J- I'm giving a copy of this to CJ as well. These are Gene's notes on how to talk about our health care agenda.
—P

Clinton Plan:

- **Medicare reforms:**

  -- Saves $116 billion in CBO-scored Medicare spending. In so doing, constrains Medicare to about 6 percent per person growth rates -- about 10-15 percent below CBO's private sector per person growth rates. [Republican plans were between 23-31 percent below the CBO's current private sector growth rates.]

  -- Achieves savings primarily through reimbursement changes to providers, i.e., doctors, hospitals, nursing homes, home health care providers, and medical equipment suppliers. [E.G., Reducing update payments to hospitals, moving to a new prospective payment system for nursing homes and home health care providers, and establishing a single conversion factor to be used for limiting reimbursement for physician services.] DO WE HAVE TO GO OVER HOME HEALTH TRANSFER?

  -- Extends the provision requiring the Part B premium to be set at 25 percent of program costs -- set to decline to increases in inflation in 1998. (This achieves about $X billion out of your $116 billion of CBO scored Medicare savings.)

  -- Calls for the establishment of a whole host of new private plan options, including PPOs, provider service networks, and HMOs with a point-of-service option, but that also assures that these plans compete on cost and quality -- and not risk selection -- and also require Medigap insurers to allow beneficiaries who have chosen these plan to come back to their fee-for-service plan without being underwritten again. (This proposal will hopefully help beneficiaries avoid the problem of being --or feeling -- locked into a managed care option that they no longer wish to stay in.)

  -- Includes a hole host of new preventive benefits, including the elimination of all copayments for mammography services, the coverage of colorectal screening, the coverage of the cost of preventive injections for such illnesses as pneumonia and influenza, and the establishment of a diabetes self-management benefit.

  -- Takes an important first step toward providing for a long-term care benefit by adding a new respite benefit for families of Medicare beneficiaries who have Alzheimer's Disease.

- **Medicaid reforms:**

  -- Eliminates the time-consuming and labor-intensive waiver process for states wishing to use managed care or home and community-based services as an alternative for institutional services.

  -- Eliminates and reforms costly payment requirements like the Boren amendment and the cost-based reimbursement requirements for community health centers.

  -- Empowers states to cover additional people by...

- **Non-Medicare health reforms:**

  -- Successful reform must be achieved on a step-by-step manner though a bipartisan process. We saw the fruits of our labors this year when we enacted the Kennedy-Kassebaum bill, the 48 hour rule, and the mental health parity provision after Senator Dole left the Senate.

  -- We can and should do more:

  1. Workers' Transition Initiative would provide premium assistance for up to six months for individuals who are in-between jobs. It would help an estimated 3 million people a year, including 700, 000 children, and is paid for in my balanced budget.

  2. Voluntary Purchasing Coalitions would hopefully make health insurance for small business more affordable and accessible.

  3. Building on K/K and 48-hour rule, we should pass legislation prohibiting health plans from interfering with communication between health care professionals and their patients about treatment options. I have also just announced the upcoming establishment of an advisory panel on consumer protections and quality.

ECONOMY/BUDGET QUESTIONS

MEDICARE/SOCIAL SECURITY:

1. **Entitlement Reforms.** We constantly read that all entitlements are out of control and that we can't really balance the budget unless entitlements are addressed. What are you going to do to reform entitlements?

2. **Social Security.** This election seems mostly about who can brag about how much they are going to spend on older Americans. Most people my age assume that Social Security is not going to be there when we retire. What are going to do and wouldn't it be more fair just to let us have the money to invest in IRAs?

3. **Social Security COLAs. (TO THE PRESIDENT)** A lot of people say that inflation is exaggerated and that we could have more money around if we cut the inflation rate. Are you willing to do this and use the money for deficit reduction or education? Can you explain your willingness in Money Magazine to cut COLAs?

4. **Managed Care.** Everyone I know have had problems with managed care. Yet, it seems that the only thing that the two of you agree on is moving more and more people -- particularly Medicare recipients to managed care. How can you support expansion of managed care ~~given~~ when it is a program that gives doctors and hospitals an incentive to cut quality to maximize profits?

5. **Medicare. (TO THE PRESIDENT)** We're sick and tired of you trying to scare people on Medicare. You and Mrs. Clinton said that you could cut Medicare without hurting anyone. Now when the Republicans do exactly the same thing you say it is the worst thing in the world.

   TO DOLE: What did you mean when you said you were proud of your vote against Medicare?

DEFICIT/BUDGET:

6. **National Debt:** While you say that the deficit is going down, the debt has gone up over $1 trillion under you and is likely to go up another $1 trillion. Some say that our children will have to pay 82% tax rates to get rid of this debt. What are you going to do to get rid of this debt?

7. **Specifics on Spending Cuts:** Both of you seem to announce new proposals every day on how you are going to spend our money. Yet, you don't seem to ever tell us the specifics. Tell us now Mr. President some programs you are going to eliminate entirely and programs you specifically are going to eliminate and what you are going specifically cut to pay for your new proposals?

X specifics on corporate welfare - why won't you call it?

HEALTH CARE:

8. **Health Care Coverage. (TO THE PRESIDENT)** You were right/wrong to try to do universal coverage. Health care costs continue to rise out of control. Will you do it again? I'm really sorry that you seem so intent on backing off on that goal. I am hoping a Democratic Congress might help you return to passing one.

9. **Health Care Coverage: (TO DOLE)** You have criticized the President for his health care plan but what is your plan for health care?

I can't afford health insurance...

ECONOMY:

10. **Downsizing. (TO THE PRESIDENT)** You say the economy is good, but companies are downsizing. I work for defense contractor that has laid off 4,000 workers in the last five years. Tell me what you are going to do for those of us who are the victims of downsizing, because none of these make-believe tax cuts are going to help me if I don't get a new job?

11. **New Jobs Are Not Good Jobs. (TO THE PRESIDENT)** You keep talking about 10 million jobs. My wife and I are probably two of the jobs you are counting but I can assure you we don't think we are better off. I was making $22 an hour with Boeing; now I have an new job making $12.50 an hour and my wife works $7 an hour for 20 hours a week. We are working harder and earning less, so I want to know what you say to families like ours.

    TO DOLE: I'm doing much better. I've gone from making $12.50 an hour to $22 an hour. Why do you say the economy is so bad. We're doing much better in California than we were under Bush.

TRAINING/TRANSITIONS:

12. **Policies for Job Losers:** We hear a lot about college from both of you. Not everyone can go to college. Lot of us, however, are already in the workforce. I lost my job 14 months ago. What can either of you do or propose that is actually going to help someone like me get a good job again?

SMALL BUSINESS/MINIMUM WAGE:

13. **Small Business -- Burdens on minimum wage. (TO THE PRESIDENT)** I own a small hardware store -- and I have to keep costs very low in order to compete against some of the large chains. One of the ways I do it is to hire about 30 teenagers to work after school and on weekends. Now, because of this minimum wage law, you have raised my costs about $40,000 -- taking away almost all of the profit I made last year. Now I am thinking about closing down one of my stores. How does that make people better off?

Preferred Citation: **"The Proposed Medicaid Block Grant Does Not Guarantee Basic Health Care Coverage to Anyone," (Washington: The Center On Budget and Policy Priorities, 1995 [http://epn.org/cbpp/cbhcov.html]).**

THE PROPOSED MEDICAID BLOCK GRANT DOES NOT GUARANTEE BASIC HEALTH CARE COVERAGE TO ANYONE

Revised November 21, 1995

The reconciliation conference report requires states to cover low-income pregnant women, children under age 13 and the disabled under their Medicaid block grant. Contrary to popular impression and various media accounts, however, these requirements *do not assure these Medicaid beneficiaries even a basic level of health care coverage.*[1] According to CBO, "because of the flexible definition of medical assistance in the bill and the fact that states would be able to establish their own definitions of disability, the actual effects of (these) apparent mandates, could be minimal."[2]

Pregnant Women and Poor Children

While states would have to "cover" poor pregnant women and children under age 13, states would *not* be required to provide these beneficiaries with any particular level of medical assistance other than immunizations for children. This provision thus is largely cosmetic. Essentially, it directs states:

1. to provide poor pregnant women with some level of medical coverage, with the level being left entirely to the discretion of the state; and
2. to provide poor children under age 13 with immunizations.

Any additional service to poor children is purely optional, as is any particular service for poor pregnant women. These individuals would *not* be entitled to Medicaid coverage as it exists today or to "health care coverage" as most Americans think of it. Moreover, poor children age 13 and older — and low-income children of any age with family income just slightly above the poverty line — need not be covered at all.

Disabled Individuals

The provision concerning disabled people is even more limited. While states would be required to cover disabled persons, states would decide who would be considered disabled. The Senate version of this provision had required states to define as disabled those persons who receive federal Supplemental Security Income benefits based on their disability, but this provision was dropped in conference. States would be free to narrow the definition of disability

as much as they wished.

Furthermore, like the provision relating to pregnant women and children, the provision relating to the disabled allows states to determine the health care services to be covered. A state could meet this requirement by providing extremely stepped-down coverage to a relatively small group of beneficiaries that it defined as disabled. Thus, this provision, too, has little effect and is largely cosmetic. For example, a state could more than satisfy this provision if it limited coverage of disabled people to those residing in state institutions or if it extended coverage to a broader group of disabled people but covered only catastrophic care.

Fiscal Pressures Will Make it Likely That Even Protected Beneficiaries Will Lose Coverage for Some Services under the Block Grant

The lack of even basic coverage guarantees for these vulnerable groups is significant when viewed in the context of the reduced resources that states will have for Medicaid. The Medicaid block would reduce *federal* Medicaid payments to states by $163 billion over seven years. Reductions in *state* funding the bill allows could lead to *total* federal and state funding reductions of a much larger amount, with the total reduction potentially climbing as high as $420 billion over seven years.[3]

Moreover, in a block grant system, the federal government no longer shares any of the increases in costs that may occur if a recession increases the number of uninsured poor, the number of uninsured grows for other reasons, or the cost of covering chronically ill or severely disabled people rises more rapidly than expected. If states are unwilling or unable to assume costs that exceed their block grant funds, the flexibility granted to states under the block grant would allow them to take any number of steps to limit spending.

The issue is not whether states want to leave large numbers of people without health care coverage. The question is whether, under a block grant with dramatically reduced and capped federal spending, states would have much choice other than to reduce coverage, particularly in recessionary or inflationary times. States could end all coverage for certain groups of disabled people or sharply reduce the benefits provided to various other groups of individuals, including poor pregnant women and young children, without violating the "guarantees" included in the conference report.

NOTES

1. The bill also includes "set-aside" provisions that require states to spend a portion of their Medicaid block grant funds on each of four beneficiary groups — elderly people, disabled people, families with children and pregnant women, and low-income Medicare beneficiaries. These set-asides, however, are quite low because in general they are set at 85 percent of past spending on *mandated* services provided to *mandated* beneficiaries. Such spending accounts for *less than half* of all Medicaid spending. Thus, the set-aside percentages are far below the percentages that states currently spend on each of the designated beneficiary groups. In any event, a state can ignore these set-aside requirements beginning in fiscal year 1998 as long as the state certifies that it can meet the needs of the designated groups with less dollars. That certification is not subject to challenge.
[return to text]

2. Congressional Budget Office Cost Estimate of Title VII, Subtitle B — Medicaid reconciliation recommendations of the Senate Committee on Finance, October 20, 1995. The Senate Finance provisions are virtually identical with the final provisions adopted in conference. The lack of any enforceable federal right to Medicaid coverage also confirms that the bill provides no assurance of health care coverage to even the most vulnerable Medicaid

beneficiaries.
[return to text]

3. See, Center on Budget and Policy Priorities, *How Deep Are the Federal, State, and Total Medicaid Funding Cuts?*, November 21, 1995.
[return to text]


Go to *Idea Central*'s Welfare and Families Page

...or to the Center on Budget and Policy Priorities home page.

The history of Republican attempts to eliminate financial protections for Medicaid patients' families

1. Spousal/Family Impoverishment and Imposition of Liens

In the context of individual entitlement for nursing home care, current law (Section 1924 (pg. 1242)) establishes rules that States must use in determining how much of a couple's income and assets must be protected for the maintenance of the community spouse (the remainder may be applied to the cost of nursing home care for the Medicaid-eligible institutionalized spouse, thereby lowering the payment that the State must make to the nursing home. Beneficiaries and spouses may bring actions against a state in Federal court to enforce compliance. (Spouses remaining in the community may keep about $1,200 per month in income and about $15,000 in savings to maintain his or her independence).

Section 1917 (pg. 1186) prohibits States from placing a lien on a nursing home resident's home or family farm if a spouse, dependent or disabled child lives in the home.

Since 1965, Medicaid (Section 1902(a)(17)) has prohibited States from making adult children financially responsible for the cost of nursing home or other long-term care covered by Medicaid for their parent or parents. Twenty nine states have laws on the books which hold adult children financially liable and would prevail if these federal protections are repealed.

a) Senate Finance Committee Mark - repealed Title XIX (Medicaid) and did not maintain any of the protections against spousal impoverishment, family impoverishment, or the imposition of liens. On September 28, 1996, Senator Conrad introduced an amendment to retain current law protections against impoverishment for spouses of nursing home residents who remain in the community. The amendment **passed** by voice vote. On the same day, Senators Baucus and Chafee introduced an amendment prohibiting states from imposing liens against a home of moderate value or family farm, as a condition of the spouse of the individual receiving nursing home care or other long-term care benefits. It was **accepted** without objection.

b) Commerce Committee Mark - (September 22, 1995) Repealed rules that States must use in determining how much of a couple's income and assets must be protected for the maintenance of the community spouse; repealed current law prohibition against financial responsibility requirements for adult children; repealed current law protections against liens; and barred Federal court actions by beneficiaries, applicants, or adult children to enforce their rights against States. Required only that States receiving block grant funds provide a "description" of the eligibility standards they use "to prevent the impoverishment of the community spouse."

Mr. Markey's amendment to maintain current law provisions relating to spousal impoverishment **failed** on a party-line vote, 18-23. Mr. Klink's amendment to maintain current law provisions with respect to adult children failed on a party-line vote of 17-23.

c) House-passed bill - Repealed individual entitlement to nursing home care. Repealed current law protections against placing a lien against the home of a nursing home resident, even if the home was occupied by a spouse of dependent child. Repealed protections against requiring adult children to pay for cost of parent's care, unless the child had income below the median for the state. Restored spousal impoverishment protections, but no right of action by individual in Federal courts to enforce protections. Moreover, spousal impoverishment provisions were rendered meaningless by repeal of provisions preventing nursing homes from charging families amounts in addition to Medicaid payments. On October 26, 1995, the House passed the bill 227-203.

d) Senate-passed bill - Restored some current law protections against spousal impoverishment (sec 2116, pg. S16235), but did not include protections against holding families financially liable for the cost of nursing facility and other long-term care services for the child's parent. The bill included the limited provision prohibiting states from imposing liens against a home of moderate value or family farm (Section 2135(g)(2) pg. S16244). On October 28, 1995, the Senate passed the bill 52-47. Senator Dole voted **in favor** of the bill.

e) Final Conference agreement - Repealed individual entitlement to nursing home care. . Repealed protection against requiring an adult child with a family income above the median income (as defined by the state) to contribute to the cost of covered nursing facility services and other long-term-care services (Sec. 2115(f)). Section 2135 (g) of the final bill expressly allowed States to "stake such actions as it considers appropriate to adjust or recover from the individual or the individual's estate any amounts paid as medical assistance to or on behalf of the individual under the MediGrant plan, including through the imposition of liens against the property or estate of the individual." Thus, there were no protections against the imposition of liens on nursing home residents' homes, even when a spouse or dependent child is living in the home.

Included current law protections against spousal impoverishment (Sec. 2115), but rendered them meaningless by repeal of provisions preventing nursing homes from charging families amounts in addition to Medicaid payments.

On November 17, 1996, the Senate passed the conference agreement 54-45. Senator Dole voted **in favor** of final passage. On December 6, 1995, President Clinton vetoed the bill.

Source: Minority Staff of the Senate Committee on Labor & Human Resources, October, 1996

The history of Republican attempts to eliminate nursing home quality standards

1. Nursing Home Quality Standards

Current Law: Section 1919 (pg. 1194) sets forth detailed Federal quality requirements for nursing facilities participating in Medicaid, as well as detailed provisions for monitoring and enforcement of compliance with those requirements by the State and Federal governments. In addition, current law allows individual beneficiaries (or family members) to bring suit against States in Federal court to enforce their rights under these requirements.

a) Senate Finance Committee Mark - Repealed current law quality requirements for nursing facilities as well as current law monitoring and enforcement provisions. The Mark left nursing home quality standards up to the states with no Federal enforcement. On September 29, 1995, Senator Pryor introduced an amendment to retain current law Federal nursing home quality standards and Federal enforcement; it failed on a 10/10 tie vote. Senator Dole voted **against** the amendment.

A second Pryor amendment to require HCFA approval of state nursing home standards -was also defeated by a 10/10 tie vote and once again, Senator Dole voted **against** the amendment.

b) House Commerce Committee Mark (reported 9/22/95) - Also repealed current law quality requirements for nursing facilities as well as current law monitoring and enforcement provisions. States receiving block grant funds establish their own standards for nursing homes and their own program for certifying compliance with those standards. Expressly bars beneficiaries and family members or providers from enforcing their rights against a State in Federal court.

Mr. Waxman introduced an amendment to retain current law requirements for nursing homes, as well as current law monitoring and enforcement provisions. It was defeated on a party-line vote, 17-26.

c) Senate Floor - On October 26, 1995, Senators Pryor and Cohen introduced a floor amendment to provide for continuation of current law nursing home quality requirements. The amendment passed 51 to 48. Senator Dole voted **against** it.

Subsequently, the Republicans undermined the Pryor/Cohen amendment with the Roth "omnibus" amendment which included Section 2137 allowing States to receive a waiver from the federal government standards if it had its own equivalent or stricter standards--but without federal enforcement of these standards. The Roth amendment passed 57-42. Senator Dole voted **in favor** of the amendment.

d) House Floor - On 11/17/95, the bill passed the House and included similar provisions to those reported by the Commerce Committee (Section 2137); no amendments were offered.

e) Senate Floor Motion to Instruct - On November 13, 1995, Senator Pryor introduced an amendment instructing the managers to insist upon maintaining Federal nursing home reform quality provisions of current law and to provide for Federal quality standards and mechanisms for enforcement of such standards. It passed 95 to 1. Senator Dole voted in favor of the Motion.

f) Final Conference Bill - Section 2137 ignored the motion to instruct and substantially weakened the federal nursing home quality standards by eliminating major standards and weakening enforcement. Specifically, the bill:
1) barred beneficiaries, family members and providers from enforcing their rights against a State in Federal court.
2) revoked an individual's guarantee to services;
3) repealed the Secretary's authority to ensure quality and undermines enforcement authority;
4) loosened quality of care requirements on facilities at the risk of residents;
5) weakened nursing home survey and certification requirements; and
6) diluted current State and Federal enforcement tools to ensure quality.
7) altered the nursing aide training provisions by creating more exemptions from the minimum requirements.

On November 17, 1996, the Senate passed the conference agreement 54-45. Senator Dole voted in favor of final passage. On December 6, 1995, President Clinton vetoed the bill.

Source: Minority Staff of the Senate Committee on Labor and Human Resources -- October, 1996

Philosophies Clash and Dollars Don't Add Up On White House, Republican Medicare Plans

By CHRISTOPHER GEORGES
Staff Reporter of THE WALL STREET JOURNAL

WASHINGTON—The White House and Republican Medicare plans are nearly $130 billion apart, but the policy difference seems even greater: The GOP plan would ultimately protect taxpayers while the White House would preserve health-care benefits for the elderly.

"There's a huge difference in philosophy," says Marilyn Moon, a health-care expert at the Urban Institute and a public trustee of the Medicare Trust Fund. "For things being equal, beneficiaries should prefer the president's plan, while taxpayers should prefer the Republican's plan," says Robert Reischauer, former director of the Congressional Budget Office, now at the Brookings Institution.

The conflict underscores generational tension implicit in the budget debate. But it also highlights the tricky balancing act that politicians on both sides are trying to pull off: Medicare beneficiaries are also taxpayers, and polls show that most Americans in all age groups favor reduced government spending. Yet younger taxpayers, who bear the burden of Medicare, have a stake in keeping the program healthy for their retirement.

The two sides will have to choose between the GOP's ensured savings and Democrats' ensured benefits.

Though both sides claim commitment to a balanced budget, the key Republican priority is protecting taxpayers from the costs of social programs. They want to impose spending caps on programs such as Medicare and Medicaid.

Democrats also would cut program spending. But if more money is needed for beneficiaries, they would require taxpayers to provide it. "The major difference is that Republicans wrote down a budget, and Clinton said the budget is whatever it turns out to be," says Uwe Reinhardt, a Princeton University economist.

Comparison Shopping

How the differences would play out:

The Republican plan includes a hard ceiling on how much can be spent on Medicare—about $1.6 trillion over the next seven years. Thus if a Medicare beneficiary enrolls in a health-maintenance organization, the government would pay the HMO, on average, about $5,000 next year. Each year that payment would increase by a set amount—about 5.8%—even if the HMO operating costs rose, say, 10% for the same level of services. (Medicare spending has risen nearly 10% annually in recent times, but some experts predict this rate will slow in coming years.)

If HMO costs for providing a given level of services rise more than the 5.8%, a private health-care plan, under the GOP proposal, could charge elderly members higher premiums. It also could try to save money by becoming more efficient or by skimping on services.

More importantly, the one solution *ruled out* by the GOP is giving private plans more money to cover higher costs. "If the growth rate is higher than anticipated, Republicans are saying, 'lots of luck,' " says Ms. Moon.

GOP 'Global Budget'

Of course, beneficiaries could opt out of HMO plans and migrate back to traditional fee-for-service Medicare. But Republicans also would apply a cap to these services. If health-care costs rose faster than the GOP budget allots, doctors, hospitals and other providers would have to absorb the losses. That, in turn, could come back to bite the beneficiaries. If doctors, for example, see their Medicare payments cut deeply, they might stop seeing Medicare patients, explains Robert Doherty of the American Society of Internal Medicine, which represents physicians.

"The rate of reductions is too steep under the Republican plan," he says.

Republicans defend their "global budget" by saying current and future taxpayers won't be burdened if health-care costs continue to increase at current rates. "You must cap spending now if you care about the next generation," says Stuart Butler of the conservative Heritage Foundation. "President Clinton is saying, 'We'll pay for whatever you need,' but he's also saying, 'We don't care about your children and grandchildren.' "

The administration's approach contains no cap. Instead, White House officials looked at projected costs of providing health care and scaled back expected payments by $97 billion. For example, if a doctor is now scheduled to receive $100 in 1997 for a certain procedure under Medicare, the physician might receive, say, $95 under the new plan.

Medicare Differences

Some of the key differences between the Republican and Clinton Medicare plans

- GOP plan would save $226 billion over seven years; Clinton plan, $97 billion.
- GOP plan would, overall, reimburse doctors, hospitals and other providers less than the Clinton Plan.
- GOP plan includes faster increase in Part B (doctor's services) premiums.
- GOP plan would set a specific dollar limit on the amount Medicare could spend annually. Clinton plan seeks to slow the growth of spending, but has no surefire mechanism to ensure savings.

DOLE-GINGRICH BUDGET: MEDICARE PLANNED MEDICARE POLICY CHANGES

1ST STORY of Level 1 printed in FULL format.

The New York Times

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LENGTH: 2114 words

HEADLINE: BATTLE OVER THE BUDGET: MEDICAL CARE;
In G.O.P. Plan, Some See a Widening Gap Between Sick and Healthy

BYLINE: By MARTIN GOTTLIEB

BODY:

Along with reinventing the way medical care is provided to the elderly and poor, the Medicare and Medicaid legislation agreed to by House and Senate negotiators would profoundly change the nation's health insurance system, allowing companies to vastly increase the marketing of an encyclopedic array o policies to the nation's sickest people.

Republicans and other proponents hail the changes as fostering competition creating greater personal choice and containing costs. But many critics, including consumer advocates and Democrats, fear that the changes would push healthy and sick into different forms of coverage, which would tear at an underpinning of insurance: that the healthy subsidize the less healthy in plan to which they all belong.

The agreement was reached on Thursday by negotiators for the Republican ajorities in the House and Senate, after the two chambers passed differing ersions of legislation that would slash $435 billion in anticipated growth in seven years from Medicare, the health care program for the elderly, and Medicaid, which covers many poor people, the disabled and residents of nursing homes. The revised legislation is expected to be voted upon by both houses shortly.

Under the Medicare provision, 37 million elderly Americans would be allowed to leave the traditional Medicare program and use money from that program to sign up for managed care plans; plans of various sorts run by doctors; plans offered by unions and associations; traditional plans where members pay for each service they receive, or medical savings accounts, a favorite of Speaker Newt Gingrich and the Republican leadership.

They could also more easily buy "dread disease" policies, which insure against specific illnesses like cancer, but which have been strongly criticized by consumer groups.

To Republicans, opening this marketplace of options would hold down health care costs by making the elderly more responsible for their medical choices. "What comes out of all of this is a more innovative way to deliver more health care to more people at lower costs," said Representative Thomas J. Bliley Jr. the Virginia Republican who heads the House Commerce Committee.

But critics worry that healthier Medicare recipients would join private lans, which would court them actively, leaving most of the sickest people

isolated in the Government-run program. This, they say, could threaten the viability of the traditional program over time by causing escalating deficits. One result, they say, would be lower payments to doctors and hospitals that would lead them to leave the program.

The critics also contend that cuts in anticipated growth in Medicaid would lead states to curtail their rolls, creating what some social scientists predic would be millions more uninsured.

Republicans strongly dispute this, maintaining no one would lose insurance.

Henry Aaron of the Brookings Institution, a Washington research center, was not as hopeful.

"Insurance companies and public programs will become leaner and quite literally meaner," Mr. Aaron said, "not because they're run by mean people, but because competitive pressures will force them to be so."

President Clinton has vowed to veto the final legislation. In an interview before the negotiators reached their agreement, Mr. Clinton's special assistant for health care, Chris Jennings, said the President had "grave concerns" about medical savings accounts and the prospect of "millions more uninsured" as a result of changes in Medicaid.

Encouraging a Shift To Private Plans

A hallmark of the Medicare legislation is the encouragement of private heal plans, which now cover 10 percent of the program's recipients, grouped in a fe regions.

Under the legislation, the elderly would be able to take an annual credit, average more than $4,500, and use it to buy coverage. If the beneficiary signe with a managed care plan, the money would probably cover an annual payment for services at least equal to those under current Medicare, but access to doctors would probably be limited.

The Government would provide selection advice to recipients, monitor the plans' marketing and administer enrollment.

Larry Mayewski, an analyst with A. M. Best & Company, an insurance rating agency, estimated conservatively that 30 percent of Medicare recipients, or mc than 10 million people, would enroll in the plans. Others predict more than twice the interest. Plans would likely try to entice consumers by offering mor benefits than Medicare, like prescription drugs and eyeglasses, that would obviate the need for the supplemental policies that 70 percent of the program' recipients now buy.

But many experts fear a balkanization of healthy and sick.

A 1993 study of Medicare recipients who had joined health maintenance organizations found that healthier people disproportionately were attracted tc

the plans, causing the Government to lose rather than save money. Indeed, critics say, plans often target the healthy by offering items like credit for exercise classes.

While the managed-care industry disputed the findings of the 1993 study, .andall S. Brown, of Mathematica Policy Research Inc., who headed the effort, said he believed that sicker recipients stayed in the conventional program to insure that they could keep their own doctors, which is often impossible in managed care plans.

"If you're an 80-year-old person and you suffered a heart attack three year ago and a doctor saved your life, you're not going to give up that doctor for $50 a month," Mr. Brown said.

The ability of private associations to organize coverage for their members a particular concern to many who are critical of the privatization, because, they say, groups representing the more affluent, who are generally healthier, could negotiate for better coverage. This would cause their members to leave t general pool even more quickly.

Uwe Reinhardt, a health care economist at Princeton University, also said that cost figures almost compelled private plans to seek out the healthy.

In 1993, when the average Medicare expenditure per person was $4,030, the average for the healthiest 90 percent of recipients was only $1,430; the avera for the sickest 10 percent was $28,000.

Gail Wilensky, who ran Medicare during the Bush Administration, said, "This is probably the single most serious technical problem we have to deal with, bu he answer isn't to say, 'My God, we can't have choice.' "

Rather, Ms. Wilensky said, the Government should calibrate more finely payments for the elderly that reflect their health status. If healthier people sign with private plans, she said, they should take reduced sums with them, while sicker people should be credited with a total that reflects their cost c care.

Many professionals say that such analyses, while being explored, are extremely difficult to execute well.

Individual Approach To Containing Costs

If some experts worry that managed care plans would skim healthy recipient from the conventional Medicare program, many of the large plans are concerned that the healthy would be skimmed from them by medical savings accounts.

These accounts have been championed by the Golden Rule Insurance Company o Indiana, whose political action committee contributed $621,775 to the Republi and Democratic National Committees since 1991, according to the public intere group Common Cause. All but $46,000 went to Republicans.

Since 1985, the committee has given $309,526 to Congressional candidates, including Mr. Gingrich. In addition, Golden Rule was the sponsor of a televisi show presided over by Mr. Gingrich, and company officials gave $35,000 this ye to Gopac, the political committee Mr. Gingrich headed until last May.

The Speaker praised the savings account idea in his recent book.

Under the legislation, Medicare recipients could buy a high deductible plan contributed to by Medicare, as long as they opened a medical savings account that the program could help fund with money left over after the insurance premium was covered. Interest on account balances would be tax free and surpluses could be rolled over each year.

Account money could be spent on anything, but nonmedical expenses would be subject to income taxes.

To proponents, the concept would work wonders at containing costs, because the elderly would have incentives not to seek unneeded care -- and would also have the security of catastrophic coverage.

"What medical savings accounts do is give seniors more control over their health care dollars," said Merrill Matthews Jr., health policy director of the National Center for Policy Analysis, a Dallas research group that has champion the idea and that also receives contributions from Golden Rule. "It gives them the ability to benefit financially from being a prudent health care shopper."

A study commissioned by the center, which included assumptions that its author wrote involved "significant uncertainty," predicted that the savings accounts would result in Medicare savings of $134 billion to $195 billion over seven years. But the Congressional Budget Office estimated that the bill would cost taxpayers $4 billion in that time.

Although Mr. Matthews said the accounts would be popular with sick and healthy alike, the budget office estimated that only 2 percent of Medicare beneficiaries would be interested and that they would likely be among the healthiest.

E. Richard Brown, head of the American Public Health Association, which represents public health professionals, said that in addition to siphoning the healthy and putting the traditional Medicare program at risk, the account concept "creates all the wrong incentives, incentives for people not to get preventive care" by allowing them to keep money they do not use.

The bill would also broaden the range of policies that could legally be sol to the elderly. And, in the eyes of critics, it would weaken a requirement tha other policies include cautionary statements that they could duplicate coverag under Medicare or other plans.

Gail Shearer of Consumers Union, an advocacy group, said this provision wou open up the sale of hospital indemnity and dread-disease policies to older people. Because these policies are more profitable to insurers than other type of insurance, Consumers Union has called them the worst buy in the market. St insurance commissioners have also criticized these policies.

From the mid-70's to the late 80's, scandals erupted in many states when older people, pressured by fear-mongering sales tactics, bought stacks of these policies, which often proved worthless.

Proponents of these policies argue that many plans have provided extra money r co-payments, deductibles and compensation for lost income. The excesses, they say, were caused by a few bad apples, and, they maintain, Congress never intended to simply outlaw the policies when it enacted safeguards five years ago.

Aflac, a Columbus, Ga., insurance company whose political action committee has contributed at least $1.76 million to candidates since 1987, is the country's largest cancer insurance carrier and has lobbied to relax restriction on these policies.

Some See Millions Becoming Uninsured

In the Medicaid proposals, the $170 billion cut in projected spending over seven years has led many experts to fear that millions would become uninsured. The Urban Institute, a Washington research organization, estimated that more than eight million people who would have been covered by Medicaid in 2002 would likely be without insurance because hard-pressed states would be forced to keep them from the rolls.

In a recent paper for the Robert Wood Johnson Foundation, Kenneth E. Thorpe, Tulane University, estimated that the number of people with no health surance could rise from today's roughly 40 million to as many as 66 million i 2002, when changes in Medicaid are combined with the rising number of employees who do not receive coverage through work.

Congressional Republicans headedly dispute these findings.

"Nobody wants to increase the number of uninsured people -- that would be crazy," said Mike Collins, spokesman for the House Commerce Committee. "We believe the basic premise of these studies is flawed and states, by utilizing managed care options, will be able to deliver a lot more bang for the buck."

John Holihan, an author of the Urban Institute study, said the use of manage care had figured in the study's computations.

"What we're getting more and more from people," Mr. Holihan said, "is that our assumptions are optimistic."

LANGUAGE: ENGLISH

LOAD-DATE: November 18, 1995

U.S. Department of Health and Human Services

The Office of Disability, Aging and Long-Term Care Policy
Room 424-E, Humphrey Building
200 Independence Ave., SW
Washington, D.C. 20201

FAX (202)401-7733

TO: Pauline Abernathy + Jennifer Klein NUMBER OF PAGES: Cover + 21

FAX NUMBER: (202) 456-2878 DATE: 11-7-95

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REMARKS/COMMENTS

FAX TRANSMISSION

U.S. Department of Health and Human Services
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TOTAL NUMBER OF PAGES TRANSMITTED: 5 + cover

COMMENTS:

Nursing home fact sheet,
as discussed.

HHS FACT SHEET

DRAFT
As of 10/2
12 —

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE

Contact: HHS Press Office
(202) 690-6343

NURSING HOME REFORM IN JEOPARDY
HOUSE AND SENATE PLANS THREATEN BIPARTISAN PATIENT PROTECTIONS

Overview: At the end of September, House and Senate committees voted to replace the state/federal Medicaid partnership with a new system of block grants. These new grants would eliminate federal requirements for decent care and abolish the guarantee to provide financial help to older Americans with nursing home bills they cannot afford. As these standards are threatened, we should take care to remember the abuses that made them necessary, acknowledge the interim successes, and identify the further work to be done in this crucial area of public health.

BACKGROUND

Nursing home standards were developed on a bipartisan basis under President Reagan and were implemented throughout the Reagan, Bush and Clinton Administrations. Since 1986, both parties have agreed on the need to protect nursing home residents from neglect and abuse through the development of a more flexible enforcement system, working particularly with the nursing homes themselves.

- In 1986, the Institute of Medicine (IoM) published a study of the regulation of nursing homes, entitled "Improving the Quality of Care in Nursing Homes." In addition to documenting many problems in nursing homes, the study found that many facilities were "gaming" the enforcement system by coming into quality compliance only briefly when threatened with a shutdown but not sustaining any commitment to long-term compliance. The study recommended that HCFA implement a range of intermediate remedies to deter violations.

- The IoM report culminated in the passage of reform legislation in the Omnibus Budget Reconciliation Act of 1987. In signing the reconciliation act, President Ronald Reagan endorsed a bipartisan agreement of comprehensive reform, including requirements for:

-more-

-- a residents' "bill of rights;"
-- requirements for standardized individual resident assessments and plans of care;
-- nurse aide training and competency requirements, including a registry of nurse aides found to have abused residents;
-- detailed survey, certification and enforcement requirements designed to encourage provider compliance.

- On July 1, 1995, HHS implemented the last major phase of the nursing home reform. New enforcement regulations took effect to assure that the agreed-upon standards were being met. These enforcement rules provide a variety of remedies that can be applied for deficiencies of varying scope and severity. For the first time, federal and state enforcement agencies are able to choose the remedy that best suits the seriousness of the situation. The new rules are meant to ensure continuous internal quality control and improvement by the nursing homes themselves.

EFFECTS OF NURSING HOME REFORM

Nursing home practices have already improved as a result of reform.

-- Since the nursing home law went into effect, the number of drugged or restrained residents has been reduced. A study by the Research Triangle Institute indicates that, between 1988 and 1992, there has been an almost 50 percent reduction in the use of physical restraints. Estimates in the reductions of antipsychotic drug use range from decreases of 19 percent to decreases of 59 percent.

-- Independent research has shown a 25 percent decrease in hospitalization rates and improved functional outcomes from 1990 to 1993, attributable to nursing home reforms.

ENFORCEMENT

Most facilities are able to comply with existing federal requirements. Fewer than 10 percent of the nursing homes surveyed will be sanctioned for violations. However, some serious problems uncovered during enforcement spotlight the need for continued federal requirements in this area. Examples of substandard practices include:

-- In a Maryland facility, a resident died due to strangulation from a restraint because the resident was not properly supervised while wearing the restraint.

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-- A resident in an Florida facility was sexually assaulted by a nurse's aide and was found bruised and bleeding by a nurse assistant. The same perpetrator had attempted an assault on another resident.

-- A resident in an Indiana facility was found to have maggots and larvae in a foot wound and had to be hospitalized. The nursing home staff acknowledged that they do not "always have enough staff to give baths" to the residents.

-- A resident in an Indiana facility, who needed respiratory assessments every four hours, was left without the treatments for a seven-hour period and died.

CONGRESSIONAL PROPOSALS

Without these nursing home standards and the enforcement system to implement them, some facilities would continue to provide unacceptable care to the nation's elderly and disabled. The House and Senate block grant proposals, as they emerged from committee, proposal eliminate assurances of quality care and protection for residents from abuse and neglect.

The House and Senate proposals, would:

-- repeal all federal quality and enforcement standards, eliminating even basic federal requirements for fire safety and infection control. Residents could no longer rely on uniform standards to protect them from abuse and to safeguard their right to be treated with dignity. States would be permitted to allow poor quality care to occur without sanction or penalty.

-- transfer to states new responsibilities with less money to discharge them. States would be required to develop and enforce their own new requirements with severely limited funding. Quality requirements would vary from state to state, and multi-state nursing home chains who find the variations burdensome could decide to operate homes only in states with less regulation, thereby reducing access to and quality of care.

-- eliminate standards for the training and testing of nurse aides. The training and testing of these frontline caregivers would no longer be a federal requirement.

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As early hospital discharges increase, nursing homes are being called upon to provide more care in more complex situations. Residents in these facilities need more, not less, assurances that aides are adequately trained.

-- eliminate standards for registries of qualified aides. These registries track individuals who have completed approved training as well as those who have abused, neglected or stolen from residents. These registries are a great resource to nursing homes and other health care providers.

-- potentially increase the cost of providing care to residents by limiting the capacity of nursing homes to treat more complex patients. A recent study by the Research Triangle Institute and others suggest that implementation of the nursing home standards has saved money by reducing the hospitalization of residents. Preliminary findings show that between 1990 and 1993, the hospitalization rate of nursing home residents dropped from 28.4 percent to 19.5 percent, resulting in estimated Medicare savings of at least $2 billion. Eliminating nursing home standards could reverse this trend and lead to increased costs to the Medicare program.

SUPPORT FOR MAINTAINING PATIENT PROTECTIONS

"...the Republicans in Congress have proposed a budget that will undermine the dignity and independence of our senior citizens...It ends the national commitment that any senior citizen, regardless of how much money they have or don't have, will have access to quality doctors and good facilities...the Republican plan would eliminate all national standards for nursing home care...Congress should strip these outrageous provisions from the budget bill. They're inconsistent with our core values. They're not what America is all about, and they are certainly not necessary to balance the budget."

-- President Bill Clinton, Radio Address to the Nation, Sept. 30, 1995

"Seven years ago, President Reagan signed a bipartisan law protecting the rights and the health of people in nursing homes...Working together, Democrats and Republicans; consumers and industry; federal and state governments devised a system of protections for nursing home residents. The results have been nothing short of remarkable...

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"So, with those results, what do the Republicans in Congress propose to do? They propose to repeal those nursing home rules -- every last one of them -- and dump this responsibility back on you [the states]."

-- Secretary Donna E. Shalala, Speech to Medicaid Directors
Sept. 29, 1995

"We've never supported wholesale elimination" of federal rules...And inevitable fights over states' rules are "certainly a concern."

-- Linda Keegan, American Health Care Association
USA Today, Sept. 25, 1995

"Everyone has heard the horror stories about the bad old days in nursing homes. Why go back to them?...No credible evidence exists to justify reversing course...Seniors are in nursing homes because of advanced age, mental or physical disabilities, to recover from hospitalization or because they have no one to care for them. They are frail and vulnerable. They deserve all the protection the public can provide."

-- *USA Today* editorial
Sept. 27, 1995

FAX COVER SHEET

OFFICE OF LEGISLATIVE & INTER-GOVERNMENTAL AFFAIRS

Number of Pages: 4 Date: 12/4/95

To: Jen Klein From: SUSAN N. HILL SNH

Fax: 202 456-2878 Fax: 202-690-8168

Phone: Phone: 202 690-8170

REMARKS: I hope you find this helpful. Please call me with questions and/or comments

HEALTH CARE FINANCING ADMINISTRATION
200 Independence Ave., SW
Room 341-H, Humphrey Building
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DRAFT

CONFERENCE AGREEMENT: NURSING HOME QUALITY PROVISIONS

The Conference Agreement would gut current law by eliminating major quality standards and protections for nursing home residents. The bill would significantly diminish the Secretary's authority to enforce quality standards. Specifically the bill would:

Major Provisions:

Revoke an individual's guarantee to services –

- Eliminate the requirement that a facility provide services to "attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident." A facility would no longer have to make sure that residents achieve their greatest potential.

- No longer require a facility to deliver social services, pharmaceutical services, activities, and dental services to "each" resident. Instead, it would require that these services be provided to "residents" as a whole while not addressing individuals' unique needs and preferences.

Eliminate financial protections for beneficiaries–

- Delete all current protections against discrimination in admission. Allow facilities to require payments from residents or their families as a condition of admission or continued stay.

- Repeal provision requiring the Secretary to define costs which may be charged to the personal funds of Medicaid beneficiaries and which costs are included in the Medicaid rate.

Repeal the Secretary's authority to ensure quality –

- Shift the responsibility to "assure that requirements which govern the provision of care in nursing facilities..and the enforcement of such requirements" *from the Secretary to the State.*

- Add language permitting States or the Secretary to deem a facility (as having met certification requirements) accredited by a private accrediting agency.

Undermine the Secretary's enforcement authority –

- Significantly change the Secretary's role in enforcing standards. Require the Secretary to first notify a State of a deficiency and wait a "reasonable period of time" to allow the State to take action. The Secretary can only take action against the facility if the State fails to do so.

Abandon critical National resident assessment criteria –

- Eliminate the requirement that the resident assessment instrument be based on a minimum data set of core elements and common definitions and approved by the Secretary.

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Other provisions in the Conference Agreement:

Revoke residents rights –

- Abolish a resident's right to refuse transfers that are required by facilities to attain coverage for residents' under a different public payment program.
- Exempt facilities from giving 30-day advance notice of transfer or discharge under certain circumstances.
- Delete current requirement that facilities give information to residents about advance directives.
- Allow a facility to deny visitation to a resident under certain circumstances.
- Require that the facility must provide assurance to the State, instead of to the Secretary as under current law, of the security of all personal funds of residents deposited with the facility.
- Excuse facilities from notifying residents of their account balances when they are in danger of exceeding the asset limit for Medicaid eligibility.

Loosen quality of care requirements on facilities at the risk of residents-

- Eliminate the requirement that facilities with 120 or more beds must have at least one social worker employed full-time.
- Give States, instead of the Secretary as under current law, the authority to establish requirements for nurse aide training programs.
- Provide a disincentive to become a nurse aide by deleting the requirement that the State provide for the reimbursement of training costs (for a nurse aide employed not later than 12 months after completing training).
- Give States, instead of the Secretary as under current law, the responsibility to set standards for qualifications of nursing facility administrators.
- Eliminate the Secretary's role in establishing criteria for assessing the administration of facilities, including: governing body and management; agreements with hospitals regarding transfers of residents to and from hospitals and other facilities; disaster preparedness; direction of medical care by a physician; laboratory and radiological services; clinical records; and resident and advocate participation.

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Weaken nursing home survey and certification requirements –

- Eliminate the requirement that States conduct periodic educational programs for the staff and residents in order to present current survey and certification regulations, procedures and policies.

- Reduce the frequency of standard surveys from "not later than 15 months" to "not later than 24 months". Also requires that, "in the case of a facility which has been subjected to an extended survey..., a standard survey shall be conducted not later than 12 months after the date of the preceding extended survey."

- Reduce the frequency of special surveys from "within 2 months" of any change in ownership, administration, management, or director of nursing, to "within 4 months."

- Retain the Secretary's authority to develop, test and validate the survey protocol, but gives the State, instead of the Secretary, the authority to establish minimum qualifications for the survey team.

- Delete the requirement that the Secretary provide for the comprehensive training of State and Federal surveyors and that surveyors take the training if offered.

- Reduce the frequency of validation surveys conducted by the Secretary from "each year" to "at least every third year."

- Rescind the Secretary's authority to penalize a State with inadequate survey and certification performance with a reduction in administrative costs.

- Limit the Secretary's authority to conduct a survey of a facility to when she has "found substantial evidence of a pattern of noncompliance...." Eliminates the Secretary's ability to make "independent and binding" determinations in these cases.

- Change the requirement that the State and the Secretary make information concerning all surveys and certification available to the public from within "14 calender days" to "a reasonable time."

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Dilute current State and Federal enforcement tools to ensure quality --

- Delete current provisions authorizing the imposition of retroactive civil money penalties for the days in which a facility was not in compliance with requirements.
- Delete the requirement that civil money penalties collected be used to protect the health or property of residents.
- Reduce the maximum civil money penalty from $10,000 for each day of noncompliance to $5,000 for each day of noncompliance.
- Repeal the provision that directs the State to design a system that swiftly imposes remedies and imposes incrementally more severe fines for repeated or uncorrected deficiencies. Deletes the States authority to provide other specified remedies, such as directed plans of correction and prohibition of facility-conducted nurse aide training.
- Replace the provision that States "shall" impose denial of payment for all individuals admitted to a facility if that facility remains out of compliance for 3 months, with language that States "may" do so.
- Delete current language providing funding for temporary management and other expenses associated with implementing remedies to a State.
- Delete the language authorizing States to establish a program to reward, through public recognition, or both, nursing facilities that provide the highest quality care to Medicaid residents.
- Delete current provisions concerning overlapping Secretarial and State enforcement authority.

/RTI RESEARCH TRIANGLE INSTITUTE

Social and Health Policy Research Center
Program on Aging and Long-Term Care

919 929 3962 (Home #)

MEMORANDUM

TO: Mary Harahan

FROM: Catherine Hawes

SUBJECT: Restraint Reduction -- 50% is probably OK to use

DATE: September 29, 1995

1. Use of physical restraints is an item in the MMACS/OSCAR data set that facilities and surveyors complete at the annual federal survey in each participating facility.

2. An estimate of 50% reduction in restraints is probably accurate, using these data, particularly if the measure is taken from 1987, 1988 or even 1990 and compared to use in 1994 or 1995. Even taking 1990 MMACS data at approximately 38% use of restraints (for 1990) to 1994 at 20-21%, you see a reduction of about 48%. If you want us to, we can do runs on the MMACS and OSCAR data to verify the reports published elsewhere. However, I also checked my lit review and found a summary on restraint prevalence prior to (and where available, post) OBRA. If you like I can on Monday bring you a copy of a table, I think. Anyway, one cite you can use in the published lit. for a reduction of this magnitude is:

Robert Kane, Carter Williams, I. Franklin Williams, and Rosalie Kane (1993). "Restraining Restraints: Changes in A Standard of Care." ANNUAL REVIEW OF PUBLIC HEALTH - 1993, Vol. 14:546 - 584.

3. Our data are a late 1990 estimate for 2,100 + residents in 269 nursing homes in 10 States and an early 1993 estimate for 2,100 residents in the same 255 homes. We found a 50% reduction for residents who were cognitively intact and a 25% reduction overall (among all residents). Our figure is probably more conservative because: (1) it's from 1990 as the baseline to 1993 as the "end-point," which is probably catching the wave late and may be missing even more change in 1994 and 1995; (2) we had independent assessors (RNs) rather than facility staff or surveyors completing the instrument; (3) there is tremendous variation across the country in restraint use pre-OBRA (e.g., 25% to more than 85% by some counts - and we found 60% in one State pre OBRA), so our States may under present the drop, compared to national averages.

FAX COVER SHEET

Friday, September 29, 1995 05:50:35 PM

To: MARY HARAHAN
Attention: from Catherine HAWES
Fax #: 1-202-401-7733

From: CHARLES D. PHILLIPS or CATHERINE HAWES
Voice: (919) 929-3962

Fax: 1 page and a cover page..

/RTI RESEARCH TRIANGLE INSTITUTE

Social and Health Policy Research Center
Program on Aging and Long-Term Care

MEMORANDUM

TO: Pam Doty

FROM: Catherine Hawes

SUBJECT: Response to your request for information about our presentation at GSA on effects of OBRA-87 Nursing Home Reforms

DATE: September 26, 1995

At the annual meeting of the Gerontological Society of America, the project team that led the development of the national nursing home resident assessment instrument (RAI) presented the preliminary results from our evaluation of its effects on quality of care. This presentation was made as part of a symposium on the effect of the RAI for the GSA's scientific meeting in November, 1994. While the formal report on our findings has not yet been released by HCFA, we have prepared articles reporting the findings and submitted abstracts with all of the results and two of the five "results" articles to HCFA. Two of the articles are currently under review at *JAGS*. We anticipate six articles will be submitted to *JAGS* and appear in one issue reporting the full range of findings.

A summary of the major findings we reported as preliminary findings (which means that they had not yet been released as a final report to HCFA) appears on the next page. **Please note that the results speak not only to the effects of the RAI alone but also to other aspects of OBRA, such as the new regulations on restraint reduction.** Feel free to cite them and to call me with any additional questions at (919) 541-6340 or 929-3962 (home). Also, if you want to discuss the cost estimates with Vince or Charles, Vince can be reached at (401) 863-3492 and Charles at (919) 541-6877. The cost estimates, by the way, are not part of our formal work for HCFA. We are in the process of linking the post-OBRA cohort to the Medicare claims files and when the debated over OBRA arose this summer, we proposed making the same link for the pre-OBRA cohort and analyzing the cost effects as part of our contract. Unfortunately, HCFA only allows contracts to run for six years, and we couldn't get the longitudinal claims files processed and analyzed in 2 months. Thus, we have resorted to a "back of the envelope" estimation process during the last few days. If HCFA still lives after October 1, I guess we will go in for a grant to analyze the real costs.

Thanks for all your help!

SYMPOSIUM AT THE ANNUAL SCIENTIFIC MEETING OF THE GERONTOLOGICAL SOCIETY OF AMERICA

Atlanta, Georgia: November, 1995

THE EFFECT OF THE RESIDENT ASSESSMENT INSTRUMENT (RAI) ON THE QUALITY OF CARE IN NURSING HOMES

Dr. Charles D. Phillips, Ph.D., M.P.H., Symposium Chairperson[1]
Dr. Catherine Hawes, Ph.D.[1], Dr. John N. Morris, Ph.D.[2]
Dr. Vincent Mor, Ph.D.[3], Dr. Brant Fries, PhD.[4]

During the symposium, the research team reported the results from an evaluation of the effects of the implementation of the regulations on resident assessment on the quality of care experienced by nursing home residents. The Resident Assessment Instrument (RAI) consists of the Minimum Data Set for Nursing Home Resident Assessment and Care Planning (MDS) and 18 special Resident Assessment Protocols (RAPs). The RAI is used by facilities as part of the OBRA-87 mandated nursing home reforms, to assess residents upon admission to the facility and to develop their plan of care. In addition the RAI is used to assess residents annually after admission and upon any significant change in their health status. Finally, the system includes Quarterly Assessments used to monitor the effects of the care plan and the need for modifications to the care plan.

The RAI evaluation study design was a pre-post test design that examined changes in the process of care and longitudinal resident outcomes as measures of quality. The major findings will be presented in a final report to HCFA and in a series of five scientific publications. Thus, the results presented at GSA are preliminary.

The evaluation was conducted in metropolitan areas and surrounding rural counties in 10 States in 269 nursing homes that were randomly selected. It involved assessment of the quality of care and resident status for more than 4,000 residents. Comparisons of process quality and resident outcomes are between a pre-OBRA period (1990 and early 1991) and a post-OBRA/RAI-implementation period in the Spring and Fall of 1993. The major findings include the following:

- There were significant and widespread improvements in the process of care.
- The impact was also seen in improved resident outcomes.
- There was a substantial reduction in hospital use (25%), suggesting the potential cost-effectiveness of the RAI and other parts of OBRA-87 &'90. This reduction was most pronounced among residents with cognitive impairment and occurred without increases in mortality and with decreases in functional decline.
- These findings suggest the RAI and other OBRA provisions significantly improved quality of care for residents and are associated with reduced costs for hospital care.

1. There was a significant increase in the comprehensiveness and accuracy of the information available in resident's medical records about their health and functional status, care needs, strengths and preferences. This is important since such information serves as the basis for developing their plan of care.

   - There has been a 24% increase in the accuracy of information the resident's nursing home records.

2. There was a significant increase in the comprehensiveness of care planning. The care plans in the post-RAI period address a greater percentage of residents' health problems, their risk factors for functional decline and accidents, and their potential for improved function.

   - There has been a 17% increase in the number of problems that are addressed in care plans.

3. There were significant improvements in a wide range of areas that affect residents' well-being, from significant reductions in tying people into chairs to greater attention to their hearing and skin care to increasing the availability of activities. These include such changes as:

   - a 30% increase in the use of hearing aids for persons with hearing difficulty
   - a 64% increase in the presence of advanced directives
   - a 29% decrease in the use of indwelling urinary catheters
   - a 27% increase in the use of behavior management programs to address disturbing behaviors such as wandering or resisting care
   - a 25% decrease in the use of physical restraints
   - a 28% decrease in the percentage of residents who are not involved in activities any of the time

4. These changes in care practices also translated into better resident outcomes and substantial reductions in hospitalizations.

- As a result of the OBRA reforms, nursing homes prevented decline among residents. After OBRA, nursing home residents had better outcomes in such areas as physical functioning in the activities of daily living (ADLs) and cognition performance. Thus nursing homes are helping residents delay the declines typically associated with the multiple chronic diseases and conditions most NH residents have.

- There was a 25% reduction in hospital days among the NH residents in the study.

1. There was a significant increase in the comprehensiveness of the information available in resident's medical records about their health and functional status, care needs, strengths and preferences.

2. There was a significant increase in the accuracy of the information available in the residents' medical records, which is important since it serves as the basis for developing their plan of care.

3. There was a significant increase in the comprehensiveness of care planning. The care plans in the post-RAI period address a greater percentage of residents' health problems, their risk factors for functional decline and accidents, and their potential for improved function.

4. There were significant improvements in a wide range of process quality measures, such as decreased use of physical restraints, increased involvement of families and residents in care plan meetings and decisions, increased use of advanced directives, increased use of psychological therapy and antidepressants for residents with depression, increased use of behavior management programs for residents with problematic behavior symptoms, such as wandering, decreased use of urinary catheters, and so on.

5. There was a significant reduction in functional decline among residents. This finding is particularly noteworthy because it occurred even though the residents in the post-OBRA/post RAI implementation period had a baseline status that was more impaired than the residents in the 1990/91 time period. Despite this gradual trend for nursing homes to serve more impaired residents, the nursing homes were providing more appropriate care and achieving greater stability and less decline among residents.

6. There was no increase in mortality in the post/OBRA period. However, there was a significant reduction in both the number of hospitalizations and the total days of hospital care among the residents over a six month period. Indeed, there was a 25 percent reduction in hospital days after the implementation of OBRA and the RAI.

---

1. Program on Aging and Long-Term Care, Research Triangle Institute, Research Triangle Park, NC.
2. Social Gerontological Research Center, Hebrew Rehabilitation Center for Aged, Boston, MA.
3. Center for Gerontology and Health Services Research, Brown University, Providence, RI.
4. Institute for Gerontology, University of Michigan, Ann Arbor, MI.

URGENT 7671	Date # of pages ▶ #2
To PAM DOTY	From CATHERINE HAWES
Co/Dept. ASPE	Co. 4326-21
Phone # (202) 690 6443	Phone #
Fax # (202) 401-7733	Fax #

Jennie -
More nursing home stuff
Pam

from the Desk of

Vincent Mor, Ph.D.

DATE: September 26, 1995

TO: Theresa Sacks

FROM: Vincent Mor, Ph.D., Director, Brown University
Center for Gerontology and Health Care Research

RE: Cost Savings Estimates from Reduced
Hospitalization of Nursing Home Residents
Associated with Nursing Home Reform

CC: Charles Phillips, Catherine Hawes, Katherine Hayes

What follows is an explanation of the estimates of savings to the Medicare program associated with a substantial reduction in hospitalization of nursing home residents observed between 1990 and 1993, the period during which many of the specific provisions of nursing home reform were implemented.

As you know, OBRA '87 contained numerous provisions affecting the conditions of participation of nursing homes in the Medicare/Medicaid programs, specifically relating to quality standards and staff training. Included in these provisions are training requirements for nurses aides, qualification standards for administrators, additional clinical documentation justifying the application of physical and chemical restraints and the introduction of a comprehensive Minimum Data Set for Resident Assessment for use in documenting the clinical problems triggering specific clinical interventions listed in the residents' care plan. An evaluation of changes in the processes and outcomes of care experienced by nursing home residents from in a random sample of 268 facilities in 10 states was undertaken by the Research Triangle Institute, Brown University, the University of Michigan and the Hebrew Rehabilitation Center for Aged. The study found reductions in physical restraints, improvements in care plans directed at ameliorating specific clinical problems, reductions in the rate at which residents decline in physical and cognitive functioning and a substantial reduction in the rate of hospitalization. While our evaluation was not designed to do so, we have conducted preliminary analyses in order to estimate the size of savings to the Medicare and Medicaid program that may have come about due to the reductions in hospitalization.

Over the six month period of our evaluation, we observed that in 1990 28.4% of the population of nursing home residents were hospitalized whereas in 1993 only 19.5% were hospitalized. Annualizing the average number of days hospitalized per capita (rather than just among users) we calculated that the average number of hospital days per resident was 7.2 in 1990 and 5.3 in 1993. Using the 1992 dollar figures from the Medicare and Medicaid Statistical Supplement (US DHHS. HCFA. ORD Statistical Supplement, 1995) . the average Medicare payment for a hospital day for an Aged beneficiary is $730. Since our sample represents all residents in facilities on a given day, we multiplied the number of hospital days by the Medicare payment per day for all 1.5 million residents of US nursing homes. For the 1990 data (using 1992 dollars) this yields $7.884 billion whereas for 1993 this yields $5.803 billion. Thus, Medicare spent over $2 billion less hospitalizing aged beneficiaries in 1993 than in 1990. This "savings" does not include the fact that many nursing home residents entering hospital are covered by Medicare for several weeks under the SNF benefit after returning to the nursing facility. Furthermore, the reduction in

XVIII ; XIX impact

hospitalizations also implies a reduction in the use of ambulances to transport [illegible] to and from the hospital.

There are possible Medicaid costs and savings as well. Medicaid pays the deductible for one day of care as well as the co-payment for hospitalizations lasting 60 days or more. However, except in states that reimburse facilities for some share of the Medicaid rate for "bed-holding" days, Medicaid is not liable for the nursing home costs while residents are in the hospital. Since we had very few stays that lasted 60 days, we ignored the copayment and compared the deductible costs to the cost Medicaid would have to pay were the patient not hospitalized. Assuming that about 50% of the nursing home resident population is covered by Medicaid and therefore dual eligible, the net result of this comparison is that Medicaid would be liable for an additional $11 million in costs due to fewer patient days covered in hospital by Medicare in 1993 as compared with 1990. This estimate does not include co-insurance requirements associated with Part B services received while in the hospital.

In summary, our data suggest that at least a $2 billion dollar savings to the Medicare program may have been realized in large part due to improved quality and capacity of nursing homes to care for patient's medical problems in the nursing home. This improvement in capacity was made possible by many of the reforms that are to be eliminated if Medicaid is made a block grant without any Federal standards and guidelines. Furthermore, with relatively contracting funds available for Medicaid, states will have no incentive to encourage nursing homes to achieve the quality level needed to treat medically complex cases in the home. Rather, the incentive will be to hospitalize them since Medicare will assume the costs.

I hope that this information has been useful. As noted, the analyses are preliminary. I would be happy to supplement them with additional work should you feel it necessary.

"USA TODAY hopes to serve as a forum for better understanding and unity to help make the USA truly one nation."
—Allen H. Neuharth
Founder, Sept. 15, 1982

USA TODAY

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Today's debate: REGULATING NURSING HOMES

Dropping federal regs is an invitation to tragedy

OUR VIEW **Everyone has heard the horror stories about the bad old days in nursing homes. Why go back to them?**

Eight years ago, after 15 years of argument, Republicans and Democrats in Congress got together to correct a public embarrassment. They passed a law to stop nursing home operators from abusing or neglecting the elderly.

They had ample incentive. Reports of residents lying in excrement, dehydrated, malnourished or overmedicated were commonplace. State regulation was a failure. Public outrage was high.

It should be just as high now. The regulations created by that law are about to be weakened or stripped away — victims of an ideological crusade to curb federal authority, good or bad.

Control would return to the states, despite their history of failure.

Those pushing the new plan, House and Senate Republicans, claim their legislation is not a repeal. They say the law is ineffective. And they say it's hugely expensive.

All three claims are fiction.

Not a repeal? Under existing regulations violators are subject to financial penalties, decertification, denial of payments or takeover by temporary managers if they violate health and safety standards. Proposed changes would weaken enforcement by states that are vulnerable to powerful lobby groups. The Senate wouldn't require inspections, nurse staffing or protections against restraints or medication.

Not effective? A government study of 269 homes in 10 states cited impressive results. The study found hospitalization of nursing home residents down 25%, use of restraints down 25%, and detection and punishment of abuses increasing.

Too expensive? Quite the contrary. A study of 9,000 Georgia nursing-home residents reports a monthly $76,738 savings by curtailing unnecessary drug therapy, thanks to the regulations. And that's not an isolated case. The National Citizens' Coalition for Nursing Home Reform, a resident advocacy group, says the changes saved billions in costs attributed to poor treatment.

Even the American Health Care Association, representing nursing home owners, says costs have not been a problem.

In fact, nursing home owners signed onto the legislation when it passed in 1987. So did consumer groups. So did state officials. So did the Institute of Medicine, research arm of the National Academy of Sciences, whose 1986 report on nursing home conditions led to the reform.

No credible evidence exists to justify reversing course. If changes are necessary they should be based on the same kind of thorough study and public hearings that produced the original regulations.

Seniors are in nursing homes because of advanced age, mental or physical disabilities, to recover from hospitalization or because they have no one to care for them. They are frail and vulnerable. They deserve all the protection the public can provide.

Stop the scare stories

groups. The Senate wouldn't require in- all the protection the public can provide.

Stop the scare stories

OPPOSING VIEW **No one's going to torture grandma. The federal rules just aren't needed.**

By Thomas J. Bliley Jr.

The latest, most preposterous "Medi-scare" horror story is that our plan to fix Medicaid will allow nursing homes to fire their nurses, tie patients to their beds and sedate them to keep them quiet.

Let's turn on the lights. There's no bogeyman hiding in this closet.

A key component of our "Medigrant" bill is a "Nursing Home Resident Bill of Rights" that includes the right "to be free from abuse, including verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion." Compliance is mandatory, and states are empowered to shut down those facilities in violation.

Rather than weaken protections for nursing home patients, our bill strengthens them by ending an eight-year experiment with "federalization" of standards that by all accounts has been a total failure — a bureaucratic nightmare that is confusing, expensive and counterproductive.

Take the federal requirement that states independently assess the need for nursing home placement. After separately assessing some 81,500 patients placed in nursing homes in 1989 — at a cost of $28.5 million — California concluded that only five placements were inappropriate. That works out to $5.7 million per misplacement. What's more, the federal requirement only duplicated existing California procedures that would have revised those patients' placements anyway.

As governor of Arkansas, even Bill Clinton joined the governors of 47 other states in 1989 to criticize the nursing home regulations as inflexible federal "micromanagement." Our bill does exactly what Clinton and the other governors recommended: require the states (which enforce the rules anyway) to enact their own standards under strict federal guidelines.

Under our proposal, no state will see a penny of federal "Medigrant" assistance unless it first enacts rigorous new nursing home standards including safety; cleanliness and quality; staffing and employee training; protection of patient records, property and legal rights; and patient grievance procedures.

Nobody wants to go back to the days when nursing homes were unsafe and unsanitary, but we don't need a massive and expensive bureaucracy to protect patients. Let's recognize that all wisdom and compassion does *not* reside in Washington. The states are better suited to do this job.

Rep. Thomas J. Bliley Jr., R-Va., is chairman of the House Commerce Committee.

NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM

Comparison of
Medigrant.918 -- Sec. 2137. Quality Assurance Standards for Nursing Facilities
and the
Nursing Home Reform Act of 1987

The provisions under the Medigrant bill, recently under consideration in Congress, are being touted as including "improved nursing home standards" in the summary of the bill prepared by Representative Thomas Bliley, bill sponsor. As the following comparison shows, while the bill includes a basic outline of requirements included in the Nursing Home Reform Act, it is sorely lacking in substance and quality standards.

NO Federal Standards are included in the bill - Leaving residents and family members to rely on 50 different state standards. No one will be assured of the quality of care and services they, or a loved one, will receive from state to state.

Nursing Home Reform Act	Medigrant Bill
Quality of Care: Requirement for care and services to allow each resident to reach her highest practicable physical, mental and psychosocial well-being • Nursing & related services • Specialized rehabilitative services • Medically-related social services • Pharmaceutical services • Dietary services • Dental services • All services must be provided by qualified individuals, in accordance with a residents' plan of care, must meet professional standards of quality	NO Quality of Care provisions
Quality of Life: • The care & environment in a facility must maintain or enhance the quality of life of each resident. • Requirement for on-going activities program, directed by qualified professional, that meets the interests and needs of residents. • Participation in resident & family councils • Participation in social, religious, &	NO Quality of Life provisions

Nursing Home Reform Act	Medigrant Bill
community activities	
Resident Assessment & Care Planning • Requirement that a comprehensive, standardized, accurate, reproducible assessment of functional capability be completed for each resident within 14 days of admission and at least yearly thereafter.	Required resident assessment procedures, including care planning and outcome evaluation. NO requirement for resident and family involvement. With NO federal standard, NO uniform measurement of outcomes will be possible.
• Plan of care must be prepared with the participation of the resident, her family, and an interdisciplinary team within the facility.	
Quality Assurance • Requirement that facilities maintain a quality assessment and assurance committee, includes requirements for personnel included on the committee, how often it must meet, and its function.	Standards established for facilities shall contain provisions relating to ... quality assurance systems. NO provisions regarding function, when committee will meet, who will be on the committee.
Residents Rights: Facilities are to protect and promote the rights of each resident including:	
• Free Choice - physician, care & treatment	NO discussion of choice
• Freedom from Restraints	NO right to be free from restraints
• Freedom from physical or mental abuse, corporal punishment, involuntary seclusion	Be free from abuse, including verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.
• Privacy - accommodations, care & treatment, communications, visits	Be provided privacy in communications and to receive mail. NO provisions for privacy in care and treatment, accommodations, visits.
• Confidentiality - right to confidentiality of personal & clinical records	States must establish standards for the treatment of resident medical records. NO

Nursing Home Reform Act	Medigrant Bill
	requirement confidentiality of the records.
• Accommodation of Needs	NO provisions for accommodation of need
• Grievances - right to voice grievances without discrimination or reprisal, right to prompt efforts by the facility to resolve grievances	Right to voice grievances. NO provisions requiring facility efforts for resolution; NO provisions protecting residents from discrimination or retribution
• Examine survey results - results must be posted within the facility and accessible to residents and families.	Right to examine results of State certification inspections
• Notice of rights & services - must be oral and in writing; given at admission; also must be provided upon request; must include eligibility for medical assistance; list of items & services included in the daily rate, and included under the State medical assistance plan (when appropriate); notice of changes in rights & services	Right to receive notice of rights and services.
• This provision is one of several rights stated in the Act's regulations, "Long Term Care Facility Requirements."	Right to refuse to perform services for the facility.
• This provision is one of several rights and quality of life provisions stated in the Act's regulations, "Long Term Care Facility Requirements."	Right to retain and use personal property.
Transfer & Discharge Rights: • 30 days notice	Right to be provided with prior written notice of a pending transfer or discharge; NO specific time frame
• Facility must provide sufficient preparation & orientation for residents	NO provisions to prepare residents for transfer/discharge
• The only permitted reasons for discharge: ✓ Resident's needs cannot be met by the facility	NO provisions of appropriate reasons for transfer/discharge

Nursing Home Reform Act	Medigrant Bill
✓ Resident no longer needs the services provided by facility ✓ Safety of the resident or others is endangered ✓ The health of the resident or others is endangered ✓ After appropriate notice, the resident has failed to pay for her stay	
• The basis for the transfer/discharge must be documented in the clinical record	NO requirement for documentation
• Notice of bed-hold and required readmission policy	NO requirement for readmission policy; NO notice of bed-hold policy
• Requirement that states provide a fair mechanism for hearing appeals on transfers and discharges.	NO fair hearing requirement.
Access & Visitation Rights • Immediate access to residents must be permitted for the ombudsman, any representative of the State, or a resident's physician	Immediate access to any resident by any representative of the certification program, the resident's individual physician, the State long term care ombudsman, and any person the resident has designated a visitor
• Immediate access, with resident's permission, for family members	
• reasonable access for other visitors, with the resident's consent	
Equal Access to Quality Care • Facilities are required to establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services for all individuals regardless of payment source.	NO provisions for quality care and services for all residents regardless of payment source.

Nursing Home Reform Act	Medigrant Bill
Admissions Policy • Facilities may not require residents or applicants to waive their rights to medical assistance, nor give assurances that they will not apply for benefits.	NO provisions protecting residents from substantial financial outlays as a pre-condition to admittance into a facility, or the ability to continue residing in a facility.
• Facilities may not charge, solicit, accept or receive any gift, money, donation, or other consideration, from any individual entitled to medical assistance, as a precondition of being admitted or staying in the facility.	
Protection of Resident Funds • Facilities must maintain a system for handling and safeguarding residents funds, including: depositing funds in excess of $50 in an interest bearing account; providing a complete accounting of each resident's funds; maintain a written record of all transactions with respect to a resident's account.	Right to be protected against the misuse of resident funds. NO provisions requiring an accounting or record of funds managed by the facility.
• A resident may not be charged for any item or service covered by medical assistance.	No provisions prohibiting facilities from charging residents for covered services.
Staff Requirements • Required 24-hour licensed nursing services sufficient to meet the needs of the residents, including a registered nurse at least 8 consecutive hours daily, 7 days a week.	Qualifications for staff sufficient to provide adequate care, as defined by by the State. NO registered nurse requirement. NO licensed nurse requirement. NO minimum staffing requirement.
• Required training and competency evaluation program (at least 75 hours) for nurse aides, including regular in-service education.	NO nurse aide training and competency evaluation. NO minimum training requirements.

Nursing Home Reform Act	Medigrant Bill
• Requirement that the health care of each resident be provided under the supervision of a physician; including having a physician available to provide medical care in case of emergency.	NO provision requiring physician supervision of health care.
Administration Requirements • Requirement that facilities use its resources effectively and efficiently to allow each resident to achieve her highest practicable level of functioning.	NO provisions made that facilities use their resources to provide good resident care and promote quality of life.
• Requirement that changes in ownership, management, administrator, or director of nursing must be provided to the state agency.	NO such provisions in the Medigrant bill.
• Facilities are required to meet Life Safety Code requirements of the National Fire Protection Association.	NO provisions requiring facilities to meet LSC requirements.
• Requirement that a facility is sanitary, maintains an effective infection control program, and is designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the general public.	Assurance of a safe and adequate physical plant for the facility. NO requirement for meeting Life Safety Code standards; NO requirement for effective infection control systems.
Survey & Certification Process • Required unannounced annual standard survey to determine compliance with standards.	Medigrant plans must establish and operate a program for certifying nursing facilities meeting the standards established and the decertification of facilities which fail to meet the standards. NO provisions for how states will determine that standards have been met; NO provision for the investigation of complaints, abuse, neglect, or misappropriation of property.
• Required investigation of allegations of resident abuse, neglect, and mis-appropriation of resident property.	
• Requirement that procedures and adequate staff are maintained to investigate	

Nursing Home Reform Act	Medigrant Bill
complaints.	
• Survey results and plans of correction must be made available to the public within 14 days after given to facilities.	Public access must be provided to the certification program's evaluation of participating facilities, including compliance records, enforcement actions, and other reports regarding ownership, compliance histories, and services provided by facilities. Upon completion of a survey, the State agency must make public the pertinent findings of the survey relating to the compliance of the facility with requirements of law.
• Requirement that copies of facility cost reports and copies of statements of ownership be made available to the public.	
•Notice of findings of noncompliance must be sent to the State long-term care ombudsman, along with notice of any adverse action taken against a facility.	NO provisions for notifying the long-term care ombudsman of results or actions taken.
• If substandard quality of care is found, the State must notify the physician of each resident found to have received substandard care and the state board responsible for licensing the facility's administrator.	NO particular notice requirements if substandard quality of care is found.
Enforcement	
• When immediate jeopardy to resident health or safety exists, immediate action must be taken to remove the jeopardy and correct deficiencies, or terminate participation under the state plan, and may provide for one or more of the other remedies provided.	When immediate jeopardy exists, the State must, at least provide for termination of certification.
• When no immediate jeopardy exists, the State may terminate participation, provide for one or more remedies, or both.	When no immediate jeopardy exists, the State may, in lieu of termination, provide lesser sanctions, including one that provides denial of payment for new admissions.
• Provides a range of remedies, including civil money penalties, temporary managers,	NO alternative remedies, or intermediate sanctions, are specified, except denial of

Nursing Home Reform Act	Medigrant Bill
denial of payment, and termination.	payments for new admissions. NO provisions for use of civil money penalties.
• NHRA requires remedies be imposed when deficiencies exist.	The State shall not make a decision (regarding sanctions) until the facility has had a reasonable opportunity to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing. NO provision is made for a hearing or appeal process for residents; facilities are being sanctioned for not meeting an administrative deadline, instead of for not meeting the standards.
	The State's decision to deny payment may be made effective only after notice to the public and to the facility, and the sanction will end a) when the facility comes into substantial compliance, or is making good faith efforts to achieve substantial compliance, or b) at the end of the 11th month after the decision is made to impose the sanction, whereby the State will then terminate participation under the State plan.

News from Senator Bill Cohen of Maine

322 Hart Building
Washington, D.C. 20510-1901
202-224-2523

FOR IMMEDIATE RELEASE

September 18, 1995 CONTACT: Michael Townsend

COHEN SAYS MEDICAID REFORM MUST PROTECT NURSING HOME RESIDENTS

WASHINGTON, D.C. -- Concerned that important protections for nursing home residents could be eliminated, Senator Bill Cohen, R-Maine, today urged Congress to preserve nursing home standards as it works to reform the Medicaid program.

"In 1987, we enacted important legislation to improve the quality of life for residents in nursing homes," said Cohen. "That law included standards for the quality of care for residents, tougher requirements for staff training and a crackdown on abuse. Many of those rules, which have been developed over the past several years, are just now being enforced.

"Turning the Medicaid program into a system of block grant to states without maintaining strong quality standards would s us back to the dark days of substandard, unmonitored nursing homes. Each state would be allowed to regulate those nursi homes in whatever way they chose, with no federal standar

result could be a devastating decline in the quality of care for residents."

Cohen acknowledged that proposals to turn Medicaid into a block grant are intended to improve services and save money. But he insisted that patient rights should not be sacrificed in the process.

"It should be our goal to find ways to cut costs without forgetting our most vulnerable citizens. The nearly 2 million seniors currently living in nursing homes and their families have the right to expect a high standard of care in an environment free from abuse and neglect."

Cohen cited statistics showing that, in 1993, 11.8 percent of nursing homes were cited for violations of federal requirements.

"Nursing homes with a pattern of violations are being systematically cited and forced to correct their deficiencies," said Cohen. "If we eliminate all federal standards of care, the progress we have made in recent years will be reversed, placing millions of elderly and disabled Americans at risk."

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EXECUTIVE OFFICE OF THE PRESIDENT

Washington, D. C.

FAX TRANSMITTAL COVER SHEET

DATE: 08-Nov-95

TO: JEN KLEIN

SUBJECT: NURSING HOME QUALITY STANDARDS

FROM: PAULINE M. ABERNATHY 456-5374
NATIONAL ECONOMIC COUNCIL

If there are any problems receiving this transmission,
please call the sender, or (202) 395-7370.

REPUBLICAN BUDGET WIPES OUT QUALITY STANDARDS FOR NURSING HOMES AND INSTITUTIONS CARING FOR THE MENTALLY RETARDED
November 6, 1995

Republican Budget Jeopardizes Fundamental Protections for Nursing Home Residents

? Under the guise of reform, the House Republican budget throws away decades of progress by repealing federal nursing home quality standards. Since enactment of these federal quality standards, nursing home quality has improved dramatically: the use of physical restraints has declined 25%, dehydration among residents has declined 50%, and hospitalization rates have declined 31%. (Source: RTI and HCFA.) Without these federal standards and enforcement, nursing home residents will be vulnerable to abuse and neglect, to being inappropriately restrained, and dumped onto the streets when they run out of money.

? Moreover, both House and Senate plans repeal the requirement that Medicaid cover nursing home care at all. Their cuts will force states to deny coverage to hundreds of thousands of nursing home residents by 2002.

? In response to criticism, Senate Republicans reinstated the federal standards, but allow states with "equivalent or stricter" standards and enforcement to receive Medicaid waivers. Yet the federal government would have no way to ensure that states enforce these standards. Most recently, federal surveyors found 14% of nursing homes out of compliance with the federal standards. (Source: HCFA.) And states would have to enforce their standards with much less Medicaid funding than they receive under current law.

Both Senate and House Republican Budgets Entirely Repeal Standards for Institutions Caring for People with Mental Retardation and Developmental Disabilities

? Both eliminate federal standards, and do not require states to issue standards that would assure even the most basic rights, such as protection from abuse and neglect, treatment designed to assist the person to achieving the greatest level of independence, and the right to adequate health care. States do not currently have such standards.

? Neither plan requires states to maintain their current level of services -- in facilities or in home and community-based care -- for people with mental retardation and developmental disabilities. And both plans eliminate the guarantee of anything more than custodial care.

Medicaid Currently Ensures Quality Nursing Home Care and Fundamental Protections
In 1986, a major report documented widespread substandard or poor care at nursing homes in every state. In response to these deplorable conditions, President Reagan signed into law federal minimum standards for nursing homes that: protect nursing home residents from abuse and neglect; limit the use of physical and chemical restraints; prohibit nursing homes from evicting residents when they run out of money and

qualify for Medicaid; give nursing home residents the right to appeal decisions without retribution; and ensure that nursing aides are trained and do not have a history of abuse. The 1987 law has dramatically improved the quality of nursing home care, but more progress is needed.

Medicaid Currently Provides Standards for Institutions Caring for the Mentally Retarded Prior to the adoption of federal standards, people with mental retardation and developmental disabilities were routinely subject to abuse and lacked even minimally safe and sanitary living conditions. In response, federal standards were adopted in the 1970s and strengthened under President Reagan. The federal presence has made a difference -- the federal process on average finds 17% of facilities out of compliance with the federal standards. (Source: HCFA.)

Medicaid and Nursing Homes

In 1987, President Reagan signed a law establishing new protections for Americans residing in nursing homes. The Omnibus Budget Reconciliation Act of 1987 (OBRA '87) followed a 1986 report by the National Academy of Science's Institute of Medicine (IOM), which documented an epidemic of substandard care in nursing home facilities around the country. The IOM found that more than half the nursing homes in nine states had care so poor it jeopardized the health and safety of residents. In 27 states, at least one-third of facilities had such deficiencies.

Among the issues confronted in OBRA '87 were:

- Excessive use of physical restraints and psychotropic drugs to immobilize residents in their beds.
- Unsanitary conditions, including excessive bed sores and dirty kitchen facilities.
- Absence of registered nurses and poorly trained nurses' aides.
- Physical and verbal intimidation of residents.

OBRA '87 began a process of nursing home reform that continues today. New standards began to be put in place in 1990. Nursing home surveyors were re-trained and new manuals were developed with a strong emphasis on the quality of care delivered. In July 1995, new enforcement regulations were put into effect, including severe penalties for nursing homes that fail to comply with these standards.

Even before enforcement penalties were in place, OBRA '87 has resulted in dramatic improvements in the quality of nursing home care in the U.S. The use of physical restraints and psychotropic drugs has been sharply reduced. The number of registered nurses on duty in nursing homes has increased as has the level of training for nurses' aides.

But this work is not yet complete. Examples of poor quality nursing home care continue to be found. While the IOM found substandard care in as many as one in two nursing homes, the Health Care Financing Administration now finds such problems in about one in five facilities that are surveyed and only 35 facilities nationwide that fail to meet the tough new standards.

Following are some examples of substandard care found by HCFA inspectors:

Maryland. A nursing home resident was strangled to death because the resident was not properly supervised while wearing a physical restraint.

Florida. A resident was sexually abused by a nurse's aide. Ten other residents had multiple bruises and skin tears as a result of nursing assistants transferring, lifting, or pulling up the residents in bed.

Indiana. A resident was hospitalized after maggots and larvae were found in a foot wound. The nursing home said it did not have enough staff to give baths.

Texas. A resident was hospitalized after being force fed with a syringe and aspirated.

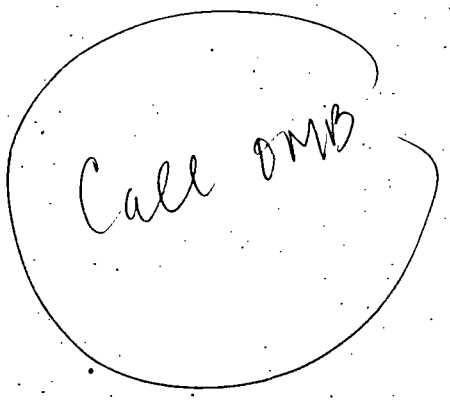
Maine. Twelve residents developed pressure sores in a facility. In 10 of those cases, the sores were found to be avoidable.

Hawaii. Residents of a home were repeatedly intimidated through verbal and physical abuse by the staff.

South Dakota. Residents were found to be losing weight because of an inadequate diet. One resident lost 16 pounds and now weighs 75 pounds.

Washington. Six residents have shown a marked decline in their abilities to walk, transfer, or move in wheelchairs because of an excessive use of restraints.

PRESIDENT CLINTON'S BALANCED BUDGET: HEALTH CARE REFORMS



March 25, 1996

President Clinton's Balanced Budget: Health Care Reforms

Contents

EXECUTIVE SUMMARY:

President Clinton's Balanced Budget: Health Care Reforms

The President's balanced budget will protect and strengthen Medicare and Medicaid. It will:

- Preserve our commitment to the elderly, people with disabilities, women, children and families as we make Medicare and Medicaid more efficient.

- Improve Medicare by offering new choices of high-quality health plans and delivery systems, and by providing new preventive benefits and a new respite care benefit for families coping with Alzheimer's Disease.

- Extend the life of the Medicare Hospital Insurance Trust Fund for at least a decade without imposing any new costs on Medicare beneficiaries.

- Protect the federal guarantee of coverage under Medicaid, while providing new flexibility for states to administer their programs within a targeted growth rate for spending per beneficiary.

- Establish strong new protections against fraud and abuse in the health care system.

The President's balanced budget also includes important health initiatives that increase the availability and affordability of private health care coverage for working Americans. Specifically, it will:

- Reform the insurance system to ensure that workers don't lose their insurance if they lose a job or change jobs, limit the use of pre-existing condition exclusions, and establish voluntary purchasing cooperatives so that small businesses can obtain more affordable health insurance coverage.

- Provide assistance for workers who are temporarily unemployed and need short-term financial support to help them keep health insurance coverage.

- Make health benefits more affordable for individuals who are self-employed by increasing the tax deductibility of health benefits.

- Simplify the administration of the health system so that fewer dollars are spent on overhead, and health professionals are freed from unnecessary paperwork.

Preserving and Strengthening Medicare

Medicare provides health care benefits to 37 million elderly Americans and individuals with disabilities. The President's plan maintains the 30-year national commitment to this program and makes it more efficient.

The President's balanced budget proposal builds on the Administration's 1993 deficit reduction package, which strengthened the Medicare Hospital Insurance (Part A) Trust Fund, with additional Medicare reforms. It includes $124 billion in savings over the next seven years and would assure the fiscal integrity of the Trust Fund through at least the next decade, while imposing no new cost increases on Medicare beneficiaries.

Key elements of the President's Medicare proposal are:

- **Continued Expanded Choice of Plans Under Medicare:** The President's plan retains a strong, traditional Medicare fee-for-service program while increasing choices of alternative health plans or delivery systems. It will:

  - Expand beneficiary choice among health plans and delivery system options that guarantee high quality care for reasonable costs, including preferred provider organizations (PPOs), provider networks, and point-of-service HMOs;

  - Provide beneficiaries with detailed information about the providers and health plan choices available in their area, thereby facilitating the enrollment process;

  - Improve Medicare's method for paying health plans and delivery systems;

  - Foster better quality of care provided by health plans; and

  - Enhance choice/portability through Medigap reforms.

- **A More Cost-Effective Medicare Program:** The $124 billion in savings included in the President's plan are sound, responsible reforms that will make the program more efficient while providing sufficient funds to ensure beneficiaries have access to high-quality health care.

  These changes will protect the Medicare Hospital Insurance Part A Trust Fund and maintain the Part B premium at 25 percent of program costs as under current law. The plan will:

  - Reduce payments to hospitals, physicians, and other providers while ensuring that high quality health care providers continue to serve Medicare beneficiaries;

- Reform Medicare financing for graduate medical education and training provided by the nation's academic health centers and teaching hospitals;

- Assure that the Medicare Trust Fund will be sound for the short and mid-term, and place it in a much stronger position to deal with the long-term problem when the baby boom generation retires.

- An Improved Medicare Program: The President's plan improves Medicare program. It will:

  - Invest limited resources to expand cost-effective preventive benefits, including coverage for mammography, colorectal screening, and preventive injections for pneumonia, influenza and hepatitis B.

  - Establish a respite care benefit for families of victims of Alzheimer's Disease;

  - Redirect medical education funds from managed care payments to medical teaching and research institutions, and establish a new commission on medical education and workforce priorities.

Combating Fraud and Abuse

The Clinton Administration stepped up efforts to combat fraud and abuse with remarkable results. One key has been Operation Restore Trust -- a pilot program launched earlier this year in New York, Florida, Illinois, Texas, and California. The President's plan would take Operation Restore Trust nationwide.

The President's plan would also give law enforcement officials substantial additional authority and resources to investigate, prosecute, and sanction those who defraud federal health programs; ensure adequate and dependable sources of funds to support program integrity activities; and change reimbursement policies that inadvertently may have contributed to abuse and fraud.

Protecting and Improving Medicaid

Medicaid provides acute and long-term health care services to 36 million low-income women, children, families, older Americans, and people with disabilities. Nearly half of Medicaid recipients are children but approximately two-thirds of Medicaid expenditures are for care for the elderly and people with disabilities.

The President's proposal maintains the 30-year collaboration with the states to guarantee coverage for needed health services while making Medicaid more effective and efficient. It would reduce federal Medicaid spending by $59 billion over seven years.

Key elements of the President's Medicaid proposal are:

- Guarantee of Coverage: People now or scheduled to be covered under current law would retain their Federal guarantee of health care coverage.

- Cost Effectiveness: To limit the growth in federal Medicaid expenditures, a per capita limit would be established to constrain the rate of increase in federal matching payments per beneficiary. These limits maintain the federal financial commitment to states in the event of an economic downturn that could require states to add beneficiaries. Federal payments for disproportionate share hospitals would also be tightened and states would have the flexibility to target these payments to a range of essential community providers, including federally qualified health centers and rural health centers.

- Unprecedented State Flexibility: States would get much greater flexibility to change how they deliver and pay for services, so that they can reduce costs, not coverage. For example, states would be authorized to implement managed care plans and provide home and community-based care without federal waivers.

- Quality Protection: Existing federal standards and enforcement for nursing homes and institutions for people with mental retardation and developmental disabilities would be maintained. Quality standards for managed care systems would be updated and enhanced.

- Financial Protection: Protections against impoverishment for spouses of nursing home residents would be retained, as would the guarantee that Medicare premiums and cost-sharing be paid for by Medicaid for low-income beneficiaries.

Long-Term Care

Frail elderly Americans and younger persons with disabilities frequently require home and community-based long-term care to assist them in carrying out the routine activities of daily life. The President's plan would improve access to such services by establishing a new benefit in the Medicare program for family members of beneficiaries with Alzheimer's disease. They would be eligible for up to 32 hours of respite care each year under this new benefit.

In addition, the President's plan preserves Medicaid's guarantee of coverage for Americans who need nursing home care, as well as the protection of Federal standards and oversight of quality. Access to home and community-based care is enhanced by new flexibility the plan affords states that wish to provide this alternative to nursing home care.

Protecting Working Americans

Today, most working Americans receive their health care insurance coverage through their employer, but the security of that coverage often depends on economic conditions and on insurance rules that can exclude coverage for some people. There has been strong, bipartisan support for taking steps to reform the health insurance market to preserve and protect the coverage of working Americans.

The President's plan includes the following insurance reforms and programs to protect workers:

- **Pre-existing Medical Conditions:** Insurers and group health plans could no longer exclude individuals from coverage because of pre-existing medical conditions. Insurers in the small group market would be required to sell coverage to small businesses regardless of the health status of the workers they employ.

- **Enhanced Portability of Coverage:** Under the President's plan, "job lock" would be eliminated by ensuring that workers who change jobs don't lose their health care coverage.

- **Ensuring Coverage for Temporarily Uninsured Workers:** Grants would be made available to the states to provide for a six-month period of private health benefits for laid-off workers who lose their coverage when they lose their jobs and receive unemployment benefits.

- **Small Business Assistance:** Grants would be provided to states to help them create voluntary small group insurance purchasing cooperatives to encourage competition and affordability in the small group market. Upon state request, the Federal Employees Health Benefits Program could require its participating health plans that serve the small group market to make themselves available through purchasing cooperatives established by the state.

- **Tax Deduction for the Self-Employed:** Self-employed individuals, including farmers, would be allowed to deduct 50 percent of the cost of their health insurance premiums from their taxable income.

Administrative Simplification and Security of Health Information

The health care system includes a tremendous amount of red tape and paperwork that often interferes with providing care to patients. The President remains committed to reducing these burdens. Standards would be adopted to simplify the use of electronic health information transactions. New federal standards would be developed to assure the security and privacy of individual medical information contained in electronically conducted health care transactions.

PRESERVING AND STRENGTHENING MEDICARE

The President's plan saves $124 billion over seven years, extends the solvency of the Medicare Hospital Insurance Trust Fund, and does not impose new costs on beneficiaries. The plan also expands health plan choices for beneficiaries, provides new benefits, improves Medicare's health plan payment methodology, fosters continuous improvement in health plan quality, helps beneficiaries become more informed about their choices, and levels the playing field for Medicare managed care plans and Medicare supplemental coverage.

I. EXPANDING MEDICARE MANAGED CARE OPTIONS

The President's plan further expands Medicare managed care options by statutorily authorizing the participation of a range of health delivery plan options, including preferred provider organizations (PPOs), provider sponsored organizations (PSOs), and other alternative delivery systems that meet strong consumer protection standards. These health delivery plans would qualify for designation as "participating" plans if they met the following criteria:

- Benefits. At a minimum, benefits under the plan should be the benefits available under fee-for-service Medicare.

- Quality. Beneficiaries should receive high quality care that increases the likelihood of needed and desired health outcomes.

- Access. Beneficiaries should have timely access to all medically necessary and appropriate covered care.

- Financial Liability. Out-of-pocket expenditures under the plan should not be greater than the cost sharing that beneficiaries would experience if they stayed in fee-for-service Medicare. This includes provisions to preclude extra balance billing for authorized plan services and to provide the same protections afforded under Medicare fee-for-service for non-authorized services. In addition, plan premiums should not vary based on health status or age.

- Financial Soundness. Beneficiaries should be protected from the risk of interruptions to their care that could result from the insolvency of a plan or its providers.

- Appeals, Complaints, and Grievances. Beneficiaries should have access to timely and fair resolution of any appeals, complaints, or grievances.

- Information. Beneficiaries should have timely access to comprehensive, understandable information about plans, including: basic policies and procedures, consumer satisfaction, and plan performance.

- Marketing and Enrollment. Beneficiaries should not be coerced to enroll in a plan, prevented from enrolling in a plan of their choice due to health status, or encouraged to disenroll from a plan.

- Accountability. Beneficiaries should be assured that those purchasing services on their behalf will establish, monitor, and enforce beneficiary protections.

II. IMPROVING MEDICARE'S MANAGED CARE PAYMENT METHODOLOGY

The plan phases in a series of improvements in Medicare payment methods, while testing alternatives. Under the plan, the Administration would:

- Reduce extreme regional variation in the capitated payments to plans contracting with Medicare and immediately increase rates in rural areas by: delinking payments to plans from fee-for-service expenditures at the local level; adopting a blended payment methodology; and creating a minimum payment amount.

- Maintain linkage and equity with the fee-for-service program at the national level by updating payment rates based on projected growth in per capita Medicare spending.

- Test new risk adjusters for capitated payments in order to improve the accuracy of rates and to reduce the impact of selection on Medicare payments.

- Conduct demonstrations on a competitive pricing methodology, under which Medicare's payments to plans would be based on plan bids.

- Create a partial-risk payment alternative to the current inefficient cost payment option. Under the partial-risk payment methodology, plans would be paid on a fee-for-service basis subject to an annual limit. Plans would share in savings achieved below the limit.

Specific savings proposals are discussed in Section VII under "Medicare Managed Care."

III. FOSTERING CONTINUOUS IMPROVEMENT IN HEALTH PLAN QUALITY

The plan would enhance quality assurance by building on existing mechanisms and cooperative efforts with national organizations. Under the plan, the Administration would:

- Create partnerships with public and private purchasers, consumer groups, and managed care plans to focus on developing population-based outcome measures and encounter data systems that could assure quality of care.

- Collaborate with national quality assurance organizations to develop plan performance indicators relevant to the Medicare population.

- Expedite the process for terminating non-compliant plans and expand authority for intermediate sanctions (e.g., freezing new enrollment).

- Develop a proposed regulation (to be released in August 1997) establishing consistent standards for quality assurance and performance measurement. These standards, when implemented, would replace the "50/50" rule, which requires Medicare and Medicaid membership not to exceed 50 percent of total plan enrollment. As an interim measure, they would give the HHS Secretary authority to waive the "50/50" rule in specified circumstances.

- Give plans the option of contracting with an independent organization, approved by the HHS Secretary, to certify that the plan has met internal quality assurance requirements.

IV. BENEFICIARY INFORMATION/LEVEL PLAYING FIELD

The plan would develop information to help Medicare beneficiaries become more informed about their choices, and level the playing field for Medicare managed care plans and Medicare supplemental coverage. The plan would:

- Authorize the HHS Secretary to (1) develop standardized comparative materials for beneficiaries about managed care and Medigap plans, and (2) contract out to a third-party to provide enrollment and disenrollment activities for Medicare managed care plans. To assure adequate funding, all plans would contribute to the costs of these activities.

- Work with the National Association of Insurance Commissioners to develop an approach to standardize additional benefits offered by managed care plans and to move to community rating of Medigap policies.

- Eliminate barriers to beneficiaries enrolling in the managed care or Medigap plan of their choice by: (1) establishing an annual 30-day simultaneous open enrollment period for all managed care and Medigap plans; (2) giving newly-entitled beneficiaries a special open enrollment period; and (3) allowing beneficiaries leaving managed care to re-enroll in Medigap plans, without prejudice.

- Strengthen current safeguards for managed care enrollees by protecting enrollees who go outside their plans to receive services without plan authorization.

V. EXPANDED BENEFITS

The plan strengthens the Medicare benefit package by expanding coverage for important preventive care, and it takes steps to encourage families to keep beneficiaries in the community and simultaneously avoid institutional costs for Medicare and Medicaid. The new preventive benefits include: annual mammograms for beneficiaries age 50 and over; waiver of cost-sharing for mammography; several procedures for the early detection of colorectal cancer (including barium enemas); blood glucose monitors and associated supplies and professional assistance for managing diabetes; and increasing Medicare payments for preventive injections.

The plan also establishes a new respite care benefit for beneficiaries with Alzheimer's disease or other irreversible dementia. Under this benefit, Medicare beneficiaries with cognitive impairment would be eligible to receive up to 32 hours per year of non-medical care, giving the beneficiary's informal care givers (e.g., children, spouse) a break from the constant demands of caring for these beneficiaries.

VI. STRENGTHENING MEDICARE

The President's plan saves $124 billion over seven years (FY 1996-2002)[1] and ensures the solvency of the Hospital Insurance, or Part A, Trust Fund through at least the next decade.

To achieve these savings, the plan modifies Medicare payments in a number of ways. The plan ensures that Medicare acts as a prudent purchaser and provides incentives to hospitals for efficiency by constraining updates for hospital operating costs, reimbursing reasonable levels for capital costs, reforming medical education payments, reforming add-on payments for extremely costly (i.e., outlier) cases, and reforming the rules governing transfers from a hospital to a post-acute care facility.

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[1]All savings and cost estimates for Medicare are from preliminary CBO scoring dated February 28, 1996.

The plan also changes Medicare physician payments by (1) tying allowable volume growth, which in turn affects fee increases, to the growth in real gross domestic product (GDP) per capita (plus an additional factor), and (2) implementing proposals that create incentives for physicians to deliver quality care efficiently. In addition, the plan reforms payments to home health agencies and skilled nursing facilities by establishing interim payment systems in preparation for rapid implementation of a new prospective payment system.

The plan achieves savings from managed care by tying growth in managed care payments to overall Medicare growth per person. It also removes payments for graduate medical education and disproportionate share hospitals from the AAPCC and redistributes all of the savings to ensure that teaching hospitals caring for Medicare managed care enrollees are compensated directly for the cost of training physicians. Finally, the plan maintains the Part B premium at 25 percent of program costs, reduces payments for durable medical equipment and ambulatory service center services, ensures that Medicare pays for services only after a beneficiary's primary insurance has paid appropriately, reduces the regulatory burden on clinical labs under the Clinical Laboratory Amendments Act (CLIA), and employs a wide variety of strong new initiatives to combat fraud and abuse.

VII. MEDICARE SAVINGS PROPOSALS

Part A -- Hospital Insurance Trust Fund

Medicare Part A provides insurance coverage for hospital, home health, skilled nursing facility (SNF), and hospice care. Most Americans age 65 or older are entitled to Part A coverage. This coverage is financed primarily through a payroll tax of 2.9 percent, paid equally by the individual and employer. Reductions in Part A expenditures, combined with reform of the home health benefit, will extend the solvency of the Part A Trust Fund through at least the next decade.

Under Medicare, hospitals are paid in one of two ways. Most are paid under a prospective payment system (PPS), under which fixed hospital payments per admission are established based on a patient's diagnosis before services are provided. Certain specialty hospitals (i.e., rehabilitation, childrens, long-term care, and psychiatric care hospitals) are paid based on their costs in a base year.

Hospital Proposals

- Reduce the "Market Basket" Payment Update for Inpatient Hospital Services. Under current law, inpatient hospital prospective payment rates are updated annually by a "market basket index" that reflects inflation in the prices of operating an inpatient facility. The update has often been reduced in past budget reconciliation acts -- in OBRA 1993, it was reduced by between 0.5 and 2.5 percentage points in FY 1994-1997. An update of

less than the full market basket is given to reflect anticipated productivity gains and provide an incentive for hospitals to increase efficiency. **This proposal would reduce the hospital market basket index update for prospectively paid hospitals by 1.5 percentage points for each year between FY 1997 and FY 2002.** For 1997, a hospital paid under the prospective payment system would receive about a 2.1 percent increase rather than about a 3.1 percent increase (which reflects the current law reduction of .5 percentage point for that year). The proposal would continue the OBRA 1993 reductions, thereby eliminating a sudden increase in baseline spending that would occur under current law. The Prospective Payment Assessment Commission (ProPAC), created by Congress to offer advice on policies affecting Medicare payments to hospitals and other facilities, recommends a market basket reduction of 1.5 to 2.0 percentage points for the short term.

This proposal also would reduce the update by 1.5 percentage points in FY 1997-2002 for hospitals that are exempt from Medicare's hospital prospective payment system (i.e., psychiatric, rehabilitation, long-term care, cancer, and children's hospitals). This proposal also would reform the methodology for paying PPS-exempt facilities. Exempt hospitals would continue to be reimbursed based on their costs in a base year, subject to limits, but the base year would be updated to use more recent data. Cost limits would be subject to a ceiling of 150 percent of the national average and a floor of 70 percent of the national average (specific to each type of facility). Facilities still would be eligible for payments above their limits under certain conditions, but incentive payments for facilities whose costs are below their targets would be ended.

Seven-year savings from reducing the hospital market basket index update are $19.7 billion. Seven-year savings from reducing the PPS-exempt hospital market basket index update are $1.1 billion.

- Extend OBRA 1990 Reductions for Hospital Capital Payments. Hospitals receive payments for their capital-related costs (e.g., construction, maintenance) based on the number of Medicare patients they treat. **This proposal would set future hospital capital payments by updating 1995 capital rates for inflation. In effect, this proposal permanently captures the savings from the OBRA 1990 capital provision, which limited payments for capital under PPS to 90 percent of what they would have been under a reasonable cost system.** Without this extension, capital payments to hospitals increased about 16 percent in FY 1996. This proposal could be considered an efficiency adjustment to recoup excessive Medicare capital reimbursement of the late 1980s. In addition, the current base amount reflects overestimated capital costs, and should be modified to reflect more accurate data. The Office of Inspector General recommends that capital payments be reduced to prevent overpayment to hospitals.

  In addition, this proposal would pay 85 percent of capital costs for PPS-exempt hospitals and units for FY 1997-2002.

  Seven-year savings from limiting capital payments to prospective payment hospitals are $6.1 billion. Seven-year savings from limiting capital payments for non-prospective payment hospitals are $1.4 billion.

- Reform of Long-term Care Hospital Reimbursement. Hospitals with average stays of more than 25 days by all patients are considered long-term care hospitals. These hospitals are currently exempt from the prospective payment system. **This proposal would make new long-term care hospitals subject to the PPS, effective upon enactment.** PPS has proven to be an effective mechanism for increasing efficiency and controlling costs in other inpatient hospitals.

  Seven-year savings are $0.7 billion.

- Graduate Medical Education (GME) Reform. Medicare pays teaching hospitals for a share of the direct (i.e., resident salaries and fringe benefits, teaching costs, and institutional overhead) and indirect costs they incur in providing graduate medical education. The indirect costs are reimbursed through the IME adjustment to the diagnosis related groups (DRGs). But direct costs are based on Medicare's share of hospital-specific, per resident amounts that reflect a hospital's 1984 cost per resident, indexed for increases in the level of consumer prices.

This proposal actually contains three individual proposals, including two program expansions.[2] Most experts agree that the current GME and IME payment methodology is flawed. ProPAC analysis suggests that teaching hospitals are overcompensated, especially in terms of the IME adjustment, and there is general consensus (e.g., Council of Graduate Medical Education, the Physician Payment Review Commission) that GME/IME payments encourage hospital-based specialty training at the expense of primary care training. This proposal is designed to slow the growth in Medicare spending on graduate medical education while encouraging more primary care training.

Seven-year savings are $7.4 billion.

- Establish National Commission on Medical Education and Workforce Priorities. **This proposal would establish the National Commission on Medical Education and Workforce Priorities within the Department of Health and Human Services.** The Commission would: (1) develop and recommend policies to address the preservation of academic health centers' research and educational capacity and the supply, composition, and support of the future health care workforce; and (2) make recommendations concerning the most effective allocation of training resources to ensure that the numbers and competencies of health care professionals are responsive to national needs.

  There are no Medicare savings or costs associated with this proposal.

[2]The three proposals would: (1) cap the total number and the number of non-primary care residency positions reimbursed under Medicare at the current level; (2) count work in non-hospital settings for IME; and (3) allow GME payments to non-hospitals (e.g., Federally Qualified Health Centers) for primary care residents in those settings, when a hospital is not paying for the resident's salary in that setting.

- Telemedicine. Telemedicine uses telecommunications technology to provide patients with real-time interactive examination and consultation from medical professionals who are at a remote site. **This proposal would establish a grant program to support the development of telemedicine networks in rural areas.**

- Rural Health Outreach Grant Program. This proposal would establish a grant program to demonstrate the effectiveness of outreach to populations in rural areas that do not normally seek, or have access to, health or mental health services.

  Seven-year investment for both telemedicine and the rural health outreach grant program is $0.2 billion.

- Medicare Dependent Hospitals. OBRA 1989 established a Medicare Dependent Hospitals classification, which allowed small rural hospitals with more than 60 percent of their utilization from Medicare patients to receive higher payments based on the method Sole Community Hospitals. **This classification was discontinued as of FY 1995. This provision would once again reinstate the classification and allow Medicare Dependent Hospitals to receive higher payments.**

  Seven-year investment is $0.1 billion.

- Rural Primary Care Hospitals (RPCH). The RPCH program seeks to preserve rural residents' access to hospital care by allowing certain hospitals to convert to limited service, short-stay hospitals and receive reasonable cost reimbursement. The program is currently authorized in only seven states. **This proposal would make several improvements to the RPCH program, including: extending the program to all states, expanding the allowable number of beds, extending the allowable length of stay and establishing a minimum separation distance between RPCHs. This proposal also would eliminate the Essential Access Community Hospital (EACH) designation for new hospitals, while allowing existing EACHs to continue to be paid on a reasonable cost basis.**

  Seven-year investment is $0.2 billion.

Home Health Agencies

- Extend Savings from OBRA 1993 Home Health Cost Limits Freeze. Medicare pays for covered home health services on a cost basis, subject to limits that are updated annually. OBRA 1993 eliminated the update for home health cost limits from July 1, 1994 to July 1, 1996. **Although this proposal would not extend the freeze, it would permanently**

extend the savings realized from setting future home health limits by not allowing for the inflation that occurred during the freeze. Without new legislation, spending would revert to pre-freeze levels.

- Reform Home Health Payment: Home health services are one of the fastest growing areas of Medicare expenditures, and there is widespread consensus that the high rate of growth in home health expenditures must be addressed. This proposal combines three individual proposals designed to reform the reimbursement system for home health services, improve financial management, and control fraud and abuse:

  1. Establish a Prospective Payment System (PPS) for Home Health Services -- Medicare reimburses home health agencies on a cost basis, subject to limits. However, Medicare's retrospective reimbursement rates often contribute to increased expenditures by failing to control volume. **This proposal would constrain growth in expenditures through lower cost limits over the short run and implement a per-episode PPS for home health in 1999.** Budget-neutral rates under the PPS would be calculated after first reducing, by 15 percent, expenditures that exist on the last day prior to implementation. HCFA is currently running a demonstration to test a per-episode home health PPS.

  This proposal would take the following interim steps to help reduce home health costs and control volume:

  - **Beginning October 1, 1996, reduce the current cost limits from 112 percent of the mean to 105 percent of the median.**

  - **Beginning October 1, 1996, implement an additional limit, based upon aggregate per beneficiary costs in a base year.** Payment would be the lesser of: (1) the actual costs (defined as Medicare allowable costs paid on a reasonable cost basis); (2) the per visit cost limits; or (3) a new agency-specific per beneficiary annual limit calculated from 1994 reasonable costs. Effective January 1, 1997, or as soon as feasible, the agency-specific per beneficiary limit would be modified to provide for regional or national variations in utilization by calculating the limit through a blend of 75 percent of the agency-specific cost or utilization in 1994 with 25 percent of the national or regional cost or utilization in 1994.

    Home health agencies (HHAs) with costs or utilization experience less than 125 percent of the mean national or regional aggregate per beneficiary cost or utilization experience for 1994, and with year-end costs below the agency-specific per beneficiary limit, would share 50 percent of the savings for FYs 1997-1999. The shared savings, however, could not exceed 5 percent of an agency's aggregate Medicare reasonable cost in a year. The interim reimbursement mechanism

- Reduce Indirect Medical Education (IME) Adjustment to 6 percent. Through the IME adjustment, Medicare recognizes the higher indirect costs that teaching hospitals incur in running a teaching program (e.g., additional tests and procedures that residents may order as part of their training). Currently, the IME adjustment is based on a teaching hospital's ratio of interns and residents to beds (IRB), with payments increasing by about 7.7 percent for each 10 percent increase in a hospital's IRB. ProPAC analysis suggests that the current IME adjustment overcompensates hospitals. It recommends initially reducing the adjustment to 7 percent and, in the future, further reducing it to a level that corresponds more closely with the actual relationship between teaching intensity and costs. Health Care Financing Administration (HCFA) data also suggest that a lower IME adjustment would more accurately reflect what teaching hospitals actually experience. **This proposal would reduce the IME adjustment to 6.5 percent in FY 1997, 6.3 percent in FY 1998, and 6 percent in FY 1999 and thereafter.**

  Seven-year savings are $6.3 billion.

- Refine Outlier Payment Methodology. Currently, hospitals are eligible for additional payments, called outlier payments, when they serve long-term patients or those who require exceptionally costly care. When the outlier amount is paid, teaching and disproportionate share (DSH) hospitals also receive additional IME and DSH payments added to the outlier payments. **This proposal would eliminate increased IME and DSH payments that are attributable to the outlier payments, but would allow hospitals to count IME and DSH as part of costs that trigger outlier payments, effective FY 1997.** Consequently, teaching and DSH hospitals would receive a greater portion of outlier payments. ProPAC supports this change as being consistent with the intent of the PPS.

  Seven-year savings are $3.2 billion.

- Redefine Hospital "Transfer." Currently, hospitals that move patients to PPS-exempt facilities and SNFs "discharge" the patient and receive a full DRG payment. This policy overpays hospitals and contributes to higher post-acute expenditure growth rates, because these sites end up caring for more acutely ill patients. **Under this proposal, moving a patient from a PPS hospital to a non-PPS hospital or SNF would be considered a hospital "transfer" rather than a discharge. Reimbursement for each transfer reimbursements would be made on a per diem basis, subject to a cap equivalent to the DRG payment.**

  Seven-year savings are $5 billion.

- Expand "Centers of Excellence" Demonstration. Currently, HCFA is conducting a demonstration that pays 10 facilities, considered "centers of excellence," a flat fee to provide cataract or coronary artery bypass graft (CABG) surgery. The facilities were selected on the basis of their outstanding experience, outcomes, and efficiency in performing these procedures. **This proposal would expand centers of excellence demonstrations to all urban areas by allowing Medicare to pay select facilities a single rate for all services associated with CABG surgery or other heart procedures, knee surgery, hip surgery, and other procedures that the HHS Secretary determines appropriate.** This approach gives hospitals incentives to provide high quality care more efficiently. Beneficiaries would not be required to receive services at these centers.

  Seven-year savings are $0.2 billion.

- Sole Community Hospitals (SCH). SCHs are the sole source of inpatient services reasonably available in a geographic area. Payments for SCH services are currently based on FY 1982 or FY 1987 costs (updated annually) or a standard federal amount. **This proposal would base SCH payments on FY 1992 and 1993 costs, although SCHs could still be paid based on updated 1982 or 1987 costs or the federal rate if it would yield higher payments.**

  Seven-year investment is $0.3 billion.

- Rural Referral Centers. The Rural Referral Center designation is a special classification for large rural hospitals that provide a large amount of specialized hospital services. **This proposal would allow hospitals designated as rural referral centers as of FY 1994 to continue to be treated as rural referral centers. This proposal also would increase the wage adjustment for rural referral centers whose wages are between 100 percent and 108 percent of the average wage in their area.**

  Seven-year investment is $0.1 billion.

would be in effect until a full per-episode home health PPS is implemented in 1999.

2. Eliminate Periodic Interim Payments (PIP) for HHAs -- PIP was established to help simplify cash flow for new home health providers by paying them a set amount on a bi-weekly basis. Then, at the end of the year, PIP is reconciled with actual expenditures. But, with about 100 new HHAs joining Medicare each month, access to home health care is no longer a problem, and new providers no longer need PIP to encourage them to participate in Medicare. Further, the Office of Inspector General has found that Medicare tends to overpay providers who receive PIP, and has a hard time recovering the money. **This proposal would eliminate PIP for home health agencies simultaneous with PPS implementation.**

3. Base Payments on Location of Service Delivery -- HHAs are often established with a home office in an urban area and branches in rural areas. When HHAs bill Medicare, payment is based on the higher wage rate for the urban area, even though the service delivery occurred in a rural area. **Under this proposal, payments would be based on the location where the services are *rendered*, not where the services are *billed*, beginning January 1, 1997.**

Total seven-year savings from home health reforms are $9.1 billion.

- Shift Financing of a Part of the Home Health Benefit to Part B. **This proposal divides the financing of the Medicare home health benefit between Part A and Part B -- without changing general coverage and eligibility rules or imposing any beneficiary cost sharing.** Under this proposal, effective in FY 1997, the first 100 visits following a three-day hospital stay would be reimbursed under Part A. All other visits, including those not following hospitalization, would be reimbursed under Part B. (Part B visits would not be subject to the Part B coinsurance or deductible; this shift also would not impact the Part B premium.) For those beneficiaries who are eligible for only Part A or Part B, the benefit would be financed completely by the part for which they are eligible. This proposal also would clarify current policy on the definitions of "intermittent" and "part-time or intermittent" skilled nursing and home health aide services. By creating a post-hospital home health benefit under Part A, this proposal would recognize that Part A covers only acute care services. It allows Part B to finance the longer-term, and more expensive, portion of home health services. And by restructuring the home health benefit so that Part B bears more of the costs, this proposal would extend the solvency of the Part A Trust Fund.

Medicare spending shifted from Part A to Part B over seven years is $62.1 billion.

Skilled Nursing Facilities

- Extend Savings from OBRA 1993 SNF Cost Limits Freeze. Payments for SNF routine services are made on a reasonable cost basis, subject to certain SNF cost limits that are updated annually. OBRA 1993 eliminated the update for FY 1994 and FY 1995. Beginning in FY 1997, SNF routine payments would not reflect the effects of the freeze. **Although this proposal would not extend the freeze, it would permanently extend the savings realized from setting future limits by not allowing for the inflation that occurred during the freeze.**

- Reform the SNF Reimbursement System. Within Medicare, the SNF program is one of the fastest growing benefits, with both increased volume and costs driving the overall increase in SNF expenditures. SNFs provide daily skilled nursing care to Medicare beneficiaries for conditions related to a prior hospitalization. Medicare reimburses SNFs on a cost basis, subject to certain limits. For SNFs, limits are applied only to the routine services (i.e., room and board, nursing, administration, and other overhead); ancillary (e.g., drugs, physical therapy, speech therapy) and capital-related costs are not subject to any limits. Medicare's current retrospective reimbursement rates contribute to rising expenditures by providing incentives to increase costs.

  This proposal would make the following changes in SNF reimbursement:

  - **Establish an interim prospective rate for routine costs, beginning in FY 1997. These rates would be based on facility-specific costs, subject to regional limits.** The regional limits would be based on data from freestanding SNFs only. Freestanding SNFs tend to have lower costs than hospital-based SNFs. SNFs would be reimbursed under this system until a full SNF PPS is implemented in FY 1998.

  - **Eliminate new provider exemptions and new exceptions to the cost limits, beginning in FY 1997.** Currently, new Medicare SNF providers are exempted from the cost limits for three to four years. These exemptions allow SNFs to be reimbursed for inflated costs for several years. An exception currently is provided for SNFs that provide atypical care (e.g., sub-acute care) or are forced to operate under extraordinary circumstances (e.g., earthquakes, hurricanes). In the case of exceptions, an upward adjustment to the cost limit is determined. Exceptions effectively allow SNFs to fully bill Medicare for more costly sub-acute care services, which Medicare reimbursement would not completely cover. SNFs that had exceptions in the base year would be protected under a hold harmless provision, because the limit plus the exception amount would be included in the

base year cost. The HHS Secretary may also make future adjustments, based on case mix, to the routine payment rates.

- **Establish limits on ancillary services.** Ancillary services would be subject to limits based on amounts payable for similar services on a fee-for-service basis under Part B.

- **Require consolidated billing, beginning in FY 1997.** The HHS Office of Inspector General and others have reported that some Part B suppliers bill Medicare for supplies that were never delivered to nursing home residents. **This proposal would require SNFs to bill Medicare for all services its residents receive (except the services of physicians, certified nurse midwives, psychologists, hospice services, and nurse anesthetists), prohibiting payment to any entity other than the SNF for services or supplies furnished to Medicare-covered inpatients. SNFs also would be required to include HCFA Common Procedure Codes on their Part B bills.** This proposal will reduce double billing for some supplies and services and reduce beneficiary Part B copayments for services covered under Part A. It also will provide data necessary to construct a SNF PPS rate that covers ancillary services. (This proposal is discussed in the "Eliminating Waste, Fraud, and Abuse" section.)

- **Establish a full SNF PPS, beginning in FY 1998.** The prospective rate would be designed to cover all three (i.e., routine, ancillary, and capital-related) SNF costs. Budget-neutral rates under the new system would be calculated after first reducing, by 7 percent, rates that exist on the last day of FY 1997.

- Establish Therapy Guidelines. As part of their SNF care, Medicare beneficiaries are eligible for occupational (OT), physical (PT), speech, and respiratory therapies. While some SNFs employ their own therapists, many use contractors to provide these services. In the latter case, either the SNF or the contractors can bill Medicare. Medicare spending on therapy services has risen significantly over the last several years, and Medicare has established salary equivalency guidelines for PT and respiratory therapy. These guidelines determine the maximum Medicare payment for this service. However, similar guidelines have not been developed for OT and speech-language pathology. In a March 1995 General Accounting Office (GAO) report, GAO found that Medicare needs tighter rules to curtail overcharges for nursing home therapy and recommended that HCFA set limits to ensure that Medicare does not pay more for therapy services than other health care purchasers. **This proposal would apply salary equivalency guidelines for OT and speech language therapy and update the existing PT and respiratory therapy guidelines, effective October 1, 1996.**

  Total seven-year savings from SNF reforms are $8.3 billion. (Note: Some savings from the consolidated billing and therapy guidelines provisions are attributable to Part B.)

Medicare Managed Care

- Reform Medicare Managed Care. While managed care appears to have reduced private health care costs, studies indicate that it does not reduce Medicare costs, due to a flawed payment methodology and favorable selection. Under current law, Medicare is required to pay HMOs a capitated rate equal to 95 percent of fee-for-service costs.

  This proposal includes several policies to improve the current payment methodology. It would:

  - **Reduce current geographic variations in managed care payment rates.** This proposal would raise payment levels for certain counties, encouraging HMOs to enter new markets and provide more beneficiaries with a choice of plans. It also would limit payments for counties whose rates have been inflated by high service utilization in the fee-for-service sector.

  - **Tie managed care payment growth to overall Medicare expenditure growth per person.** This growth rate allows for a fair and reasonable increase in managed care payments.

  - **Eliminate the GME, IME and DSH payments included in HMO rates; redistribute these funds to teaching hospitals and managed care plans with teaching programs.** These payments would be distributed directly to academic

medical centers, and to HMOs that run their own residency programs (i.e., incur most of the costs of an approved residency program).

- **Conduct a competitive pricing demonstration to test a market-based alternative payment methodology.** Under the demonstration, rates to all HMOs in an area would be established using a competitive pricing methodology. It is part of a long-range strategy to improve the payment methodology for managed care products.

Seven-year savings from revising the Medicare managed care payment methodology are $23.7 billion. (Note: Some savings from this provision are attributable to Part B.)

Part B -- Supplementary Medical Insurance Trust Fund

Medicare Part B provides insurance coverage for physician services, hospital outpatient services (including diagnostic testing and ambulatory surgery), clinical laboratory services, durable medical equipment (e.g, wheelchairs, oxygen services, medical supplies), and other medical services. Payments for physician fees, clinical laboratory services, and durable medical equipment are based on fee schedules. Payments for other services reasonable costs or reasonable charges. The program provides for annual updates of based on payment amounts to reflect inflation and other factors.

Part B coverage is voluntary; almost all of those who are eligible for Part A coverage choose to buy Part B coverage. Part B is financed through (1) beneficiaries' monthly premiums which will continue to cover 25 percent of program costs under the Administration's proposal, and (2) general Federal revenue.

Physicians

- Establish Single Conversion Factor and Reform Method for Updating Physician Fees. Each year, the fees paid to doctors who serve Medicare beneficiaries are updated to account for medical inflation. In addition, the update is adjusted according to a formula that compares actual spending on physicians' services to a spending "standard" established each year according to a complex statutory formula. For purposes of updating fees, Medicare divides doctors' services into three categories: surgical services, primary care, and all other services (e.g., diagnostic tests). Because of different growth rates and spending standards, the three categories have received different updates each year since 1992, when a major payment reform was implemented.

Between 1992 and 1995, the basic payments increased as follows: 29.7 percent for surgical services, 19.6 percent for primary care services, and 13.8 percent for medical services. The Physician Payment Review Commission (PPRC) has stated repeatedly that these different rates of increase are inconsistent with the basic principle of physician payment reform -- i.e., physician fees should vary only according to the relative amount of resources used to provide services.

This proposal would implement several PPRC recommendations to improve the physician payment system. First, a single conversion factor would go into effect in 1997 (the conversion factors for 1996 will be at the levels established by the HHS Secretary under current law). Second, the single conversion factor for 1997 will be based on the 1996 conversion factor for primary care services ($35.42), updated for 1997 based on performance relative to the overall Medicare Volume Performance Standards (MVPS) for FY 1995. Third, to set spending growth targets beginning with FY 1996, the MVPS would be replaced with a sustainable growth rate based on growth in real GDP per capita plus one percentage point (rather than historical volume and intensity growth). This policy would affect updates to the single conversion factor beginning in 1998. Fourth, an upper limit on fee increases of 3 percentage points above medical inflation would be set. And fifth, the lower limit on fee increases would be increased from 5 percentage points to 8.25 percentage points.

Seven-year savings are $13.5 billion.

- Make Single Payment for Surgery. Under certain conditions, Medicare will make an extra payment for each physician or other practitioner who assists the primary surgeon during an operation. These "assistants-at-surgery" are paid a percentage of the fee paid to the primary surgeon. Both the Rand Corporation and the PPRC have reported that there is substantial geographic variation in the use of assistants for the same surgical procedure. This evidence suggests a lack of medical consensus on the use of assistants, which suggests that, in some cases, the use of an assistant-at-surgery may not meet the criteria for medical necessity.

  This proposal would make the same payment to primary surgeons, regardless of whether they use an assistant-at-surgery for whom Medicare makes a separate payment. In effect, Medicare's payment to the primary surgeon would be reduced by the amount of the payment for the surgeon's assistant-at-surgery. The HHS Secretary would specify exceptions for specific procedures or special situations.

  Seven-year savings are $0.6 billion.

- Extend OBRA 1993 Reduction in Payments for Physician Overhead Expenses. Medicare's fee schedule payment for each physician service is made up of three parts: payment for the physician's work, payment for overhead costs or "practice expenses" (e.g., office rent, employee wages), and payment for malpractice insurance costs. On average, about 41 percent of each payment is for overhead costs. Unlike the payment for the physician's work, which is based on an estimate of the actual resources involved in providing a service, practice expense payments are based on historical charges. In some cases, this distorts the fee schedule, because the resulting practice expense payment is inappropriately large relative to the work payment.

  In 1993, Congress considered legislation to implement a permanent, resource-based payment system for practice expenses. To address the existing payment distortion and begin the transition to the new system, OBRA 1993 reduced practice expense payments for certain services. For services meeting certain conditions, the excess practice expense payment is reduced by 25 percent of the difference in 1994, 1995, and 1996, subject to a limit on the total reduction. Because it intended to have a permanent solution to the payment distortions in place by 1997, Congress limited the cut to three years (through 1996). However, legislation mandating the permanent solution was not passed until late 1994, delaying the new payment system until 1998. **This proposal would extend the OBRA 1993 practice expense payment cut for one more year (i.e., through 1997) and reduce the limit on the reduction from 128 percent to 115 percent of the physician work payment.**

  Seven-year savings are $0.7 billion.

- Create Incentives to Control High-Volume Inpatient Physician Services. Urban Institute research has found wide variation among hospitals in the volume of physician services per admission, even after adjusting for case severity, teaching hospital status, and disproportionate-share status. Given a limited consensus on clinical practice guidelines and regional differences in practice styles, some amount of variation in volume and intensity is inevitable. But this variation in the volume of physician services suggests there is room for efficiency improvements. This proposal would create incentives to encourage physicians with high-volume inpatient practice styles to become more efficient.

  This proposal would limit payments to groups of physicians practicing in hospitals whose volume and intensity of services per admission exceeded 120 percent of the national median for urban hospitals (125 percent in 1999 and 2000) and 140 percent for rural hospitals. For each physician practicing in hospitals above those limits, 15 percent of each payment would be withheld during the year. If the physicians collaborate in order to efficiently manage the volume and intensity of the services they provide during the year, the physicians would receive the withheld payments, plus interest at the end of the year. The policy would not be implemented until 1999, to give physicians

time to organize themselves to control volume and intensity while maintaining the delivery of high-quality care.

Seven-year savings are $2.3 billion.

- Direct Payment to Physician Assistants, Nurse Practitioners, and Clinical Nurse Specialists in Home and Ambulatory Care Settings. Medicare currently pays for services provided by physician assistants, nurse practitioners and clinical nurse specialists -- but only in limited settings (primarily rural areas and nursing facilities). **This proposal would expand coverage to include home and ambulatory care settings in which a separate facility or provider fee is not charged.** Further, these providers would have the option of billing Medicare directly for covered services (as opposed to receiving the payments through their employer).

  Seven-year investment is $0.7 billion.

Hospital Outpatient Departments (OPDs)

- Extend OBRA 1993 Reduction in Payments to Outpatient Departments Made on a "Reasonable Cost" Basis. Although there are several payment methodologies for services delivered in the hospital outpatient setting, some outpatient department services are still made on a reasonable cost basis. OBRA 1990 reduced payment for these services by 5.8 percent for FY 1991-1995. OBRA 1993 extended this reduction through FY 1998. In both cases, sole community hospitals and rural primary care hospitals are exempt from this reduction. **This proposal would permanently extend the 5.8 percent reduction.**

- Extend OBRA 1993 Reduction in Payments to Outpatient Departments for Capital Costs. Hospital outpatient departments receive payments for their capital-related costs (e.g., construction, maintenance) based on the number of Medicare patients they treat. OBRA 1990 reduced payments for outpatient department capital costs by 10 percent for FY 1992-1995. OBRA 1993 extended this reduction through FY 1998. In both cases, sole community hospitals and rural primary care hospitals are exempt from this reduction. **This proposal would permanently extend the 10 percent reduction.**

- Correct the "Formula-Driven Overpayment." Current law requires Medicare to use a flawed formula to calculate payments for most ambulatory surgeries, radiology procedures, and diagnostic services performed in hospital outpatient departments. For these services, Medicare's payments are not reduced by the full amount of beneficiary coinsurance. Thus, the Medicare payment is higher than it should be, and hospitals have an incentive to increase charges, which also increases costs to beneficiaries. **This proposal would correct this so-called "formula-driven overpayment" by allowing**

Medicare to fully deduct beneficiary coinsurance payments received by the hospital before the program makes its payments.

Seven-year savings from the three OPD proposals are $15.0 billion.

- Establish a Prospective Payment System for Outpatient Department Services. Medicare's current outpatient payment methodologies do not create incentives for providers to operate efficiently, and allow beneficiary coinsurance to grow as a percentage of total outpatient payments. **This proposal would implement a PPS for outpatient department services, starting in 2002. The new PPS would be designed to limit growth in Medicare outpatient expenditures by providing incentives for providers to operate efficiently, and gradually reduce beneficiary coinsurance as a percentage of total outpatient payments.**

  This proposal would be implemented in a budget-neutral manner.

Medicare Managed Care

- Reform Medicare Managed Care Payments. See discussion on page 16.

Other Providers

- Freeze Durable Medical Payments and Reduce Oxygen Payments. Durable medical equipment covered by Medicare includes items ranging from electric heat pads and wheelchairs to oxygen equipment and hospital beds. Medicare also covers artificial limbs and other prosthetic and orthotic devices. Medicare's fees for these items are based on fee schedules that are updated annually by the consumer price index for urban consumers (CPI-U). Durable medical equipment is one of the fastest growing areas of Medicare spending; CBO's most recent projections (December 1995) show Medicare spending for these medical items growing by over 13 percent per year from 1996-2002. **This proposal would freeze updates for durable medical equipment, and orthotics, and prosthetics from 1997-2002. It would also reduce overpriced payments for oxygen and oxygen equipment by 10 percent beginning in 1997.**

  Seven-year savings are $2.3 billion.

- Reduce Updates for Ambulatory Surgical Center Fees Through 2002. Medicare pays for ambulatory surgical center (ASC) services on the basis of prospectively determined rates. These rates are updated annually for inflation using the CPI-U. OBRA 1993 eliminated updates for ASCs for FY 1994 and FY 1995. Utilization of ASC services has escalated rapidly since the mid-1980s. In addition, the number of ASC facilities has increased

dramatically over the same period, suggesting that Medicare's payment rates are more than adequate to cover facility costs. In 1984, there were 155 ASCs participating in Medicare; by 1993, over 1,600 ASCs were participating.

This proposal would reduce the annual CPI update for ASC fees by 2 percentage points for each year between FY 1997 and 2002.

Seven-year savings are $0.8 billion.

- Expand Centers of Excellence. See description on page 10.

- Extend Part B Premium at 25 percent of Program Costs. Premiums for 1991-1995 under the Supplementary Medical Insurance (SMI) program are specified in the Medicare law. OBRA 1993 set the Part B premium at 25 percent of SMI program costs for 1996-1998. Beginning in 1999, the percentage increase in the premium will be limited to the Social Security cost of living adjustment (COLA). **This provision would permanently set Part B premiums at 25 percent of SMI program costs.** The monthly premium in calendar year 2002 under this proposal would be $67.50 (preliminary CBO estimate).

  Seven-year savings (net of interactions with Part B program savings) are $6.9 billion.

Preventive Services Benefit Expansions (all in Part B)

- Waive Cost-Sharing for Mammography Services. Although Medicare's coverage of mammography services began in 1991, only 14 percent of eligible beneficiaries without supplemental insurance received mammograms during the first two years of the benefit. One factor is the required 20 percent coinsurance. To remove financial barriers to women seeking preventive mammograms, **this proposal waives the Medicare coinsurance and the deductible, effective January 1, 1998.**

- Cover Annual Screening Mammograms for Beneficiaries Age 50 and Over. OBRA 1990 mandated coverage of biannual screening mammography for Medicare beneficiaries over age 65. **This proposal would cover annual screening mammograms for beneficiaries age 50 and over, without coinsurance or a deductible, effective January 1, 1998.**

  Seven-year investment for both mammography benefits is $4.8 billion.

- Cover Colorectal Screening. **Effective January 1, 1998, this proposal would cover four common preventive screening procedures -- barium enema, colonoscopy, sigmoidoscopy, fecal-occult blood test -- for detection of colorectal cancers.** Current law provides for these procedures only as diagnostic services.

  Seven-year investment is $0.8 billion.

- Increase Payments to Providers for Preventive Injections. **Effective January 1, 1998, this proposal would increase the payment for administration of Medicare-covered preventive injections, which include pneumonia, influenza, and hepatitis B vaccines.** It is expected that enhanced payment will increase utilization of these vital preventive services. The proposal would waive the Part B deductible and coinsurance for all of these injections.

  Seven-year investment is $0.5 billion.

- Establish Diabetes Self-Management Benefit. **Effective January 1, 1998, this proposal would provide Medicare coverage of diabetes outpatient self-management training services rendered by a certified provider in an outpatient setting.** The proposal would also allow Medicare to cover blood-glucose monitors and associated testing strips as durable medical equipment for both Type II and Type I diabetics.

  Seven-year investment is $0.5 billion.

- Establish Respite Benefit. **This proposal would establish a Medicare respite benefit for beneficiaries with Alzheimer's disease or other irreversible dementia, beginning in FY 2002. The benefit would cover up to 32 hours of care per year and would be administered through home health agencies or other entities, as determined by the HHS Secretary. The benefit would apply to home-based services as well.**

  Seven-year investment is $1.1 billion.

Medicare Parts A and B (proposals that affect outlays from both the HI and SMI Trust Funds)

Medicare as Secondary Payer (MSP)

Some Medicare beneficiaries have health coverage through an employer group health plan, workers' compensation, or automobile and liability insurance. In these cases, Medicare pays after a beneficiary's primary insurer, subject to certain restrictions and conditions.

- Extend Medicare as Secondary Payer (MSP) Provisions from OBRA 1993. Under current law, Medicare is a secondary payer under specified circumstances when beneficiaries are covered by other third-party payers. Medicare is secondary payer to workers' compensation, automobile, medical, no-fault, and liability insurance. To identify primary payers, OBRA 1993 extended, through FY 1998, the data match among HCFA, the Social Security Administration (SSA), and the Internal Revenue Service (IRS). In addition, OBRA 1993 extended, through FY 1998, an OBRA 1990 provision making Medicare the secondary payor for ESRD beneficiaries who are enrolled in employer group health plans for 18 months after they become eligible for Medicare benefits. Finally, OBRA 1993 also extended, through FY 1998, an OBRA 1990 provision making Medicare the secondary payor for disabled beneficiaries with employer-based health insurance. **This proposal would permanently extend these three MSP provisions.**

  Seven-year savings (Part A and B combined) are $5.6 billion.

- Establish Better Coordination of Insurance Coverage. **This proposal would require a beneficiary's other insurance plan to tell Medicare when that beneficiary is covered.** Currently, Medicare has problems getting this information, resulting in billions of dollars in Medicare payments made on behalf of beneficiaries whose private insurance should have covered the service.

- Clarify Medicare Secondary Payer Authority. The Supreme Court recently invalidated long-standing Medicare rules on MSP, limiting Medicare's ability to make collections in certain situations. **This proposal would clarify Medicare's authority.**

- Eliminate Fraud and Abuse. **This proposal (described in the following section entitled "Combating Fraud and Abuse") would eliminate fraud and abuse in the Medicare by: providing Medicare with modern administrative tools to detect fraud, ensuring that individuals and entities who defraud Medicare are penalized or banned from the program; preventing participation by individuals and entities seeking to defraud the program; and by maintaining necessary resources for eliminating fraud and waste in Medicare.**

  Seven-year savings from the three proposals (Part A and B combined) are $3.4 billion.

- **Physician Self-Referral Prohibitions.** Medicare law prohibits physicians from making referrals to medical facilities in which they have a financial interest. This "self-referral" ban covers certain "designated health services" (e.g., laboratory tests, MRI procedures) that are specified in the law. Some general exceptions to the ban are provided in current law. **This proposal would expand the current exceptions to include services that are furnished in a "shared facility" (defined in the legislation), in ambulatory surgical**

centers, and by hospice programs. The proposal also clarifies the requirements for permissible compensation arrangements.

Seven-year cost is $0.3 billion.

Note: Because of rounding, savings estimates for individual proposals may not equal the total savings.

COMBATING FRAUD AND ABUSE

This President's plan combats fraud and abuse in the Medicare program by: (1) ensuring that Medicare has the necessary resources to prevent and to eliminate fraud and abuse, (2) providing Medicare with modern administrative tools to detect fraud, and (3) ensuring that individuals and entities who defraud Medicare are penalized, or even banned from the program, and that individuals and entities seeking to defraud the program are not allowed to participate.

I. EXPAND OPERATION RESTORE TRUST

The initial phase of Operation Restore Trust, which was limited to five states (New York, Florida, Illinois, Texas and California), has proven that a concentrated and collaborative effort among law enforcement and program policy agencies can reverse the growing trend of Medicare fraud and abuse. The plan would expand Operation Restore Trust nationwide. The cost of these efforts will be offset by even greater savings to the Medicare Trust Funds.

Furthermore, the President's plan to attack fraud and abuse would:

- Establish a Fraud and Abuse Control Program to coordinate HHS and Department of Justice anti-fraud activities. The program would be funded through mandatory general fund and Medicare Trust Fund appropriations.

- Establish the Medicare Integrity System program (previously named the Benefit Quality Assurance Program) to provide a stable and increased source of funding for Medicare payment safeguards activities and ensure that claims are paid properly.

- Establish mechanisms for tracking savings that result from Medicare payment safeguards and anti-fraud and abuse activities.

II. UTILIZE MODERN TOOLS TO FIGHT FRAUD AND ABUSE

The plan would:

- Allow Medicare to contract competitively with private entities that want to perform administrative activities.

III. ESTABLISH PROVIDER QUALIFICATIONS AND PENALTIES

The plan would broaden HHS' authority to eliminate fraud and abuse and provide new tools to ensure stringent enforcement by:

- Establishing new conditions to exclude from Medicare individuals and entities with a history of abuse.

- Authorizing Medicare to require Social Security, tax identification, and employer identification numbers from entities wishing to bill Medicare. These added requirements would help the program administrators determine if employers or other individuals have a history of defrauding Medicare.

- Creating a national data base with names of those who have a history of health care fraud, to facilitate coordination among various organizations at the state and Federal levels.

- Extending current civil monetary penalty authority.

- Extending the Medicare/Medicaid Anti-kickback Statute.

Seven-year savings from our efforts to combat fraud and abuse are $3.4 billion.

PROTECTING AND IMPROVING MEDICAID

The President's Medicaid plan saves $59 billion in Federal expenditures over seven years. The plan has three components: unprecedented, new flexibility for states to administer the program, a per capita cap, and reduced and re-targeted disproportionate share hospital (DSH) spending. Under a per capita cap, the federal guarantee of coverage would be retained, and spending per beneficiary would be federally matched up to a set level. The cap would be set using spending per beneficiary in a base year, increased by an annual growth limit. The plan also would re-target, and limit the size of, DSH payments.

I. STATE FLEXIBILITY PROVISIONS:

The President's plan would give states substantially increased flexibility in managing their Medicaid programs.

A. Provider Payment

The plan would:

- Repeal the Boren Amendment.
- Repeal other special federal payment requirements. Federal requirements related to payment for obstetrical and pediatric services would be repealed. Federal requirements that most FQHCs/RHCs be paid based on costs also would be repealed (starting in FY 1999).
- Repeal the requirement that forces States to pay for private insurance when it is cost-effective. The plan would give States the option of purchasing group insurance and negotiating their own payment rate.

B. Delivery Systems

The plan would:

- No longer require States to seek and be granted a federal waiver to establish managed care delivery systems (e.g., primary care case management, HMOs). States would continue to offer Medicaid enrollees a choice of plan or delivery system, but they would not be required to do so in rural areas. Choice of providers within plans would be maintained in rural areas. Special provisions would be made for including Indian health providers and Native Americans in managed care systems.

- Modify managed care requirements by repealing (1) the upper payment limit for managed care contracts and (2) federal prior approval of HMO contracts over $100,000. States would be allowed to offer managed care in one part of the state without making available in all parts of the state. The plan also would extend the state option for a six-month lock-in and guaranteed extension of eligibility to all managed care enrollees.

- Modify managed care quality-of-care requirements by repealing both the requirement that 25 percent of every plan's enrollees be non-Medicaid and the independent external review requirement, while adding a provision requiring states to develop a quality improvement strategy, consistent with federal standards, to ensure that managed care providers maintain reasonable access and quality health care.

- Allow States to provide home and community-based services at state option, without federal waivers.

- Allow States to establish programs enabling non-profit organizations to receive capitated payments for providing comprehensive acute and long-term care services to frail elderly who are eligible for institutional care.

C. Administration

The plan would:

- Repeal special minimum qualification standards for certain physicians who serve pregnant women and children.

- Repeal federally-mandated administrative requirements. Instead, the plan would give authority to establish similar requirements for:

  - Personnel (e.g., merit personnel standards, training of sub-professional staff); and

  - Cooperative agreement requirements.

- Re-engineer Medicaid Management Information System (MMIS) requirements to retain the required use of standardized claims formats and standardized HCFA reporting requirements.

- Repeal the duplicative annual resident review for people with mental illness or mental retardation in nursing homes under Pre-Admission Screening and Annual Resident Review (PASARR).

- Allow nurse-aide training to be conducted in certain rural nursing homes that are currently not allowed to conduct nurse-aide training..

D. Eligibility Expansions and Simplification

The plan would:

- Enable states to expand or simplify eligibility for individuals up to 150 percent of the federal poverty level through a simplified and expedited procedure. The plan would continue to limit federal matching by the aggregate limit, which would be based on current law eligibility and be constrained to the lower of the aggregate cap for current eligibles or projected state spending below the cap.

- Allow States to modify the eligibility levels under which they provide coverage for optionally-eligible groups of pregnant women and children, so long as they continue to meet the minimum mandatory federal eligibility requirements.

II. FEDERAL OVERSIGHT PROVISIONS

A. Eligibility

The plan would:

- Retain current mandatory and optional eligibility groups, including welfare and SSI cash and non-cash groups, poverty level children and pregnant women, so-called "medically needy" (individuals that qualify for Medicaid by spending much of their income on high medical expenditures), qualified Medicare beneficiaries, and specified low-income Medicare beneficiaries.

- Retain current protection against spousal impoverishment.

B. Services

The plan would:

- Retain the requirement that states continue to offer all Medicaid mandatory services.

C. Payment

The plan would:

- Allow States to impose nominal copayments on HMO enrollees. The plan would continue all other current law restrictions on copayments.

- Retain requirement for federal matching and DSH payment requirements from the 1987 and 1991 laws, and per hospital limits included in OBRA 93. The plan would also retain the prohibition on using so-called "provider taxes and donations" as state spending in order to get Federal matching payments.

D. Administration

The plan would:

- Expand the Medicaid Eligibility Quality Control sample size to a level necessary to ensure statistically valid findings. The number of beneficiaries used to calculate the cap would be adjusted if the eligibility error rate exceeded the current law standard of three percent of total eligibles. Error rates would be determined for each of the four groups.

- Refine current reporting requirements to develop an enforcement mechanism for the per capita cap.

E. Quality

The plan would:

- Retain quality-of-care provisions, such as OBRA 87 nursing home reform provisions and the regulation of intermediate care facilities for people with mental retardation, as well as uncapped funding for the state survey and certification activities, and peer review organization (PRO) utilization review provisions.

- Continue beneficiary protection requirements and administrative provisions that require states to ensure quality of care:

  - Use a single state agency to administer or supervise the administration of the plan;

  - Provide reasonable opportunities for all citizens to appeal and obtain a hearing on State actions;

  - Submit proposed program changes for public review and comment;

  - Make post-decisional records publicly available (e.g., policy guidelines, correspondence, court filings);

  - Consult with medical experts and establish procedures regarding medical appropriateness and standards of care paid for under Medicaid;

  - Safeguard information about recipients.

- Conduct a study to investigate the relationship among quality, access and provider payments to address the need for adequate access to Medicaid.

- Require public notice and comment when determining nursing home payment rates.

- Retain current fraud and abuse provisions and uncapped funding for the State fraud control units.

- Change requirements related to State contracts with health plans:

  - States must develop an overall quality improvement strategy, including plan standards, monitoring strategies, and data analysis;

  - States may require plans to report certain information from the plan's patient data;

  - Health plans must demonstrate the capacity to deliver all contracted services for all populations; and

  - Health plans must maintain an internal quality assurance program and grievance process.

F. Current Demonstration Waivers

The plan would subject all States to the per capita limits, including those with statewide demonstration programs. The same per capita growth rates would apply to all states.

- Enrollment Base: The plan would permit states that have implemented demonstration programs to choose between two approaches for maintaining their eligibility expansion: (1) including demonstration eligibles in their enrollment base for calculating their aggregate limit, or (2) calculating their aggregate limit off of current law eligibles, and expanding enrollment in a budget-neutral manner within this cap.

- Interaction with DSH Changes: The plan would not redefine DSH expenditures that had been re-directed to capitation payments.

III. PER CAPITA GROWTH LIMITS POLICY

A "per capita cap" policy limits federal spending without risking the loss of health coverage. It sets, for each state, a federal spending "cap" per beneficiary, which adapts automatically to the size and type of each state's Medicaid beneficiary population.

Under the President's plan, the cap would limit per beneficiary spending growth to a specified index. If a state's actual spending exceeded the cap, the federal government would match only up to the cap, using the current federal medical assistance percentage (FMAP) for the State.

The cap would be coupled with enhanced flexibility, enabling each state to use individual strategies to control Medicaid costs.

A. Calculation of the Cap

Under the plan, the cap would be the product of three components:

- o total state and federal spending per beneficiary (annualized) in 1995, the base year;
- o an index (for years between the base year and the current year);
- o the number of beneficiaries (annualized) in the current year.

To allow for a change in the mix of Medicaid beneficiaries over time, the plan would calculate the cap by using the specific spending per beneficiary and number of beneficiaries in four subgroups: the aged, individuals with disabilities, non-disabled adults, and non-disabled children. Once the cap is calculated, it would be multiplied by the FMAP to calculate the maximum federal spending in each state.

The per capita cap would become effective in FY 1997.

B. Spending

The plan would:

- o Exclude from the cap, payments for DSH, state fraud control units, survey and certification, and Medicare premiums and cost-sharing. Also excluded from the cap are payments to the Indian Health Service and other Indian health providers and the Vaccines for Children Program.
- o Include most administrative costs in the base year calculation.
- o Adjust the base year for disallowances and prior period adjustments.
- o Make Section 1115 demonstrations subject to the per capita limits. States would continue to be able to expand and simplify eligibility in a budget-neutral manner.

C. Beneficiaries

The plan would:

- o Make all beneficiaries, except qualified Medicare beneficiaries and any new groups covered under state eligibility expansions, subject to the cap.

D. Index

The plan would:

- Index growth in spending per beneficiary using an inflation-based index -- a five-year rolling average of historical growth in nominal GDP per capita -- adjusted with a plus or minus factor to meet budgetary targets. Using CBO's December 1995 baseline and assumptions, the growth index would be slightly different. The same index would be used for each eligibility category and state.

IV. ENFORCEMENT

The plan would:

- Enforce the cap on an aggregate state level, based on the sum of subgroup caps for each of the beneficiary enrollment categories. This allows states to invest savings from one group to offset the costs of another.

- Modify the current reporting requirements to implement the per capita cap.

  - Disaggregate, by beneficiary group, spending projections for upcoming quarters.

  - Change expenditure reports to include enrollment data and to reference expenditure and beneficiary categories. The plan would require states to submit monthly beneficiary data on a quarterly basis. This data would be used to determine final aggregate spending limits for states. All categories would be comparable to the categories used in the cap calculation.

  - Continue and expand audits of the financial data on the expenditure reports to examine spending by beneficiary group. The plan would subject enrollment information to a review based primarily on a trend/outlier analysis.

- Continue the current system for reconciling actual and allowed spending and adjust quarterly grants to reflect updated information as it becomes available. The final reconciliation would occur after the actual data from the full fiscal year were reported.

The plan would use a quarterly grant process similar to that used to announce DSH allotments. HCFA would use a specified set of information submitted by States and its own review to set preliminary and final allotments for states. HCFA would publish these allotments in the Federal Register, and they would be used to adjust quarterly grant awards.

V. REDUCING AND RETARGETING MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

The President's plan would reduce and retarget the amount of Federal Medicaid Disproportionate Share Hospital (DSH) payments made by states to hospitals serving large low-income and uninsured populations.

- Reducing payments

  Beginning in FY 1997, the plan would phase out States' Federal DSH payments by FY 2000, and phase in a new, optional DSH program by FY 2000. This transition would occur in 25 percent increments and result in approximately $39 billion in savings by FY 2002.[3]

- State allotments

  Transition: Between FY 1997 and FY 1999, each state's allotment, or limit on Federal matching payments, would be the sum of the phased-out current payments and phased-in new allotment. In FY 1997, this amount would be equal to 75 percent of the FY 1995 Federal DSH payments to the state, plus 25 percent of the FY 2000 state allotment. In FY 1998, the amount would be equal to 50 percent of the FY 1995 Federal DSH payments to the state, plus 50 percent of the FY 2000 state allotment. And in FY 1999, the amount would be equal to 25 percent of the FY 1995 Federal DSH payments and 75 percent of the FY 2000 state allotment. By FY 2000, the allotments would be based solely on the allotment formula of the new DSH program.

[3]All savings are staff estimates using CBO December 1995 baseline.

New Program: In FY 2000 and subsequent years, state allotments would be based on each state's share of low-income patient days for a core set of providers. A "low-income patient day" would be defined as either an inpatient day or a day with one or more outpatient visits for uninsured and Medicaid patients. These days would be summed for a core set of providers in each state. Each state's allotment would be determined by multiplying the total Federal limit in the year by the state's days divided by the nation's days. Federal funding for this new program would be limited to $5.0 billion in FY 2000, $4.5 billion in FY 2001, and $4.0 billion for subsequent fiscal years.

o Program Design:

Transition Period: Before FY 2000, the plan would continue current laws regarding DSH (with the exception of the allotment structure). New program rules would begin on October 1, 1999.

Optional Program: The DSH program would be optional, beginning in FY 2000. States choosing to participate could do so throughout the current state plan amendment process and would have an additional requirement to produce an annual report describing which providers in their state received funds and how much they received.

Eligible Providers: A "core provider" would be (1) a hospital whose low-income utilization rate exceeds 25 percent and (2) children's hospitals whose low-income utilization rate exceeds 25 percent or whose Medicaid inpatient utilization rate exceeds 20 percent or is one standard deviation above the mean receiving Medicaid payments in the state. The plan also would give States the option of designating other hospitals that serve a disproportionate number of low-income patients with special needs.

Provider Payments: The plan would require States with DSH program to pay core providers and give them the option of paying additional providers that meet the core provider standard. The plan would retain limits on maximum payments to facilities and rules about payment proportionality.

o Annual State report: The plan would require States to submit an annual report to the HHS Secretary and make it available to the general public. The report would include:

- a list of DSH providers and their uncompensated care amount;
- the amount of DSH payments to each provider;
- an explanation of how state payments (including payments based on uncompensated care and undocumented persons pools) related to the state plan; and

– a demonstration of how the allocation affected uncompensated care.

o Transition Pools.

The plan would designate three capped pools of Federal funds for payments to specific states and providers to help them transition to the new Medicaid program.

1. **Undocumented Persons Pool**

The plan would create this temporary pool for states with high numbers of undocumented persons to help pay for emergency health services. State matching payments would not be required. The pool would be funded at $700 million per year for fiscal years 1997 through 2001.

The 15 states with the highest number of undocumented persons, according to Immigration and Naturalization Service data (October 1992), would be eligible. Each state would receive an allotment from the pool, according to its share of the total number of undocumented persons in the 15 states.

2. **Pool for Federally-Qualified Health Centers & Rural Health Clinics**

The plan would create a pool for supplemental payments limited to $500 million annually to federally-qualified health centers (FQHCs) and rural health clinics (RHCs).

3. **Transition Pool**

The plan would create a pool for payments to states to assist in the transition to the new Medicaid program. Federal funding amounts of $3.1 billion in fiscal years 1997 and 1998 and $2.5 billion in fiscal years 1999 and 2000 would be authorized.

VI. COMMISSION ON FEDERAL AND STATE EQUITY IN MEDICAID

- The plan would establish a two-year commission to study the need for, and methods for, changing federal Medicaid matching payments to the states to better reflect the differing effects of demographics, health care utilization, and economic variation. The commission would be expected to examine differential growth in the population below poverty, as well as for those eligible for Medicaid within states and across states. The commission would also investigate trends in health utilization and spending within states and among different population groups. Finally, the commission would examine differences due to economic factors such as wages, per capita income, state tax capacity, and state tax efforts.

- The commission would be composed of 18 members -- six would be appointed by the President, six appointed by the President pro tempore of the Senate, and six appointed by the Speaker of the House. These appointees would include representatives of state governments, beneficiaries, and the general public. The commission would submit recommendations and report on its work to the Secretary of Health and Human Services and the Congress two years after its first meeting.

PROTECTING WORKING AMERICANS: INSURANCE REFORMS

The President's plan contains insurance reforms to make health coverage more accessible, portable, and affordable. The plan would restrict pre-existing condition exclusions; require insurers to issue, renew and, ultimately, rate group coverage without regard to health status; and prohibit insurers from imposing lifetime benefit maximums, or caps, on benefits for specific conditions. In addition, the plan would provide financial assistance to states to help promote the establishment of health insurance purchasing cooperatives.

I. ACCESS AND COVERAGE PROTECTION: Measures to improve working Americans' ability to obtain and maintain coverage.

A. Group Market

The plan would:

- Define the "small group" market as 1-50 employees (i.e., self-employed individuals and sole proprietors would be covered) and limit the use of health status in setting small group premium rates.

- Limit pre-existing condition exclusions to 12 months, and ensure that they are imposed only for conditions diagnosed or treated within the six months prior to health plan enrollment. This proposal would apply to plans of all sizes.

- Reduce, by one month for each month of coverage a new enrollee had under a prior plan, the period of exclusion for pre-existing conditions. This proposal would apply to all plans.

- Require insurers to renew coverage to employer groups, regardless of any group member's health status.

- Require insurers to make coverage available to all eligible groups, regardless of any group member's health status (generally referred to as "guaranteed issue").

- Require insurers to provide an open enrollment period of at least 30 days for new employees.

- Prohibit insurers from individually rating new enrollees in an existing group health plan (i.e., new enrollee premiums must be the same as other enrollees with similar demographic characteristics). Although this proposal would apply to plans of all sizes, it would primarily benefit small businesses.

- Prohibit insurers and self-insured employer plans from imposing (1) caps on benefits for specific diseases or medical conditions (e.g., AIDS) and (2) lifetime maximums on total benefit payments. This proposal would apply to all plans.

B. Individual Market

The plan would:

- Require insurers in the individual market to offer coverage to persons who: (1) had health insurance over the previous 12 months, (2) lost the coverage under certain circumstances (e.g., loss of employment, death of a spouse, divorce, change of residence), and (3) applied for individual coverage within 60 days of losing their previous coverage.

  - The plan also would require insurers to offer coverage at the average price for someone with the same characteristics and without pre-existing condition exclusions.

- Limit the ability of insurers to impose pre-existing conditions.

- Require insurers to renew coverage for all individual policyholders at the same rate as people with similar demographic characteristics, without regard to health status.

II. AFFORDABILITY: Measures to make coverage more affordable for the self-employed and to limit variations in small group premiums.

The plan would:

- Increase gradually, to 50 percent, the tax deduction for self-employed individuals.

- Limit premium variations for small businesses by phasing out, over a four-year period, the use of claims experience, duration of coverage, and health status in determining rates. Other factors, such as age and family composition, could be used in rating, but they would have to be actuarially justifiable.

III. ENCOURAGE COMPETITION: Measures to restructure the market to promote competition among insurers based on efficiency and service.

The plan would:

- o Provide grants to States to establish purchasing coops. Certain conditions would be imposed (e.g., not bearing any insurance risk; being geographically based; offering multiple plans; etc.). The assistance would total $25 million the first year.

- o Permit the Federal Employees Health Benefit Program (FEHBP) to require its local commercial carriers to participate in purchasing cooperatives at state request.

IV. ENFORCEMENT OF INSURANCE REFORMS

The plan would:

- o Codify reforms into Federal law.

- o Ensure that states enforce requirements that affect insurance carriers, and require states to submit an enforcement plan to the HHS Secretary.

- o Enforce, through the Labor Secretary, requirements affecting self-insured plans. Plans that fail to comply would be subject to civil penalties under the Employee Retirement Income Security Act of 1974 (ERISA).

ENSURING COVERAGE FOR TEMPORARILY UNEMPLOYED FAMILIES

Building on the insurance reform provisions, the President's plan would establish a demonstration program to make funds available for states to finance up to six months of coverage for unemployed workers and their families. The program would be available to unemployment recipients with incomes below a certain threshold, who had employer-based coverage in their prior jobs. The plan would give states substantial flexibility to administer the demonstration program. A Presidential Commission would study and provide recommendations as to whether the program should be made permanent.

I. FEDERAL FUNDING FOR STATES

The President's plan would:

- Provide annual grants under a four year demonstration program to participating states. HHS would operate a program in a state that chooses not to participate.

II. ELIGIBILITY FOR COVERAGE

- Recipients would be required to have made an unemployment insurance claim and to be in active status.
- Coverage would not exceed six months.
- Individuals would have to have had health insurance coverage through their last employer for at least the six previous months (including plans where the employee paid the full cost).
- A full subsidy would be provided up to 100 percent of the poverty level for family income and phased out at 240 percent of the poverty level.
- An employed spouse could not have health insurance coverage or, if covered, the employer could contribute no more than 50 percent of the premium.
- The individual/family could not be eligible for Medicaid or Medicare.
- Individuals would be eligible based on their place of residence.

- No reduction could be made in the duration or amount of unemployment benefits as the result of an individual participating in the health care coverage program.

III. BENEFITS

- States would have flexibility in how to use funds to assure access to an insurance product:
  - COBRA coverage from their prior employer;
  - an insurance product in the private market (with the general standard being a product equivalent to the Blue Cross/Blue Shield standard option plan);
  - alternative means of coverage (e.g., state high risk pools, Medicaid buy-in, special plan for the temporarily unemployed).

- States would have the option of extending eligibility periods or providing a more generous package using state funds.

- Any reduction in either the duration or extent of health coverage benefits would have to be approved by the HHS Secretary.

IV. ADMINISTRATION

- A Presidential Commission would study and provide recommendations as to whether the program should be made permanent.

ADMINISTRATIVE SIMPLIFICATION AND SECURITY OF HEALTH INFORMATION

Under the President's plan, the HHS Secretary would be required to adopt standards from among those already approved by private standards developing organizations for certain electronic health transactions, including: claims, enrollment, eligibility, payment, and coordination of benefits. These standards must address the security and privacy of health information on the electronic network. The plan would require health plans to use the approved standards if requested by a provider or other health plan. The plan would not allow private health plans to require providers to change their current procedures.

I. GENERAL REQUIREMENTS TO PROMOTE DEVELOPMENT OF AN ELECTRONIC HEALTH INFORMATION NETWORK

The plan would require the HHS Secretary to adopt standards developed by a private standards developing organization, or standards in common use, for electronic health information transactions. The HHS Secretary also would have to establish standards for the security and privacy of electronic transmission and storage of health information.

Under the President's plan, health plans (i.e., any public or private entity which provides or pays for the cost of health benefits) could conduct the specified electronic transactions using such standards, and must use such standards if requested to do so by a provider, employer, or another plan.

- Health plans could meet this requirement either directly or through a "health information network service" -- an entity that processes nonstandard data elements of health information into standard data elements. The HHS Secretary could establish criteria for voluntary certification of "health information network services;" such certification would indicate that the entity meets the requirements established under the President's plan.

- The HHS Secretary could develop standards only if the adoption or modification of existing standards were inadequate.

- The HHS Secretary would be required to adopt such standards within 18 months of enactment. Health plans could be required to use the standards 24 months after the HHS Secretary adopts them (36 months for small plans).

- The plan would not limit any public health authority or reporting requirements.

- The plan would not require the disclosure of health information or expand access to health information.

II. STANDARDS FOR INFORMATION TRANSACTIONS AND DATA ELEMENTS

Under the plan, the HHS Secretary must adopt standards for electronic transactions and data elements relating to financial and administrative matters, specifically:

- Claims or equivalent encounter information, claims status, and claims attachments;
- Enrollment and disenrollment;
- Eligibility;
- Health care payment and remittance advice;
- Premium payments;
- First report of injury; and
- Referral certification and authorization.

The HHS Secretary could set standards for other financial and administrative transactions. But the standards shall not require disclosure of trade secrets or confidential commercial information.

The HHS Secretary would also be required to:

- Adopt standards for providing unique identifiers for individuals, employers, plans, and providers for use in the health care system.
- Select code sets for appropriate data elements.
- Specify procedures for the electronic transmission and authentication of signatures; these will preempt state laws (such as "quill pen" laws that require paper records) and satisfy Federal and state requirements for written signatures.
- Develop rules and procedures for determining a health plan's financial liability when benefits are payable under two or more plans (coordination of benefits).

- Recommend to Congress (no earlier than two years and not later than six years after enactment) a plan for implementing uniform data and electronic exchange standards for patient medical record information.

III. STANDARDS FOR SECURITY AND PRIVACY OF HEALTH INFORMATION

The HHS Secretary's security standards would:

- Require reasonable and appropriate administrative, technical, and physical safeguards to protect and ensure the integrity and confidentiality of the information.

- Take into account the technical capabilities of existing systems, implementation costs, the needs of small and rural health care providers, the need for training, the value of audit trails, and the needs of law enforcement agencies to investigate health care fraud and abuse.

The HHS Secretary's privacy standards would address:

- The rights of an individual who is the subject of such information;

- The procedures to be established for the exercise of such rights;

- The authorized uses and disclosures of such information;

- Adequate security practices; and

- Reasonable access for law enforcement agencies to investigate health care fraud and abuse.

IV. PENALTIES

General: Under the plan, people who do not comply could face a civil penalty of not more than $1000 per violation, with an annual limit of $250,000. The HHS Secretary would be able to waive or reduce penalties and could not impose penalties if the failure to comply were due to reasonable cause and was corrected.

Penalties for Wrongful Disclosure: A person who uses a unique identifier for an unauthorized purpose, or obtains or discloses individually identifiable health information in violation of the privacy standards in the plan, could be fined no more than $50,000, and imprisoned no more than one year, or both. If the offense is committed under false pretenses, the maximum penalties would increase to $100,000 and five years imprisonment. If the offense is committed with intent to use individually identifiable health information for commercial advantage, personal gain, or malicious harm, the maximum penalties would increase to $250,000 and 10 years imprisonment.

V. EFFECT ON STATE LAW

The plan would supersede state laws, except when the state law is more stringent with respect to the privacy of individually identifiable health information, or the HHS Secretary determines that the State law is necessary to prevent fraud and abuse.

VI. HEALTH INFORMATION AND PRIVACY ADVISORY COMMITTEE

The plan would increase the authority of the National Committee on Vital and Health Statistics by: (1) expanding committee functions to include the study of data policy related to the electronic exchange of, and uniform data standards for, health information; and (2) making the committee responsible for advising the Secretary and the Congress on the status and the future of the health information network. In addition, the plan would:

- Expand the fields of expertise from which Committee members may be chosen to include electronic interchange of health information, consumer interests in health information, health data standards, and employment-based health plans;

- Require the committee to report to the HHS Secretary its recommendations to facilitate adoption of shared data standards and electronic exchange of health information; and

- Change the Committee's name to the "Health Information and Privacy Advisory Committee."