AMENDMENT TO COMMITTEE PRINT (H.R. 3600)

OFFERED BY MR. MCKEON

Page 102, line 16, insert after "networks" the following: "and community health networks".

Page 104, line 10, insert before the period the following: "and community health networks (as defined in section 1902(7))".

Page 106, line 6, after "from" insert "a community health network and from".

Page 238, strike lines 9 through 12 and insert the following:

(a) QUALITY ASSURANCE.—Each carrier providing a health plan shall—

(1) comply with such quality assurance requirements as are imposed under subtitle A of title V with respect to such plan,

(2) provide for an ongoing program to assure the quality of health care services furnished to enrollees under such plan that—

(A)(i) to the maximum extent possible, relies primarily on evaluating and comparing practice patterns (rather than routine case-by-case review) to identify problems, and

(ii) to the extent it employs case-by-case review—

(I) uses practicing health professionals with appropriate clinical training to make review determinations,

(II) provides timely access to case reviewers through a toll-free telephone number,

(III) makes the coverage and utilization review requirements of the plan, and the standards applied for such reviews, available to providers and the public,

(B) stresses health outcomes, and

(C) includes review by physicians and other health care practitioners of—

(i) outcomes, and

(ii) the process followed in the provision of such services, and

(3) develops with the practitioners and providers participating in such plan, and implements, a process to ensure the appropriate use of clinically relevant practice guidelines in the prevention, diagnosis, and treatment of diseases, disorders, and other health conditions of enrollees.

Page 239, after line 21, insert the following:

SEC. 1414. COORDINATION OF CARE.

A carrier shall establish and implement, with respect to each of its health plans, mechanisms for coordinating the delivery of care across provider settings and over time, including at least mechanisms for—

(1) linking patient registration and medical record information so that it is accessible to all parts of the plan and, consistent with State law, this Act, and other Federal law, assures the confidentiality of patient information,

(2) assisting enrollees to obtain necessary care, including preventive services, and

(3) coordinating the services furnished to an enrollee when more than one practitioner or provider is involved.

SEC. 1415. HEALTH STATUS IMPROVEMENT PROGRAM.

A community health network that is exempt from taxation under paragraph (3) or (4) of section 501(c) of the Internal Revenue Code of 1986 shall develop and implement a community health status improvement process, in cooperation with other plans, local public health officials, and community organizations from the same service area, that—

(1) provides for an assessment of community health status that identifies important health status problems in such area,

(2) implements measures to address such problems, and

(3) evaluates the efficiency and effectiveness of such measures in addressing such problems.

The results of evaluations made pursuant to paragraph (3) shall be made publicly available on at least an annual basis.

Page 240, line 1, strike "SEC. 1414." and insert "SEC. 1416.".

Page 332, beginning on line 6, strike "The Board may request" and insert the following:

(1) IN GENERAL.—The Board may request

Page 332, line 11, strike "The Board" and insert the following:

(2) REQUIREMENTS FOR COMMUNITY HEALTH NETWORKS.—In the case of a request under paragraph (1) in relation to a community health network, the Secretary shall request that the NAIC, in

developing such model standards, take into account—

(A) excess/stop-loss, reinsurance, security, guaranty, or other financial arrangements adequate to enable the network to fully meet all of its financial obligations on a timely basis, and

(B) the characteristics particular to a network, including but not limited to, the size of its financial exposure, and the extent to which health care services are purchased by the network or are otherwise provided by providers who have an interest in or are employed by the network.

(3) ACCEPTANCE OR MODIFICATION OF STANDARDS.—The Board

Page 417, line 19, strike "organization, or" and insert "organization, community health network, or".

Page 420, insert after line 4 the following (redesignating subsequent paragraphs accordingly):

(7) COMMUNITY HEALTH NETWORK.—The term "community health network" means an arrangement that is organized by health care providers (including medical practitioners), community groups, or both,

and such other organizations as may be designated by the arrangement, to provide health care services to an enrolled population in a service area.

AMENDMENT TO COMMITTEE PRINT (H.R. 3600)

OFFERED BY MR. KLINK

Page 90, after line 23, insert the following:

(10) Abortions, except where—

(A) a woman suffers from a physical disorder, illness, or injury that would, as certified by a physician, place the woman in danger of death if the fetus were carried to term; or

(B) the pregnancy is the result of a forcible rape or incest.

(c) CONSTRUCTION OF ABORTION EXCLUSION.—Subsection (b)(10) shall not be construed to remove or diminish coverage of any reproductive health service, family planning service, or service for pregnant women otherwise provided for under this Act, except abortions.

Page 91, after line 13, insert the following:

(c) NO AUTHORITY TO ALTER ABORTION EXCLUSION.—Notwithstanding any other provision of this Act, the Board may not expand the comprehensive benefit package to include any abortion that is excluded under section 1141(b)(10).

Klinik Substance

Abuse Amendment →

3 %

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[DISCUSSION DRAFT]

AMENDMENT TO COMMITTEE PRINT (H.R. 3600)

OFFERED BY MR. MILLER OF CALIFORNIA

Page 30, strike lines 16 through 19 and insert the following:

(which are subject to section 1115), except—

(1) medical detoxification as required for the management of medical conditions associated with withdrawal from alcohol or drugs (which is not covered under such section); and

(2) treatment of a substance abuse disorder that is necessary in order to ensure continuity of care for an individual receiving hospital services other than such treatment, where the individual was receiving substance abuse treatment covered under section 1115 prior to receiving such other hospital services.

Page 42, line 1, strike "nonresidential" and insert "community services for".

Page 42, line 11, strike "NONRESIDENTIAL, and insert "INTENSIVE COMMUNITY SERVICES,".

Page 42, line 14, strike "nonresidential" and insert "community services for".

Page 42, line 17, strike "case management" and insert "~~case management,~~ screening and assessment, crisis services,".

Page 42, line 22, strike "disorder;" and insert "disorder or, in the case of an individual 5 years of age or less than 5 years of age, is at risk for such a mental disorder;

Page 43, strike lines 8 through 19 and insert the following:

(2) CASE MANAGEMENT.—An eligible individual is eligible to receive coverage for case management if the individual is eligible to receive coverage for, and is receiving, mental illness and substance abuse treatment with respect to a diagnosable mental disorder or a diagnosable substance abuse disorder.

Page 44, line 8, strike "nonresidential" and insert "community services for".

Beginning on page 44, strike line 19 through page 45, line 2, and insert the following:

(A) an inpatient of a hospital or a psychiatric hospital; or

(B) a resident of a residential treatment center, residential detoxification center, crisis

residential program, mental illness residential treatment program, therapeutic family home, group treatment home, community residential treatment program, or recovery center for substance abuse.

DP. 45 Strike 21–25 p 46 · 1–5 – yes, strike this provision

Beginning on page 46, strike line 15 through page 47, line 5 (and redesignate provisions accordingly).

Page 47, after line 18, insert the following:

(E) ANNUAL AND LIFETIME LIMIT ON HOSPITAL TREATMENT.—Prior to January 1, 2001, such treatment, when furnished to an inpatient of a hospital that is not a psychiatric hospital, is subject to an aggregate annual limit of 90 days. Such treatment, when furnished to an inpatient of a psychiatric hospital, is subject to an aggregate annual limit of 45 days and an aggregate lifetime limit of 190 days per individual.

(F) ANNUAL LIMIT ON RESIDENTIAL TREATMENT.—Prior to January 1, 2001, such treatment, when furnished in a setting other than a hospital or psychiatric hospital, is subject to an aggregate annual limit of 135 days. The number of covered days of inpatient mental

illness and substance abuse treatment that are available to an individual under the annual and lifetime limits described in subparagraph (E) shall be reduced by 1 day for each 3 covered days of residential mental illness and substance abuse treatment that are provided to the individual.

Page 47, line 19, strike "NONRESIDENTIAL TREATMENT.—" and insert "COMMUNITY SERVICES.—".

Page 47, line 21, strike "nonresidential" and insert "community services for".

Page 48, line 14, strike "nonresidential" and insert "community services for".

Page 48, strike lines 16 through 22 (and redesignate provisions accordingly).

Beginning on page 49, strike line 16 through page 50, line 14, and insert the following:

(B) ANNUAL LIMIT.—Prior to January 1, 2001, such treatment is subject to an aggregate annual limit of 90 days, except with respect to individuals less than 22 years of age such annual limit shall be 180 days.

Page 50, line 16, strike "nonresidential" and insert "community services for".

Page 50, line 22, strike "nonresidential" and insert "community services for".

Page 51, strike lines 5 through 8 and insert "this subtitle.".

Beginning on page 52, strike line 8 through page 54, line 23 (and redesignate provisions accordingly).

Page 55, after line 12, insert the following (and redesignate provisions accordingly):

(f) UTILIZATION REVIEW REQUIREMENT.—

(1) IN GENERAL.—The mental illness and substance abuse services that are described in this section are not covered for an individual, after each applicable set of visits or set of treatment days described in paragraph (2) has been provided to the individual, unless the health plan in which the individual is enrolled determines, based on a utilization review, that such services continue to be medically necessary or appropriate.

(2) SETS OF VISITS AND TREATMENT DAYS.—

(A) SETS OF VISITS.—The sets of visits referred to in paragraph (1) are—

(i) 1 initial set of 10 consecutive regularly-scheduled outpatient psychotherapy visits provided to an individual during a period that does not exceed 12 months; and

(ii) each subsequent set of 15 consecutive regularly-scheduled outpatient psychotherapy visits provided to the individual that immediately follows the initial set of visits described in clause (i) or another set of visits described in this clause.

(B) SETS OF TREATMENT DAYS.—The sets of treatment days referred to in paragraph (1) are—

(i) 1 initial set of 10 consecutive days of inpatient and residential mental illness and substance abuse treatment; and

(ii) each subsequent set of 15 consecutive days of inpatient and residential mental illness and substance abuse treatment provided to the individual that immediately follows the initial set of treatment days described in clause (i) or another set of treatment days described in this clause.

(3) MODIFICATION OF NUMERICAL SETS BY BOARD.—The National Health Board may by regulation modify the number of visits or days that constitute a set referred to in paragraph (1).

(4) MODIFICATION OF NUMERICAL SETS BY STATES.—With respect to mental illness and substance abuse services that are provided in a State, the State may modify the number of visits or days that constitute a set referred to in paragraph (1), if the modification decreases such number below the number specified in paragraph (2) or specified by the Board under paragraph (3).

Page 86, strike the items relating to intensive nonresidential mental illness and substance abuse treatment, outpatient mental illness and substance abuse treatment, and outpatient psychotherapy and insert the following:

Intensive community services for mental illness and substance abuse treatment	1115	No copayment	20 percent of applicable payment rate

Outpatient mental illness and substance abuse treatment (except psychotherapy provided to an individual at least 22 years of age, collateral services, and case management)	1115	$10 per visit	20 percent of applicable payment rate
Outpatient psychotherapy for individuals at least 22 years of age and collateral services	1115	$25 per visit until January 1, 2001, and $10 per visit thereafter	50 percent of applicable payment rate until January 1, 2001, and 20 percent thereafter

Page 97, after line 22, insert the following (and redesignate provisions accordingly):

(7) CONTINUITY OF CARE FOR MENTAL AND SUBSTANCE ABUSE DISORDERS.—Ensuring continuity of care for individuals who require mental illness and substance abuse services described in section 1115, but are not covered for such services because of annual or lifetime limits described in such section, by contracting with providers who provide mental illness and substance abuse services described in such section, unless suitable agreements with such providers cannot be reached.

Page 224, beginning on line 11, strike "Each carrier" through line 17 and insert the following:

(1) IN GENERAL.—Each carrier providing a health plan with an integrated health network (as

defined in section 1902(25)) shall enter into such agreements with health care providers or have such other arrangements as may be necessary to assure the provision of all services covered by the comprehensive benefit package to eligible individuals enrolled with the plan through such a network.

(2) SPECIAL REQUIREMENTS FOR MENTAL ILLNESS AND SUBSTANCE ABUSE SERVICES.—Each carrier providing a health plan with an integrated health network shall enter into such agreements with health care providers or have such other arrangements as may be necessary—

(A) to demonstrate specifically that the carrier has the ability to provide, through such network, to individuals who have severe mental illness, serious emotional disturbance, or a substance abuse disorder, medically necessary or appropriate ~~inpatient and residential mental illness and~~ residential substance abuse treatment (described in section 1115(c)), intensive community services for mental illness and substance abuse treatment (described in section 1115(d)), and outpatient mental illness and substance abuse treatment consisting of case management (described in section 1115(e)(1)(H);

(B) to ensure that the items and services described in subparagraph (A) are provided to all individuals enrolled under the plan by providers who have a demonstrated ability to identify individuals who require such treatment and to deliver such treatment within a reasonable distance from the residence of an individual;

(C) to ensure continuity of care for individuals who require mental illness and substance abuse services described in section 1115, but are not covered for such services because of annual or lifetime limits described in such section, by developing appropriate plans and linkages with public agencies that may provide such services; and

(D) to ensure that the carrier has established, or is establishing, linkages with existing mental illness and substance abuse service delivery programs in the plan service area for services that are required under section 1115(g) to be provided through an organized system of care.

(3) SPECIAL REQUIREMENT TO CONTRACT WITH STATE-DESIGNATED PROVIDERS.—In the case of a carrier with respect to which a State has made a

finding that the carrier has not satisfied the requirement in subparagraph (A) or (B) of paragraph (2), the carrier, if directed by the State, shall contract with providers designated by the State as having demonstrated experience in providing the services described in paragraph (2)(A).

Jennifer -

Also, would it be possible to get a separate cost for the special needs part of the Miller dental amendment?

Susie
(225-5768)

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(3)

AMENDMENT TO COMMITTEE PRINT (H.R. 3600)

OFFERED BY MR. OWENS

Page 69, beginning on line 4, strike "Act," and all that follows through line 5 and insert the following:

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Act and other items of durable medical equipment relating to RESPIRATORY SUPPORT, bathing, toileting, or lifting (such as bathtub lifts and grab bars) which are essential to the prevention of complications of an existing illness, injury, disorder, or other health condition.

ON LINE 2, after "to" add "respiratory support,"

AMENDMENT TO COMMITTEE PRINT (H.R. 3600)

OFFERED BY MR. PAYNE

we need to talk? K

Page 169, line 17, strike "**CHILDREN**" and insert "**INDIVIDUALS**" (and conform the table of contents accordingly).

$200 M to cost of new program

Page 404, line 2, strike "**Children**" and insert "**Individuals**" (and conform the table of contents accordingly).

Page 404, line 5, strike "**CHILDREN**" and insert "**INDIVIDUALS**" (and conform the table of contents accordingly).

Page 404, line 7 and line 10, strike "Children's" and insert "Individuals".

Page 404, line 11, insert "and each eligible adult (as defined in subsection (c))" after "(b))".

Page 404, line 12, strike "subsection (c)" and insert "subsection (d)".

Page 404, insert after line 23 the following new subsection (and redesignate the succeeding subsection accordingly):

(c) ELIGIBLE ADULT DEFINED.—In this subtitle, an "eligible adult" is an eligible individual who—

(1) for years prior to 1998, is a resident of a participating State;

(2) is not an eligible child under subsection (b) or a qualified child under section 1934(b) of the Social Security Act (as added by section 4222(a)); and

(3) is a pregnant or post-partum woman who has adjusted family income at or below 185 percent of the applicable poverty level (as defined in section 1902(36)).

Page 405, line 2, strike "child," and insert "child or an eligible adult,".

Page 405, line 4, insert "or adult's" after "child's".

Page 405, line 6, insert "or adult" after "the child".

Page 405, line 21 and line 25, insert "and eligible adults" after "children".

Page 406, line 2, insert "and each eligible adult" after "child".

Page 406, line 7, strike "**CHILDREN'S**" and insert "**INDIVIDUALS**" (and conform the table of contents accordingly).

Page 406, line 10, strike "Children's" and insert "Individuals".

Page 683, line 7, strike "CHILDREN'S" and insert "INDIVIDUALS".

Page 683, line 20, strike "CHILDREN'S" and insert "INDIVIDUALS".

Page 684, line 8, strike "Children's" and insert "Individuals".

Page 686, line 18, strike "Children's" and insert "Individuals".

Page 775, line 17, strike "Children's" and insert "Individuals".

AMENDMENT TO COMMITTEE PRINT (H.R. 3600)

OFFERED BY MR. MILLER OF CALIFORNIA

Beginning on page 69, strike line 24 through page 70, line 19, and insert the following:

(1) Emergency dental treatment, including extractions, for bleeding, pain, acute infections, and injuries to the maxillofacial region.

(2) Prevention and diagnosis of dental disease, including examinations of the hard and soft tissues of the oral cavity and related structures, radiographs, dental sealants, fluorides, and dental prophylaxis.

(3) Treatment of dental disease, including noncast fillings, periodontal maintenance services, and endodontic services.

(4) Space maintenance procedures to prevent orthodontic complications.

(5) Orthodontic treatment to prevent severe malocclusions.

(6) Full dentures.

(7) Medically necessary oral health care.

(8) Any items and services for special needs patients that are not described in paragraphs (1) through (7) and that—

(A) are required to provide such patients the items and services described in paragraphs (1) through (7);

(B) are required to establish oral function (including general anesthesia for individuals with physical or emotional limitations that prevent the provision of dental care without such anesthesia);

(C) consist of orthodontic care for severe dentofacial abnormalities; or

(D) consist of prosthetic dental devices for genetic or birth defects or fitting for such devices.

(9) Any dental care for individuals with a seizure disorder that is not described in paragraphs (1) through (8) and that is required because of an illness, injury, disorder, or other health condition that results from such seizure disorder.

Page 70, strike line 22 and all that follows through page 71, line 4, and insert the following:

(1) PREVENTION AND DIAGNOSIS.—

(A) EXAMINATIONS AND PROPHYLAXIS.—The examinations and prophylaxis described in subsection (a)(2) are covered only annually, ex-

cept for individuals less than 18 years of age and special needs patients.

(B) DENTAL SEALANTS.—The dental sealants described in such subsection are not covered for individuals 18 years of age or older. Such sealants are covered for individuals less than 10 years of age for protection of the 1st permanent molars. Such sealants are covered for individuals 10 years of age or older for protection of the 2d permanent molars.

Page 71, line 8, strike "age." and insert "age and special needs patients.".

Page 72, line 1, strike "INTERCEPTIVE".

Page 72, beginning on line 3, strike "are not covered." and insert "are covered only for individuals at least 6 years of age, but less than 12 years of age, who have severe dentofacial abnormalities.".

Page 72, after line 6, insert the following:

(5) DENTURES.—Prior to January 1, 2001, the dentures described in subsection (a)(6) are not covered, except for special needs patients. On or after such date, 1 set of such dentures are covered for an individual every 8 years, except if the individual is

a special needs patient, in which case the limitation does not apply.

(c) DEFINITIONS.—For purposes of this subtitle:

(1) MEDICALLY NECESSARY ORAL HEALTH CARE.—The term "medically necessary oral health care" means oral health care that is required as a direct result of, or would have a direct impact on, an underlying medical condition. Such term includes oral health care directed towards control or elimination of pain, infection, or reestablishment of oral function.

(2) SPECIAL NEEDS PATIENT.—The term "special needs patient" includes an individual with a genetic or birth defect, a developmental disability, or an acquired medical disability.

Page 87, strike the items relating to dental care and space maintenance procedures and insert the following:

Dental care (except prevention and diagnosis of dental disease described in section 1126(a)(2), space maintenance procedures described in section 1126(a)(4), and orthodontic treatment described in section 1126(a)(5))	1126	$10 per visit	20 percent of applicable payment rate
Prevention and diagnosis of dental disease described in section 1126(a)(2)	1126	No copayment	No coinsurance
Space maintenance procedures described in section 1126(a)(4) and orthodontic treatment described in section 1126(a)(5)	1126	$20 per visit	40 percent of applicable payment rate

AMENDMENTS TO COMMITTEE PRINT (H.R. 3600)

OFFERED BY MR. PAYNE

Page 933, line 18, strike "and".

Page 933, line 21, strike the period and insert a comma.

Page 933, insert after line 21 the following:

"(D) in any case in which the complainant or the family of the complainant is entitled to a reduction in cost sharing under part V of subtitle C of title I of the Health Security Act or a premium discount under section 6104 of such Act, payment by the health plan for out-of-network second opinions for the purpose of obtaining medical expertise as required to resolve issues before the hearing officer, and

"(E) availability of interpreters and other measures to promote accessibility to full participation by parties whose primary language is not English or by parties with disabilitities for whom full participation would not otherwise be accessible by reason of such disabilities.

AMENDMENT TO COMMITTEE PRINT (H.R.3600)

OFFERED BY MR. PAYNE

Page 341, insert after line 20 the following:

(18) CERTAIN PHYSICIANS SERVING UNDERSERVED AREAS.—Physicians who regularly practice not less than 20 hours per week, and are regularly available evenings and weekends, to provide services—

(A) to individuals who are members of medically underserved populations (as defined in section 330 of the Public Health Service Act), or

(B) in health professional shortage areas (as defined in section 332 of such Act).

Committee on Education and Labor

WILLIAM D. FORD, CHAIRMAN
U.S. House of Representatives
Washington, DC 20515

(202) 225-4527
FAX - (202) 225-9070

FAX COVER SHEET

DATE: _____

TO: Jennifer Klein

FROM: Karen Lanpher

NUMBER OF PAGES IN THIS TRANSMISSION: 2 (including cover)

COMMENTS:

1) Owens

2) Clerk

Let's talk about before you do anything

Thanks!!

PLEASE CALL IF THERE ARE ANY PROBLEMS WITH THIS TRANSMISSION.

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AMENDMENT TO COMMITTEE PRINT (H.R. 3600)

OFFERED BY MR. OWENS

Page 66, line 17, strike "and".

Page 66, strike lines 18 through 19 and insert the following:

(3) outpatient speech-language pathology and audiology services; and

ADDICTION TREATMENT IN THE CLINTON HEALTH PLAN

The Clinton Health Plan in its present form provides less coverage for addiction treatment than presently required under Pennsylvania law.

PROBLEMS FOR INPATIENT ADDICTION TREATMENT

--- The Clinton Health Plan calls for a combined 30 days for mental health and addiction treatment. No other illnesses in the Health Plan are combined in this way.

Pennsylvania law requires group health insurance and HMO plans to provide 30 days inpatient for addiction treatment alone. Mental health benefits are separate. For this reason, combining the two as proposed in the Clinton plan erodes the existing service coverage.

--- The Clinton Health Plan provides up to 30 days inpatient. (a ceiling)

Pennsylvania law (Act 64 of 1986 and Act 106 of 1988) requires a mandated minimum of 30 days (a floor).

PROBLEMS FOR THOSE IN NEED OF LONG TERM INPATIENT TREATMENT

--- The Clinton Health Plan makes no provision for long term treatment. Although not everyone needs inpatient treatment, for those who do, long term inpatient care must be available. Groups typically in need of long term inpatient treatment are : adolescents, criminal justice referrals, pregnant addicted women and the elderly.

Pennsylvania law (Act 152 of 1988) provides for long term inpatient treatment for addictions through state Medicaid. Pennsylvania will spend over $40 million on this critical treatment service in 1994-95. Presently, Pennsylvania is the only state in the nation with such a law. We are considered real leaders on this nationally. Under the Clinton proposal, we will lose this benefit.

POLITICS

There has been a great deal of activity in Washington as the drug and alcohol treatment field struggles to address these concerns in Congress. After this activity, the Clinton administration announced and proposed large increases in the alcohol/drug Block Grant presumably to address long term treatment needs. This is a good sign however, lock Grant funding levels have been inconsistent over the years. The Block Grant is an annual political football and few states can count on it over time to provide financial stability and allow for planning. For Pennsylvania, it has ranged from $12 million to almost $60 million with the high end of the range being relatively unusual.

Clinton administration claims about the Health Plan providing coverage for everyone are simply not the case with the long term treatment groups.

OTHER PROBLEMS WITH THE CLINTON HEALTH PLAN

--- Outpatient and partial hospitalization services are discretionary.

In Pennsylvania, state law requires coverage of these services.

--- The Clinton Health Plan calls for trade-offs between inpatient and outpatient services.

Pennsylvania law, recognizes the need for a full continuum of care and allows no such trade-offs.

--- Hospital inpatient treatment is essentially eliminated and hospital detoxification is severely limited.

We need the hospital based programs we have for the medically compromised and to provide backup for the non-hospital treatment services. In addition, in many parts of our state the only treatment available for miles is hospital based.

--- There is no maintenance of effort clause or requirement in the Clinton Health Plan. This could lead to states reducing levels of service already in place.

--- Under the Clinton Plan family treatment is not provided unless the addicted person is in treatment.

Under Pennsylvania law, a parent can take the kids and begin family treatment without the addicted perons.

---- Under the Clinton Plan, co-payments are required on some outpatient services. Given that this is a disease of denial, negative incentives to seek care make little sense. People in need of this treatment already stay away in droves! Also, given that untreated addiction drives up health care use for addiction related illnesses, we should be paying for outreach and creating incentives to seek care.

PROBLEMS WITH MANAGED CARE

--- The Clinton Health Plan is to be administered by managed care.

Managed care in Pennsylvania already avoids providing anywhere near the mandated minimums required under state law. The Clinton Health Plan fails to provide strong consumer protections for addicted people

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SUBJECT = INPATIENT NON-HOSPITAL REHABILITATION - SHORT AND LONG TERM
8 RECOMMENDED AMENDMENTS

(A) SHORT TERM INPATIENT NON-HOSPITAL REHABILITATION

1. RECOMMENDED LANGUAGE CHANGE: PAGE 51, DELETE ALL OF SECTION (B), CHANGE TO READ: (45+46)

SECTION (B) RESIDENTIAL SUBSTANCE ABUSE TREATMENT.----

(i) SUBJECT TO SUBPARAGRAPH (D), SUCH TREATMENT IS COVERED FOR A MINIMUM OF 30 DAYS FOR SUBSTANCE ABUSE AND FOR A MINIMUM OF 30 DAYS FOR MENTAL HEALTH. WHERE THE INDIVIDUAL RECEIVING TREATMENT POSES A THREAT TO THEIR OWN LIFE OR SAFETY OR THE LIFE OR SAFETY OF ANOTHER INDIVIDUAL, ADDITIONAL TREATMENT MAY BE PROVIDED. WHETHER SUCH A THREAT EXISTS SHALL BE DETERMINED BY A HEALTH PROFESSIONAL WITH SPECIFIC SKILLS, CERTIFICATION OR LICENSURE IN THE ILLNESS UNDER REVIEW .

EXPLANATION:

This language ensures that the short term drug and alcohol inpatient non-hospital insurance benefit for the still employed is maintained at the same level as now in Pennsylvania. Without this language, mental health and drug and alcohol are pitted against each other for the same meager 30 day benefit. The language also ensures that the reviewer of individuals in need of additional care know something about the illness under review.

(B) LONG TERM INPATIENT RESIDENTIAL TREATMENT

2. RECOMMENDED LANGUAGE : ADD AFTER SECTION (B) (i):

(B) (ii) SUCH TREATMENT IS COVERED IN DRUG AND ALCOHOL THERAPEUTIC COMMUNITIES AND HALFWAY HOUSES FOR A MINIMUM OF 18 MONTHS.

EXPLANATION:

This language ensures that long term treatment continues to be available in the state. Presently, these services are funded through a combination of Pa. Medicaid dollars (Act 152 of 1988) and federal Block Grant monies. If destitute individuals and the employed are pulled together in the Clinton plan, then the treatment needs of both populations also must be reflected in the benefit coverage. Block Grant funding has not been stable over the years, is re-negotiated in each budget cycle and cannot be relied upon to as the sole source of funding for what is now the Medicaid population.

Addicted populations effected by the lack of a long term treatment benefit in the Clinton plan include: criminal justice patients who are sentenced to treatment in these settings, adolescents, pregnant addicted women and the elderly.

16

(46)

PAGE 51, SECTION (D) ANNUAL LIMIT

3. RECOMMENDED LANGUAGE CHANGE: DELETE THE SECTION AND REPLACE WITH:

PRIOR TO JANUARY 1, 2001, RESIDENTIAL TREATMENT FOR MENTAL HEALTH AND SUBSTANCE ABUSE IS SUBJECT TO AN ANNUAL LIMIT OF 60 DAYS FOR MENTAL HEALTH AND 60 DAYS FOR SUBSTANCE ABUSE.

EXPLANATION:

SUCH A LIMIT ON THE SHORT TERM BENEFIT SHOULD NOT CAUSE UNDO HARM THROUGH 2001.

7

SUBJECT = INPATIENT HOSPITAL TREATMENT FOR SUBSTANCE ABUSE
1 RECOMMENDED AMENDMENT

c477

1. RECOMMENDED CHANGE: PAGE 82, SECTION (E), DELETE SECTION (E) AND CHANGE TO READ:

SUBSTANCE ABUSE TREATMENT, WHEN PROVIDED TO AN INPATIENT OF A HOSPITAL OR PSYCHIATRIC HOSPITAL, IS COVERED UNDER THIS SECTION ONLY FOR MEDICAL DETOXIFICATION ASSOCIATED WITH WITHDRAWAL FROM ALCOHOL AND DRUGS AND FOR INDIVIDUALS MEETING THE AMERICAN SOCIETY OF ADDICTION MEDICINE CRITERIA FOR HOSPITAL INPATIENT DETOXIFICATION OR REHABILITATION. ALCOHOL AND DRUG DETOXIFICATION SHALL BE CONSIDERED EMERGENCY CONDITIONS PURSUANT TO THE EMERGENCY CARE PROVISIONS OF THIS ACT.

EXPLANATION:

This allows the 10-12 hospital detoxification/rehabs in Pennsylvania to continue to admit patients only if they are appropriate for such care using the ASAM. This also sets standards to permit and govern the use of hospital detoxes. Detoxification should be exempt from pre-certification processes that tend to delay care. Detox admissions should be reviewed retrospectively before any payment is made. This will prevent relapse and harm to the patients. Emergency admission language could instead be placed in the EMERGENCY AND URGENT CARE SERVICES section on page 234, Sec 1406, (b).line 23. You will find it also placed there at the end of this list of amendments.

8

SUBJECT - INTENSIVE NONRESIDENTIAL TREATMENT
4 RECOMMENDED AMENDMENTS

1. RECOMMENDED CHANGE: PAGE 54, (2) (A) (48)

DELETE CONTENT OF SECTION (A) (2)(A), REPLACE WITH THE FOLLOWING LANGUAGE:

(A) HEALTH PLANS SHALL PROVIDE INTENSIVE NONRESIDENTIAL MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT.

2. RECOMMENDED CHANGE: PAGE 54, (2) (B) (i) DELETE CONTENT OF (i) AND CHANGE TO: (49)

(i) TO AVERT THE NEED FOR TREATMENT IN RESIDENTIAL OR INPATIENT SETTINGS;

EXPLANATION:

Intensive outpatient or partial hospitalization services are a necessary part of the full continuum of care and should not be at the discretion of the states. Once again, Pennsylvania law already mandates this coverage and it is NOT seen as an "alternative" to inpatient. Many people move from inpatient into this intensive outpatient setting as they begin to re-integrate into the community. It enhances recovery and helps prevent relapse.

3. RECOMMENDED CHANGE: PAGE 54-55, SECTION (C) ANNUAL LIMIT (i) , DELETE CONTENT OF (i) AND REPLACE WITH: (49)

(i) IN GENERAL.- PRIOR TO JANUARY 1, 2001, SUCH TREATMENT IN ALL SETTINGS IS SUBJECT TO AN ANNUAL LIMIT OF 120 DAYS FOR MENTAL HEALTH AND AN ANNUAL LIMIT OF 120 DAYS FOR SUBSTANCE ABUSE.

EXPLANATION:

Once again, in the Clinton plan, treatment for mental health problems is pitted against substance abuse treatment. Why aren't any other diseases pitted against each other in this way in the Clinton plan? In addition, the full continuum of care must be established and not be subject to trade-offs.

4. RECOMMENDED CHANGE: PAGE 55 SECTION (C) (ii) ADDITIONAL DAYS, DELETE AND REPLACE WITH: (50)

9

(iii) ADDITIONAL DAYS - A MAXIMUM OF 60 ADDITIONAL DAYS OF INTENSIVE NONRESIDENTIAL MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT MAY BE PROVIDED TO AN INDIVIDUAL IF A HEALTH PROFESSIONAL WITH SPECIFIC SKILLS, LICENSURE OR CERTIFICATION IN THE ILLNESS UNDER REVIEW DETERMINES THAT SUCH ADDITIONAL TREATMENT IS NEEDED.

EXPLANATION:

The language ensures that the reviewer of those in need of additional care has skills and training appropriate to the task.

TOPIC = OUTPATIENT TREATMENT

3 RECOMMENDED AMENDMENTS (52)

1. RECOMMENDED CHANGE: PAGE 57-58, (2)(B) DELETE THIS SECTION

EXPLANATION:
Outpatient services are part of the needed continuum of care and should not be left to the discretion of the health professional or the plan. Pennsylvania law requires outpatient services to be provided as part of the continuum.

(52-53)

2. RECOMMENDED CHANGE : PAGE 58, SECTION (C) ANNUAL LIMITS, (i), DELETE THE CONTENT OF THE SECTION AND CHANGE THE SECTION TO READ:

(i) PSYCHOTHERAPY AND COLLATERAL SERVICES . - PRIOR TO JANUARY 1, 2001, PSYCHOTHERAPY AND COLLATERAL SERVICES ARE SUBJECT TO ANNUAL LIMITS OF 30 VISITS FOR EACH TYPE OF SERVICE. ADDITIONAL VISITS MAY BE COVERED, AT THE DISCRETION OF THE HEALTH PLAN IN WHICH THE INDIVIDUAL RECEIVING TREATMENT IS ENROLLED.

EXPLANATION:

Trade-offs of this sort fly in the face of establishing a meaningful continuum of care.

53,54

2. RECOMMENDED CHANGE: PAGE 58 AND 59 AND 60, SECTION (C) (ii),SUBSTANCE ABUSE COUNSELING AND RELAPSE PREVENTION - DELETE SECTION (ii) (I) AND (II) AND REPLACE WITH:

(ii) SUBSTANCE ABUSE COUNSELING AND RELAPSE PREVENTION . -WITHIN 12 MONTHS AFTER INPATIENT AND RESIDENTIAL TREATMENT OR INTENSIVE NONRESIDENTIAL TREATMENT, 30 VISITS IN GROUP THERAPY SHALL BE COVERED FOR SUBSTANCE ABUSE COUNSELING AND RELAPSE PREVENTION.

EXPLANATION:

Once again, the language change eliminates complex trade-off formulas where a basic continuum needs to be established.

11

TOPIC - CONSUMER PROTECTIONS

2 RECOMMENDATIONS

RECOMMENDATION: PAGE 49, SECTION (3) SCREENING AND ASSESSMENT AND CRISIS SERVICES. ADD A SUBSECTION (i) READING:

(i) FOR THE PURPOSES OF ASSESSING INDIVIDUALS WITH SUBSTANCE ABUSE PROBLEMS FOR LEVEL OF CARE AND LENGTH OF STAY DETERMINATIONS, ALL SUCH ASSESSMENTS SHALL BE PERFORMED BY PERSONS WITH SPECIFIC TRAINING, CERTIFICATION OR LICENSURE IN THIS SPECIALITY OR ORGANIZATIONS WITH SPECIFIC LICNESURE IN THIS SPECIALITY. ALL SUCH ASSESSMENTS SHALL BE MADE USING SPECIFIC DRUG AND ALCOHOL DIAGNOSTIC CRITERIA DESIGNATED BY THE STATE HEALTH BOARDS. CRITERIA UTILIZED SHALL BE THOSE DEVELOPED OR APPROVED BY THE AMERICAN SOCIETY OF ADDICTION MEDICINE OR THOSE THAT ADDRESS AT LEAST THE FACTORS DELINEATED IN THOSE CRITERIA. FISCAL INCENTIVES OR COMPENSATION SYSTEMS THAT MAY INFLUENCE DIAGNOSIS, LENGTH OF STAY OR LEVEL OF CARE DETERMINATIONS ARE STRICTLY PROHIBITED.

EXPLANATION:

This language assures that persons or organizations assessing patient placement and treatment needs have specific skills in this speciality. The language establishes credentials, diagnostic criteria and bars fiscal incentives to deny or delay care. This is a very serious problem in Pennsylvania. Presently, those without skills specific to this illness, coupled with specific fiscal incentives to deny care are making these determinations. The best coverage in the world is no good if the patients can't access it.

RECOMMENDATION : PAGE 233, SEC.1405, GRIEVANCE PROCEDURE, LINE 21, INSERT AFTER THE WORDS "TITLE C OF TITLE V:

...AND MUST INCLUDE STANDARDS AND PROCEDURES FOR AT LEAST THE FOLLOWING: (1) ALL CONSUMERS MUST BE NOTIFIED IN CONSUMER MATERIALS OF THE RIGHT TO APPEAL A DECISION, (2) NUMBERS, ADDRESSES AND CONTACT NAMES FOR APPEALS MUST BE PROVIDED IN WRITING IN CONSUMER MATERIALS, (3) AT THE POINT OF DENIAL OF CARE, ALL CONSUMERS MUST BE NOTIFIED AGAIN OF THE RIGHT TO APPEAL, (4) CONSUMERS, REFERRAL SOURCES AND TREATMENT PROVIDERS MUST RECEIVE WRITTEN NOTIFICATION OF THE DENIAL AND THE REASON FOR THE DENIAL, (5) CONSUMERS MUST BE NOTIFIED IN WRITING OF THE FOLLOWING RIGHTS: THE RIGHT TO ATTEND THE GRIEVANCE REVIEW, THE RIGHT TO BE REPRESENTED BY A PERSON OR PERSONS DESIGNATED BY THE CONSUMER AND THE RIGHT OF THE CONSUMER AND/OR DESIGNEE TO PRESENT THE CASE AT THE GRIEVANCE REVIEW, (6) THE GRIEVANCE PROCEDURE MUST PROVIDE FOR RESOLUTION OF COMPLAINTS AND GRIEVANCES WITHIN 30 DAYS OF RECEIPT OF THE ORIGINAL COMPLAINT, (7) GRIEVANCE REVIEW BOARDS SHALL BE COMPRISED OF INDIVIDUALS WHO HAVE CERTIFICATION OR LICENSURE I THE ILLNESS ( )

10

TOPIC - COLLATERAL SERVICES

1 RECOMMENDED AMENDMENT

1. RECOMMENDED CHANGE: PAGE 49, (4) COLLATERAL SERVICES, DELETE SECTION AND REPLACE WITH:

(4) COLLATERAL SERVICES - AN ELIGIBLE INDIVIDUAL IS ELIGIBLE TO RECEIVE COVERAGE FOR OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT CONSISTING OF COLLATERAL SERVICES IF THE INDIVIDUAL IS A FAMILY MEMBER (AS DEFINED IN SECTION 1011(b)) OF AN INDIVIDUAL WHO HAS A SUBSTANCE ABUSE OR MENTAL HEALTH PROBLEM.

EXPLANATION:

The Clinton language here appears to bar help for family members unless the addict or alcoholic or mentally ill person is in treatment. The recommendation above allows the family to go for help whether or not the addict is in treatment. Pennsylvania law already provides such coverage.

TOPIC - COPAYMENTS AND DEDUCTIBLES

1. RECOMMENDATION: PAGE 56 (E) OUT-OF-POCKET MAXIMUM, DELETE THIS SECTION, LINES 4- 17

EXPLANATION:

This creates an incentive on service use that is not based on clinical factors. Proper assessment and placement of the patient must govern clinical decisions or they will be back at high rates despite the incentive system attempted here.

2. RECOMMENDATION: PAGE 60 (E) OUT-OF-POCKET MAXIMUM, DELETE THIS SECTION, LINES 13-22.

EXPLANATION:

Why would we bar applying outpatient treatment expenses against the out-of-pocket limit on cost sharing? In fact, why do co-pay at all here? Addictive diseases are diseases of denial. There is no need to create a negative incentive to seek help and every need to create a positive incentive to enter treatment. The health care use of the untreated addicted people is 10-12 times higher than for other people. Outreach and treatment of addicted people ALREADY IS A HEALTH CARE COST CONTAINMENT STRATEGY IN ITSELF.

REVIEW AND MUST BE INDEPENDENT OF THE HEALTH PLAN AND THE PROVIDER, (8) HEALTH PLANS SHALL COMPILE RECORDS ON GRIEVANCES AND EXAMINE THESE RECORDS ANNUALLY TO IDENTIFY PATTERNS AND PROBLEMS WITH CONSUMER CARE, (9) THIS ANNUAL EXAMINATION SHALL INCLUDE SURVEYS OF PLAN DISENROLLEES AND DROPOUTS, (10) PATTERNS OF UTILIZATION AND LENGTH OF STAY FOR THE FULL CONTINUUM OF CARE AND (11) RESULTS OF THIS ANNUAL EXAMINATION

SHALL BE PUBLISHED AND PROVIDED TO ALL SUBSCRIBERS AND APPROPRIATE GOVERNMENTAL AND LEGISLATIVE AGENCIES AND COMMITTEES.

EXPLANATION:

This language provides basic consumer protections to the person seeking care. It provides for consumer notification of rights including the right to appeal, provides for credentialed people on the review board, provides for timley resolution of appeals and provides an accountability system.

TOPIC = EMERGENCY CARE

RECOMMENDATION: PAGE 234 AND 231 , SEC 1406. HEALTH PLAN ARRANGEMENTS WITH PROVIDERS, AFTER THE WORDS "SERVICES TO ENROLLEES OF THE PLAN AND IN THE CASE OF EMERGENCY SERVICES WITHOUT REGARD TO PRIOR AUTHORIZATION." INSERT THE SENTENCE ON LINE 23 SAYING:

ALCOHOL AND DRUG DETOXIFICATION SHALL BE CONSIDERED EMERGENCY CONDITIONS PURSUANT TO THE EMERGENCY CARE PROVISIONS OF THIS ACT.

EXPLANATION:

Detoxification should be exempt from pre-certification processes that tend to delay care. Detox admissions should be reviewed retrospectively to avoid relapse and harm to patients. The goal here is to get the patient out of the middle .

SUBJECT - MAINTENANCE OF EFFORT AND ESSENTIAL COMMUNITY PROVIDER

In addition, we support the language from the Legal Action Center on these two issues. See attached.

Amendment 9

Essential Community Provider Amendment:
Designate Substance Abuse Treatment Programs as Essential Community Providers

Objective: The Health Security Act would not include community based drug and alcohol treatment programs among the list of designated essential community providers. Such designated providers would be guaranteed the right to participate in provider networks established by health plans and to be treated as favorably as other providers.

While each substance abuse treatment program could seek such designation individually, each would have to demonstrate that the plan is otherwise unable to provide adequate substance abuse services in the area served by the program and that either the area is a designated health professional shortage area or the population to be served is a medically underserved population, as defined in the Public Health Services Act.

This amendment would add substance abuse treatment programs that receive funds under Titles V (categorical grants) and XIX (Substance Abuse Treatment and Prevention Block Grant) of the Public Health Services Act to the designated list.

Rationale:

A. Community-based Substance Abuse Treatment Programs are Essential Community Providers.

Community-based drug and alcohol treatment programs provide high quality, low cost and effective services to the majority of people who receive substance abuse care. They treat individuals with the most chronic drug and alcohol problems, those without health insurance and those who have exhausted their insurance or have been denied access to care.

The lack of substance abuse training in medical schools has left primary care physicians, including those in community health centers, unprepared to diagnose drug and alcohol problems or treat such problems. As a result, they do not have the training or expertise to provide such care and could never fill the gap if specialized substance abuse programs did not exist.

Without such community-based programs, the Nation's substance abuse treatment system would certainly fall apart. Moreover, the institutions that rely upon them, including the criminal justice (community corrections) and social services systems, would be in disarray if such programs were not available.
Community-based programs also play an integral role in improving the general health of individuals with substance abuse problems.

Treatment programs are often the first point of entry into the health care system for many poor, addicted individuals who have multiple, costly health conditions, including HIV/AIDS and tuberculosis. These individuals generally distrust the traditional health care system and are not welcomed to it. Without community based treatment programs, they might never be linked to necessary health care.

Finally, these programs will continue to provide services under the publicly funded system, which will continue to exist until a fully comprehensive substance abuse benefit is included in the benefit package. These providers must remain viable providers under the reformed system in order to avoid a two-tiered system when the private and public systems are finally integrated.

At the same time, community based providers need the assistance afforded "essential community providers" to survive the transition to a reformed health system. Many operate totally outside the general health care system and will be at a great disadvantage -- notwithstanding their cost competitiveness and expertise -- if they are not given a fighting chance to join provider networks.

Such programs should not be required to seek designation on an individual basis. This process is burdensome, and it is unclear whether many community-based treatment providers could satisfy the criteria. Undoubtedly, many plans will try to develop their own substance abuse provider network that would purportedly meet the need in the area. In addition, some community-based programs may not be in a designated health professional shortage area.

B. <u>Substance Abuse Programs That Receive Federal Block or Categorical Grant Funding Have the Same Federal Funding Connection As Other Designated Essential Community Providers</u>.

Community-based substance abuse programs that are funded under the Substance Abuse Block Grant and various federal categorical grant programs are no different from other providers that have been designated "essential community providers." The federal funding connection for such programs is as direct as that connection to Ryan White Act providers (who are designated as "essential"): in both systems federal funds go to state or local authorities which then distribute the funds to local providers. Each recipient of block grant or categorical grant funds can be identified by either the state or federal government.

Similarly, maternal and child health providers are funded under a block grant mechanism that is no different from the substance abuse block grant. Block grant funds go to each state which then distributes them to individual providers.

There is no principled reason to exclude these providers from the list of essential community providers. But to do so will even more

seriously impair our nation's ability to provide substance abuse care.

Amendment

Section 1582(a), add a new subsection (12):

(12) A public or private nonprofit entity that provides substance abuse treatment services and that receives funding for such services under Titles V or XIX of the Public Health Services Act.

Amendment 10

State Funding For Substance Abuse Services: Require States to Maintain Their Level of Funding for Substance Abuse Treatment Until A Comprehensive, Unlimited Benefit is Provided.

Objective: The Health Security Act would not require States to maintain their level of funding for substance abuse treatment even though a comprehensive benefit is not provided. This amendment would require States to maintain their funding level for these services until a comprehensive, unlimited benefit is in place.

Rationale: The substance abuse benefit in the Health Security Act with its strict day limits and merger with mental illness care will not provide coverage for many who now receive care in the publicly funded system. The Administration has recognized that the publicly funded system must remain in place until a comprehensive benefit is provided in order to serve those who cannot access services under the proposed benefit, those who exhaust their benefit or are denied services and those not covered under reform. (Although the level of funding and possible offsets in the federal system have not been defined.)

State and local funds currently account for at least half of the treatment dollars in each state. In 1993, public funds accounted for $4.33 billion of the $6.7 billion our nation spent on substance abuse treatment. (Lewin-VHI at 6 and 13).[1] Yet the Health Security Act does not require States to maintain their funding for such services during the transition to a comprehensive benefit.

Reliance on the publicly funded system will remain great under the Administration's plan for several reasons. First the substance abuse benefit is an acute care benefit that will not cover the longer term care needs that many individuals need. Second, utilization review will limit access to the private system and continue client "dumping" into the public system. It is estimated that under the Health Security Act, $3.69 billion in public funds will be needed to just maintain the level of care now obtained. (Lewin-VHI at 19).

Clearly, state and local funds will be needed to maintain current treatment services and expand services to those who do not now get care in the publicly funded system.

Amendment:

Add Subpart C -- State Funding of Substance Abuse Services to Title

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[1] Lewin-VHI, Inc. Healthcare Reform and Substance Abuse Treatment: The Cost of Financing Under Alternative Approaches. (February 2, 1994).

III, Subtitle F, Part 2.

Subpart C -- State Funding of Substance Abuse Services

Section 3531 State Funding of Substance Abuse Services

(a) In General -- As a condition of being a participating State under title I, each State shall agree to maintain expenditures of non-Federal amounts for substance abuse treatment at a level that is not less than the average level of such expenditures maintained by the State for the two fiscal years preceding the first fiscal year in which the State could have become a participating state.

(b) Waiver -- The Secretary shall determine based on the report submitted pursuant to Section 3511 and other information requested by the Secretary whether to waive all or part of the requirement under paragraph (a). Under no circumstances, will a state be permitted to reduce its expenditures before an unlimited substance abuse benefit is included as part of the comprehensive benefit package in title I.

Going from

1 → 5

↓

Maintain → you

Can't get beyond

5

Minimize → if you

don't get it

you will go

back to 3

490-0323

TO: Subcommittee on Labor Management-Relations
FROM: Gary Karnedy
RE: Outpatient Rehabilitation
DATE: April 3, 1994

PROPOSAL TO ELIMINATE MOST OF THE 6.5% LONG TERM COST ESCALATION IN THE OUTPATIENT REHABILITATION SECTION

The administration projected cost balloon arising form the Chairman's mark can be eliminated in large part by placing the Maintenance and Prevention Program we proposed back on April 4th into the mark. Under the Chairman's current language, outpatient rehabilitation is provided by rehabilitation specialists to minimize limitatioins and prevent deterioration.

This program would limit these treatments dramatically. This program would replace specialist outpatient rehabilitation prevention and maintenance treatment to an initial visit and periodic oversight. The ongoing services in these instances would be provided by family members or the patient themselves. would administer. The professional would merely provide an initial consultation and periodic oversight of the patient needs.

This amendment would place back in the original language we had proposed back on April 4th with one revision which would make clear that prevention and maintenance treatment would only be provided under this program.

REVISE 1123(b)(2) by striking the language in the first paragraph and adding:

A "To the extent that the services describe in paragraph 1 are for the purpose of maintaining function or preventing deterioration, such services ~~should~~ be limited to:"

ali

c. Amendment Language:

SECTION 1123 OUTPATIENT REHABILITATION SERVICES

(a) Coverage - The outpatient rehabilitation services described in this section are:

(1) outpatient occupational therapy;

(2) outpatient physical therapy;

(3) outpatient speech-language pathology and audiology services; and

(4) outpatient respiratory therapy.

(b) Limitations. Coverage for outpatient rehabilitation services is subject to the following limitations:

(1) RESTORATION OF CAPACITY OR MINIMIZATION OF LIMITATIONS. - Such services include only items or services used to restore functional capacity or minimize limitations on physical and cognitive functions as a result of an illness, injury, disorder, or other health condition.

(2) MAINTENANCE OR PREVENTION PROGRAM. - Services described in paragraph (1) include the following outpatient rehabilitation services designed to maintain functioning or prevent or minimize deterioration:

(a) The initial evaluation and periodic oversight of the patient's needs by a qualified rehabilitation health professional;

(b) the designing by the qualified rehabilitation health professional of a maintenance or prevention program that is appropriate to the capacity and tolerance of the patient and the treatment objectives;

(c) the instruction of the patient, family members, or support personnel in carrying out the program; and

(d) reevaluations.

(3) REEVALUATION --

(a) At the end of each 60-day period of outpatient rehabilitation services (other than services described in paragraph (2)), the need for continued services shall be reevaluated by the person who is primarily responsible for providing the services. Additional periods of services are covered only if such person determines that the requirement in paragraph (1) is satisfied.

I don't think that this is meant to be deleted. In other words, (a) and (b)(1) do not change. Only (b)(2) changes.

(b) Periodically, outpatient rehabilitation services described in paragraph (2) shall be reevaluated by a qualified rehabilitation health professional.

RATIONALE FOR ADDITIONS TO AMENDMENT:

1. SPEECH PATHOLOGY -- This bill limits coverage to "outpatient speech pathology services for the purpose of attaining or restoring speech" This description does not reflect the breadth of need or current coverage. Speech-language pathologists work with individuals who have either language or swallowing disorders and Medicare, Medicaid, and private health plans cover these services. Audiology services are important for individuals with hearing loss and are covered by most private health insurance plans. Diagnostic audiology is covered by Medicare.

2. RESPIRATORY THERAPY -- This language is consistent with existing Medicare and private insurance coverage, and was intended to be included in the Health Security Act. Outpatient respiratory therapy is an accepted, cost-effective modality for the treatment of individuals with compromised cardiopulmonary systems.

3. MAINTENANCE OR PREVENTION PROGRAM -- This language is needed to clarify the intent of the section. This language is based on Medicare policies, and is consistent with statements made by the Administration that the bill language is intended to include training individuals, their families, and others to continue working to maintain function and prevent deterioration.

Under Medicare policy, "maintenance programs" are covered. The premise of the policy under Medicare is that repetitive services required to maintain functioning or prevent or minimize deterioration do not necessarily involve complex and sophisticated therapy procedures and consequently provision by a qualified health care professional are not always required for safety and effectiveness. However, Medicare also recognizes that the specialized knowledge and judgment of a qualified rehabilitation health professional may be required to establish, monitor, and oversee a maintenance program.

The proposal includes the term "rehabilitation health professional" in lieu of "therapist". This change is consistent with the definition of "health professional" set out in section 1582 of the Health Security Act.

2. SPECIALIST AS GATEKEEPER -- Amendment to Section 1402 (See B of March 24 memo)

a. Define what "disability" would qualify for access to a specialist as their primary care physician for the purposes of a

Ed & Labor
Senate Labor

SEC. 1124. DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, ORTHOTICS, AND **PROSTHETICS**.

(a) COVERAGE.- The items and services described in this section are-

(1) durable medical equipment;

(2) prosthetic devices (other than dental devices) which replace all or part of the function of an internal body organ (**including devices that are surgically inserted, devices that are physically attached to the body,** such as colostomy bags and supplies directly related to colostomy care, and **external devices;**
or external body parts

(3) **orthotics** (leg, arm, back and neck braces) and **prosthetics** (artificial legs, arms, ~~and~~ eyes); and
including and breasts

(4) (A) accessories and supplies ~~which~~ are used directly with **equipment or devices described in paragraphs** (1)-(3) to achieve the therapeutic benefits of such equipment or devices or to assure the proper functioning of such equipment or devices,

(B) replacements of such equipment or devices **when required in cases of loss, irreparable damage, wear, or because of a change in the patient's condition,** and

(C) repair and maintenance of such equipment and devices;

(5) fitting (**including adjustments**) and training for use of the items described in paragraphs (1) through (4).

(b) LIMITATION.-An item or service described in this section is covered only if it improves functional ability or prevents or **minimizes** deterioration in function.

(c) DURABLE MEDICAL EQUIPMENT.- For purposes of this subtitle, the term "durable medical equipment" has the meaning given such term in section 1861(n) of the Social Security Act.

May 2, 1994

MEMO FOR: Jack Lew, Len Nichols, Jennifer Klein
RE: Education and Labor Clarifications
****

The amendment offered by Congressman Owens evidently created substantial confusion. I attempted to clarify the issues with both Paul Seltzman (sp?) and Phyllis Borzi this evening. As far as I can tell, they are now (and even before) working from the same set of numbers.

Amendment 1 offered by Owens

Would eliminate cost sharing for those under 200% of poverty.

We had given staff two ranges; $34 Billion between 1996-2000 assuming all those under 200% of poverty enrolled in an HMO and $87 Billion if all were enrolled in a FFS plan. As I noted, however, if this offer were actually made, there would be no incentive for the near poor to enroll in HMOs; thus the high number is more likely closer to truth.

Owens thought he could raise revenue in the following manner: increase the FFS out of pocket limit from $1500 to $2500. This reduces the FFS premium by 5%. Assuming there is little, if any, movement of individuals into FFS plans (given the now lower premium), this would save about $13 Billion between 1996-2000. At the outside extreme (not likely) is a full 5% reduction which saves $29 Billion over 5 years. If you assume more aggressive migration into the FFS plan, a more realistic outer bound would be $20---so $13 to $20 seems a reasonable range.

In addition, Owens wanted to impose a 3% premium assessment on "unsubsidized" individuals and firms. I have no such numbers, but Seltzman (I believe erroneously) thought Len gave him $25.5 Billion in revenues between 1996 and 2000 (about $8.5 billion/year). I offered the following: there are approximately $1.6 trillion in regional alliance premiums between 96-00 (this is a calendar year calculation); a 3% tax raise approximately $50 Billion in federal revenue--slightly more would be raised if we use the Ed and Labor benefit package. Of this, however, approximately $20 billion would be required to pay for higher federal subsidies (remember, their starting subsidy base is $21 Billion higher than our $396). This leaves net $30. So the package would appear to raise $43-$50 over the five years.

I discussed other options with both Paul and Phyllis as well. In particular, I gave each of them the cost sharing estimates for the HMO plans from my April 20, 1994 memo (i.e. $22 Billion for reducing HMO cost sharing to the cash assistance level for those under 150% of poverty.....). At 150% of poverty, waiving cost sharing in the FFS plan was estimated by Mays at $52 Billion (60% of the 200% of poverty figure. Owens may bring this amendment back---the range of cost would be $22 to $52 Billion--again however the likelihood is that the upper range is the best guess. Paul wanted some language to push the figure closer to $22; we discussed adding language to the effect that cost sharing would be reduced for the near poor if they enrolled in HMOs when available. This raises issues concerning both the capacity and availability of HMOs. I gave no specifics concering any estimate if this language were added.

With respect to Phyllis, I gave her a talley sheet on the deficit---

Starting point	+$70
Added benefits of 2.5%	+$87
State and local amendment	+$100 (guess)
Medicaid wrap for under 22 and 200%	+$113.6

the committee wanted to finance the Medicaid component with a 0.3% premium surcharge--I told them this was not sufficient. Best guess is about 1.3% (this raises about $20 Billion or so, and costs about $10 Billion in subsidies). At issue here is the base we are applying the assessment to--the estimate was completed with the augmented benefits, but prior to the state and local amendment. In any event, they recognize the 0.3% is not enough.

SUBCOMMITTEE ON
HEALTH AND THE
ENVIRONMENT

FAX COVER SHEET

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From the Desk of

Ruth Katz
Anne Lebbon
Karen Nelson

Attention:	Jennifer Klein
Organization:	

Phone:

Fax: 456-2878

Pages Following Cover Sheet: 2

Message:	

F:\HSA\EDLABOR\SUB\AB.003 H.L.C.

[DISCUSSION DRAFT]

AMENDMENT OFFERED BY _____

TO THE AMENDMENT OFFERED BY _____

In the matter proposed to be inserted by the amendment—

(1) after "abortion" insert "that is implemented by"; and

(2) before the period at the end insert "and that applies regardless of the source of payment for an abortion".

[Discussion Draft would amend Klink amendment to read as follows:]

Amendment to Committee Print (H.R. 3600)

Offered by _____

Page 435, after line 2, insert the following (and conform the table of contents of Title I accordingly):

Sec. 1913. Preservation fo State Authority Regarding Abortions

Nothing in this Act shall be construed to preempt any constitutionally permissible regulation of abortion by a State or a subdivision of a State and that applies regardless of the source of payment for the abortion.

F:\HSA\EDLABOR\SUB\AB.001 H.L.C.

AMENDMENT TO COMMITTEE PRINT (H.R. 3600)

OFFERED BY _____

Page 435, after line 2, insert the following (and conform the table of contents of title I accordingly):

SEC. 1913. PRESERVATION OF STATE AUTHORITY REGARDING ABORTIONS.

Nothing in this Act shall be construed to preempt any constitutionally permissible regulation of abortion that is implemented by a State or a subdivision of a State and that does not distinguish [or discriminate] on the basis of the financial or insured status of persons.

Why not?
source of payment/
funding for the service.

→ Unlawful for ~~any~~ health
Ins. to cover abortion
Subject to [§], as
~~any~~

Committee on Education and Labor

WILLIAM D. FORD, CHAIRMAN
U.S. House of Representatives
Washington, DC 20515

(202) 225-4527
FAX - (202) 225-9070

FAX COVER SHEET

DATE: May 2, 94

TO: Jennifer Hyne

FROM: Karen Lacy

NUMBER OF PAGES IN THIS TRANSMISSION: ____ (including cover)

COMMENTS:

There are 4
not 3.
Thanks

PLEASE CALL IF THERE ARE ANY PROBLEMS WITH THIS TRANSMISSION.

AMENDMENT TO COMMITTEE PRINT (H.R. 3600)

OFFERED BY MR. OWENS

Beginning on page 67, strike line 22 through page 68, line 19, and insert the following:

(1) durable medical equipment;

(2) prosthetic devices (other than dental devices) which replace all or part of the function of an internal body organ, including devices that are surgically inserted, devices that are physically attached to the body (such as colostomy bags), and external devices;

(3) leg, arm, back, and neck braces;

(4) artificial legs, arms, and eyes;

(5) accessories and supplies that are used directly with equipment or devices described in paragraphs (1) through (4)—

(A) to achieve the therapeutic benefits of such equipment or devices; or

(B) to assure the proper functioning of such equipment or devices;

(6) replacements of equipment and devices described in paragraphs (1) through (4) when required—

Replace NME 5(a)(p.67) — no cost — Sen. Lang.

Jennifer intro page 65

no cost

(A) in cases of loss, irreparable damage, or wear; or

(B) because of a change in the patient's physical condition;

(7) repair and maintenance of equipment and devices described in paragraphs (1) through (4); and

(8) fitting (including adjustments) and training for use of equipment and devices described in paragraphs (1) through (4).

AMENDMENT TO COMMITTEE PRINT (H.R. 8600)
OFFERED BY MR. OWENS

Page 69, beginning on line 4, strike "Act," and all that follows through line 5 and insert the following:

Act and other items of durable medical equipment relating to bathing, toileting, or lifting (such as bathtub lifts and grab bars) which are essential to the prevention of complications of an existing illness, injury, disorder, or other health condition.

P:\HBA\EDLABOR\SUB\OWENS.004 plb H.L.C.

not in mark

AMENDMENT TO COMMITTEE PRINT (H.R. 3600)

OFFERED BY MR. OWENS

Page 67, line 17, before the period insert "or that limitations on physical or cognitive functions are being minimized".

1-6.5% premium increase

Done Jul...

• Outpatient Rehabilitation:

• Ad. thought was in: ; no cost re: Gary K.

[DISCUSSION DRAFT]

AMENDMENT TO COMMITTEE PRINT (H.R. 3600)

OFFERED BY MR. OWENS

[Suggested language for technical amendment]

At the end of section 1124(c), insert the following:

Such term also includes items of durable medical equipment that do not meet the all of the criteria under such section, if such equipment is functionally equivalent for a specific individual to equipment described in such section.

Changes to the benefits package

women

pap smears, pelvic exams,
& clinical breast exams.....Sec. 1114, pp. 37-40

mammograms.....Sec. 1114, pp. 39, 40

waiver of monetary contribution
for contraceptive drugs & devices
for women below 200% of poverty.....Sec. 1271, p. 174

(also "provider" issue)provision
for direct access to an Ob/Gyn.....Sec. 1405, p. 218

Need estimate

mental health

CBO - At most, 5%

integration of mental health systems.....Sec. 3511, pp. 560-567

organized system of care for children.....Sec. 1115, pp. 55-59

outpatient rehabilitation - Sec. 1123, pp. 66-67

durable medical equipment - Sec. 1124, pp. 67-69

vision & hearing care - Sec. 1125

hearing aids for children under 18.....p. 69

dental care - Sec. 1126

individuals with seizure disorders.....p. 70

transportation services - Sec. 1120

Need estimate

inter-island air transportation.....p. 63

inter-island transportation for companion.....p. 63

Issue: Supremacy clause -

- Have we preempted all state mandates? Insurance laws? Abortion regulations e.g. notification, waiting

LOCATION OF PROVIDER CHANGES

Following is a list of where some of the changes relative to provider issues may be found in the Williams substitute:

OB/GYNs - pg. 218
- lists the primary care services provided by OB/GYNs, and specifies that OB/GYNs are not to be paid specialist rates for these services

need essential community providers - pg. 340
- identifies which providers have been added to the list of those automatically designated

need essential community providers/sunset provision - pg. 231
- extends sunset from 5 to 7 years

risk adjustment - pg.323
- this section details the risk adjustment methodology; this section does not include the provision requiring the plan to pass the extra money along to the provider... I do not know where that is

need specialists as gatekeepers - pg. 218
- requires plans that use gatekeepers to have some specialists as gatekeepers for individuals with disabilities

need Psychologists - pg. 662
- in the rural initiative, Psychologists have been added to the list of underrepresented minority and disadvantaged persons whose training is needed in the medical profession

need non-discrimination rule/non-physician providers - pg. 219
- plans must offer access to sufficient number of non-physician providers within each class of providers

Subcommittee on Labor-Management Relations
Markup of Health Care Reform

Republican Amendments to H.R. 3600 (by subject)

A. *Republican Alternative*

Republican Alternative (Rep Roukema)

B. *Special Populations*

Increase Access to High Quality Health Care in Underserved and Rural Areas (Rep Gunderson)

C. *Mandates & Subsidies*

- **Strike Employer Mandate** (Rep Boehner)
- **Make Individual Purchase of Insurance Voluntary** (Rep Fawell)

D. *Structure*

Alliances/Coops

- **Strike the Premium Caps** (Rep Armey)
- **Eliminate Negotiated Fee Schedules** (Rep Roukema)
- **Preserve Self-Insured Option** (Rep. Gunderson)

AMENDMENT TO COMMITTEE PRINT (H.R. 3600)

OFFERED BY MR. GUNDERSON

(Page & line numbers refer to introduced bill)

Page 613, after line 23 insert the following (and redesignate the succeeding subsection accordingly):

(3) In the proposal the applicant specifies how a full continuum of services will be provided.

(4) In the proposal the applicant specifies how the proposed health plan will utilize existing health care facilities in a manner that avoids unnecessary duplication.

(c) USE OF FUNDS.—

(1) IN GENERAL.—Funds made available under this section may be used for the following:

(A) To develop integrated health networks, utilizing existing local providers and facilities where appropriate, with community involvement.

(B) For information systems, including telecommunications.

(C) For transportation services.

(D) To develop rural emergency access care hospitals (as defined in paragraph (3)).

(2) LIMITATIONS.—Funds made available under this section shall not be used for the following:

(A) For a telecommunications system, unless the system is coordinated with, and does not duplicate, such a system existing in the area.

(B) For paying off existing debt.

(3) RURAL EMERGENCY ACCESS CARE HOSPITALS DESCRIBED.—For purposes of paragraph (1), a rural emergency access care hospital is a facility with the following characteristics:

(A) It is a hospital that is in danger of closing due to low inpatient utilization rates and operating losses.

(B) The closure of the facility would limit the access of individuals residing in the facility's service area to emergency services.

(C) The facility has entered into (or intends to enter into) an agreement with another hospital that will accept the transfer of patients.

(D) A physician is available on-call to provide emergency medical services on a 24-hour-a-day basis.

(E) The facility must have a practitioner who is qualified to provide advanced cardiac life support services (as determined by the State in

which the facility is located) on-site at the facility on a 24-hour-a-day basis.

(F) The facility meets such staffing requirements as would apply under section 1861(e) of the Social Security Act, except that the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open, but must provide emergency care on a 24-hour-a-day basis.

Page 617, line 3, strike "and".

Page 617, line 5, strike the period and insert a semicolon.

Page 617, after line 5, insert the following:

(3) to issue an annual report that assesses the coordination of emergency medical services activities throughout the State;

(4) to develop, periodically review, and revise as appropriate guidelines for emergency medical services, including (for various typical circumstances) recommendations on the number and variety of professionals, equipment, training, and availability of technology (including communications technology); and

(5) to develop recommendations on how the emergency medical services delivery system may be more responsive to the unique needs of underserved rural areas.

Kuykendall - Defeated

Engel/Martinez (2) - Passed - 1 along party lines, 1 unanimously

Gunderson - Passed, unanimously

Owens - (1) Defeated (only Owens voted for it)

- Will eliminate for copays & deductibles for everyone under 200% of ↓ poverty
- 34 - 87 billion
  - ↓ if all in FFS
  - if limited to HMOs

Additional funding of 30% per premium ~~worker~~ of those who are not subsidized

(2) Defeated ~~(same for 150% of poverty)~~ 15-12

Same for 150% of poverty)

$1 prescription

$2 visit or service provided

- 21 - 50 billion depending on whether ~~increased~~ in FFS or HMOs

Yes - Miller, Engel, Becerra, Martinez, Woolsey, Romero-Barcelo, Clay

[#2: Immediate application of 7.9% cap to State and local governments]

AMENDMENT TO COMMITTEE PRINT (H.R. 3600)

OFFERED BY MR. ENGEL AND MR. MARTINEZ

Page 760, amend lines 4 thrtough 13 to read as follows:

(2) EXCLUSION OF FEDERAL GOVERNMENT AND CERTAIN EXPERIENCE-RATED EMPLOYERS.—Paragraph (1) shall not apply to—

(A) the Federal Government before 2002; and

(B) a experience-rated employer which is treated as a community-rated employer under section 6131(a)(2).

Page 761, before line 1, insert the following:

(3) SPECIAL RULE FOR STATE AND LOCAL GOVERNMENTS.—In the case of an employer that is a State government, or unit of local government, or a unit or instrumentality of such government, for years before 2002, the limiting percentage shall be as follows:

(A) For 1996, 1997, or 1998, 8.7 percent.

(B) For 1999, 8.5 percent.

(C) For 2000, 8.3 percent.

(D) For 2001, 8.1 percent.

AMENDMENT TO COMMITTEE PRINT (H.R. 3600) OFFERED BY MR. ENGEL AND MR. MARTINEZ

Page 244, strike lines 1 through 4.

Page 243, after line 17, insert the following:

(D) STATE AND LOCAL GOVERNMENTS.—A State government, a unit of local government, or an agency or instrumentality of State or local government, including any special purpose unit of State or local government, but only with respect to a group health plan that is established or maintained by such government, agency, or instrumentality, and only if such plan—

(i) offered health benefits as of September 1, 1993, and

(ii) as of both September 1, 1993, and January 1, 1996, has more than 5,000 full-time employees in the United States entitled to health benefits under the plan.

Page 245, after line 13, insert the following (and redesignate the succeeding paragraph accordingly):

(4) FULL-TIME EMPLOYEES OF STATE AND LOCAL GOVERNMENT SPONSORS.—Each full-time employee of a member of a State or local government, or agency or instrumentality, which has an election in effect as a large group sponsor (and each

full-time employee of such a government, agency, or instrumentality) is eligible to enroll in an experience-rated plan offered by such sponsor.

Page 246, at the end of line 20, add the following: "The previous sentence shall apply to governmental plans notwithstanding , section 4(b)(1) of the Employee Retirement Income Security Act of 1974.".

Page 247, at the end of line 2 add the following: "Such term does not include a State government, a unit of local government, and an agency or instrumentality of State or local government, including any special purpose unit of State or local government.".

Page 249, line 5, strike "AND RURAL COOPERATIVES" and insert ", RURAL COOPERATIVES, AND STATE AND LOCAL GOVERNMENTS".

Page 249, line 7, strike "or (C)" and insert ", (C), (D)".

'onforming Amendments to subtitle E of title VIII.)

Page 870, after line 16, insert the following:

"(D) STATE AND LOCAL GOVERNMENTS.—A State government, a unit of local government, or an agency or instrumentality of State or local government, including any special purpose unit of State or local government, but only with

respect to a group health plan that is maintained by such government, agency, or instrumentality, and only if such plan—

"(i) offered health benefits as of September 1, 1993, and

"(ii) as of both September 1, 1993, and January 1, 1996, has more than 5,000 full-time employees in the United States entitled to health benefits under the plan.

Page 872, after line 10, insert the following (and redesignate the succeeding paragraph accordingly):

(4) FULL-TIME EMPLOYEES OF STATE AND LOCAL GOVERNMENT SPONSORS.—Each full-time employee of a member of a State or local government, or agency or instrumentality, which has an election in effect as a large group sponsor (and each full-time employee of such a government, agency, or instrumentality) is eligible to enroll in an experience-rated plan offered by such sponsor.

Page 873, at the end of line 16, add the following: "The previous sentence shall apply to governmental plans notwithstanding , section 4(b)(1).".

Page 873, at the end of line 22 add the following: "Such term does not include a State government, a unit of local government, and an agency or instrumentality of

State or local government, including any special purpose unit of State or local government.".

Page 875, line 23, strike "AND RURAL COOPERATIVES" and insert ", RURAL COOPERATIVES, AND STATE AND LOCAL GOVERNMENTS".

Page 875, line 25, strike "or (C)" and insert ", (C), or (D)".