percent and 24 percent, respectively, for rehabilitation facilities. Real costs per discharge and length of stay both declined less for long-term facilities, compared with the other two groups. One possible explanation for this is that a long-term hospital loses its designation if its average length of stay falls below 25 days. Lengths of stay declined by 27 percent and costs per discharge fell by 11 percent for these providers.

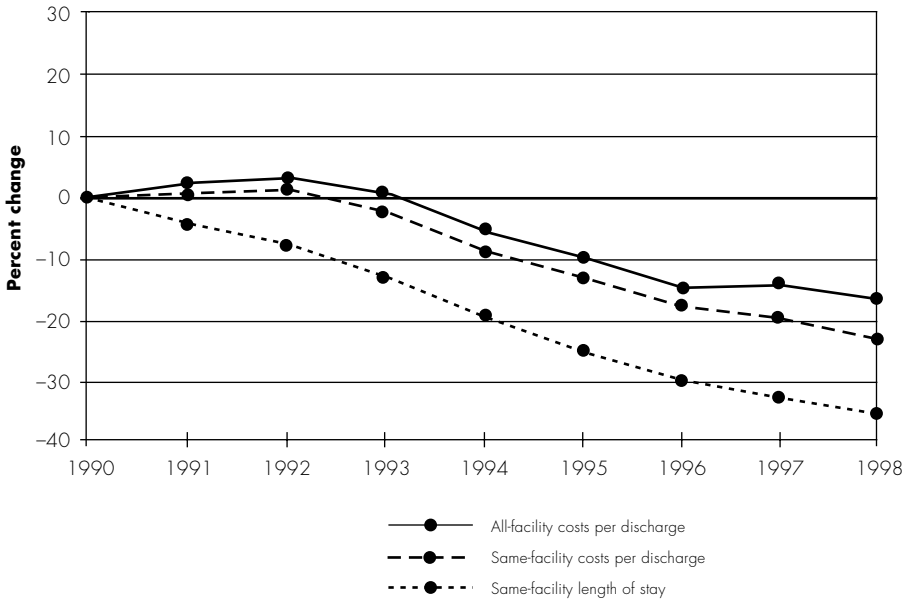
During 1998, the first post-BBA year, real costs per discharge continued the trend, declining between 2 and 3 percent for the three major PPS-exempt providers. Although lengths of stay declined at about the same rate as costs per discharge for both psychiatric and rehabilitation facilities from 1997–1998, lengths of stay remained constant for long-term facilities.

The entrance of new facilities raised cost growth from 1990–1998 beyond what it would otherwise have been, because a new facility establishes high costs during its base year. Comparing the rate of growth in real costs per case on a same-facility basis with the rate for all facilities

2 Costs per discharge were adjusted for inflation using the gross domestic product (GDP) implicit price deflator.

FIGURE 6-3

Cumulative change from 1990 in Medicare length of stay and real costs per discharge, psychiatric hospitals and units, fiscal years 1990–1998



Note: 1998 cost report data are about 50 percent complete. Same-facility analysis (same facilities compared for 1990 and 1991, 1991 and 1992, and so forth) eliminates the effect of the entry of new facilities on the measured annual changes in length of stay and costs per discharge. Analysis of all facilities, in contrast, accounts for the cost-increasing effect of new entry of the facilities each year. Medicare costs per discharge are adjusted for inflation using the GDP implicit price deflator.

Source: MedPAC analysis of Medicare Cost Report data from HCFA.

isolates the cost-increasing effect of facilities in the first year of operation. By 1998, the additional cost growth attributed to first-year facilities was 5 percent for rehabilitation facilities, 7 percent for psychiatric facilities, and 20 percent for long-term hospitals.

Medicare inpatient margin

Margins—payments minus costs, divided by payments—for the three major PPS-exempt providers increased substantially before the BBA, from large losses in 1990 to moderate gains in 1997 (Figure 6-5). The margin also increased dramatically for children's hospitals, but not cancer hospitals. However, children's hospitals' margins were negative from 1990 to 1997, and were extremely low from 1990 to 1993, ranging from -16.8 to -24.4 percent. Cancer hospitals' margins increased less than did those of any other PPS-exempt group and were negative from 1990 to 1997 except for 1996, when the margin was 0.1 percent (Figure 6-6).

The BBA reversed the trend in rising Medicare operating margins of rehabilitation, psychiatric, and long-term facilities that had occurred from 1990 to 1997. Cancer and children's hospitals' margins do not seem to have been affected by the BBA to the same extent as the other three classes of facilities.

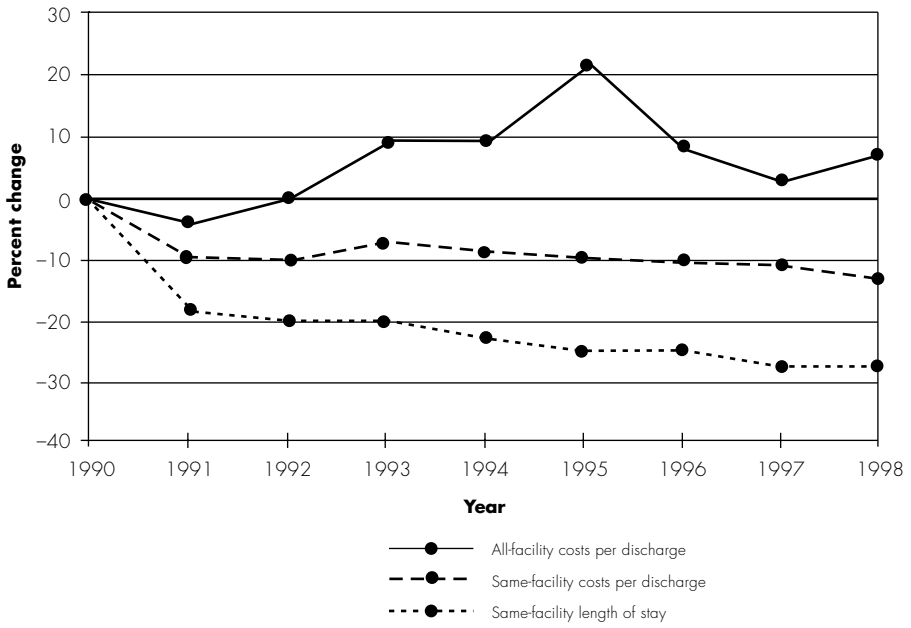
There are at least two reasons why margins increased so rapidly from 1990 to 1997 for PPS-exempt providers. First, differences in margin growth between older and newer facilities may have contributed to differences in overall margin growth. Newer facilities received more generous payments than older facilities because of inequities created by TEFRA. BBA provisions designed to address these inequities were implemented in FY 1998. Before HCFA implemented the BBA, newer facilities had an incentive to accrue higher baseline-year costs and therefore receive higher base payments. Furthermore, because they start from a higher base rate, newer facilities generally have been able to hold their cost-per-discharge increases below those of older facilities. This reduces the probability that newer facilities will exceed their facility-specific targets, thereby further increasing their margins over time.

Second, the rapid declines in lengths of stay in rehabilitation, psychiatric, and long-term facilities lead to low growth in costs per case; if payments per case continue to increase at a higher rate, margins will rise. In the cost-based TEFRA payment system, lower growth in costs resulting from drops in lengths of stay produces correspondingly lower payments. However, annual increases in payment limits were greater than the growth in costs per case, suggesting that the effects of declining lengths of stay were not being taken into account in updates to the limits. Therefore, fewer facilities were affected by the limits and more facilities were receiving bonus payments from 1990 to 1997.

The trend of declining lengths of stay would not be problematic for the Medicare program if it were due to changes in the mix of patients treated or to treatment innovations that allowed patients to reach the same level of functioning earlier in an episode of care. However, if decreased lengths of stay were due to site-of-care substitution, facilities would be shifting costs to other settings. Although the declines in lengths of stay for PPS-exempt facilities were about the same as those for PPS facilities, the rise in margins was less for PPS-exempt facilities because of the cost-based

FIGURE 6-4

Cumulative change from 1990 in Medicare length of stay and real costs per discharge, long-term hospitals, fiscal years 1990–1998



Note: 1998 cost report data are about 50 percent complete. Same-facility analysis (same facilities compared for 1990 and 1991, 1991 and 1992, and so forth) eliminates the effect of the entry of new facilities on the measured annual changes in length of stay and costs per discharge. Analysis of all facilities, in contrast, accounts for the cost-increasing effect of the entry of new facilities each year. Medicare costs per discharge are adjusted for inflation using the GDP implicit price deflator.

Source: MedPAC analysis of Medicare Cost Report data from HCFA

system. In the PPS-exempt payment system, the cost savings resulting from a decline in lengths of stay produce a corresponding drop in payments, except for the partial offset of bonus payments. In contrast, facilities paid prospectively realize the full savings resulting from shorter stays.

Medicare margins declined substantially for rehabilitation, psychiatric, and long-term facilities during FY 1998, the first post-BBA year (Figure 6-5). From 1997 to 1998, the aggregate margin decreased from 6.3 percent to 1.8 percent for rehabilitation facilities, from 2.6 percent to -2.3 percent for psychiatric facilities, and from 4.9 percent to -1.8 percent for long-term hospitals. In contrast, cancer hospitals' Medicare margin was relatively constant from 1997 to 1998, and the margin increased for children's hospitals from -2.7 percent to -0.8 percent (Figure 6-6). These two classes of facilities were exempt from the BBA-mandated payment caps.

The BBA provisions were also successful in narrowing the margin gap between older and newer facilities for the three major PPS-exempt providers and children's hospitals (Table 6-3). The difference in margins between older and newer rehabilitation facilities was small in both 1997 and 1998. For psychiatric facilities, the difference narrowed from 2.5 percent in 1997 to 1.9 percent in 1998. The difference for long-term hospitals established before and after 1990 dropped from 3.1 percent in 1997 to 1.3 percent in 1998. For children's hospitals, the gap declined from 6.2 percent in 1997 to 3.2 percent in 1998. Nine of the 10 cancer hospitals were exempt before 1990, so the margin gap is less relevant for this class of providers.

Updates to target amounts

The Commission's update framework for PPS-exempt facilities includes three components. Market basket forecast accounts for annual changes in the prices of goods and services used by PPS-exempt providers. Forecast error corrects for prior inaccuracies in the market basket projection. The Commission also considers the effect of the industry's adoption of treatment advances on the cost of providing care.

RECOMMENDATION 6A

The Secretary should increase the target amount update formula for fiscal year 2001 by up to 0.3 percentage points above the market basket amount.

The components of the Commission's update framework for PPS-exempt facilities are similar to those used in the PPS update, with two major exceptions. First, the framework does not include a productivity adjustment because PPS-exempt facilities are paid on a cost basis. In contrast to prospectively paid facilities, if PPS-exempt facilities reduce costs by improving productivity, payments usually also decrease. Prospectively paid hospitals receive the full benefit of productivity gains, while the benefit for PPS-exempt facilities is limited to the possibility of receiving a bonus payment.

Second, the update for PPS-exempt facilities does not take into account changes in case mix. Originally, difficulty with predicting resource costs according to a patient classification system caused the so-called "TEFRA facilities" to be excluded from the PPS system. However,

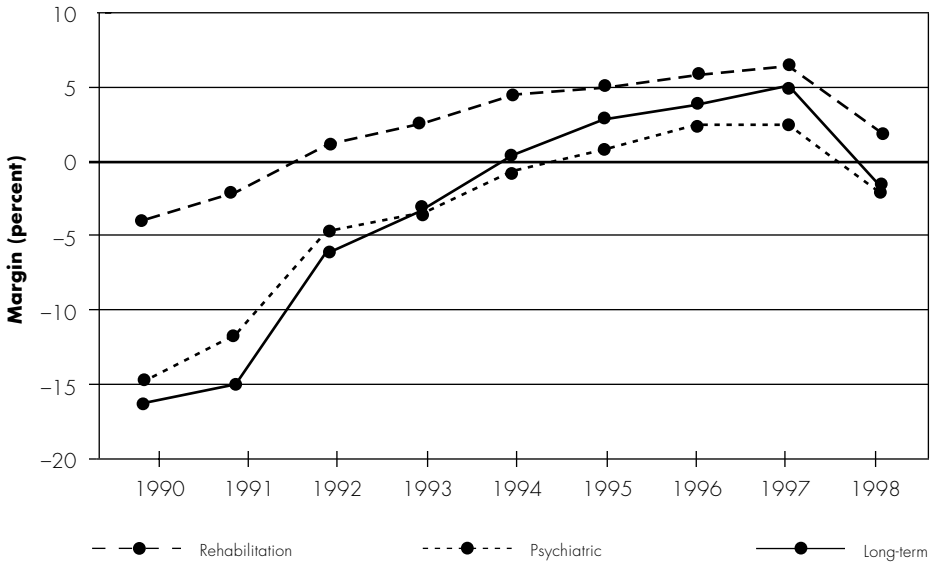
changes in case mix will be accounted for when the three major PPS-exempt providers move to prospective payment.

Literature review provided no evidence of major new scientific and technological advances put into widespread use at PPS-exempt facilities during the past year. However, the Commission proposes a 0–0.3 percent adjustment range to account for unmeasured advances that undoubtedly have had some effects on delivery of care at PPS-exempt facilities: for example, new drugs to treat bacterial infections, depression, clotting problems, and Parkinson's disease. This range is lower than that proposed for PPS facilities because treatment at PPS-exempt facilities tends to be less technology intensive.

The FY 2001 market basket forecast for exempt facilities is 3.1 percent, with no correction for FY 1999 forecast error. Including an adjustment for scientific and technological advances, the sum of the components for the update framework for facility target amounts to PPS-exempt facilities would be equal to the market basket increase plus 0–0.3 percent (Table 6-4). ■

FIGURE 6-5

Medicare operating margins for long-term hospitals and rehabilitation and psychiatric hospitals and units, fiscal years 1990–1998

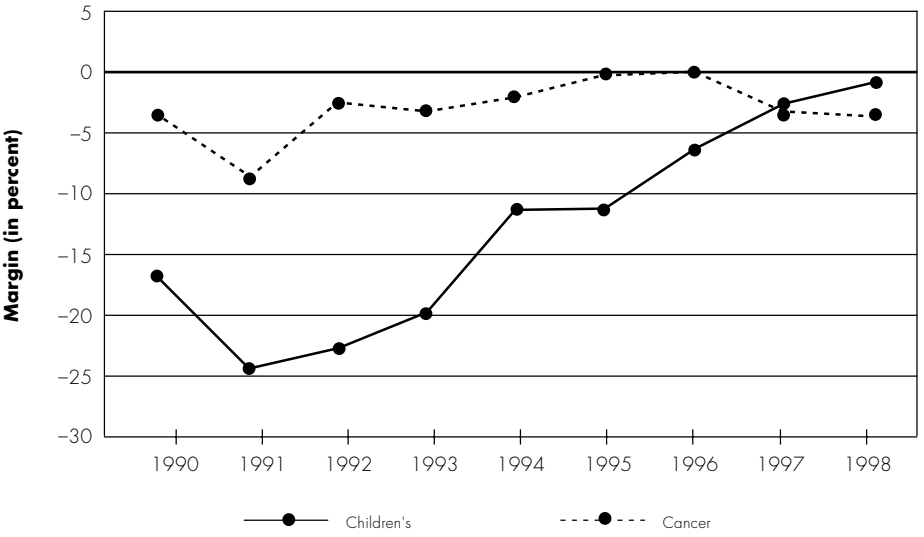


Note: 1998 cost report data are about 50 percent complete. Margin is a facility's payments minus costs, divided by payments.

Source: MedPAC analysis of Medicare Cost Report data from HCFA.

FIGURE 6-6

Medicare operating margins for children's and cancer hospitals, fiscal years 1990–1998



Note: 1998 cost report data are approximately 50 percent complete. Margin is a facility's payments minus costs, divided by payments.

Source: MedPAC analysis of Medicare Cost Report data from HCFA.

TABLE 6-3

Medicare operating margins, by year first subject to exemption from prospective payment, fiscal years 1997 and 1998

	1997 margins		1998 margins	
Facility type	**Exempt 1990 or earlier**	**Exempt after 1990**	**Exempt 1990 or earlier**	**Exempt after 1990**
Rehabilitation facilities	6.3%	6.0%	1.8%	1.9%
Psychiatric facilities	1.8	4.3	−1.7	−3.6
Long-term hospitals	2.9	6.0	−2.7	−1.4
Children's hospitals	−3.3	2.9	−1.1	2.1
Cancer hospitals	−3.1	N/A	−3.5	N/A

Note: N/A (not applicable). Cost report data for 1998 are about 50 percent complete. Nine of the 10 PPS-exempt cancer hospitals were exempt before 1990.

Source: MedPAC analysis of Medicare Cost Report data from HCFA.

TABLE 6-4

Update framework for facility target amounts, fiscal year 2001

Component	**Percent**
FY 2001 market basket forecast	3.1%
Correction for FY 1999 forecast error	0.0
Allowance for scientific and technological advances	0.0 to 0.3
Sum of components	MB+0.0 to MB+0.3
Basis of update formula in legislation	MB

Note: FY (fiscal year), MB (market basket). Market basket values and forecasts supplied by HCFA as of April 2000.

Source: HCFA Office of the Actuary and MedPAC analysis.