DRAFT

MEDICAID SAVINGS PROPOSALS

The President's Medicaid proposal would reform Medicaid rather than repeal it, guaranteeing health and long-term care coverage for all Medicaid recipients. It will save an estimated $59 billion over seven years in a responsible way by limiting spending growth per beneficiary (a "per capita cap") and reducing and retargeting Medicaid Disproportionate Share Hospital (DSH) payments to hospitals that serve large numbers of Medicaid and uninsured patients. The plan also offers states considerably more flexibility to design the payment and delivery systems.

- **Per Capita Cap ($29 billion):** A per capita cap maintains the current matching structure but limits the growth in Medicaid spending on a per person basis. The limit would be calculated based on 1995 spending per beneficiary by group (aged, disabled, adults and children). The spending per beneficiary in the base year would be multiplied by an "index", to update the base-year spending for inflation. This index averages 5.3 percent between 1996 and 1997. Beginning in 1997, the number of full-year beneficiaries in each state would be multiplied by the limit on the spending per beneficiary to determine the maximum amount of spending that the Federal government will match. Medicare spending, DSH Payments, and certain administrative expenditures (e.g., fraud and abuse control) would be excluded from the limits.

- **Disproportionate Share Hospital Payments Changes ($29 billion):** DSH payments would be reduced and retargeted. The current (1995) Federal payments to states would be phased out, with a 25 percent reduction in 1997, 50 percent reduction in 1998, and 75 percent reduction in 1999. Three new programs would be created to better target the funding.

    - **Targeted DSH Program:** A program similar to the current DSH program would be established to better target this funding. Payments from this pool would begin with 25 percent funding in 1997, 50 percent in 1998 and 75 percent in 1999. Its Federal funding cap is $5 billion in 2000, $4.5 billion in 2001, and $4 billion in 2002. Funding from the fixed Federal pool would be allotted to states on the basis of their share of low-income days. This is defined as the state's percent of the nation's inpatient days and outpatient visits for uninsured and Medicaid patients. States would still contribute to the program through matching payments (using the current matching rates).

    - **Undocumented Persons Pool:** A $3.5 billion pool to help states with large numbers of undocumented persons would be created. This 100 percent Federal pool would be in effect between 1997 and 2001, and would be allocated to states in proportion to their number of undocumented persons. It is intended to be used for emergency care for undocumented persons.

    - **Federally Qualified Health Centers and Rural Health Centers Pool:** As part of the proposed changes to promote state flexibility, the mandate for states to pay Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) on a cost basis would be repealed. To ease the change in funding for these facilities, a program would be created with $500 million in funding for each year between 1997 and 2002.

    In addition, $3.5 billion in Federal funds would be available in 1997 and 1998 to smooth cross-state equity issues.

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Medicaid Savings (fiscal years; dollars in billions)

	1995	1996	1997	1998	1999	2000	2001	2002	1996-2002
Baseline	89.1	97.2	107.2	118.1	129.7	142.5	156.8	172.6	**924.1**
Savings		0.0	-1.4	-2.1	-3.3	-4.5	-7.3	-10.5	**-29.2**
Index Value:		6.5%	6.5%	6.0%	5.5%	5.0%	4.5%	4.5%	**5.3%**
Nominal GDP Plus:		2.7%	2.4%	1.7%	1.4%	1.0%	0.6%	0.5%	
DSH									
Gross Savings		0.0	-1.9	-4.0	-6.0	-8.0	-9.2	-10.3	**-39.4**
Pools: FQHC Pool			0.500	0.500	0.500	0.500	0.500	0.500	**3.0**
Undocumented Pool			0.627	0.673	0.702	0.733	0.764		**3.5**
Transition Pool			1.5	1.5	0.5				**3.5**
Total									
Savings		0.0	-0.7	-3.4	-7.6	-11.3	-15.3	-20.3	**-58.5**
Growth		9.1%	9.6%	7.7%	6.5%	7.4%	7.9%	7.6%	**8.0%**
Per capita growth		5.5%	5.5%	4.4%	3.6%	4.6%	5.1%	4.9%	**4.8%**

Assumptions:

- Estimated by group
- Offset of 33%
- Administrative costs included; Medicare cost sharing excluded.
- CBO December baseline; does not include any adjustment for state-specific growth rates.
- New DSH Pool: $5 billion in 2000; $4.5 billion in 2001; $4.0 billion in 2002.

Daschle Medicare Proposal -- Summary

PART A

Revising PPS Hospital Payments

o Reduce Hospital Prospective Payment System Update

Currently, the fiscal year 1997 payment update for hospitals is set at the hospital market basket rate of increase (MB) minus 0.5 percentage points and at MB thereafter. The proposal would set the update at MB-1.0 percentage points for each year from FY 1997 through 2000, and MB- 1.5 percentage points for FYs 2001 and 2002.

o Extend Prospective Payment System Capital Reduction from OBRA-90

The Omnibus Budget Reconciliation Act of 1990 (OBRA-90) required that aggregate capital payments under the capital prospective payment system equal 90% of what they would have been under a reasonable cost system. The proposal would permanently capture the savings from the OBRA-90 payment reduction by giving the full update to the rates in effect at the end of OBRA-90 provision (9/30/95). Effective 10/1/95.

o Reduce Medicare Disproportionate Share Hospital (DSH) Adjustment

The proposal would reduce the current Medicare disproportionate share adjustments for eligible PPS hospitals by 10 percent, effective FY 1999.

o Reduce the Indirect Medical Education (IME) Adjustment

Currently, the indirect medical education (IME) adjustment for hospital payments is 7.7 percent for every 10 percent increase in a hospital's resident-to-bed ratio. The proposal would reduce the IME adjustment from 7.7 percent to 7.2 percent for discharges between January and September 1996, 6.8 percent for discharges during FY 1997 through FY 1999, 6.3 percent for discharges during FY 2000 and 6.0 percent for discharges beginning with FY 2001.

o Reform Graduate Medical Education Payments

The proposal would reform Medicare graduate medical education (GME) policy in the following ways:

- Cap the total number of residency positions and the number of non-primary care residency positions that would be reimbursed under Medicare, at a hospital-specific level, effective 10/1/95 for direct (DGME) and indirect (IME) GME payments.

- Currently, hospitals cannot include residents in non-hospital settings for purposes of their IME adjustment. The proposal would allow them to count residents in non-hospital settings as long as their resident-to-bed ratio does not increase, effective 7/1/96.

- Currently, only hospitals are eligible to receive GME payments. The proposal would allow DGME payments to certain non-hospital settings when the non-hospital is paying for the resident's salary in that setting, effective 7/1/96.

o Establish National Commission on Medical Education and Workforce Priorities

The proposal would establish the National Commission on Medical Education and Workforce Priorities within the Department of Health and Human Services. The Commission shall develop and recommend to the Secretary specific policies to address the preservation of the research and educational capacity of the nation's academic health centers, and the supply, composition and support of the future of the health care workforce. The Commission should determine and recommend the most effective way to allocate training funds in furthering the goals of a rational workforce policy to ensure that the numbers and competencies of health care professionals are responsive to the nation's needs.

o Eliminate Add-Ons For Outliers

The proposal would change the way that indirect medical education (IME) and disproportionate share hospital (DSH) payments are calculated for cost outlier cases, effective with discharges beginning in FY 1996. The DSH and IME adjustments would no longer be made to the outlier portion of a hospital payment.

o Redefine the Meaning of a Discharge

The proposal would define a discharge, for PPS payment purposes, as being a discharge of a patient from a PPS hospital to home, including discharges with subsequent home health care. Consequently, discharges to non-PPS facilities (such as long-term care hospitals, rehabilitation hospitals/units, and psychiatric hospitals/units) and skilled nursing facilities would be considered "transfers" for payment purposes, effective 10/1/95.

o Remove IME/GME/DSH from Medicare Risk-Contractor Reimbursement Formula

Medicare now pays risk-contracting HMOs at a level equal to 95 percent of the estimated per capita cost to Medicare for beneficiaries served by fee-for-service providers, called the adjusted average per capita cost (AAPCC). Payments for indirect medical education (IME), direct graduate medical education (DGME), and disproportionate share hospitals (DSH) are included in the AAPCC formula. The proposal would remove these payments from the AAPCC formula beginning with CY 1998. Payments from the savings would be made to HMOs, teaching hospitals, and DSH hospitals, subject to a cap equal to 100

percent of net savings.

PPS-Exempt Hospitals

o Long-Term Care Hospital Moratorium

Prohibit additional long-term care hospitals from being excluded from PPS, effective upon enactment.

o Reduce PPS-Exempt Update

The proposal sets the update for the target amounts of PPS-exempt hospitals and units at MB-1.0 for FYs 1996 through 2000 and MB-1.5 for FYs 2001 and 2002. Starting in FY 1996, target amounts for these facilities would be rebased using an average of two recent years of cost data, target amounts would be limited to 150 percent of the national average, bonus payments would be eliminated and shared-risk payments would be reduced..

o Reduce PPS-Exempt Capital Payments

Capital payments for PPS-exempt facilities are currently reimbursed on a reasonable cost basis. The proposal would reduce these payments to 85 percent of reasonable costs PPS-exempt facilities for FYs 1996 through 2002.

Rural Hospitals

o Sole Community Hospitals

Sole Community Hospitals (SCHs) are currently paid based on the highest of three base years: a 1982 hospital-specific rate, a1987 hospital-specific rate, or the Federal Rate. This proposal adds a fourth option for a base year: the average of 1992 and 1993 hospital-specific costs. This would provide more updated payment rates for SCHs whose costs have significantly changed in recent years.

o Rural Primary Care Hospital (RPCH) Program

The proposal would expand the Rural Primary Care Hospital Program (RPCH) to all states. Currently, the RPCH program is limited by statute to seven states. The proposal would change the conditions of the program to: (1) expand the size limitation for RPCHs to allow up to 15 inpatient beds; (2) expand the length of stay limitation to 96 hours; (3) change the reimbursement methodology to reasonable cost, recalculated annually; (4) eliminate the deadline for a PPS system; (5) expand options for referral relationships and eliminate the Essential Access Community Hospital (EACH) designation (grandfather current EACHs); (6) delete the provision relating to compliance with hospital requirements when a facility is closed; (7) establish a minimum separation distance

between facilities; and (9) allow RPCHs to utilize all of their beds (up to the maximum 15) as swing beds if they have a swing-bed agreement.

The proposal would also grandfather all Montana Medical Assistance Facilities as RPCHs as of the date of enactment.

o Rural Referral Centers

Many RRCs lost their status in FY95 when they failed to continue to meet the criteria for being an RRC. This proposal grandfathers all RRCs that were in existence as of September 30, 1991 so that all RRCs that lost their status in FY95 would be reinstated..

Currently, in order for an RRC to qualify for a higher wage index, the average wage in the RRC must be at least 108 percent of the average wage in the wage index area to which it is applying. This proposal phases in the criteria for reclassification, so that hospitals with wages between 100 and 108 percent of the average wage would qualify for some increase in their wage index, although not the full amount.

o Payments to Physician Assistants and Nurse Practitioners

Makes direct payment to PAs and NPs in outpatient or home settings at 85 percent of the physician fee schedule amount.

o Telemedicine

The proposal provides additional funding to PHS for telemedicine demonstration projects.

o Rural Health Outreach Grants

Establishes a grant program to study the effectiveness of outreach initiatives to rural populations that do not normally seek or do not have access to health or mental health services.

o Revise DSH Threshhold for Rural Hospitals

The proposal changes the criteria for DSH to make it easier for rural hospitals to qualify for DSH and to give them higher payments when they do qualify. Makes the requirements similar to requirements for urban hospitals.

o Centers of Excellence

The proposal would expand centers of excellence to all urban areas by contracting with individual centers using a flat payment rate for all services (Part A and Part B) associated with cataract or CABG surgery. The Secretary would be granted authority to designate other services that lend themselves to this approach. Beneficiaries would not be required

to receive services at these centers, but would be encouraged to do so with a rebate from Medicare to the beneficiary equal to 10 percent of the government's savings resulting from use of the center. Effective 10/1/96.

Nursing Home Facilities

o Extend Savings from OBRA 1993 Skilled Nursing Facility (SNF) Cost Limits

The Omnibus Budget Reconciliation Act of 1993 (OBRA-93) placed a two-year freeze on updates to skilled nursing facility costs. The proposal would permanently capture the savings from this freeze by adjusting the data upon which the limits are based so that they do not reflect increases in costs that occurred during the freeze.

o Skilled Nursing Facility Prospective Payment

Under current law, most skilled nursing facilities (SNFs) are paid on a retrospective, reasonable cost based payment system. The proposal would implement a prospective payment system for SNF services for cost reporting periods beginning on or after October 1, 1996.

Under the interim system, routine costs would be paid at a facility-specific prospective rate, subject to regional limits. Regional limits would be calculate for each of the nine Census Divisions and for urban/rural location. The cost limits would continue to be based on 112 percent of the mean of costs for free-standing facilities. Costs in a base year would be examined for each facility, and the lessor of the: facility's cost or regional limit will be trended forward to the first effective period of the interim PPS. Facility-specific rates and regional limits would be updated by the SNF market basket each year. Savings would be generated from establishing regional limits using data only from freestanding SNFs and eliminating new cost limit exceptions and new provider exemptions. Hospital-based SNFs and low volume facilities currently paid under a special PPS system would be granted hold-harmless protection for an interim period. The Secretary may allow exceptions to the payment rates in the interim PPS system for case mix change on a budget neutral basis, if the automated minimum data set becomes available nationally before the full PPS is implemented.

Capital would be paid under the interim system at reasonable cost, as in the current system. Ancillary services would be subject to limits based on amounts payable for similar services on a fee-for-service basis under Part B. New providers would be paid at the regional limits for routine costs.

Consolidated billing and coding provisions would be established. Consolidated billing would require claims for Part B services (except for physicians, physician assistants, nurse

practitioners, certified nurse midwives, qualified psychologists, and certified registered nurse anesthetists) furnished to SNF residents to be made by the SNF, rather than billed directly by the supplier, effective FY 1997. SNFs would also be required to include HCFA Common Procedure Codes on their Part B bills.

A full prospective payment system for all SNF services (routine, ancillary and capital) would be implemented beginning in FY 1998. Budget-neutral rates under the new system would be calculated after first reducing rates that exist on the last day of the interim system by seven percent.

o Therapy Guidelines

Currently, salary equivalency guidelines exist for physical therapy and respiratory therapy. The proposal would revise these guidelines according to an explicit statutory formula, effective 1/1/96. The proposal would also establish salary equivalency guidelines for Medicare payment of speech-language pathology and occupational therapy services.

Home Health

o Extend Savings from OBRA 1993 Freeze on Home Health Cost Limits

The Omnibus Budget Reconciliation Act of 1993 (OBRA-93) imposed a two-year freeze on updates to home health cost limits. This proposal would permanently capture the savings from this freeze by adjusting the data upon which the limits are based so that they do not reflect increases in costs that occurred during the freeze.

o Home Health Payment Reform

Under current law, home health agencies (HHAs) are paid retrospectively for costs per visit, subject to a statutory limit set 112 percent of the mean costs of all freestanding (not hospital-based) agencies. This two-part proposal would: (1) establish an additional set of cost limits and a savings sharing feature on an interim basis (for FY 1997 through FY 1999), and (2) introduce in FY 2000 a new payment system that pays prospective rates for case-mix adjusted episodes of home health care. (During the interim period, HCFA would be authorized to collect data from HHAs that would allow it to design a valid case mix adjustment system in anticipation of the FY 2000 prospective payment system.)

The interim payment system would be effective 10/1/96. Payments would be the lowest of: (1) actual costs (defined as Medicare allowable costs paid on a reasonable cost basis); (2) per visit cost limits set at 105 percent of the median cost for freestanding HHAs (as opposed to the current law limit of 112 percent of the mean costs); or (3) an agency-specific per beneficiary annual limit calculated from CY 1994 reasonable costs. The latter

two limits would be updated annually by the home health market basket index. Effective 1/1/97, or as soon as feasible, the Secretary would modify the agency specific per beneficiary annual limits to provide for regional or national variations in utilization.

A savings sharing feature would allow those HHAs whose cost experience is below 125 percent of the mean national or census region per beneficiary cost experience for the base year, and whose year-end reasonable costs are below the agency-specific per beneficiary limit, to share 50 percent of the savings (i.e., the difference between an agency's reasonable costs and its limit). The shared savings could not exceed five percent of an agency's aggregate Medicare reasonable cost in a year.

A prospective payment system that pays HHAs on a per episode basis would be implemented in FY 2000. Budget-neutral rates under the new system would be calculated after first reducing rates that exist on the last day of the interim system by 15 percent.

o Eliminate Home Health Periodic Interim Payments (PIP)

Under current law, some HHAs may receive periodic interim payments (based on estimates) in lieu of payments based on actual claims. (Mid-year corrections and end-of-year settlements adjust for over-and under-payments.) Under this proposal, PIP payments to HHAs would be eliminated with the introduction of a prospective payment system (FY 2000).

o Home Health Payment at Location of Service

Currently, payment for home health services is tied to the location where the service is billed, which is typically the urban location of the HHA's home office. This proposal would link payment for home health services to the zip code of the site where the service was furnished (the patient's home), beginning with FY 1997.

o Establish Post-Hospital Home Health Benefit in Part A and Transfer Other Home Health Costs to Part B

Effective 10/1/96, this proposal shifts about half of the financing for the Medicare home health benefit from Part A to Part B by redefining the benefit under Part A as a "post-hospital" home health benefit and establishing a new Part B home health benefit. Under the proposal, the first 100 home health visits provided to a beneficiary following discharge from a hospital would be paid under Part A if such services begin within 30 days of discharge and the hospital stay was at least 3 days. All subsequent visits would be paid under Part B. For beneficiaries who do not have a prior hospital stay, all home health visits would be paid under Part B. Beneficiaries using services under Part A or Part B would not be charged a copayment nor be responsible for paying a deductible. The shift in financing would not result in an increase to the Part B premium. The proposal also

codifies the definitions of "intermittent" and "part-time or intermittent" skilled nursing and home health aide services to conform to current practice.

Medicare Secondary Payor (MSP)

o Extend Expiring Medicare Secondary Payor (MSP) Provisions from OBRA 1993

The Omnibus Budget Reconciliation Act of 1993 (OBRA-93) extended three Medicare secondary payor provisions: the IRS/SSA/HCFA data match to identify situations where another insurance plan is primary to Medicare; Medicare as secondary payor for certain disabled beneficiaries covered by an employee's large group health plan; and the provision lengthening the MSP period for End Stage Renal Disease (ESRD) beneficiaries from 12 to 18 months. This proposal would permanently extend these three Medicare secondary payor provisions.

o Insurer Reporting and Court Case Settlement

The proposal would require all third party payers to gather information and report to the Secretary on Medicare Secondary Payor (MSP) situations, effective January 1, 1996.

Medicare MSP policy would be reformed and clarified by four proposals that improve the Secretary's ability to recover mistaken primary payments, and mitigate the impact of the decision of the Circuit Court, effective 1/1/96.

+ Clarify that Medicare may recover mistaken primary payments from a third party payer without regard to procedural contract limitations, such as claims filing limitations, imposed by the third party payer.

+ Clarify that entities from which Medicare may recover include insurers, third party administrators (TPAs) that make payments on behalf of insurance plans, and other plan fiduciaries. These entities may seek to recover the repayment to Medicare from the plan, employer or other party, as may be appropriate.

+ Specify that if a third party payer did not make a primary payment in full when required to do so, the third party payer or other entity from which Medicare may recover must repay Medicare the lesser of the amount Medicare paid or the third party payer's full primary payment obligation if the plan can prove that it did not know and could not have reasonably been expected to have known that it was the proper primary payer for services provided to the Medicare beneficiary.

  Require entities that receive duplicate Medicare and third party payer primary payments to repay to Medicare the full Medicare payment received, plus interest.

+ If an employer or other plan sponsor took into account the Medicare entitlement of the individual and did not provide coverage to the beneficiary, the employer or other plan sponsor must repay Medicare twice the amount that Medicare paid for all services provided to the Medicare beneficiary during the period that group health plan coverage was not afforded.

  Further, if an entity billed both Medicare and the third party payer, or knew that both had been billed, the entity would be required to repay double the amount that Medicare paid, plus applicable interest on this amount.

Additional Fraud and Abuse

The proposal broadens HHS authority to establish provider qualifications and penalties and provides new tools to ensure stringent enforcement. Provisions would: establish new conditions to exclude individuals and entities with a history of abuse from Medicare; establish criminal sanctions; provide resources for anti-fraud activities; authorize Medicare to require Social Security Numbers, tax identification numbers and employer identification numbers from entities wishing to bill Medicare; create a national data base of those with a history of health care fraud to facilitate coordination among various organizations at the State and National levels; extend current Civil Monetary Penalty authority; and, extend the Medicare/Medicaid Anti-kickback statute.

PART B

o Hospital Outpatient

On January 1, 1996, the formula-driven overpayment will be eliminated.

On January 1, 2002, OPD services would be paid according to a prospective payment system established by the Secretary. The PPS would be budget neutral relative to what Medicare payments would have been in 2002 and also budget neutral to what total beneficiary coinsurance would have been in 2002.

o Modify Physician Target/Update System

The proposal would revise the system that sets physician targets and incorporates performance relative to the target into future physician updates. Cumulative expenditure targets would be used, based on real gross domestic product per capita plus one percentage point (rather than historical physician volume and intensity). The behavioral offset for update changes would be eliminated from the target. The maximum reduction in updates due to performance would be increased from 5 to 7 percentage points and limits on annual bonuses would be set at 3 percentage points. These changes would be effective

for targets beginning with fiscal year 1996.

Effective January 1, 1996, the proposal would replace the three different factors currently in use to determine the level of payment under the physician fee schedule with a single physician conversion factor that would be set at $35.42 for 1996. There would be a two-year transition to the single conversion factor for surgical services: the 1996 conversion factor for surgical services would be $38.10. (Compared to 1995, there would be an increase in Medicare expenditures for physicians' services.)

The proposal clarifies that the update for anesthesia services will be the same as the update for surgical services in 1996 and 1997.

o Make Single Payment for Surgery

Under the proposal, Medicare would pay the same amount for a surgery regardless of whether or not the primary surgeon elects to use an assistant-at-surgery to whom Medicare now makes a separate payment. The Medicare payment for the primary surgeon would be reduced by the amount paid for any assistant-at-surgery used by the surgeon. The Secretary may specify exceptions by procedure or situation. Effective January 1, 1996.

o Further Reduce Physician Overhead Payments

The relative value paid for each physicians' service is based on three components: (1) a work component, (2) a practice expense component, and (3) a malpractice component. These three components are combined into a single relative value for the service. The work component is based on the relative resources of physician time and effort for a procedure, but the practice expense and malpractice relative value compoents are based on historical charges.

OBRA 93 reduced relative value units for practice expense by one-quarter of the difference between practice expense and work relative value units of certain procedures in each of 1994, 1995, and 1996. However, reductions in practice expense relative value unitswere limited so the resulting value did not fall below 128 percent of work relative value units. The proposal would reduce practice expense relative value units in 1997 in the same manner as they were reduced in 1994, 1995, and 1996 (by the OBRA 93 provision). In addition, the floor on reductions would be lowered from 128 percent of work relative value units to 115 percent. As in OBRA 93, services with no work component and services performed at least 75 percent of the time in the office would be exempted.

o Control the Volume of In-Hospital Physicians' Services

A system to control the high volume of in-hospital physician services would be implemented effective January 1, 1999.

o Competitive Bidding for Selected Part B Items and Services

Under the proposal, the Secretary to contract competitively by geographic area for certain Medicare Part B services and supplies. Contracts would be entered into with entities that meet quality standards and are able to furnish a sufficient amount of the item or service. The following would be the initial items for competitive procurement: enteral and parenteral nutrients, supplies and equipment and MRIs and CT scans. The Secretary may add other items as appropriate.

If the competition does not result in a reduction in the price of these services of at least 15 percent from the price levels that would otherwise have occurred in 1997, then the Secretary would reduce Medicare fees for these services by the amount needed to result in a 15 percent price discount from 1997 levels, effective January 1, 1997. Authorization to implement the competitive system would begin on enactment.

o Competitive Bidding for Laboratory Services

Under the proposal, the Secretary to contract competitively by geographic area for Medicare clinical diagnostic laboratory services. Contracts would be entered into with entities that meet quality standards and are able to furnish a sufficient amount of tests..

If the competition does not result in a reduction of at least 15 percent in the price of all laboratory service from the price levels that would have occurred in 1997, then the Secretary would reduce Medicare fees for these services by the amount needed to result in a 15 percent price discount from 1997 levels, effective January 1, 1997. Authorization to implement the competitive system would begin on enactment.

o Classify Additional Tests as Automated Tests

The proposal would add several chemistry tests to the existing list of tests that are classified and paid as automated tests, effective January 1, 1996. These tests are commonly performed as part of a profile of lab tests on automated equipment but are currently paid for separately at higher rates.

o Modifications to CLIA

The proposal would (1) remove the requirement of biennial laboratory inspections, allowing as-needed inspections based on criteria set by the Secretary; (2) mandate that all routine inspections be announced; and (3) reduce application requirements for CLIA certificates and remove biennial re-application requirements.

o Self-Referral Compensation

The proposal would: (1) add exceptions for shared facility services and for capitated payments (if designated health services are included), (2) entirely exclude intraocular lens, eyeglasses, and contact lenses from designated health services subject to prohibitions, (3) include DME and parenteral and enteral nutrients, equipment and supplies in the exception for in-office ancillary services, (4) delineate the requirements for permissible compensation arrangements, thus making the requirements uniform for all arrangements, (5) repeal the exception for physicians' services.

o Reduce Payments for Oxygen

The proposal would reduce payments for oxygen and oxygen equipment by 10 percent, effective January 1, 1996, and freeze updates for DME and O&P between 1996 and 2002.

o Reduce Updates for Ambulatory Surgery Centers (ASCs)

The proposal would reduce the consumer price index updates for ambulatory surgical services by 2 percentage points per year between 1996 and 2002.

o Part B Premium

The Part B premium would be set at 25 percent of program costs permanently beginning with CY 1999. (Under current law, the 25 percent rule applies for 1996, 1997 and 1998; for years after 1998, the premium would be updated by the Social Security cost of living adjustment).

New Benefits

o Preventive Benefits

The proposal includes coverage of new preventive benefits. The program would start six months after enactment and would run through 2001, at which time the Secretary would make a recommendation to Congress as to whether the benefits should be made a permanent part of the Medicare benefit package. The new preventive benefits include:

+ Expanded Coverage for Mammography Services

OBRA 90 mandated coverage of biannual screening mammography for Medicare beneficiaries over age 65, subject to a 20 percent copayment. The proposal would extend mammogram coverage to include annual screening mammograms for Medicare beneficiaries over age 49, without copayment or deductible

+ Provide Colorectal Screening

The proposal would cover annual screening for fecal-occult blood tests for Medicare beneficiaries over age 65 and less frequently for younger persons under a periodicity schedule determined by the Secretary. Medicare would also cover barium enemas, screening flexible sigmoidoscopies and screening colonoscopies on a periodicity schedule determined by the Secretary.

+ Preventive Injection Payment

The proposal would increase the payment for administration of certain preventive injections provided in physician offices from the current average of $4 to a uniform national payment of $9, and set payments for most entities paid on a reasonable cost basis equal to the allowance for physicians. Extra billing limits are established and the deductible and coinsurance for the hepatitis B vaccine is waived.

o Medicare Respite Benefits for Beneficiaries with Alzheimer's Disease

The proposal would introduce a Medicare respite benefit for beneficiaries with Alzheimer's disease or other irreversible dementia, effective for FYs 1996 through 2001. The benefit would cover up to 32 hours of care per beneficiary per year and would be administered through home health agencies or other entities, as determined by the Secretary. Services would be provided in the home or in a day care setting.

Managed Care

o Expanding Choice in Medicare

The Administration's approach to expanding and improving choice in Medicare involves three elements that are interrelated:

1. Expanding the managed care options available to Medicare beneficiaries and the types of organizations offering Medicare products. The bill would allow Preferred Provider Organizations and Provider Sponsored Organizations (PSOs) to contract with Medicare on a risk or a new partial risk basis (described below under Improved Payment Methodology).

2. Revising Medicare's health plan payment methodologies (risk and cost) and developing an alternative methodology. The bill would break the link between fee-for-service payments and Medicare's payments to private health plans. Plans would receive the greater of (1) a minimum payment rate ($310 in 1996, rising to $325 in 1997 and indexed thereafter), (2) a blended rate based on current local and

national experience, or (3) a minimum annual increase of 2%. Special payments to teaching and certain other hospitals that are included in current payment rates because of the link to fee-for-service payment would be removed. The adequacy of future year's rates would be assured by an index tied to the rate of growth in private health insurance costs adjusted for differences in the Medicare benefit package and Medicare utilization levels.

As a potential replacement for the revised payment methodology for risk plans, the bill provides authority for a demonstration of competitive pricing. During this demonstration, Medicare payments to plans would be based on a bidding process whereby competition among participating plans would determine payment levels (within certain limits). The demonstration would begin in 1997 and the Secretary of HHS would be required to make recommendation to Congress on the use of competitive pricing for plan payment by 2002.

As part of the bill, the current archaic cost contracting options would be replaced with a partial risk methodology. Under this approach, plans would be paid Medicare's fee-for-service amount, minus a withhold, for the provision of services to enrollees. Total payments at the end of the year would be compared with a target, initially set at 95 percent of the AAPCC. Plans would share on a 50/50 basis in savings below 95 percent and costs between 95 and 105 percent. Plans would be responsible for all costs above 105 percent.

3. Helping Medicare beneficiaries become more informed about their choices and leveling the playing field for Medicare managed care plans and Medicare supplemental coverage. HHS, through a third party, would develop standardized comparative materials for beneficiaries that would allow them to compare the benefits and costs of plans available in their geographic area. The third party would also be responsible for all enrollment and disenrollment activities. All managed care plans would be required to be open during a designated thirty day period.

HHS would work with the NAIC on two initiatives: (a) In order to facilitate the comparison of benefits offered by managed care plans to Medigap options, the additional benefits provided by managed care plans would be standardized. In addition, current Medigap standard packages would be reexamined and restructured in order to facilitate cross comparison. (b) All Medigap plans would be required to community rate their premiums, as risk plans currently do.

The current limited open enrollment requirement for Medigap plans would be expanded to the requirement that currently applies to risk and cost contractors. Medigap plans would have to be open to all Medicare beneficiaries during the thirty day open enrollment period designated for managed care plans.

The appeals process would be strengthened by reviewing the current timeliness standards and creating a process for expedited appeals.

HHS would be given authority to waive the 50/50 rule for plans in certain situation such as plans responding to state initiatives to enroll Medicaid beneficiaries or expanding into rural areas.

Other Provisions

o Inherent Reasonableness

The proposal would add clarifying language to the Social Security Act to give Medicare carriers authority to make determinations of inherent reasonableness.

→ $101.7 billion

Changes to Daschle Medicare Proposal

(1) Delete Preventive Benefits
(2) Delete Respite Benefit
(3) Add OPD Capital and Operating Expense Extenders
(4) Drop PPS Capital and Substitute Conference Agreement PPS Capital
(5) Physicians: Use Larger Limits on Reductions in Updates from Coalition Bill
(6) PPS Update: MB-1.5% FY 97-00
(7) PPS Exempt Update: MB-1.5% FY 97-00
(8) IME: Reduce to 7.0% in FY 96, 6.3% in FY 97 and 98, 5.8% in FY 99 and 5.5% in FY 00, 01 and 02

Also under consideration: Limit Medicare capitation payments to Medicare fee-for-service growth rate. Pricing needed without and with changes (1) to (8) above.

→ #129

1/16/96 DRAFT

Alternative Approach to Certification & Monitoring of Medicare Health Plans

This proposal provides that the States will have primary responsibility for the certification and monitoring of Medicare-contracting health plans. Until 1999, the certification and compliance standards will be Federal standards, administered by approved States or by the Secretary of HHS. Beginning in 1999, States can have more stringent standards if approved by the Secretary.

Development of Standards

The Federal standards for certification of health plans and for monitoring and enforcement will be developed in consultation with appropriate parties and are to be promulgated as interim final rules by June 30, 1996. There will be special solvency standards for PSNs.

"Deeming" of State Programs of Certification and Monitoring

- States will have primary responsibility for certification of health plans seeking a Medicare contract. Once a State certifies a health plan, the plan is eligible for a Medicare contract, except as provided for below.

- States will also have primary responsibility for monitoring health plans' continued compliance with standards.

- States will assume responsibility for certification and monitoring of Medicare health plans at the point at which the Secretary finds, after a request by the State, that

  - The State's standards are substantially equivalent to Federal standards.

  - The State has the ability and sufficient resources to carry out the certification function to the Secretary's satisfaction.

  - The State has the ability and sufficient resources to carry out the monitoring function (discussed below) to the Secretary's satisfaction.

- For plans in States that have not been "deemed," the certification process and plan monitoring will continue to be a Federal process.

- Beginning in 1999, States may impose more stringent requirements on Medicare health plans, as long as these requirements are imposed on all health plans in a non-discriminatory manner. States would have to have Secretarial approval before imposing more stringent standards.

- Although a State may certify that an entity meets all requirements and is eligible for a

Medicare contract, the Secretary will continue to have the authority to deny a contract to an otherwise eligible organization if the Secretary determines either that the organization cannot bear the level of risk of a Medicare contract, or the organization is not otherwise able to administer a Medicare contract effectively (similar to section 1876(h) of the current Social Security Act provisions).

Federal Role in Deemed States

- The Secretary will exercise a "look-behind" function to ensure that a State's certification and monitoring process continues to meet the requirements for "deeming." The look-behind approach will be modeled on that used for survey and certification of Medicare providers, including Federal review of a sample of plans.

- Certain administrative tasks will continue to be done by the Secretary: enrollment and disenrollment of Medicare beneficiaries; payment to plans; approval of adjusted community rate (ACR) proposals; approval of Medicare marketing material; development of comparative material; monitoring resolution of complaints; and administering the Medicare reconsideration and appeals process. The Secretary will approve any waivers of the 50/50 requirement. The Secretary will also determine the nature of external quality review.

- While the States will make recommendations for enforcement actions against plans that are out of compliance with standards, the Secretary will determine the appropriate sanction or contract action.

- For multi-State organizations, certain certification and/or monitoring functions may be done at the Federal level to the extent that efficiencies are possible. These functions will be determined by the Secretary.

User Fees

- User fees will be collected from plans for both the certification and monitoring activities.

Transition Period

- Prior to development of Federal standards, all existing contractors will be grandfathered, and new contracts could be awarded under current rules. Plans would have to comply with new standards as of the contract year following publication of the interim regulations.

Federal Pre-Emption

- Once Federal standards are promulgated, they would override State licensure requirements for PSNs (in regard to their Medicare business) until such time as the state is deemed.

OMB Package (1/5/96) versus Daschle $129 billion Package
(dollars in billions)

	OMB	Daschle	
Part A Proposals			
Hospitals			
Updates for PPS Hospitals	-13.8	-20.1	?
PPS Capital	-9.2	-7.6	
DSH	-1.9	-1.8	
IME	-8.2	-8.9	?
Medical Education	-2.1	-3.2	
Outliers	-3.7	-3.3	
Transfers	-5.5	-5.6	
Moritorium on LTC Hospital Exclusions	-0.7	-0.8	
PPS Exempt Hospitals	-0.6	-2.1	?
Non-PPS Capital	-1.6	-1.2	
Sole Community Hospitals	0.5	0.3	
Rural Primary Care Hospitals	0.2	0.2	
Rural Referral Centers	0.1	0.7	
Floor on area wage index	0.1	N/A	
Skilled Nursing Facilities			
Maintain SNF Freeze	*Included in Total for SNF below*		
Interim SNF PPS	Included in Total for SNF below		
Full SNF PPS	Included in Total for SNF below		
SNF Total	-7.4	-7.3	
Salary Guidelines for Therapy Services	Included in Total for SNF below		
New Benefits			
Respite	2.2	N/A	
Total Part A	**-51.6**	**-60.7**	
Part B Proposals			
Physician Payments	-20.9	-17.8	
Extend OBRA 93 Reduction in Overhead Payments	-0.6	-0.7	
Single Fee at Surgery	-0.9	-0.7	
Set incentives for in-hospital Physician Services	-2.8	-2.3	
Payment Limits for Risk Contracts	Included in Medicare Choice		
Direct Payment for PAs and NPs	0.3	0.3	
OPD PPS (effective 2002)	0.0	0.0	
Eliminate FDO	-4.5	-14.4	
Extend OBRA 93 Capital Reduction	-0.5	-0.5	
Extend OBRA 93 Payment Reduction	-1.3	-1.3	
ASC Update	-0.2	-0.2	
Payment Freeze (ASCs and Hospice)	-0.6	N/A	
Oxygen 10% cut -- Freeze DME and O&P	-2.4	-2.5	
Automated Lab Tests	0.0	0.0	
Clinical Lab Fee Freeze (96-02)	-2.8	N/A	
Competitive Bidding for Labs	N/A	0.0	
Competitive Bidding -- Other Part B Services	N/A	0.0	
Waive Cost-Sharing for Mammography	Included in estimate of annual Mammograms		
Annual Mammograms	2.1	N/A	
Pelvic Exams and Pap Smears	0.2	N/A	
Vaccines	0.4	N/A	

Colorectal Screening	0.0	N/A
Prostate Testing	0.3	N/A
Diabetes Management	0.4	N/A
Telemedicine	N/A	N/A
Rural Health Outreach Grants	N/A	N/A
DSH Threshold	N/A	0.9
Premium - Gross Savings	-16	
Premium Offset	9.2	
Premium Savings Net of Offset	-6.8	-4.9
Total Part B	-40.6	-45.0
Parts A and B		
Centers of Excellence	0.2	0.2
Maintain HHA Freeze	Included in total for Home Health below	
Interim HHA Payments	Included in total for Home Health below	
HHA PPS	Included in total for Home Health below	
Location of HHA Services	Included in total for Home Health below	
PIP Elimination	Included in total for Home Health below	
Total Home Health	-9.3	-9.1
Certain HHA as Part B	N/A?	0.0
MSP	-5.8	-5.6
Expanded Medicare Choice (OMB net of AAPCC give-back)	-12.8	-21.8
Remove Education, DSH from AAPCCs	N/A	12.8
Preventing F&A (total)	-4.2	-1.4
Amendments to Enforcement Authorities	Included in total for fraud and abuse above	
Resources for Anti-Fraud Activities	Included in total for fraud and abuse above	
Amendments to Criminal Law	Included in total for fraud and abuse above	
Coordination of Benefits	N/A	0.0
Contractor Reform	N/A	0.0
Fee Schedules	N/A	0.0
Surgical Dressings	N/A	0.0
Miscellaneous effective dates - slippage	N/A	1.5
Total Parts A and B	-31.9	-23.4
TOTAL	**-124.1**	**-129.1**

Differences between OMB $124 billion package and Daschle $129 package

- The effective dates of several policies differ due to CBO's decision in scoring the Daschle package to slip most effective dates by one year. This change in effective dates results in lower savings in the Daschle plan as compared to the OMB package due to lost savings in 1996 as well as the compounded out-year effect in some policies.

- The Daschle plan eliminates the formula-driven overpayment (FDO) in 1996 whereas OMB eliminates FDO in 2002. This results in FDO savings of $14.4 billion in the Daschle plan versus $4.5 billion in OMB's package.

- The OMB package includes a payment freeze for ambulatory surgical centers and hospices (savings: $0.6 billion). The Daschle plan includes a CPI-2 for seven years for ASCs.

- The OMB package includes a clinical lab fee freeze from 1996-2002 (savings: $2.8 billion). The Daschle plan establishes competitive bidding for labs which does not achieve any scorable savings.

- Managed Care in the OMB package achieves higher savings than in the Daschle package. The managed care savings, net of the AAPCC give-back, are $12.8 billion in the OMB package versus $9 billion in the Daschle plan.

- The OMB package achieves larger savings ($4.2 billion) in fraud and abuse than the Daschle package ($1.4 billion).

- The OMB package includes the preventive benefits of annual mammograms, waives cost-sharing for mammography, pelvic exams and pap smears, vaccines, colorectal screening prostate testing, and diabetes management (total cost $3.4 billion). The OMB plan also establishes a new respite benefit (cost $2.2 billion). The Daschle package does not include these additional benefits.

Daschle

Medicaid $ 51.7 Billion

MEDICAID — $51.7 Billion (7 yrs)

This proposal would reform the Medicaid program rather than repeal it, guaranteeing health and long-term care coverage for all Medicaid recipients. It achieves $51.7 billion in savings in a responsible manner by limiting spending on a per person basis (a "per capita cap") and reducing and retargetting Medicaid Disproportionate Share Hospital (DSH) payments to hospitals that serve large numbers of Medicaid and uninsured patients. The plan provides special payments for Federally Qualified Health Centers and States that have large numbers of undocumented immigrants, and gives States additional flexibility to allow them to more efficiently administer their Medicaid programs. Finally, this plan would retain current nursing home quality standards as well as spousal impoverishment protections and provisions that protect the financial resources of adult children whose parents are in nursing homes.

Savings Proposals

- **Per Capita Cap ($22.2B).** A per capita cap would limit the amount of Federal spending per eligible person while retaining current eligibility and benefit guidelines. This approach guarantees that the elderly, disabled, and pregnant women and children meeting certain criteria will continue to be eligible for health benefits while reducing the rate of increase in Medicaid spending to a level that is sustainable for States and the Federal government.

- **Disproportionate Share Hospital Payments ($29.5B).** Disproportionate Share Hospital (DSH) payments would be reduced and retargeted to specific institutions, including public hospitals, children's hospitals, Federally Qualified Health Centers and Rural Health Clinics. An additional fund is created for States with large numbers of undocumented immigrants.

Provisions to Increase State Flexibility

- **Boren Amendment.** This plan repeals the Boren Amendment, eliminating provider payment requirements that are imposed on States.

- **Managed Care.** This plan would allow States to move toward managed care and other types of cost-effective arrangements without Federal waivers.

- **Home and Community Based Care.** States would be allowed to move populations needing long-term care from nursing homes to home and community based care without having to seek Federal waivers.

Protections for Low-Income Seniors and Native Americans

Retains current policy of assisting low-income seniors by assuming responsibility for their Medicare premiums, copayments, and deductibles and retains current payment protections for Medicaid-eligible Native Americans treated in Indian Health Service facilities.

MEDICARE -$102 Billion (7 yrs)

This proposal implements reforms that strengthen and improve Medicare, reducing its rate of growth by $102 billion (net) over seven years and guaranteeing the solvency of the trust fund for more than a decade. Specific reforms provide seniors with more choices of private health plans, improve Medicare's fee-for-service program by making it more efficient and responsive to beneficiary needs, tackle fraud and abuse through programs applauded by law enforcement officials, reduce the rate of growth of provider payments, and extend the 25% Part B premium.

Highlights of Provider Payment Reforms and Program Savings

- **Hospitals ($40 B).** Reduces inflation update for hospitals and payments for capital and indirect medical education; reforms payments for graduate medical education.
- **Managed Care ($22 B).** Reforms payments by using reasonable rate of growth limits on updates for managed care payments, removing payments made for disproportionate share and medical education and reducing current geographic variation in payments.
- **Physicians ($15 B).** Reforms physician payments by collapsing the current three conversion factors into a single update for all physicians; replaces current "volume performance standards" with a "sustainable growth rate."
- **Home Health Care ($9 B)/Skilled Nursing Facilities ($7 B).** Implements a series of interim payment reforms before the establishment of separate prospective payment systems for home health care and skilled nursing facilities.
- **Fraud and Abuse ($7 B).** Introduces aggressive and comprehensive policies to stamp out Medicare waste, fraud, and abuse and extends and enhances Medicare secondary payor policy.
- **Other Providers ($5 B).** Freezes or reduces payments for durable medical equipment and ambulatory surgical centers.
- **Beneficiaries ($7 B).** Requires beneficiaries to pay 25% of Part B costs.

Provisions to Improve Rural Health Care

This proposal implements a variety of measures to enhance access to and quality of health care in rural areas. These include an extension of Rural Referral Center program, direct Medicare reimbursement for nurse practitioners and physician assistants, improvements to the Sole Community Hospital program, and an expansion of the Rural Primary Care Hospital program.

Program Improvements and Preventive Benefits (+$11 B)

A series of reforms transform the fee-for-service program from a bill-paying insurance program into a responsive health plan by giving Medicare the authority to adopt the same types of purchasing and quality techniques pioneered by private sector payers. The proposal also expands and improves Medicare managed care by (1) ensuring beneficiary protections while increasing the types of plans (including PPOs and PSNs) available to seniors and (2) instituting a coordinated annual open enrollment process during which beneficiaries use comparative information to choose among managed care and supplemental insurance options. A preventive benefits demonstration program provides respite care for Alzheimer's patients, annual mammograms and elimination of mammography co-insurance, and colorectal cancer screening.

Premiums

96	97	98	99	'00	'01	'02
42.50	45	48.70	52.30	58.10	62.50	67.90

OFFICE OF LEGISLATIVE & INTER-GOVERNMENTAL AFFAIRS FAX COVER SHEET

# of Pages: Cover + 4

DATE: 2/9/96

TO: Jennifer

Fax: 456-2878

Phone:

FROM: Debbie

Fax: (202) 690 - 8168

Phone:

REMARKS:

HEALTH CARE FINANCING ADMINISTRATION

Washington, D.C.

February 8, 1996

Medicaid Flexibility Issues – Daschle bill

This paper reflects changes to the Medicaid bills to bring the Daschle and Administration Bills into conformity.

A Outstanding Issues:

1) o **Disallowances** -- Neither bill includes any provision that would better target HCFA's disallowance authority. The States's would like HCFA's disallowance authority to be more narrowly defined so that disallowances would be commensurate with the seriousness of the violation. See note attached.

2) o **New Item: Work Transition** -- The Daschle bill removes the 1998 sunset provision from current law. We have had no discussions/agreement on this issue. From a policy view this a good idea, there may be some cost impact.

o Items to be included in future bill:

3) **Home Care** -- The Daschle and Administration bills include the repeal of Sections 1929 (Home and Community Based Care for Functionally Disabled Elderly Individuals) and 1930 (Community Supported Living Arrangements); and do not include an exception for the Texas program (the only State delivering such services). HCFA has been working on this issue and it may be address it in later versions.

Indiana Base – Neither bill addresses the unique circumstances related to the FY 1995 base year for the State of Indiana.

Items agreed upon:

B Changes need to be made to the OMB Bill to make it conform with the Daschle Bill:

o **Managed Care Requirements** -- The Daschle bill provisions that establishes additional Federal standards for managed care plans and PCCM providers were not included in the latest Daschle bill. In general, these detailed requirements duplicate the more general quality assurance program requirements already included in the same section of the bill and elements of current law that would remain in place. The general language in the Administration's bill should be expanded to address two provisions, solvency standards and financial reporting requirements, are not covered by the current general language or current law.

o **Managed Care/Anti-Fraud Standards** -- The Daschle bill would establish new anti-fraud rules for mandatory managed care programs. These were deleted from the latest

Daschle bill. General anti-fraud language should be added to the Administration's bill managed care language.

- **State Commission on health reform** -- The Daschle language includes a State Commission on Health Reform in addition to the Commission on Medicaid which is included in both packages. These two commissions were folded into one commission in the latest Daschle bill. These changes should be made to the Administration Bill.

- **Eligibility Flexibility** -- The 30 percent limitation included in the Administration bill should be dropped, unless there are scoring issues.

- **Combined State plan submission**. The Administration bill permits States to submit a combined State plan for their LTC programs, health insurance programs for the uninsured, and Medicaid. This should be dropped from the Administration bill. [Section 11357], because the other programs were not included.

- **Elimination of requirements for annual independent review of HMO care**. The Administration bill eliminates this annual quality review requirement because new quality language would take a prospective approach to ensuring quality of care. This should be deleted form the Administration's bill. [Section 11354]

C. Technical Changes

There are numerous technical changes need to be made to the OMB legislative language to make it agree exactly with the Daschle language. These details will be provided to OMB by COB Friday.

Changes already made to the Daschle Bill:

- o **Managed Care** -- The following provisions in the Daschle bill were dropped at this time.
  - Rules for plans' and States' payment for emergency services (with or without prior authorization), including a new statutory definition of emergency medical conditions; and
  - A clarification that restrictions on matching payments for organ transplants, services provided by providers who are excluded from Medicaid, and certain drug products, also apply to managed care plans.
- o **Managed care/FQHCs** -- Additional language included in the Daschle bill that would amend managed care contracting rules and require all managed care plans to contract with all RHCs and rural FQHCs within their services areas were dropped.
- o **Transportation** -- This Daschle provision makes nonemergency medical transportation services optional. This provision was deleted from the Daschle Bill.
- o **Home Health** -- This Daschle provision makes home health services for individuals entitled to nursing facility services optional. This provision was deleted from the Daschle Bill.
- o **Performance partnerships** -- The Daschle bill provides for State-Federal partnerships under which the Secretary establishes performance objectives and measures and States develop plans based on these (or on a State-justified, State-specific modification). This provision was deleted from the Daschle Bill.
- o **Elimination of physician qualification requirements.** The Administration bill eliminates the physician qualification requirements for pediatric and obstetrical services in current Law. The Daschle bill did not. This provision was added to the Daschle bill. [Section 11342]
- o **Eligibility** -- Enable States to reduce eligibility for pregnant women and infants to the minimum mandatory level (133% FPL). This provision was added to the Daschle bill.
- o **Copayments** -- Modify section 1916 to permit nominal copayments for HMO enrollees -- all other current restrictions would be retained. This provision was be added to the Daschle bill.

A1 Disallowances

Jna 25, 1996

NOTE TO DON

RE: Disallowances provision and Mark Miller/Bonnie Washington concerns

From Letty

Talked at length to Bonnie W. Main points:

- o Provision was in early Byrd bill, therefore had to have $0 from CBO. No reason that should change under a per capita cap program.
- o Provision has to do with amounts of disallowance, not deferrals.
- o Doesn't open up new State gaming opportunities. Leaves Secretary and DAB in decision-making driver's seat.
- o Nothing much will change in Lasoswki's world if this is enacted or not. But States think it's a big deal. The proposal has been on every NGA/APWA legislative wishlist for the past five years. Enacting it would save them worries, time, and lawyer bills, even if it won't change the ultimate amounts of disallowances actually taken. HCFA could operate just fine without it.
- o Going back on it now or significantly narrowing it would renege on a deal with the Governors.
- o We cooked up two possible changes to the language (see attached). A little change mainly for appearances, and a bigger change (from the "Secretary shall" to the "Secretary may").
- o Bonnie will also explore informally talking to CBO and sharing these points with them. It wasn't clear throughout the conversation if it was Mark M. who objected to the proposal or CBO or what.

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January 29, 1996

DRAFT

Medicaid Issues -- Daschle bill

This paper contains three sections. The first notes policy issues with the Daschle bill. The second notes provisions in the Administration bill not included in the Daschle bill. The third describes areas of additional State flexibility.

I. Policy issues:

o Eligibility Flexibility -- Both bills permit expansions to people with incomes of up to 150 percent of poverty. [Section 3011. Optional extension of coverage to additional individuals, subject to poverty-related or caseload limits. (Page 24, lines 20-23)]

The Administration bill includes two options, one permitting expansions up to 150 percent of poverty, the other undefined except that it could not result in caseload increases of more than 30 percent. The Daschle bill omits the second option. The Administration plan restricts the States' ability to expand eligibility beyond levels that can be supported by the overall spending limits.

o Managed Care Requirements -- The Daschle bill includes a new provision that establishes additional Federal standards for managed care plans and PCCM providers. New standards would include: nondiscrimination on the basis of health status, access to services, quality assurance, solvency, encounter data, and financial reporting. [Section 3025. Requirements to ensure quality of and access to care under managed care plans. (pp 36-7)]

These requirements generally duplicate the quality assurance program requirements in the same section of the bill. Only solvency standards and financial reporting requirements would not be covered by the more general language. Adding these explicit standards to the Administration's bill would make it more similar to the Coalition bill.

o Managed Care/Anti-Fraud Standards -- Establish new rules for mandatory managed care programs. Elements include:

- prohibitions on plans' associations with providers or entities who are prohibited from contracting with the Federal government or excluded from participating in Medicare;
- Restrictions on plan marketing practices;
- Requirements that States maintain conflict-of-interest safeguards for employees who develop contracts with health plans;
- Rules for States' default enrollment processes for individuals who do not choose a

health plan or primary care case management;

- Requirements that plans annually submit audited financial statements and net earnings reports to the State;

- Rules for plans' and States' payment for emergency services (with or without prior authorization), including a new statutory definition of emergency medical conditions; and

- A clarification that restrictions on matching payments for organ transplants, services provided by providers who are excluded from Medicaid, and certain drug products, also apply to managed care plans.

[Section 3061. Preventing Waste, Fraud and Abuse in Medicaid Managed Care]

These requirements would be perceived as legislative micro-management of State contracting procedures.

o Managed care/FQHCs -- Additional language would amend managed care contracting rules and require all managed care plans to contract with all RHCs and rural FQHCs within their services areas. Plans would be required to pay these providers either fee-for-service rates that reflect "market rates." [Section 3041(b) -- Conforming amendments]

This new language represents a significant policy change. We believe that it would reduce the States' flexibility to contract with managed care networks and provide a disincentive for managed care plans to enter into Medicaid contracts.

o Home Care -- The Daschle and Administration bills include the repeal of Sections 1929 (Home and Community Based Care for Functionally Disabled Elderly Individuals) and 1930 (Community Supported Living Arrangements). [Section 3031. Home and community-based services as State option without need for waiver.]

If section 1929 is repealed and no alternative authority is provided, Texas (the only State delivering such services) would have to terminate its ongoing program. HCFA is working to revise our policy so that Texas continues to have the flexibility to provide home and community-based services under this section. We question whether Texas' authority for this benefit should still be repealed.

HCFA has been working on this issue and intends to address it in later versions.

o Transportation -- This Daschle provision makes nonemergency medical transportation services optional. This provision is not in the Administration bill.[Section 3034. Making nonemergency medical transportation services optional.]

This provision would require a definition of "nonemergency services" and raises concerns

regarding access to care.

o Home Health -- This Daschle provision, that makes home health services for individuals entitled to nursing facility services optional, is not in the Administration bill. [Section 3035. Making home health services for individuals entitled to nursing facility services optional. (Page 43)]

It is unclear what this targeted reduction in benefits is intended to accomplish. By making home health services optional while retaining nursing facility as mandatory, this provision creates an institutional bias. Currently, the mandatory home health services benefit is an important source of home and community based care, and we expect that both the strong opposition from both consumers and industry groups.

o Performance partnerships -- The Daschle bill provides for State-Federal partnerships under which the Secretary establishes performance objectives and measures and States develop plans based on these (or on a State-justified, State-specific modification). Content requirements are imposed on both efforts. The Secretary would produce annual reports on progress both at the national level and in each State, based on information provided by the States. The Administration bill does not include such a provision. [Section 3056. Performance partnerships and State rankings. (Page 53)]

Under this provision, the Secretary is not given tools necessary for reasonable implementation and accountability. For example, this provision does not give clear authority regarding how these State plans are approved, nor any enforcement mechanism.

o State Commission on health reform -- The Daschle language includes a State Commission on Health Reform in addition to the Commission on Medicaid which is included in both packages. We question whether both Commissions are necessary. The functions of the State Commission on Health Reform focus on implementation issues while the Commission on Medicaid is primarily focused on financial equity. Possibly these two could be folded into one commission or the implementation commission could be eliminated.

II. Provisions in the Administration bill, not in Daschle.

- Section 11357. Combined State plan submission.

The Administration bill permits States to submit a combined State plan for their LTC programs, health insurance programs for the uninsured, and Medicaid. The Daschle bill doesn't.

Policy concern:

The desirability of this provision depends on the broader context of reform in State activities in long-term care and health insurance for the uninsured.